

**A Q-Sort Study: service user and trainee psychologists' perspectives of
recovery in a community-based project.**

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Thesis Abstract

The concept of recovery in mental health has changed over time and reflects our increased understanding of the factors that are important to service users and mental health professionals in defining recovery. This thesis investigates service user and trainee psychologists' perspectives of recovery in a community-based project. The first part of this thesis reviews the literature on the development of our understanding of recovery in mental health. The search strategy that was developed yielded 9 studies that met the inclusion criteria and a further 3 studies were added following a hand-search of relevant literature. Four themes were identified that charted the development of our understanding of recovery: i) Recovery over the past decade; ii) Changing Perceptions of Recovery; iii) The rise of service user involvement; and iv) New ways of providing services. The review identified that there was a move from a medical model towards a recovery based model. The second part of this thesis is a Q-methodological study that investigates service user and trainee psychologists' perceptions of recovery in a community based project. The sample of 23 participants comprised 12 service users and 11 trainee clinical psychologists. Participants sorted 50 statements related to the process of recovery from mental health problems. A Centroid Factor Analysis revealed a 3 Factor Solution. Factor 1 was solely endorsed by trainee clinical psychologists and proposed that understanding and social support is the key to recovery. Factor 2 was solely endorsed by service-users and proposed that attending Growthpoint and medication was the key to recovery. Factor 3 was endorsed by both service-users and trainee psychologists and proposed that attending Growthpoint and personal growth was the key to recovery. A visual representation of the conceptual space is presented through the use of multidimensional scaling. An in depth interpretation of the factors is presented and the implications of the research are discussed. The third part of this thesis is a reflective paper whereby the author uses a narrative approach to compare her experience of recovery from diabetes to the experience of recovery from mental health problems. The author uses Q-Sort methodology to compare factor viewpoints that emerged from the Q-Sort analysis and combines this with the model of Reflective Practice developed by Atkins & Murphy (1994).

Paper 1: Literature Review

The changing perspectives of recovery in mental health:

A literature review

Heather Wood

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Instructions to Authors included in Appendix 1A

Abstract

The concept of recovery in mental health has changed over time and reflects our increased understanding of the factors that are important to service users and mental health professionals in defining recovery. The shift from a perspective of recovery based upon symptom alleviation, to the idea that recovery is a process to facilitate positive personal and social change is an important development. Accordingly, a question that arises from such a paradigm shift relates to how we actually provide mental health services. A literature search was conducted that explored the development of our understanding of recovery in mental health. The search strategy that was developed yielded 9 studies that met the inclusion criteria and a further 3 studies were added following a hand-search of relevant literature. Four broad themes were identified in the literature that charted the development of our understanding of recovery. These were i) Recovery over the past decade; ii) Changing perceptions of recovery; iii) The rise of service user involvement; iv) New ways of providing services. These papers were evaluated and factors that could inform how we provide mental health services were discussed. To what extent is symptom alleviation important to service users? What are people's thoughts or experiences about medication? Do the clinicians who provide mental health services have the same ideas about what is important in recovery as the people who use mental health services? What do community-based projects offer service users that mainstream services do not? The theoretical considerations of the recovery model are discussed and the role of psychology in the development of the recovery model is highlighted along with suggestions for future research.

Introduction

The traditional approach to recovery in people with mental health problems has usually focused on improvements in symptoms and occupational functioning (Silverstein & Bellack, 2008). Symptomatic recovery is often measured using psychometric tools which pertain to the reduction in symptoms in a variety of conditions such as depression, psychosis and anxiety. But while these are important outcomes they may not always reflect the idiosyncratic experience of recovery and factors that people find important as individuals. For example, the emergence of service-user research groups has led to a re-evaluation of the medical model and the idea that the alleviation of symptoms is the primary aim of recovery (Pitt, Kilbride, Nothard, Welford & Morrisson, 2007). Instead it is proposed that other factors including achieving positive personal change and social change may be more important. Pitt et al identify key themes of *“rebuilding self”*, *“rebuilding life”* and *“hope for the future”* as the primary aims of recovery for service users and this reflects the desire of service users to gain an increased understanding of their own problems and to develop an idiosyncratic journey of recovery that reflects the factors that are important to them. Other researchers echo these sentiments and propose that a person experiencing mental health problems does not have to experience a traditional cure where there is a complete cessation of symptoms. It is proposed that a person may continue to experience episodes of symptoms yet have a restored sense of self, purpose and meaning in life (Higgins & McBennett, 2007).

This shift from a perspective of recovery based upon symptom alleviation, to the idea that recovery is a process to facilitate positive personal and social change, is an important development. A question that arises from such a paradigm shift relates to how we actually provide mental health services. Is it possible to provide services within a traditional mental health clinic to facilitate this journey of recovery? Some researchers would suggest that a mental health clinic or ward is not suited for this purpose (Holmes, 2010). It is proposed that the traditional environments in which mental health services are provided are not reflective of how we live our everyday lives. For example Community Mental Health Teams or Psychiatric Hospitals tend not to feel like they are part of the wider community. *“Nothing that happens in here is normal; not one thing occurs like it does in your own home.”* were the reflections of one service user (Holmes, 2010). The idea that recovery is best facilitated in

community settings that reflect how we live our lives is gaining momentum. Some of the pioneering work in this area relates to the concept of Psychology in the Real World. This concept proposes that community-based group work, taking place in real-life settings can help to facilitate change in people with mental health problems. There are many different projects that adopt these principles. For example Walk and Talk groups are run for people who have an interest in walking through the countryside connecting with nature and connecting with other people within their locality. Specific groups such as Thinking about Medication facilitate discussions between people who have experience of taking psychiatric medication and the effect that has had upon them. Other community based projects include Growthpoint, which is based in Stoke-on-Trent and provides a self-facilitated community with a number of different activities. For example, people can work on allotments to grow vegetables, can take part in woodwork classes or can make use of computer facilities within the project. There are regular groups to discuss mental health issues and to allow people to share their experiences. All of these projects are different from the traditional way that mental health services are provided and are indicative of a recovery based approach to providing mental health services. There are some links and commonalities to the therapeutic communities and asylum models of the past that tried to facilitate recovery. However, McDaid (2013) argues that at that time recovery was viewed as a function of the severity of illness, in contrast to the focus on personal growth and development that is characterised by more recent approaches.

Rationale / Aim of the Literature Review

Our understanding of what is important in recovery changes over time and it influences the way in which we provide mental health services. Therefore, it is important that we take time to reflect upon these changes and the many questions that may arise as our perspective changes over time;

To what extent is symptom alleviation important to service users?

What are people's thoughts or experiences about medication?

Do the clinicians who provide mental health services have the same ideas about what is important in recovery as the people who use mental health services?

What do community-based projects offer service users that mainstream services do not?

This review aims to explore the literature to identify common themes that emerge, with a view to answering these questions.

The search strategy for the literature review will be described, including the search string that was developed for electronic searches along with inclusion criteria and exclusion criteria. The papers included in the literature review will then be critically appraised and the themes that emerge in relation to perspectives of recovery will be highlighted. Finally, the findings will be discussed in relation to their clinical implications and recommendations for future research.

Method for Literature Search

A clear and thorough search strategy was adopted for the literature review. This included development of a Boolean String formula that included the main search terms developed for the literature review as well as exclusion terms to limit the number of irrelevant papers. The search string is as follows;

(Recovery OR Symptom Change OR Remission OR Wellbeing OR well-being) AND (Mental Health OR Depress* OR Anxi* OR Psychosis) AND (Service-User OR Service User OR Client OR Patient) AND (Perspective* OR Belief* OR Understand* OR Attit* OR Perception) NOT (Physical diso* OR Stroke* OR Cancer* OR Neoplasm* OR Gynecolo* OR Myocardi* OR cardio* OR Heart* OR Arthriti* OR Pain Management* OR Pain* OR Chronic Fatigue* OR Hip* OR Pulmonary* OR Asthma* OR Bowel* OR Arm Inj* OR Placebo* OR Skin Diso* OR Neuroendo*) NOT (Forensic* OR Hospitali*)

The electronic searches were conducted using EBSCOHost and Web of Knowledge and was limited to English language-based papers published between 2000 and 2013.

The electronic search yielded 79 results and the papers were assessed against the following inclusion / exclusion criteria to derive the final set of papers for the literature review.

Inclusion Criteria

- 1) The paper relates to the process of recovery in mental health problems.
- 2) The paper relates to narratives, reviews, opinions regarding recovery in mental health problems.
- 3) The papers are UK-focused or relevant to the context of UK mental health settings.
- 4) The papers are published between 2000 and 2013
- 5) The papers are published in a peer reviewed journal.

Exclusion Criteria:

- 1) There is no specific reference to recovery in mental health problems.
- 2) The paper relates to recovery in physical health problems.
- 3) The paper is not UK focused or relevant to UK healthcare settings.
- 4) The paper focuses on recovery in children or adolescents.
- 5) The paper is a letter, opinion piece or an abstract.

The full texts of 79 papers were evaluated against the inclusion and exclusion criteria. This returned 9 papers that matched the inclusion criteria. The reference lists of these papers were analysed to identify any other relevant papers and this resulted in a further three papers being identified. Therefore a total of 12 papers were identified for inclusion in the literature review. The literature search flowchart is included in Appendix 1B

These papers were critically appraised using the Critical Appraisal Skills Programme (CASP, 2013) tools. An example summary of a paper evaluated using the CASP tool is included in Appendix 1C. The results of this appraisal and a summary of the research findings are presented in the results section. In addition, themes were identified within the papers that relate to perspectives of recovery in mental health problems and these are highlighted within the narrative.

Results

A total of 12 papers were included in the final literature review.

The 9 papers identified through the search strategy were as follows; (Wood, Price, Morrison & Haddock, 2012; Aston & Coffey, 2012; Kogstad, Ekeland & Hummelvoll, 2011; Owens, Crone, Kilgour & El Ansari, 2010; Heenan, 2006; Holtom, Guest & Marlton, 2008; Higgins & McBennet, 2007; Repper, 2000; Piat, Sabetti & Bloom, 2009)

The 3 papers identified through a hand-search of the reference section were as follows; (Dinniss, Roberts, Hubbard, Hounsell & Webb, 2007; Holmes & Gahan 2006; Pitt, Kilbride, Nothard, Welford & Morrisson, 2007)

The 12 papers identified for the literature review cover a range of perspectives relating to the construct of recovery in mental health settings. The papers reflect the development of the debate over the last decade that has helped to inform our changing understanding of recovery in mental health settings. The papers are presented in four broad categories that reflect the development of that debate;

- i) The Higgins & McBennet (2007) and Piat et al (2009) papers highlight how the concept of recovery has changed over the past decade.
- ii) Repper (2000), Aston & Coffey (2012), and Wood et al (2012) papers show how those changes have influenced the way that staff, services and service-users think about the process of recovery.
- iii) Holtom et al (2008), Dinniss et al (2007), and Pitt et al (2007) identify the rise of service-user involvement in the design and delivery of services.
- iv) Owens et al (2010), Heenan (2006), Holmes & Gahan (2006) and Kogstad et al (2010) illuminate different ways of providing services that have developed as a result of a new understanding of recovery.

The papers are presented in these broad categories rather than in strict chronological order to aid the development of the narrative that has emerged over the past decade in terms of our understanding of the concept of recovery.

Overview of studies

i) Recovery over the past decade

Higgins & McBennet (2007) provided a review of recovery in the mental health context over the past decade. They highlight the idea that recovery from “*severe and persistent mental illness*” is a relatively new concept that only entered the mental health discourse in the 1980s (Deegan, 1988). The dominant discourse at that time was one of “*chronicity*”. This determined that people diagnosed with mental health problems could never reclaim or recover meaningful lives and would suffer from ongoing chronic problems. The definition of recovery at that time related to the traditional idea of a cure or cessation of symptoms. However, Higgins and McBennet contend that the concept of recovery is much wider than a reduction of clinical symptoms and is not represented by a traditional endpoint. As such this analogy with physical health problems is problematic in relation to mental health problems. Whilst this paper provides an interesting introduction to the construct of recovery, it is an opinion piece and not a research paper per se. Therefore its conclusion must be interpreted as opinion only

Early research on the definition of recovery (Anthony, 1993) describes recovery as an individual journey or process. The “*recovery of self*” involves the discovery of personal resources, new meanings and purpose in one's life but may well mean “*living well*” in the presence of mental health problems rather than a complete cessation of those problems. The paper also highlights criticism of the recovery concept. Whitwell (1999) contends that to define recovery in any other way than a return to a healthy state and absence of illness symptoms is without clinical utility. The paper provides a useful synopsis of the development of recovery as a concept. However it lacks methodological rigour and does not highlight the methodology used in the study nor acknowledge the limitations of the study.

The importance of medication in clients' definition of recovery from mental illness is examined by Piat, Sabetti & Bloom (2009). 60 participants completed a semi-structured interview that lasted between 45 and 100 minutes. Standard probe questions were used, none of which specifically mentioned medication. Data analysis identified patterns and commonalities in the data when the patients spoke about medications in their interviews and 42 patients were identified who spoke about

medication at some point in the interview. From these patterns five themes were identified that were important to people in relation to medication and the concept of recovery. 1) Finding medication that works 2) Taking medication in combination with services and support. 3) Recovery means complying with medication. 4) Recovery means having a say about medication. 5) Recovery means living without medication.

The paper acknowledges that mental health services have evolved from an illness / stabilisation model to a recovery based model. However the authors contend that psychiatric medication offers consumers possibilities for stability and self-management of symptoms and as such it is an important decision for clients to make informed decisions in relation to medication. The authors contend their interview questions did not specifically mention medication and therefore the fact that participants' responses often focused on medication highlights that this is still an important aspect of recovery for many people. However it is also highlighted in the study that clients sometimes lack the understanding that recovery from mental health problems implies much more than finding the best medication. This point is also raised by other researchers who contend that in some mental health services there is still an insistence on unconditional adherence to medication as the most important aspect of treatment and as such clients may become trapped in viewing medication as their primary aid to recovery (Ng et al, 2008). However, the paper offers a robust rationale for the role of medication in recovery and highlights the importance that some clients place on medication in aiding recovery. A limitation of the study was that the data was collected within a narrow confine of mental health services in Quebec, Canada. As such, the results of the study may not be fully relevant to mental health services in the United Kingdom.

ii) Changing Perceptions of Recovery

It has long been recognised that the introduction of a recovery focused model requires an adjustment in the working practices of mental health professionals who care for patients with mental health problems. Repper (2000) was an early proposer of such change in the working practices of nurses. She highlights the dual role that nurses often play in the provision of services. Nurses are expected to disseminate medical information regarding diagnosis, causes and prognosis of mental health

problems. They also give information and support to ensure compliance with medication but often nurses are asked to do more than this. They can help service users develop relationships that can foster hope and growth. They can help to develop an understanding of what has happened to people and can be an ally in difficult times. The author asks if these multiple roles and multiple perspectives can work together. Is it possible for nurses to be the provider of a medical perspective of recovery and develop this more holistic approach to care? People who have recovered have expressed that they do not wish to be rushed or fitted into formulaic interventions. Therefore, finding the balance between a nurse's medical skills and sensitivity to a client's needs is of great importance. The author contends that this requires detailed knowledge of community resources and an ability to work with the family and friends of clients in a culturally appropriate and sensitive way. The overall vision is to create environments that enable people to live fulfilling lives. Deegan (1988) contends that "*all of the polemic and technology of psychiatry, psychology, social work and science cannot account for this phenomenon of hope. It is the turning point that must be followed by the willingness to act*".

Repper's (2000) paper was an early proponent of the need for professional practice to change in respect to service user experience of recovery. However, although this paper gives a vision of how nursing practice needs to accommodate a recovery model, it gives little indication of how this can be achieved in practice and that is the major weakness of the paper.

Aston & Coffey (2011) highlight the difficulty of achieving this balance between medical provision and being sensitive to a client's needs in clinical practice. They contend that there are still major differences between what mental health nurses and service users think about the concept of recovery. An analysis of two focus groups (N=5 service users) and (N=6 nurses) found differing perceptions of how mental health services are delivered and the barriers that are seen to hinder the implementation of a recovery philosophy. A thematic analysis of the focus group data led to four central themes emerging; Understandings of recovery, Semantics, Therapeutics, and A Journey.

The understandings of recovery theme related to contrasting views of medical knowledge and knowledge of the concepts of recovery between the nurses and

service users. Within the nursing group recovery was described as returning back to the frame of mind prior to illness. However this definition of recovery may place an extra burden on service-users. It may be perceived that the responsibility for recovery has shifted to the individual and away from services. This suggests that nurses need to be more aware of using such definitions as “*returning to a former state of mind*” as this may lead to service users not being able to consider themselves “*recovered*” under this definition. For example one nurse defined recovery as akin to recovering after surgery and perhaps this model or analogy is not useful.

While the current study has a small sample size, these concerns that are raised may show a difference in understanding of recovery between patient and nurse groups. However participants in both groups did appear to have shared understandings of recovery as being more than a one-off event and saw it as a longer process. A possible limitation of the study is the small sample size (N=11).

Deegan & Drake (2006) contend that patients described how mental health problems had led to other problems such as long-term exclusions, including discrimination, reduced civil rights, lost roles, responsibilities, decision-making and loss of support. The changes described by patients go beyond that of health and include other major losses in areas that affect all aspects of life. As such, recovery as a process must address these issues in addition to health issues. The study also highlighted issues with semantics and the language that is used to describe the process of recovery. Two of the service users found the word “recovery” difficult to associate with mental health. They described how the word was meaningless to them as recovery was not about the word itself but about the support that was available to them. The authors believe this indicates an issue with professionals imbuing a term with specific professional meaning that is often very different to how service users define themselves and their recovery.

Wood et al (2012) carried out a Q-Sort study to determine what factors service-users thought were important in recovery from psychosis. A sample size of N =40 completed the Q-sort and analysis of the data revealed a four factor solution in relation to recovery: 1) Collaborative Support and Understanding. 2) Emotional

change through social and medical support. 3) Regaining functional and occupational goals. 4) Self-focused recovery.

Collaborative Support and Understanding. This factor (N = 8) consisted of people who felt that collaboration and positive engagement was the most important aspect of recovery. A client who endorsed this factor stated *"I viewed my experiences as very negative but when I viewed it as a positive I felt a lot better and recovered a lot quicker and I accepted all the help I could"* People who endorsed this factor tended not to focus on the negative aspects of having a mental health problem. For example statements relating to shame and embarrassment, unpleasant experiences, and how much I dwell in my experiences were not considered important.

Emotional change through social and medical support. This factor (N =10) was endorsed by those who considered emotional stability through support and treatment as a key factor to recovery. The affective impact of having psychosis, i.e. the emotional impact was prioritised over psychotic symptoms themselves. People were concerned about how experiences affected their happiness, levels of depression, and how their experiences affected the relationships. A factor exemplar stated *"I don't have nearly the same amount of the emotion as I did and I am trying to find it....my illness has left me depressed and can be quite frightening when I hit a low ...my parents are my main support when I hit a low"*

This group did not find the psychiatric characteristics of symptoms of psychosis to be important. Nor did they consider alcohol and drug use, living arrangements as a result of experiences, the amount to which voices are inside my head compared to outside my head or how loud my voices are, as being important.

Factor 3: Regaining functional and occupational goals. This factor (n=9) consisted of people who considered functional and occupational goals as being important in recovery. It was important to this group to regain life functioning and to progress with occupational goals in life. For example statements like how my experiences affect the quality and amount of sleep I get, my ability to find work as a result of my experiences, how my experiences affect my relationships with friends and loved ones, my living arrangements as a result of my experiences, my ability to look after myself, were all seen as important. In highlighting his losses one participant stated. *"I feel as though I've gone downhill, I've lost everything, job, house."* In addition, the

group did not find internal cognitive aspects to be important. Statements like how withdrawn I am as a result of my experiences, how empowered I feel over my experiences, how unpleasant my experiences of voices are, how often my experiences happen, were not seen as important.

Factor 4: Self Focused Recovery. This factor (N=5) consisted of people who thought the Self and Feelings of Isolation were important in recovery. This group felt alone and persecuted and let down by services and felt they could only be dependent on themselves for recovery. They endorsed statements related to; my experiences affect my personal freedoms and rights, how withdrawn I am as a result of my experiences, how my experiences affect my memory and concentration, how positive I view my experiences, how much I dwell on my experiences, how much religion/spirituality was involved with my experiences. One service user stated *“I feel people give me no support”*. Statements such as, how helpful I feel psychological therapies are with my experiences, the amount to which my voices are inside my head compared to outside my head, how active I was in seeking help with my experiences, were rated amongst the least important factors.

The four factor solution provides an interesting insight into recovery and the different types of recovery styles. For example, the factor related to emotional change through social and medical support highlights a group for whom the affective impacts of having psychotic experiences such as reducing distress and levels of depression are more important than the actual psychotic symptoms.

The paper also highlights the idiosyncratic nature of recovery. For example, the fourth group do not value external support and solely place importance on internal factors. It was noted that people who loaded onto this factor had more symptom experience and length of symptoms than other groups. This lends support to the idea that enduring psychotic experiences and negative service experiences are an important issue to overcome in recovery. As such, it is important to assess service users' previous relationships with services and to be mindful of the impact this can have on their individual recovery style. The limitations of the study are that the factor solution only explains 36% of the variance with eight people not loading onto any of the factors. Therefore it is acknowledged that only tentative interpretations can be

drawn from the results. It was also acknowledged that the sample size was predominantly from the same ethnic group.

iii) The rise of service user involvement

One of the driving forces behind the emergence of recovery focused care has been the involvement of service users in research related to the design and provision of mental health services. Holtom et al (2008) describe the philosophy of Plymouth Primary Care Trust who were one of the first wave pioneers with the introduction of support time and recovery (STR) workers in its mental health workforce in 2003. The paper acknowledges that many of the STR workers may themselves have experience of using mental health services or caring for people who have had mental health problems and they can draw on this personal knowledge and expertise to support clients. They described the role of STR workers as promoting independent living, providing companionship and friendship within appropriate boundaries, and providing practical support with daily living and helping people to live ordinary lives. One of the key elements of the STR programme is a central role of reflection and understanding and implementing recovery principles in the service. For example, appointing a service user as core facilitator of the reflective practice group is seen as a key step in “*de-expertising*” reflection and putting more value on the experiential perspective of service users. The main limitation of the paper is that it is an audit report that is descriptive of the introduction of an STR programme. As such it is unclear if it has been subject to peer review prior to publication.

Dinniss et al (2007) echo this importance of involving service users in the development and assessment of services. They described the process and development of an assessment tool; Developing Recovery Enhancing Environments Measure (DREEM). This small scale research project aimed to identify the perceived importance of recovery factors in a residential setting. An advisory group was established comprising ward residents and service user group representatives, as well as medical and nursing staff. All decisions were made collaboratively within the group ensuring joint ownership of the project and ensuring that service users and staff could develop an agreed understanding of the factors that are important in recovery. The resultant questionnaire is in seven sections yielding 160 datasets that

includes demographic, quantitative and qualitative measures. The questionnaire was completed by 10 residents and 26 staff and the staff and residents rated 24 components of recovery according to their importance. The staff and residents both endorsed self-identity, meaning in life, and hope as being the most important factors of recovery. This was taken as a positive affirmation that the team and service are to some extent achieving the aim of adopting a recovery-based philosophy that reflects the aims and motivations of the clients.

However there were other aspects that showed significant differences between staff and service user views. These were with respect to sexuality, spirituality, social roles, challenging stigma and a general trend for staff to rate the service effectiveness higher than the residents.

The limitations of this study are that the DREEM tool has not undergone a full psychometric evaluation and therefore its reliability and validity are unknown. Other limitations include the small sample size which means that the results may not be extrapolated to a wider population. However, this project provides a clear and structured model of recovery for staff and service users to use in evaluating their service and it promotes collaborative practice between service users and staff that was valued by all.

Pitt et al (2007) carried out a qualitative, user-led research project to examine the subjective experience of recovery in people with experiences of psychosis. They carried out seven interviews with participants who all had personal experience of psychosis and of using mental health services. The data was analysed using Interpretative Phenomenological Analysis (IPA) and several themes emerged from the data. The 3 key themes that emerged from the data were “*Rebuilding Self*”, “*Rebuilding Life*” and “*Hope for a Better Future*”.

Rebuilding of the self acknowledges that mental distress can often cause a loss of the sense of self and this can be further aggravated by the disempowering experience of mental health services. Therefore, key elements of rebuilding the self included: reconciling the past, acknowledging the effects of psychiatric treatment and making sense of the experience of mental distress. Tools for achieving these aims included sharing experiences or validating experiences, developing a critique of mental health services and seeking to take control of one's own life. In terms of the

Rebuilding Life theme, it is acknowledged that social isolation often accompanies mental distress. Therefore the recovery process involves rebuilding the life through social support and active participation in life. The Hope for a Better Future theme highlights the process of change and desire for change. Factors that are seen as important include personal transformation and change, challenging people's beliefs, and the move from social exclusion to social inclusion. In terms of achieving these aims, service users highlighted that a collaborative approach is required. They requested a wider choice of treatment options with alternatives to the medical model. They highlighted protection from harm by professionals and an end to stigma and discrimination as being important to them.

Another important aspect that emerged from the study suggests that recovery is not necessarily a linear process but consists of turning points and milestones and again this is consistent with other research that highlights recovery as a process. The main strength of the study is the involvement of service-user researchers that produces a meaningful discourse in relation to recovery from psychosis. However, the small sample size undermines the generalisability of the study.

iv) New ways of providing services

Thus far we have examined how the concept of recovery has changed over the past decade and detailed how those changes have influenced the way that staff, services and service-users think about the process of recovery. This was followed by an introduction to the idea of service-user research that has helped to develop an experiential perspective of the factors that are important to service-users in recovery. Finally, Owens et al (2010), Heenan (2006), Holmes and Gahan (2006) and Kogstad et al 2010 illuminate different ways of providing services that have developed as a result of this new understanding of recovery.

Owens et al (2010), developed a qualitative research study investigating the place and promotion of well-being and mental health services. A qualitative case study methodology was adopted and nine participants took part in the study. Five of those were from a service user group and the remainder were mental health professionals. Service users participated in a focus group and the mental health professionals took part in semi-structured interviews. The study used Interpretative Phenomenological

Analysis (IPA) to analyse the data from the focus group and semi-structured interviews. The study highlighted some areas of agreement in terms of defining well-being as a holistic concept. Service users thought of well-being as basically leading a normal life and doing ordinarily everyday things. Factors that affect the well-being of service users were raised and mental health professionals raised concerns on the effect of medication on clients' well-being. Professionals were concerned that medication can have a detrimental effect on weight gain which can lead to problems with service users' physical health. As such mental health professionals working to promote the concept of well-being within services. Service users reported positive experiences of well-being promotion. These included activities such as art therapy, college courses, day trips, exercise and physical activities including gymnasium and swimming. Service users reported that these activities gave them a sense of social inclusion, a sense of purpose and something to look forward to. However some service users felt that there was a lack of profile regarding the promotion of well-being services within the trust. Both service users and mental health professionals thought that this might be as a consequence of financial constraints. One mental health professional stated *"from a management perspective it's expensive. So if someone was anxious, you could give them a tablet that sells for less than one pence and that would help them relax a few hours..... But to say here is a healthcare assistant who can take you for a walk and a Sunday afternoon, you looking at something that costs over £10 an hour"*

The authors acknowledge that the impact of financial constraints and treatments offered to service users is difficult to establish due to a lack of previous research. However the study has strengthened research by obtaining the viewpoints of service users and MHPs on how well-being services should be provided. Another limitation is that the study was centred on one mental health trust and had a small sample size.

Heenan (2006) describes a research project in which art therapy is proposed as an effective way of promoting positive mental health. Previous research (Hillman, 2002) describes the health benefits of participation in a community choir whereby participants perceived statistically significant improvements to the general quality-of-life and emotional well-being. In Heenan's study, 20 in-depth interviews were undertaken in an art therapy group in Northern Ireland. The data was analysed using

thematic analysis and three broad themes emerged; Self-Esteem, A Safe Space and Empowerment.

The idea of art therapy has traditionally focused on the psychotherapeutic form of art therapy that is associated with Freudian analysis and verbal psychotherapy (Naumberg, 1966). However more recent approaches have proposed that engagement in the creative process *per se* is thought to have therapeutic value. This is reflected in the current findings where participants report they had low levels of self-confidence and self-worth but the art therapy programme provided a creative outlet to promote self-esteem and confidence. *“I was overwhelmed with feelings of worthlessness. I just had no belief in myself. This has given me a new lease of life. I am not particularly good at it but I am not tortured anymore by these feelings. I am more confident and less anxious.”*

Another thing to emerge from the interviews was that the art therapy course was seen to provide a safe space. The project was described as a haven as it was not part of the statutory mental health service provision. Participants described how statutory services were sometimes viewed with suspicion and mistrust and people feared being labelled in official records. As such this community-based initiative provided a safe haven to discuss mental health issues and foster a sense of hope amid the people who attended classes. People described the art classes as cathartic and provided a release for stress and anxiety.

Clients also described the art classes as being empowering. Meeting new people and interacting in a safe environment developed an increased sense of freedom. There was an agreement within the group that being treated as an individual rather than a patient or someone to be pitied was in itself empowering. The atmosphere within the group was described as being encouraging and aimed at developing independence and the focus was on what could be achieved rather than the limitations. The client group claims that this was in contrast to statutory services where the focus was on taking medication in order to *“get better”*. However service users criticised the lack of availability of such schemes and their limited opportunity to take part. They described how when the course ended they were largely left on their own or were transferred back to traditional forms of medication and intervention. Heenan contends that that the lack of accessible community-based services is an

important barrier to recovery and calls for the potential benefits of these services to be acknowledged by those in a position of power to commission mental health services. However, the paper fails to note its own limitations and it focuses purely on the provision of art therapy rather than engaging in any comparison with other forms of service provision.

Holmes & Gahan (2006) propose the concept of Psychology in the Real World: Understanding Yourself and Others as an innovative course to tackle social exclusion and stigma in mental health. The course takes place over 12 weekly sessions of two hours and participants sign up for the course in the same way they would for any other arts or education course. There are no selection criteria and it is advertised as suitable for all. During the first meeting participants select from a suggested menu of topics that they may be interested in exploring over the duration of the course. This diverse menu includes topics such as why are we so afraid of mental illness? Why are people violent? What is the point of being alive? What is that like to be listened to? The role of medication? The programme is said to be different from traditional psycho-education programmes in that the opportunity to reflect upon these questions is more interested in the wisdom of the groups rather than the wisdom of experts. Although the course utilises different teaching strategies, from lecture, to group discussion, to experiential investigation, the over-riding principal is to encourage participants to generate and formulate their own ideas and theories in response to such questions. To this extent the facilitator is not an educator but a creator of an environment in which this development can take place. A participant reported *“I thought I would be told all the answers but this is much more liberating”*.

The authors conducted an audit project to evaluate the efficacy of the course. 40 people who had attended were sent a detailed questionnaire asking them about their thoughts on the course and 23 questionnaires were returned. The questionnaire included 15 questions with an invitation to comment on each. In addition, a blank page invited participants to make general comments about the course. The results indicated that the programme had a number of positive effects including reducing stigma and loneliness and increasing social inclusion. In addition an analysis of general comments related to the study made reference to the facilitation style encompassed by the programme. This referenced the honesty, clarity, and sympathetic response that appeared helpful in creating a therapeutic environment.

Participants welcomed the trust and honesty in the group, endorsed the non-threatening environment and people felt validated that their point of view was accepted by others in the group. One participant described his experience;

“the course made an important contribution to enabling me to get out of the rut I was in and to move on with my life by leaving a long-term unhappy marriage, and enabling me to accept and value myself and to sense the care and support of others in the group”.

The authors contend that at times the course can feel like a therapy group and many of the therapeutic factors and group psychotherapy identified by Yalom (1995) appear to occur in the group setting. For example the concept of universality (The feeling that other people have similar experiences) runs through the topics and group learning experiences. Some group members who are embedded in psychiatric services hear the experiences of people who have also struggled but do not have contact with services, and this can bring about hope, imitative behaviour and interpersonal learning. This process allows people to critically reflect on their experiences in the world and this understanding of the roots of people's distressing behaviour is deemed as helpful by the majority of participants on the Psychology in the Real World courses.

To obtain a better understanding of clients' experiences of recovery, Kogstad et al (2010), analysed 347 client narratives that answered the question *“Would you like to tell a story from a special meeting with a helper or health service system that constituted a turning point in your life”*. The research question aimed to improve the understanding of the recovery process from the perspective of the person engaging professional help. The data were analysed by means of a qualitative content analysis and four main categories emerged from the data. Help to live with a disability, Rediscovering oneself, Getting through crises and Achieving a new orientation. These constructs echo earlier papers that propose the discourse of recovery as a process of achieving positive personal and social change. However, the authors propose an added dimension at a philosophical level related to the concept of recovery. They propose an existential dimension to the human condition that states that human beings are free to make their own choices and to take the responsibility for those choices. Approaching human beings from this perspective implies a focus

on freedom, dignity and meaning and acknowledges the importance of individuality as well as our relationships with other people. In this tradition Yalom (1980) in his therapeutic practice, has focused on the importance of confronting oneself with existential challenges. Such challenges can be in relation to isolation, loss and death, experiencing a lack of meaning. The question in relation to recovery is how can we promote recovery by focusing on these existential dilemmas? Kogstad contends that if people who are troubled by mental illness are supported, understood and respected in the right way then an existential sense of meaning can be engendered that provides people with the creative power to define one's own experiences in a meaningful way. Onken et al (2007) describe this dignity and the right to define one's own experiences as the primary mechanism in recovery.

However, Kogstad warns that this shift in emphasis to clinical practice based on communicative, existential and humanistic may not be easy. Whilst the paper offers an interesting perspective of the issues relating to the existential perspective of recovery, it offers little in the way of practical or clinical advice as to how this can be achieved in practice. It is advised that this humanistic approach is under attack by an evidence based movement which aims to develop standardised interventions for standardised diagnostic categories. It appears that over a decade after the development of recovery based principles there is still work to be done in advocating the right of individuals to be at the focus of their own recovery.

Discussion

In setting out the rationale for this literature review, a number of questions were set that were related to the concept of recovery in mental health. The narrative review of the literature has identified many of the key themes that are relevant to answering these questions and a summary of the key points are discussed below;

i) To what extent is symptom alleviation important to service users?

Higgins & McBennet (2007) highlighted that the early discourse in recovery from mental health problems focussed on the area of cessation of symptoms. But to what extent is that still true? An alternative viewpoint was the idea that cessation of symptoms may not be end point of recovery but rather that “*living well*” in the presence of mental health problems may be a more realistic goal (Anthony, 1993).

However, Deegan & Drake (2006) described how mental health problems can impact on other areas of life and can lead to other issues such as discrimination, reduced civil rights, loss of support and a reduction of responsibilities. Thinking about the political climate in 2015, one can understand the point that they make. In the current political climate changes to the welfare system may disproportionately affect people with mental health problems. For example changes to disability living allowance and the “bedroom tax” may affect people with mental health problems. These kinds of issues need to be considered in the context of recovery from mental health problems.

Other studies have emphasised the importance of regaining functional and occupational goals (Wood et al, 2012). Factors relating to finding work and the ability to look after oneself were seen as important as and more relevant than symptomatic recovery. This theme continues and a service user led project highlighted that the recovery process involves *rebuilding the life* through social support and active participation in life (Pitt et al, 2007). This study developed a critique of mental health services and emphasised the importance of taking control of one's own life. The quest to a wider choice of treatment options with alternatives to the medical model. The study also highlighted that sometimes mental health professionals can be harmful to the clients who they wish to help. As such, a collaborative approach to treatment is proposed.

Owens (2012) proposed that leading a normal life and doing normal things are the key to recovery. They highlighted the importance of activities such as art therapy, college courses, day trips, and physical activities as being the sorts of activities that gave them a sense of social inclusion and a sense of purpose.

Finally, Kogstad et al (2010) presents a philosophical argument that recovery in mental health has an extra dimension that mirrors the universal concepts that we share as human beings. He refers to the existential dimension of the human condition whereby as human beings we are free to make our own decisions and take responsibility for those decisions. Treating people respectfully in this way provides them with the creative power to define their own experiences and what they mean.

From this review it can be seen that alleviation of symptoms is only one aspect of recovery in mental health. Service-users place more emphasis on a holistic view of recovery. Regaining social and occupational functioning are valued. The wider impact of mental health problems in society are highlighted as being problematic. The idea of a collaborative approach to services and being involved in decisions about treatment options are seen as important. Leading a normal life and taking part in social activities are also seen as more important than symptomatic recovery.

ii) What are people's thoughts or experiences about medication?

There is some support for the viewpoint that medication plays an important role in recovery in mental health problems. Piat et al (2009) found that two thirds of participants had spoken about medication being involved in their recovery. They identified some key themes in relation to medication; Finding medication that works, taking medication in combination with services and support, recovery means complying with medication, recovery means having a say about medication and recovery means living without medication. Piat contends that medication offers possibilities for stability and self-management of mental health problems. However the others warn against the idea of clients being trapped by viewing medication as their only option (Ng et al, 2008)

Other studies offer a different perspective of medication (Wood et al, 2012). One cohort from their study suggested that medication played a role in providing

emotional stability. For those participants who were distressed by psychotic symptoms taking medication reduced the distress rather than the symptoms per se. This echoes the views Piat, and perhaps this role for medication needs further exploration. This suggests a roll of medication in stabilising symptoms in clients as a platform to engage in further exploration of mental health problems.

However, the role of medication was not universally endorsed. Owens et al (2010) suggest that medication can be responsible for other problems. For example, weight gain can affect people's self-esteem and confidence. There can also be long-term issues in taking psychotropic medication, such as extrapyramidal side-effects.

Other cohorts in the Wood et al (2012) study rejected the benefits of medication. They highlighted the benefits of collaborative support and understanding as being the most important factors in recovery.

Others encourage a frank and open discussion about the pros and cons of taking medication (Holmes & Gahan, 2006). By encouraging people to talk about their own experiences in these discussions, then the value of the experiences of the group is seen as more important than professional opinion.

The literature review reveals a multitude of opinions on the role of medication. However, it appears that there are few people who view medication as the only or sole answer to mental health issues, and there are few who completely reject the role of medication either. Therefore, medication is still seen as having a role in the process of recovery, but the views of the individual must be taken into account and a collaborative approach to decisions about medication are reported as being important.

iii) Do the clinicians who provide mental health services have the same ideas about what is important in recovery as the people who use mental health services?

It is recognised in the literature that the introduction of a recovery focused model requires an adjustment in the working practices of mental health professionals (Repper, 2000). As such mental health professionals need to offer a holistic view of recovery that not only encompasses the role of medication but much more besides.

There needs to be an increased sensitivity to clients' needs including providing services in a culturally appropriate manner (Deegan 1988). But has this been achieved in reality?

Aston & Coffey (2011) question if staff and service users have similar views on recovery. Within the nursing group recovery was described as returning back to the frame of mind prior to illness. However, such a definition is seen as problematic for service-users who may never be able to achieve such a complete cessation of symptoms and therefore could never think of themselves as "cured".

Other studies suggest that working collaboratively may help alleviate such problems. The use of service-users in the design and implementation of services can lead to a shared perspective and a process of "*de-expertising*" opinions expressed by professionals. And this can bring about a more structured focus on the experiential perspective of service users (Diniss et al 2007).

Holmes & Gahan (2006) suggest that working collaboratively with people and allowing them to co-facilitate groups encourages participants to generate and formulate their own ideas about mental health. This can create an environment where service-users feel their viewpoint is validated and accepted by others in the group.

These points highlight a mechanism for ensuring that mental health professionals and service users understand each other's perspectives. Service-user involvement in the design and implementation of services should be encouraged to provide services that are sensitive to the needs of clients and address the issues they see as important.

4) What do community-based projects offer service users that mainstream services do not?

Owens et al (2010) reported that service-users had positive experiences of using community based projects. Access to art therapy, college courses, day trips and physical activities were all highly valued. The study highlighted the holistic concept of recovery, rather than focusing on any one aspect of recovery. Participants reported that they valued living a normal life and doing normal things. However, the authors

discussed the financial constraints in providing such services and noted that access may be limited. From a management perspective, providing a tablet is far cheaper than facilitating community based activities.

There is some evidence that engagement in creative processes such as art therapy can have a therapeutic value and promote self-esteem and confidence (Naumberg 1996). It is proposed that such projects can provide a safe space and can differ from mainstream services whereby people may fear being labelled or judged and view services with a sense of mistrust. Therefore, creating a safe environment may be one important advantage of community based projects.

Another factor may relate to providing services in a way that is meaningful to people and has some form of ecological validity. This is the perspective adopted by the “*Psychology in the Real World*” approach, (Holmes, 2010) where group based work in community setting provides an alternative to mainstream services. There is an intuitive appeal to such an approach as people do not live their lives within the confines of a clinic room where mainstream services are based. Therefore, perhaps we need to consider the benefits of community based interventions as being better placed to meet service-users’ needs. The theoretical considerations that support the use of such community interventions are considered next.

Theoretical Considerations

This review has explored how perspectives of recovery have moved away from the dominant medical model towards a recovery focused model. One of the key themes that has emerged from the recovery movement is the importance of social and personal concepts of recovery (Pitt et al, 2007). Accordingly, this raises the question of why this is important. What is it about the recovery model that facilitates the process of change? What are the theoretical considerations that underpin the model of recovery?

Allen et al (2015) address these questions in relation to the Psychology in the Real World approach that informs their work in recovery from mental health problems. They advise that their approach is influenced by the work and ideas of Smail (2006). He proposes that distress is not as a consequence of inner flaws or weaknesses that

are located within an individual. In contrast, distress can be as a result of social and material circumstances that the individual cannot control and has no power to influence in his everyday life. These circumstances may be many and complex and can include social hierarchies such as class, gender, sexuality and disability amongst others. There are also individual influences such as trauma, abuse, neglect or social isolation. He suggests that the influence of these issues can lead to inequality and social isolation over which the individual can have little control or power. The idea that distress arises from “outside inwards” as a result of social and material influences is a key idea that has influenced the recovery model. Allen et al (2015) advise that this has informed their approach and they encourage people to develop “outsight” rather than “insight”. That is to have a better understanding of how social structures and norms impact on their lives rather than focus on the idea that distress emanates from within. Smail (2006) argues that the imbalance of social power is an influence on distress and we should consider the pathology, not of people, but of the world in which they live.

Allen et al (2015) highlight that these approaches aren’t always reflected in the way we provide mental health services. The dominant medical model in services still relies on medication as a proposed “cure” or alleviation of distress. Smail (2006) also points out that most approaches to therapy emphasise the need for the individual to change, rather than acknowledge that distress is caused by external factors. This causes a problem for mental health services. Smail (2006) proposes that if distress is caused by societal and material factors, then distress is not an illness. It is not caused by bad genes, faulty cognitions or an oedipal complex. Therefore, distress cannot be cured by pharmaceutical intervention as per the medical model that dominates in mental health services. Likewise, Smail questions the utility of psychological therapy in treating distress if it is concerned with developing change in the individual. He proposes that successful psychological therapy is not necessarily about the technique involved in therapy models. It is suggested that in the therapy literature that non-specific factors such as therapeutic alliance are the strongest predictor of a good outcome (Allen et al, 2015). This view is also endorsed by other researchers in the recovery community (Repper & Perkins, 2003) who propose that recovery is not linked to a particular theory or model of mental health. As such, the theoretical considerations that underpin the recovery model challenge both the

medical model and mainstream therapeutic models. Smail goes further when challenging the utility of psychological therapy;

“However much it may be valued by both patients and therapists the environment of the consulting room is not the environment in which they live out their lives and for patients in particular the influence of therapy is of minute significance in contrast with all the other people and things in their lives. Any adequate account of psychological distress, what causes it and what might alleviate it, must surely include the totality of our lives”

Allen et al (2015) propose that these shortcomings in mainstream therapy are a rationale for providing more community based services along the lines of the Walk and Talk group that they run in Shrewsbury. They discuss the advantages of their approach in terms of tackling social isolation, offering a space for people to talk more widely about influences in their lives and acknowledging that willpower alone cannot change their situation or alleviate distress.

To help facilitate the development of more community based, recovery focused services Repper & Perkins (2003) developed a framework for a recovery model which they used to highlight the important factors to include in the design and implementation of recovery focused mental health services. The Social Inclusion and Recovery Model helps to organise and synthesise the ideas about recovery that have been developed over the past decade. In doing so they highlight the factors that are important in the concept of social and personal recovery. Indeed, all of the concepts they highlight echo the themes that have been highlighted in this review.

1. Everyone’s recovery is different and deeply personal. There are no rules of recovery, or formula for ‘success’. Wood et al (2012) talk of the idiosyncratic nature of recovery.
2. Recovery does not refer to an end-product or a result. It is not an outcome but a continuing journey. Higgins & McBennet (2007) make the same point.
3. Recovery is not the same as cure. Repper (2000) made the same point in her paper that acted as a catalyst for the recovery debate.

4. Recovery is not a linear process. Wood et al (2012) highlight this point.

5. Recovery is not specific to people with mental health problems.

The Psychology in the Real World Approach (Holmes, 2010) emphasises the normalisation of experiences.

6. Recovery is about taking back control over one's life.

This was a key finding of Pitt et al (2007).

7. Recovery is about growth.

The concept of Rebuilding the Self was another finding of Pitt et al (2007).

8. Relapse is not failure, but part of a recovery process.

A common theme was the idea of recovery as a journey.

9. A recovery vision is not limited to a particular theory about the nature and causes of mental health problems. Smail (2006) makes a similar point about the utility of the medical model and psychotherapy.

10. Recovery can, and does, occur without professional interventions.

Heenan (2006) and Pitt et al (2007) made similar points in relation to having a safe haven free from professionals.

The theoretical considerations of the recovery model offers a challenge to the way that we provide mental health services. Accordingly, what role can Psychology play in the development of the recovery model?

The Role of Psychology

This review highlights that the recovery model offers a counter balance to the medical model that has been dominant in the provision of mental health services in this country. But what role is there for psychology in helping to develop the recovery model? Indeed, there may be a role for psychology at a societal level, a service

provision level and at an individual level in helping to shape and deliver the future of the recovery model.

At a societal level, it has been highlighted that social and material factors are thought to contribute to distress in individuals who have little power or influence on their environment (Smail, 2006). At this macro level, we are seeing the impact of such distress on a daily basis. The scathing cuts to benefits and social welfare budgets under the current government are having a terrible impact on peoples' lives. It is estimated that 80 people per month are dying after "fit to work" assessments (Ryan, 2015). This is an untenable situation and as a profession and society we need to be doing more to address these issues. At the same time there is an acknowledgement that mental health services in this country are facing a funding deficit. There is a continuing call that Mental Health should be given parity of esteem with physical health within the NHS. It is estimated that only a quarter of those suffering from depression are in treatment (NHS England, 2015). Such disparity in society and the disproportionate effects on our poorest communities highlights the need for provision of additional mental health services to meet this demand. It also highlights that as a profession, psychology may not be doing enough to highlight the impact of social and political decisions on the most vulnerable members of our society. Do we need to be more vocal in our criticisms of politicians and those who make these decisions? Such questions are possibly outside the remit of this review but they warrant further discussion in terms of how our profession reacts to unjust and harmful policies that have such negative impacts on people's lives and mental health.

Psychology may have an important role in the development of recovery focused services. McDaid (2012) proposes that service-users and professionals need to be involved in the design of recovery focused services in a spirit of co-production. Key to this is the element of choice as to where and how services are provided and what treatments are on offer. This idea of co-production helps to redress the traditional power imbalance that has existed between client and professional within services. McDaid describes this situation as professionals being "on tap" and not "on top" within a service. McDaid raises another important point when she discussed the need for professionals to really listen to the experiences of people. Professionals need to understand the experiential perspective of people in relation to their personal understanding, aspirations, goals and knowledge about their journey of recovery.

Given that recovery focused services may not rely upon a specific therapy modality or technique (Repper & Perkins, 2013) then a shared understanding of recovery is a key aspect of the recovery model.

Although the recovery model does not ally itself to any particular therapeutic modality, there may be scope for some therapeutic models to work in alliance with the recovery model. For example, Acceptance and Commitment Therapy (ACT) and Positive Psychotherapy (PPT) may be two such models where psychology can be embedded within the recovery model and this is particularly relevant given their focus on quality of life rather than symptom alleviation.

Although it is based upon a behavioural model, Acceptance and Commitment Therapy has an emphasis on acceptance of one's thoughts, feelings and reality rather than trying to change them (Hayes, 2004). In this respect it fits in with the underlying ethos of the recovery model in that it doesn't place the cause of distress within the individual. The emphasis on defining personal values and the behavioural activation aspects of the model would also complement the recovery model. Rediscovering the Self and Personal Growth are recurring themes in the recovery literature and this could complement the exploration of personal values that is a key element in the ACT model. There could be scope within a recovery based service to run groups or offer one to one sessions using the ACT model.

Similarly, Positive Psychotherapy tackles depression by a process of engaging positive emotions and meanings rather than directly targeting depressive symptoms (Seligman, Rashid & Parks, 2006). The authors contend that the focus on building positive emotions, character strength and meaning for a person will offer resilience and may counteract any negative feelings a person may be experiencing. The model also has the advantage that it can be delivered via group sessions, one to one sessions and online sessions. As such it offers a flexible way of providing support to vulnerable people using different modalities and potentially different locations offered by the online programme.

However, the integration of psychology into recovery based services is not without potential pitfalls. A recurring theme in the literature review related to the negative experiences that people have had with mental health services. Deegan (2006) found that clients were suspicious of the language used by professionals and found it

difficult to relate to their experience. Pitt et al (2007) reported the disempowering experience of mental health services and Heenan (2006) reports that people valued a community art project as it was a haven away from statutory services. As such, people are suspicious about the value of formal psychological interventions in recovery focused projects. Therefore it is important that psychologists are aware of these issues and that any potential interventions are planned in conjunction with service users. Equally important is that psychologists respect and understand the experiential perspective of people and families who have struggled with mental health issues and the societal pressure that underpins those struggles. (McDaid, 2012)

This review has focused on the development of the debate around the recovery model that has occurred over the past decade. It has highlighted the move away from the medical model towards a recovery focused model of mental health. In this respect, the debate has been won. There is a clear groundswell of opinion from service users and mental health professionals that ensures that the provision of mental health services will continue to change in the coming years. However, still the spectre of the medical model is dominant in mental health services. Provision of psychological services and recovery-focused services are still the exception rather than the rule. For a person with a mental health issue, the first line treatment is still likely to be pharmacological rather than psychological. Perhaps the next phase of debate in mental health should relate to parity of esteem for psychological approaches in comparison to pharmacological approaches? An integration of recovery focused services with psychology could be a powerful combination. The idea of collaborative working and co-production of services is still a relatively new concept. As such, more needs to be done to integrate the recovery model into the mainstream and to educate mental health professionals to have a better understanding of the experiential perspective of the clients with whom they work. This should be the focus for the next development of the recovery model.

Limitations of the Literature Review

This literature review does not purport to be a full systematic review of the research on recovery in mental health. Therefore the extent and scope of the review is limited by the strict inclusion and exclusion criteria to generate papers for inclusion in this report. In addition, the review was undertaken by a single researcher who adopts a subjectivist epistemology. Therefore, although objectivity remains a goal to which the researcher aspires, it is acknowledged that we cannot separate ourselves from what we know and what we bring to the research process.

Future Research

The author proposes to utilise a Q sort methodology to examine service user perspectives of recovery in a community mental health setting. The Growthpoint project is a community-based project funded by North Staffordshire Combined Healthcare NHS Trust. The project provides a social space where service users can engage in a number of activities including gardening, carpentry, metalwork, art therapy, flower arranging, educational activities as well as a social space for meeting friends and having a cup of tea. The majority of the service users at Growthpoint have gone through the traditional treatment path of mental health services including psychiatric evaluation, use of medication, psychological evaluation, therapy and CBT. However, many of the service users at Growthpoint report that this non-traditional setting has been of great benefit in the recovery process. The current study aims to evaluate which factors have been beneficial in the recovery process for the service users at Growthpoint. The study also aims to evaluate which factors a cohort of trainee clinical psychologist think are important in the recovery process using the same Q-sort methodology. McDaid (2013) has highlighted the need for professionals to have a greater understanding of the experiential perspective that people have in relation to mental health services. Other researchers argue that the recovery model offers challenges to therapeutic interventions as it suggests that distress is not all illness that resides in the individual but occurs as a result of societal pressures (Smail, 2006; Allen et al 2015). The consequence of this is that it is more important for a professional to understand the experiential perspective of clients rather than adherence to a psychological model (Repper & Perkins, 2013). As such

there is a strong rationale for including trainee clinical psychologists in the current study. Being valued, understood and listened to is a key aspect of the recovery model (McDaid, 2013). Therefore evaluating the similarities and differences between service-user and trainees' views on recovery is a valid and important piece of research.

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Paper 2: Empirical Paper

A Q-Sort Study: service user and trainee psychologists' perspectives of recovery in a community-based project.

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Instructions to Authors included in Appendix 2A

Abstract

Concepts of recovery from mental health problems have developed over the past decade and we have seen a shift from models based on symptom based recovery towards models that emphasise positive personal change and the idiosyncratic nature of recovery. The current study aims to explore perceptions of recovery in a community mental health project, Growthpoint, which is a gardening project based in Stoke-on-Trent. A Q Methodology was adopted and 23 participants comprising of 12 service users and 11 trainee clinical psychologist completed a Q – Sort task. A Centroid Factor Analysis revealed a 3 Factor Solution. Factor 1 was solely endorsed by trainee clinical psychologists and proposed that understanding and social support are the key to recovery. Factor 2 was solely endorsed by service-users and proposed that attending Growthpoint and medication were the key to recovery. Factor 3 was endorsed by both service-users and trainee psychologists and proposed that attending Growthpoint and personal growth were the key to recovery. A visual representation of the conceptual space is presented through the use of multidimensional scaling. An in depth interpretation of the factors is presented and the implications of the research are discussed.

Introduction

The traditional approach to recovery in people with mental health problems has usually focused on improvements in symptoms and occupational functioning (Silverstein & Bellack, 2008). Symptomatic recovery is often measured using psychometric tools which pertain to the reduction in symptoms in a variety of conditions such as depression, psychosis and anxiety. While these are important outcomes they may not always reflect the idiosyncratic experience of recovery and factors that people find important as individuals. For example, the emergence of service-user research groups has led to a re-evaluation of the medical model and the idea that the alleviation of symptoms is the primary aim of recovery (Pitt, Kilbride, Nothard, Welford & Morrisson, 2007). Instead it is proposed that other factors including achieving positive personal change and social change may be more important. Pitt et al identify key themes of “rebuilding self”, “rebuilding life” and “hope for the future” as the primary aims of recovery for service users and this reflects the

desire of service users to gain an increased understanding of their own problems and to develop an idiosyncratic journey of recovery that reflects the factors that are important to them. Other researchers echo these sentiments and propose that a person experiencing mental health problems does not have to experience a traditional “cure” where there is a complete cessation of symptoms. It is proposed that a person may continue to experience episodes of symptoms yet have a restored sense of self, purpose and meaning in life (Higgins & McBennett, 2007).

This shift in emphasis from a perspective of recovery based upon symptom alleviation, to the idea that recovery is a process to facilitate positive personal and social change, is an important development. A question that arises from such a paradigm shift relates to how we actually provide mental health services. Is it possible to provide services within a traditional mental health clinic to facilitate this journey of recovery? Some researchers would suggest that a mental health clinic or ward is not suited for this purpose (Holmes 2010). It is proposed that the traditional environments in which we provide mental health services are not reflective of the environments where we live our everyday lives. For example Community Mental Health Teams or Psychiatric Hospitals tend not to feel like they are part of the wider community. *“Nothing that happens in here is normal; not one thing occurs like it does in your own home.”* were the reflections of one service user (Holmes, 2010).

The idea that recovery is best facilitated in community settings that reflect how we live our lives is gaining momentum. Some of the pioneering work in this area relates to the concept of Psychology in the Real World. This concept proposes that community-based group work, taking place in real-life settings, can help to facilitate change in people with mental health problems. There are many different projects that adopt these principles. For example Walk and Talk groups are run for people who have an interest in walking through the countryside connecting with nature and connecting with other people within their locality. Specific groups such as Thinking about Medication facilitate discussions between people who have experience of taking psychiatric medication and the effect that has had upon them. Other community based projects include Growthpoint which is based in Stoke-on-Trent and provides a self-facilitated community with a number of different activities. For example, people can work on allotments to grow vegetables, can take part in woodworking classes or can make use of computer facilities within the project. There

are regular groups to discuss mental health issues and to allow people to share their experiences. All of these projects are different from the traditional way that mental health services are provided and are indicative of a recovery based approach to providing mental health services.

Aim of the empirical paper

The current study uses a Q sort methodology to examine service user perspectives of recovery in a community mental health setting. The Growthpoint project is a community-based project funded by North Staffordshire Combined Healthcare NHS Trust. The project provides a social space where service users can engage in a number of activities including gardening, carpentry, metalwork, art therapy, flower arranging, educational activities as well as a social space for a meeting friends and having a cup of tea. The majority of the service users at Growthpoint have gone through the traditional treatment path of mental health services including psychiatric evaluation, use of medication, psychological evaluation, therapy and CBT. However, many of the service users at Growthpoint report that this non-traditional setting has been of great benefit in the recovery process. The current study aims to evaluate which factors have been beneficial in the recovery process for the service users at Growthpoint. The study also aims to evaluate which factors a cohort of trainee clinical psychologist think are important in the recovery process using the same Q-sort methodology. McDaid (2013) has highlighted the need for professionals to have a greater understanding of the experiential perspective that people have in relation to mental health services. As such there is a strong rationale for including trainee clinical psychologists in the current study. Being valued, understood and listened to is a key aspect of the recovery model (McDaid, 2013). Therefore evaluating the similarities and differences between service-user and trainees' views on recovery is a valid and important piece of research.

Method

Ethical Approval

The research project was submitted for peer review and ethical approval to Keele University and was approved by the Independent Peer Review Committee (Appendix 2B). Keele University acted as sponsor for the research and provided indemnity cover for the project (Appendix 2C).

The research was carried out within Growthpoint, an NHS funded service, and ethical approval was obtained from NRES Committee South Central - Hampshire B (Appendices 2D and 2E). Local Research & Development approval was granted by North Staffordshire Combined Healthcare Trust, who fund the Growthpoint project (Appendix 2F).

Q Methodology

Q Methodology has been defined as a foundation for the systematic study of subjectivity, a person's viewpoint, opinions beliefs and attitudes (Brown, 1993). Taken in combination the analysis of multiple Q Sets can reveal the shared perspectives of participants. In Q Method studies data is collected through the use of a Q-Sort task. Participants are asked to decide what is meaningful or significant from their perspective and to rank a set of statements (the Q-Set). The statements are ranked in relation to each other and utilising a sorting grid that imposes a normal distribution to the data. The data from several people or Q-Sets can then be analysed to reveal the extent to which each individual Q-Set is correlated with each other. Conducting a factor analysis of the data will reveal the common viewpoints that are present in the data (van Exel, 2005).

Other methodologies were considered for the purpose of the study. Quantitative methods could have utilised data from questionnaires about the concept of recovery. ANOVA or Logistical regression could have been used to determine differences between service-users and trainee clinical psychologists or to determine predictor variables in relation to outcomes. However, the limitation of this approach is that it would impose too much structure on the data. Questionnaires, by their nature, limit the objective responses of participants. It was felt this might not capture the rich

diversity of opinion in relation to recovery in mental health. Whereas, in a Q Sort-Study participants are asked to rank-order all of the statements. Not only does that provide a structure to the data, but participants are subjectively rating each statement against each other. This subjective element adds an additional level of complexity and richness to the data

Qualitative Methods such as Interpretative Phenomenological Analysis or Discourse Analysis were also considered. However, such methods deal with a discourse that is generated by the participant. The topics and constructs that emerge from the data are produced solely by the participants and in this sense it has a degree of ecological validity. However, the study aimed to explore experiences and understanding of recovery as defined by constructs identified in the literature. Thus Qualitative Methods were not deemed suitable for this purpose. It is proposed that Q Methodology can allow subtle differences to be seen in the data as well as highlighting major similarities and differences in subjective viewpoints (Coogan & Herrington, 2011). Therefore Q Methodology is an appropriate methodology for detecting what factors are seen as being important in recovery from mental health problems.

Developing the Q-Sort

The first draft of the Q-Sort statements was developed following a comprehensive review of the academic literature on recovery from mental health problems, relevant publications and the researcher's prior knowledge of mental health issues. A number of themes emerged from the literature that related to recovery in mental health and these included Symptom Reduction, Medication, Social Functioning, Recovery as a Process, Self-Development, Community, Social Attitudes and Relationships. In addition, themes relating to therapeutic factors that were active in group settings were identified from previous research (Yalom, 1985). Q-Sort statements were developed to reflect these themes and the first draft of the set contained over 100 statements. A focus group was held with one service user and one member of staff from the Growthpoint project. The final statements for the Q-Sort set were selected and the procedure for carrying out the Q-Sort was refined during pilot sorts using the test materials. The final Q-Sort of 50 statements falls within the recommended range

of 40-80 statements for a Q-Sort study (Curt, 1994). The final set of 50 statements is included in Appendix 2G.

A standardised distribution grid was adopted for the study. A sorting grid helps participants to rank the Q Set statements in a normal distribution, and an 11 point grid ranging from +5 to -5 was provided for this purpose (Appendix 2H).

Participants

The participants for the service-user cohort were recruited from Growthpoint in Stoke-on-Trent, a community based project funded by North Staffordshire Combined Healthcare NHS Trust. The project provides a social space where service users can engage in a number of activities including gardening, carpentry, metalwork, art therapy, flower arranging, educational activities as well as a social space for meeting friends. It is a project that the author was familiar with having visited in the past. It was the enthusiasm of the service-users that sparked an interest in investigating the recovery model within a community project. Further discussions with the Acting Head of Psychology within the trust gave further encouragement to develop the research idea. The participants for the trainee psychologist cohort were recruited from current trainees on the Doctoral in Clinical Psychology courses at Staffordshire & Keele and Manchester universities.

The study adopted a strategic sampling strategy as is recommended for Q-Sort methodology (Watts & Stenner, 2012). Within Q-Sort methodology each participant acts as a variable within the study and as such it is appropriate to recruit participants who are likely to express an interesting or pivotal point of view and have relevant knowledge of the subject. This provides the rationale for selecting participants from the service-user group to provide an experiential perspective of mental health issues. Similarly, participants from the trainee psychologist cohort provide a professional and personal perspective of mental health issues. The Q Methodology produces a subjective opinion from each participant about a topic based upon how they sort the Q statements. This allows each participant to answer using his own experiences

(Previte, Pini & McKenzie, 2007). Therefore it is methodologically appropriate to have service-users and trainee psychologists completing the same Q-sort.

In total, the study recruited 24 participants (13 service user participants and 11 trainee psychologist participants). It is recommended that Q-sort studies have a ratio of two Q-set items to every participant (Watts & Stenner, 2012). With a Q-set of 50 items and a sample size of 24 participants the current study matches this recommendation. Inclusion criteria for the study were as follows;

Service-user cohort: i) Current Service Users at Growthpoint. ii) Aged 16-65
iii) Capable of giving informed consent.

Trainee psychologist cohort: i) Current trainees on a Doctorate in Clinical Psychology course. ii) Capable of giving informed consent.

The flow path for participants in the study is as detailed in Appendix 2I.

Participant Information Sheet and Consent Forms

The service-user participants were recruited to the study from the Growthpoint project in Stoke-on-Trent. Prior to commencement of data collection, a brief presentation was given to service-users and staff to introduce the research project. Participant Information Sheets were given to those service-users who were interested in taking part in the research (Appendix 2J). An opt-in sheet was included on the Participant Information Sheet and the participants were asked to contact the researcher if they wished to take part. Similarly, Participant Information Sheets were circulated to a cohort of Trainee Clinical Psychologists and they were also asked to contact the researcher if they were interested in taking part in the research.

Those participants who agreed to take part were asked to sign a consent form prior to inclusion in the study. Separate consent forms were developed for service-user participants and trainee psychologists (Appendix 2K)

Procedure

The Q-Sorts for the service user cohort were completed at the Growthpoint project. Participants were presented with the materials for the study. These comprised of a set of Q-Sort statements that were printed and laminated on cards of equal size which had been randomly allocated a statement number. A blank distribution grid was provided to sort the statements. An A4 grid was provided to allow the participants to do a first sort of the cards (Appendix 2L), and a set of instructions was provided to the participants (Appendix 2M). The research question was included on the set of instructions and was also stated verbally by the researcher when explaining the procedure. The instructions for completing the Q-Sort are as detailed in Figure 1;

Figure 1: Q-Sort Instructions

Q-Sort Instructions (Version 1 – April 2015)

Thank you for agreeing to take part. The research question we want to answer is as follows;

“Which of these statements is the most or least important in recovery from mental health problems?”

- Each of the cards contains a statement that can relate to recovery in mental health problems.
- Based on your own experience of mental health, we hope to find out which of these statement is most important to you.
- Each card needs to be placed on the grid in front of you. The columns to the right of the grid are the most important cards are to be placed, and those statements are rated at (+5) on the grid. The least important cards go on the left hand side and those statements are scored as (-5).
- The cards placed in the middle may be those statements that you feel neutral about.
- I'll ask you to begin by first sorting the cards into 3 piles. The statements

you think are “most important”, those statements you think are “least important” and those statement you think are “neutral”.

- Next I will ask you to pick your two most important cards and place them in the far right hand column. We will then proceed to fill in the rest of the grid based on which statements you think are least or most important. Three cards would be placed in the +4 column as next most important and so on.
- Please feel free to move the cards between columns until you are happy that the grid reflects your point of view.
- If you have any questions, please ask me.
- When you have completed the Q-Sort I will ask you to complete a short questionnaire.

Thank you again for taking part!

After the participants completed the Q-Sort they were asked to examine the sort one last time to ensure that it reflected their point of view. The participants were then asked to complete a short questionnaire about their experience of taking part in the research. (Appendix 2N)

The cohort of trainee clinical psychologists completed the Q-Sort in the same way. The only differences were those Q-Sort statements that related specifically to Growthpoint as some of the trainees were not familiar with the project. Therefore when explaining the procedure before the Q-Sort, the researcher advised the trainees to think about their experience or knowledge of other community mental health projects in relation to statements that specifically mentioned Growthpoint. The majority of the trainee Q-Sorts were completed at Staffordshire University, while a small number were completed during home visits by the researcher.

Results

Descriptive Statistics

24 people agreed to take part in the research project, 13 service users and 11 trainee clinical psychologists. One participant from the service user cohort had difficulties in completing the Q-Sort and their data has been excluded from the Q-Sort Analysis. However, this participant was still able to offer a valuable input via the questionnaire and their data has also been included in the descriptive statistics. Table 1 and Table 2 highlight the demographic characteristics of the participants.

Table 1: Demographic Data - Whole cohort						
Gender	Number	Range	Minimum	Maximum	Mean	Std Dev.
Male: Age	14	34	30	64	42.21	9.504
Female: Age	10	26	27	53	36.30	11.156
Total: Age	24	37	27	64	39.26	10.330

Table 2: Demographic Data – Split by cohort						
Gender	Number	Range	Minimum	Maximum	Mean	Std Dev.
Male: Age Service-User	10	31	33	64	46.20	8.189
Male: Age Trainee Psy.	4	5	30	35	35.25	2.217
Female: Age Service-User	3	2	51	53	52	1.000
Female: Age Trainee Psy.	7	8	27	35	29.57	3.207

Table 1 demonstrates that of the twenty-four participants, fourteen were male with a mean age of 42.21 years old (sd, 9.504). Ten of the participants were female with a mean age of 36.30 years old (sd, 11.156).

Table 2 demonstrates that when the sample is split by gender and cohort, the age difference between the service-users and trainee psychologists was more pronounced.

There were ten male service users with a mean age of 46.20 years old (sd, 8.189) as compared to four male trainees with a mean age of 32.25 years old (sd, 2.217).

There were three female service users with a mean age of 52 years old (sd, 1) as compared to seven female trainees with a mean age of 29.57 years old (sd, 3.207)

Data Analysis

Twenty three Q-Sort sets were analysed using PQ Method software that was specifically developed for Q-Sort Analysis (Schmolck, 2014). The analysis and interpretation of factors followed techniques described by Watts and Stenner (2012).

Correlation Matrix

The Correlation Matrix for the initial analysis is as detailed in Appendix 2O. This demonstrates the extent of the relationships between each of the individual Q-Sorts in the sample. For example the correlation coefficient between Q-Sorts 10 and 11 is 0.58 and is significant as $r > 0.37$, $p < 0.01$ (Watts & Stenner, 2012). However, the Correlation Matrix represents the total variance and meaning expressed by the entire cohort and further analysis is required to extract the shared meaning between the individual Q-Sorts. To identify the factors that represent the key viewpoints shared by individual Q-Sorts a Centroid Factor Analysis was performed.

Factor Analysis

A Centroid Factor Analysis was carried out to determine the best factor solution present in the data. Watts and Stenner (2012) advise that Centroid Factor Analysis is the only true factor analytic method available in PQ Method. It also allows greater flexibility to be supportive of graphical, theoretical and by-hand rotations. As the current study proposes to utilise Multidimensional Scaling to provide a graphical representation of the Q-Sort data, a Centroid Factor Analysis was carried out in preference to a Principal Components Analysis. The un-rotated factor results of the Principal Components Analysis are as shown in Table 3

Table 3: Un-rotated Factor Results – Principal Components Analysis							
Q-Sorts	Factor 1	Factor 2	Factor 3	Factor 4	Factor 5	Factor 6	Factor 7
1	0.1328	-0.5364	-0.3270	0.2255	-0.1970	0.0328	-0.1072
2	0.6113	-0.1022	0.0785	0.3792	0.2904	-0.1696	0.2494
3	0.6348	-0.1238	0.1637	0.1834	0.0476	0.0381	0.1130
4	0.5204	-0.1711	0.2259	0.1163	0.0773	0.1935	0.1225
5	0.3964	-0.1180	0.3837	0.3975	0.0687	-0.0138	-0.1703
6	0.5214	-0.1348	-0.3026	-0.1754	0.1178	0.0808	-0.2609
7	0.4960	-0.2862	-0.2051	-0.0506	0.2663	0.1344	0.1002
8	0.3948	-0.5277	-0.3557	-0.1126	0.3289	-0.0521	0.1657
9	0.1984	-0.3998	-0.0260	-0.1368	-0.2105	-0.0993	0.1028
10	0.2382	-0.5347	0.2154	-0.5526	-0.1447	-0.3689	0.1583
11	0.5367	-0.1853	0.1741	-0.4197	-0.1668	-0.1822	-0.1406
12	0.3778	-0.2753	0.2939	0.1047	-0.2075	0.2395	-0.2201
13	0.5804	0.3845	0.3280	0.0781	0.0309	0.1930	0.1714
14	0.3999	0.5609	0.0469	0.2205	-0.0655	-0.1169	0.0471
15	0.4855	0.3376	0.2775	-0.2049	0.1490	0.1798	-0.0749
16	0.5456	0.0976	-0.2783	0.0774	0.1866	-0.1800	-0.0906
17	0.5756	0.2541	0.3066	0.2796	0.0624	-0.3286	-0.1774
18	0.4698	-0.0484	-0.1617	0.0410	-0.2704	0.1669	-0.1128
19	0.3560	0.4038	-0.3307	-0.2546	-0.5216	0.1460	0.0648
20	0.6138	0.1287	-0.1724	-0.1565	0.1926	-0.2418	-0.3193
21	0.5835	0.1928	0.3328	-0.2031	0.1487	0.1664	0.1711
22	0.4778	0.6066	-0.3331	-0.0468	-0.1597	0.2370	0.0327
23	0.6617	0.4770	-0.1772	0.2102	-0.0233	-0.0550	0.1751
Eigenvalues	5.5153	2.7564	1.5387	1.3165	0.9619	0.7509	0.5967
% expl.Var	24	12	7	6	4	3	3

The Kaiser-Guttman criteria state that for a factor to be interpretable then it must have an eigenvalue greater than 1 (Guttman, 1954) (Kaiser, 1960). Therefore the initial results of the Centroid Factor Analysis suggest a 4 factor model may be the best solution.

However, Humphrey's Rule (Brown, 1980) suggests that where factors are on the borderline of meeting this criteria, then further examination may be required.

Therefore further examination was carried out with regard to Factor 4. Humphrey's Rule states that a factor is significant only if the cross product of its two highest loadings exceeds twice the standard error.

In the current study, the standard error is;

$$1 / (\text{square root of the number of items in the Q-Set})$$

$$= 1 / (\text{square root of } 50)$$

$$= 1 / 7.071$$

$$= 0.1414 \text{ (Rounded up to } 0.15). \text{ Therefore twice the standard error is } 0.30$$

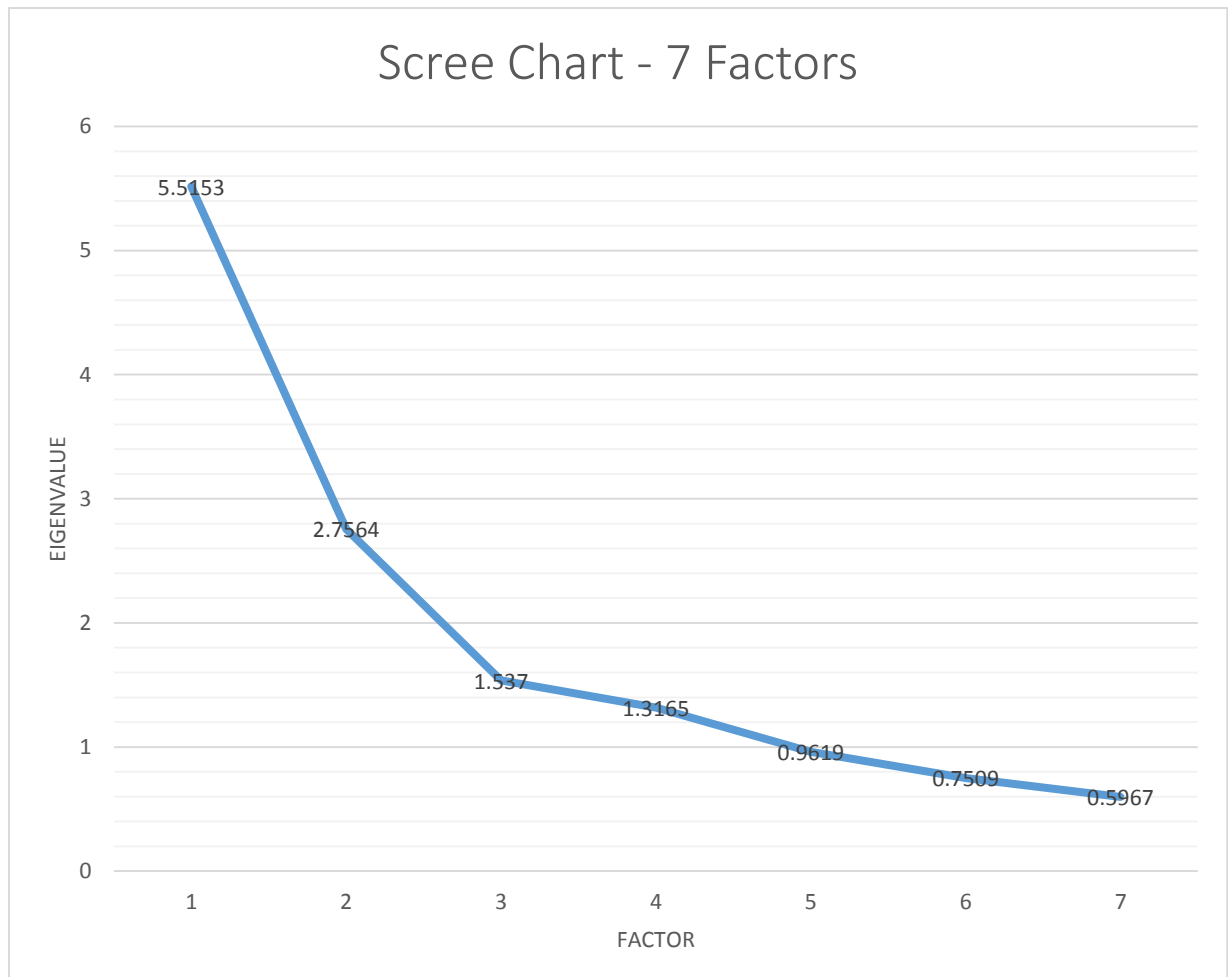
The cross product of the two highest loading for factor 4 are for Q-Sorts 10 and 11 respectively = $-0.5526 \times -0.4197 = 0.232$

Therefore Factor 4 failed to meet Humphrey's Test and was removed from the model.

Scree Plot

A Scree test was plotted to evaluate the appropriate number of factors to accept in the model (Cattell, 1966).

Figure 2: Scree Plot



The Scree Plot does not show a definitive elbow, although it begins to flatten after Factor 3. However, the eigenvalue for Factor 3 is above our criterion of 1, thus indicating that a three factor solution may be preferable to a two factor solution.

Furthermore, Watts and Stenner propose that as a rule of thumb, one factor should be extracted for every 6 Q-sorts included in the data set. As 23 data sets were included it is appropriate to adopt a three factor solution over a two factor solution.

Rotation

The Centroid Factor Analysis was re-run based on a 3 Factor Model and subjected to Varimax rotation. The resulting factor loadings are displayed in Table 4.

Table 4: Factor Loading following Varimax Rotation			
(Sig Loading = 0.37 or greater)			
Factor Matrix with an X Indicating a Defining Sort			
Q-Sort	Factor 1 Loadings	Factor 2 Loadings	Factor 3 Loadings
1	-0.1361	0.5523X	-0.0498
2	0.2970	0.2682	0.4393X
3	0.1538	0.2601	0.6711X
4	0.0599	0.2530	0.5859X
5	-0.1056	0.0652	0.6702X
6	0.4194	0.4460	0.1054
7	0.2147	0.4871X	0.2294
8	0.0927	0.7039X	0.0427
9	-0.0310	0.4706X	0.0197
10	-0.1021	0.4706X	0.0584
11	0.2815	0.3763X	0.2775
12	-0.0024	0.2997	0.3584
13	0.3979	-0.2026	0.6424
14	0.5246X	-0.3478	0.3424
15	0.4135	-0.1231	0.4230
16	0.4670X	0.2347	0.2241
17	0.3042	-0.0809	0.6302X
18	0.3717X	0.3057	0.1645
19	0.6266X	-0.0005	-0.1031
20	0.5269X	0.2586	0.2408
21	0.3563	0.0400	0.5102X
22	0.8146X	-0.1874	0.0717
23	0.7120	-0.0936	0.3934
% Explained Variance	15	11	15

Table 4 indicates a 3 Factor Model with the following structure;

Factor 1: Q-Sorts 14, 16, 18, 19, 20, 22

Factor 2: Q-Sorts 1, 7, 8, 9, 10, 11

Factor 3: Q-Sorts 6, 13, 15, 23

Confounded Q-Sorts: Q-Sorts 6, 13, 15, 23 Non-Significant: Q-Sort 12

Hand Rotation

A visual inspection of the data revealed that some of the confounded factors and the non-significant factor were approaching the required factor loading to be included in the model (0.37 or above). Therefore, using PQ Method, hand rotations were performed on the data set. A rotation of -2 degrees between Factors 2 and Factor 3 was sufficient for Q-Sort 12 to be included in the model. For Q-Sort 12, this increased the loading on Factor 3 from 0.3584 to 0.3686 (0.37 to 2 decimal places) and allowed the data to be included in the final model.

Further rotations between Factor 1 and Factor 3 were attempted to bring confounded Q-Sorts 6, 13, 15 and 23 back into the model. However, this was not successful as other Q-Sorts would need to be removed from the model for no additional gain. Therefore the following 3 Factor Model was adopted as the best solution:-

Factor 1: Q-Sorts 14, 16, 18, 19, 20, 22

Factor 2: Q-Sorts 1, 7, 8, 9, 10, 11

Factor 3: Q-Sorts 6, 12, 13, 15, 23

Confounded Q-Sorts that map onto more than one factor: Q-Sorts 6, 13, 15, 23

The final three factor model adopted accounts for 41% of the variance in the data, 15% of which is explained by Factor 1, 11% of which is explained by Factor 2 and 15% of which is explained by Factor 3. This is in line with the recommendation of Watts and Stenner (2012) that a model should explain at least 35% - 40% of the variance in the data.

The final factor loading for this solution is as detailed in Table 5

Table 5: Final Factor Loading following Varimax and Hand Rotation (-2 deg, Factor 2 and 3)

(Sig Loading = 0.37 or greater)

Factor Matrix with an **X** Indicating a Defining Sort

Q-Sort	Factor 1 Loadings	Factor 2 Loadings	Factor 3 Loadings
1	-0.1361	0.5537X	-0.0305
2	0.2970	0.2527	0.4484X
3	0.1538	0.2365	0.6797X
4	0.0599	0.2324	0.5844X
5	-0.1056	0.0418	0.6721X
6	0.4194	0.4421	0.1209
7	0.2147	0.4788X	0.2462
8	0.0927	0.7020X	0.0673
9	-0.0310	0.4696X	0.0361
10	-0.1021	0.5063X	0.0761
11	0.2815	0.3664X	0.2904
12	-0.0024	0.2870	0.3686X
13	0.3979	-0.2249	0.6349
14	0.5246X	-0.3595	0.3300
15	0.4135	-0.1378	0.4184
16	0.4670X	0.2267	0.2322
17	0.3042	-0.1029	0.6270X
18	0.3717X	0.2998	0.1751
19	0.6266X	0.0031	-0.1030
20	0.5269X	0.2501	0.2497
21	0.3563	0.0222	0.5113X
22	0.8146X	-0.1898	0.0651
23	0.7120	-0.1072	0.3899
% Explained Variance	15	11	15

Conceptual Map

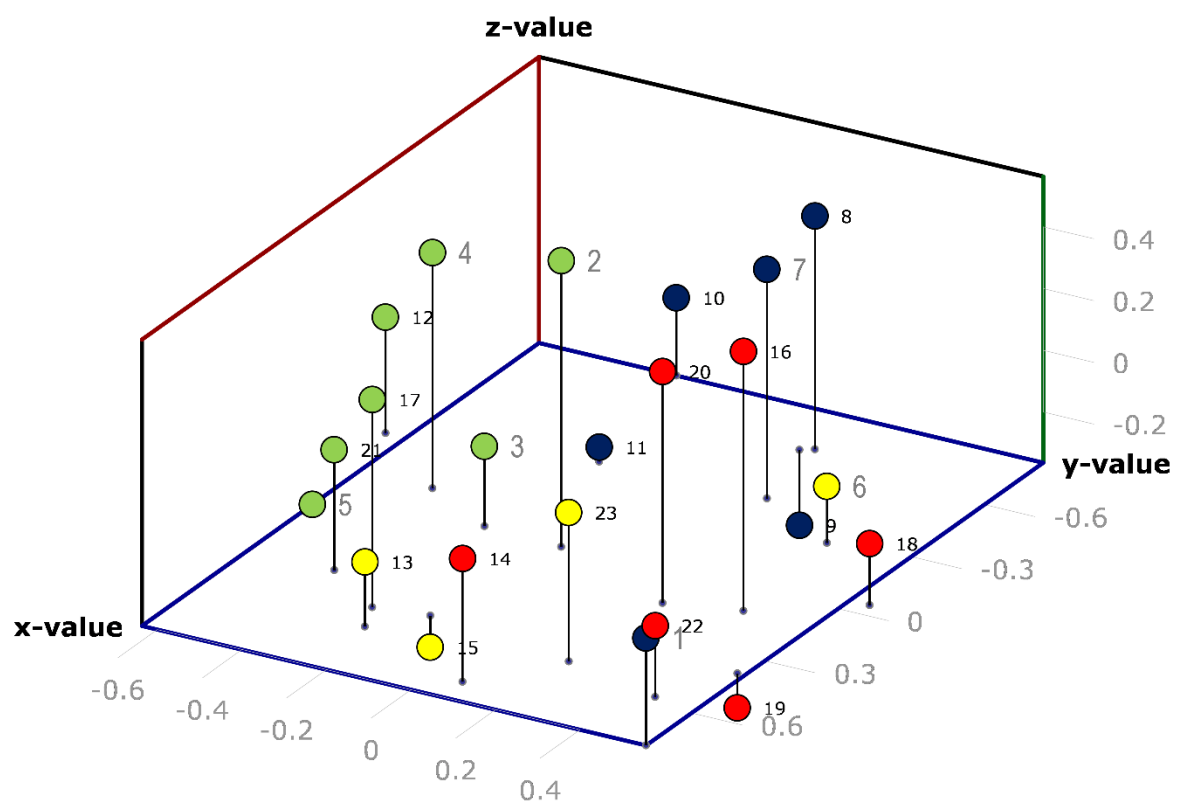
To help facilitate interpretation of the data a conceptual map of the Q-Sort data was produced using Multidimensional Scaling. The technique measures the Euclidean space or psychological distance between a data set's characteristics (Giguere 2006).

In complex data sets, such as those produced in Q-sort methodology, especially when a multi factor solution is indicated, then Multidimensional Scaling can provide a visual interpretation of the data. In this study, each individual Q-Sort has been mapped in the 3 dimensional conceptual space indicated by our 3 factor solution. In addition, the individual Q-Sorts have been colour coded to illustrate which factors they load onto. The correlation matrix adopted for our 3 factor solution was used as the input data for the Multidimensional Scaling. The Data Analysis was carried out using SPSS Version 21. The table detailing the Euclidean Distance calculated between individual Q-Sorts is included in Appendix 2P. The 3 dimensional co-ordinates calculated for the MDS graph are included in Appendix 2Q.

The colour coding for the conceptual map is as follows;

Factor 1 = Red, Factor 2 = Blue, Factor 3 = Green, Confounded Q-Sorts = Yellow

Figure 3: MDS Conceptual Map



Interpretation of the MDS Conceptual Map

The data points are displayed with anchors attached to the z-value to aid with interpretation.

Factor 1 Q-Sorts are coloured in Red. They score highest on the Y-value and participants are clustered in the conceptual space in areas that reflect this. This is the Factor One axis.

Factor 2 Q-Sorts are coloured in Blue. They score highest on the Z-value and participants are clustered in the conceptual space in areas that reflect this. This is the Factor Two axis.

Factor 3 Q-Sorts are coloured in Green. They score highest on the X-value and participants are clustered in the conceptual space in areas that reflect this. This is the Factor Three axis

Factor Arrays and Difference Scores

The final step before describing and interpreting the factors is the calculation of factor arrays and difference scores. The factor array is produced from the weighted Z-scores that are calculated during the Q-Sort Analysis. The weighted Z-scores are mapped onto the Q-sort grid and represent a reconstruction of the idealised viewpoint that defines that factor (van Exel, 2005). As such, they are a valuable tool in allowing the researcher to interpret and understand the collective viewpoint portrayed in each factor. Difference Scores examine the magnitude of difference between a statement score on any two factors. Therefore they indicate the ways in which factors are distinctive from each by highlighting those statements that are significantly different between factors. The Z-scores and corresponding rank for each statement is included in Appendix 2R. The Factor Q Sort Values for each statement is included in Appendix 2S and is indicative of the difference between factors.

Discussion

Factor array content and participant demographics were explored to develop an interpretation of the factor viewpoints and their meaning.

Figure 5: Factor Array for Factor 1

-5	-4	-3	-2	-1	0	+1	+2	+3	+4	+5
24	38	35	1	44	43	39	17	30	34	25
31	10	8	46	11	26	45	19	27	28	18
	6	22	3	12	48	29	21	42	37	
		47	15	49	23	41	2	33		
			20	4	5	16	7			
				9	13	40				
				14	50	36				
					32					

Factor 1: Trainee Psychologist viewpoint: “Understanding ourselves better and receiving social support are the keys to recovery in mental health”.

Factor 1 has an eigenvalue of 5.52 and explains 15% of the study variance. Six participants are significantly associated with this factor and these are Q-Sorts 14, 16, 18, 19, 20 and 22 respectively. All of the participants associated with this factor are trainee clinical psychologist and comprise of one male aged 31 and five females with an average age of 29.60 years.

For the people in Factor 1, Having someone to talk to about problems and gaining a better understanding of themselves were seen as the most important statements in recovery from mental health problems (25, 18: +5).

There was also a strong emphasis on social support networks and the help they could offer to a person in crisis (28: +4). In particular, the role of family support was valued as was secure living arrangements and accommodation (27, 42: +3). An understanding of the past was viewed as important and this ties in with a hope of developing goals for the future (37, 34: +4). There was a degree of importance placed on the idea of shared experience and realising that you are not the only person who feels like this (30, 33: +3) and perhaps this is indicative of a wider aim of

normalising the experiences of people who have mental health problems. This theme is further emphasised by the endorsement of statements relating to understanding how mental health problems may have changed the person and realising that life is full of ups and downs (19: +2, 36: +1). Some of these potential ups and downs are suggested when the stigma related to mental health and problems with benefits are items that were endorsed higher in Factor 1 than in other Factors (45: +1, 43, 0). Again this highlights some of the social problems that may be experienced as a result of mental health issues and re-enforces the idea of social networks providing important sources of help in overcoming those issues. However, the importance placed on social networks is undermined when being in a relationship was endorsed as the least important statement (24: -5).

There was some emphasis placed on the reduction of symptoms such as feeling less depressed and a reduction in self-harm (2: +2, 39: +1) however the route to recovery seemed to focus on the development of understanding and social networks rather than traditional mainstream services. For example, there was a rejection in the idea of medication being a solution for recovery in mental health problems. Finding medication that works, the benefits of medication and the need to take medication regularly were all statements that were ranked low (8: -3, 6: -4, 10: -4). This seems to be in contradiction with the statement that having a say in the medication that a person takes is important (7: +2). However, this could be interpreted that having a choice not to take medication is the meaning that was adopted by the participants.

Although there was a rejection of medical intervention as being important in recovery in this Factor viewpoint, there was not a strong endorsement of psychological intervention either. Seeing a counsellor or therapist and attending mental health services were not strongly endorsed and were ranked lower in Factor 1 than in the other Factors (4: -1, 22, -3) and similarly psychological therapies were not heavily endorsed (49: -1). In addition, there was a distinguishing difference between Factor 1 and the other Factors in relation to attendance at the Growthpoint project. The importance of feeling part of the Growthpoint community was highly valued by the other factors but rated low on Factor 1 (11: -1, 29: +1). This is further emphasised when learning to join in on groups is endorsed as the least important statement in

recovery from mental health issues (31: -5). The failure of the Factor 1 participants to provide an endorsement of psychological interventions or community projects like Growthpoint highlights an inconsistency in the viewpoint. As a whole, the viewpoint highlights the importance of promoting social support networks and the importance of having someone to talk to about problems. Without a strong endorsement of psychological therapy or the importance of attending projects like Growthpoint, the question arises as to where the process of recovery is facilitated?

The dilemma highlighted in the factor view is summarised by Participant 18 who stated.

“Projects like Growthpoint provide a good alternative to traditional therapies. I like how they equalise the power differences that can happen in therapy. In those settings, everyone is just the same and sharing stories and experiences with others is really important and people can guide their own recovery and look after their self. But in a way I’m drawn. My personal and professional beliefs are sometimes different and which should I go with?”

Figure 6: Factor Array for Factor 2

-5	-4	-3	-2	-1	0	+1	+2	+3	+4	+5
39	44	7	15	36	27	19	21	5	1	11
38	14	31	9	26	18	25	30	16	10	29
	40	23	35	20	32	28	6	22	8	
		41	42	24	45	2	17	4		
			37	12	50	46	48			
				47	49	34				
				43	33	3				
					13					

Factor 2: Service-User Viewpoint: “Attending Growthpoint and taking my medication are the keys to recovery in mental health. But I don’t need much interaction with others”

Factor 2 has an eigenvalue of 2.76 and explains 11% of the study variance. Six participants are significantly associated with this factor and these are Q-Sorts 1, 7, 8,

9, 10, and 11 respectively. All of the participants associated with this factor are service-users and comprise of four males, average age 46.75 years and two females, average age 51 years.

For the service-user group who comprised of Factor 2, attendance at Growthpoint and feeling part of the Growthpoint community were the most important factors related to recovery in Mental Health problems (11: +5, 29: +5). In addition, the viewpoint emphasised the importance of medication in the recovery process. Finding medication that works and taking medication regularly were highlighted as being important (8: +4, 10: +4). In addition, a reduction of symptoms related to mental health issues was endorsed, including being able to concentrate and remember things and feeling happier (1: +4, 4: +3, 5: +3). The mechanism by which these changes may occur was also seen to be important and the factor viewpoint highlighted a number of these. Attending mental health services was seen as more important in this factor than in others (22: +3). Items related to seeing a counsellor, having a good relationship with a support worker and psychological therapies were more heavily endorsed by Factor 2 than in other factors (3: +1, 48: +2, 49: 0). As well as endorsing items relating to professional support structures, being in a relationship was also seen as being more important in comparison to other factors (24: -1).

The items that were viewed as less important were religion and spirituality and a reduction in self-harm. (38: -5, 39: -5). However, many of the participants reported that they did not have a religion or self-harm and therefore it is more likely that these items simply did not apply to many people rather being reflective of a degree of importance. The factor viewpoint expressed less concern about other people's attitudes towards them (44: -4). This is highlighted where the factor viewpoint rejects the idea that social support is important to these individuals. For example, being in employment or education, meeting new people and getting support from other service users are less important to this factor than to others (14: -4, 12: -1, 26: -1). At first reading, this rejection of social support may seem at odds with the importance placed on attendance at Growthpoint and the value of being a member of the Growthpoint community. However, this may reflect the ethos of the project, where service users are able to be as active within groups or to engage in more solitary

tasks as they prefer. In addition many of the service-users have been attending Growthpoint for a long period of time and may be familiar with the people there but apprehensive about the suggestion of meeting new people or being in employment.

The factor viewpoint focuses on the need of the service-users to access as much support as they can and may be indicative of a service user group who are currently experiencing more severe problems than others. For example, they have endorsed items relating to attending Growthpoint, taking medication, attending mental health services, seeing a counsellor or therapist and accessing psychological therapy. Despite being the most likely factor to endorse the use of medication, they think it least important to have a say in the medication they take (7: -3). This may indicate an over-reliance on professional support and medical intervention. They are less concerned about gaining additional social support, other than given by Growthpoint. And they seem to have less interest in understanding themselves better, feeling positive about the future and achieving goals in the future (18: 0, 17: 2, 34: +1)

Some of the issues for this Factor are highlighted by the statement of Participant 11.

“Sometimes, I feel out of control and I get depressed when I lose control. When I’m here I don’t feel like a stranger as everyone else knows how you are feeling. But I also get medication from my GP and used to see a counsellor”

Figure 7: Factor Array for Factor 3

-5	-4	-3	-2	-1	0	+1	+2	+3	+4	+5
39	6	10	49	33	27	25	5	15	16	29
38	40	7	32	22	30	35	2	11	34	21
	1	24	37	43	28	20	42	26	17	
		8	47	3	36	14	31	13		
			9	46	41	48	12			
				19	50	4				
				45	18	23				
					44					

Factor 3: Shared Trainee and Service-Users Viewpoint: “Attending Growthpoint, looking to the future and getting involved in new activities are the keys to recovery in mental health”

Factor 3 has an eigenvalue of 1.54 and explains 15% of the study variance. Seven participants are significantly associated with this factor and these are Q-Sorts 2, 3, 4, 5, 12, 17 and 21 respectively. Of the participants associated with this factor, five are services users and comprise 5 males of average age 48.40 years. The remaining two participants are trainee clinical psychologist and comprise of one male aged 30 years and one female aged 29 years.

This was the only Factor that was comprises of both trainee clinical psychologist and service-users. The most important statements endorsed in relation to recovery from mental health related to feeling part of the Growthpoint community and building on your strengths (29, 21: +5).

Factor 3 participants endorsed statements that conveyed a sense of optimism for the future. Being able to make decisions for oneself, feeling positive and achieving goals in the future were all seen as being important (16, 17, 34: +4). And the mechanism suggested for achieving these aims related to social interaction with other people. Taking part in social activities, learning new skills and support from other service users was favoured by this group (13,15, 26: +3). There was also a degree of importance placed on reduction of symptoms and feeling less depressed (12: +2). In comparison to other factors, these people see the importance of meeting new people, joining in on groups and being in employment (31: +2, 14: +1, 12: +2). They also value the relationship that they develop with people. Learning to trust people again and meeting people who can act as role models are seen as important (23: +1, 35, +1) and finding new meaning in life are endorsed more highly in this factor than in any other (20: +1).

For this factor, medical intervention is not viewed as important, especially in comparison to the service-user group in Factor 2 who highly endorsed the use of medication (6: -4, 7: -3). However, despite endorsing the development of social relationship and interaction, the participants in this factor are less likely to talk to someone about their problems or seek help in a crisis (25: 1, 28: 0). They are also

the least likely to endorse psychological therapy or to learn about mental health conditions (49, 32: -2). This suggests that they are using the support networks that they develop in a different way. It appears they use social networks to develop and build on their own strengths and look to the future. They do not however, use social networks to discuss their problems or seek help in a crises (25: +1, 28: 0). In a similar manner to Factor 2 participants, they rejected the importance of religion or a reduction in self-harm (38, 39: -5) which reflects anecdotal comments that few of the participants had a religious faith or had self-harmed.

Some of the issues for this Factor are highlighted by the statement of Participant 3.

“Growthpoint opens the opportunity to build one’s confidence, which can open up new paths to recovery. Growthpoint is extremely important to myself and others as they allow us to grow in both confidence and self-worth and offer excellent support”

Clinical Implications

Analysis of the data produced a three factor solution.

Factor 1: Trainee Psychologist viewpoint: “Understanding ourselves better and receiving social support are the keys to recovery in mental health”.

Factor 2: Service-User Viewpoint: “Attending Growthpoint and taking my medication are the keys to recovery in mental health. But I don’t need much interaction with others”

Factor 3: Shared Trainee and Service-Users Viewpoint: “Attending Growthpoint, looking to the future and getting involved in new activities are the keys to recovery in mental health”

A key finding of the study was the emergence of separate viewpoints in relation to recovery from mental health problems for trainee clinical psychologists and for service-user participants. It might have been expected that there would be some difference in the subjective opinions of the trainees and the service-users but to have two different factors with no overlap was a surprise.

Differences between the factors:

Some of the key differences between the Factor One and Factor Two viewpoints related to medication. The service user participants endorsed statements related to taking medication regularly and finding medication that works, whereas trainee clinical psychologist were more ambivalent about those aspects. Service users also endorsed statements related to reduction in symptoms such as having fewer symptoms of a mental health problem and being able to concentrate and remember things. In contrast, the trainee clinical psychologists placed more emphasis on aspects of recovery relating to understanding the past and having someone to talk to about problems.

It was noted that the trainee cohort did not endorse statements that valued attendance at Growthpoint or community based projects whereas this statement was highly endorsed by both Factor Two and Factor Three participants. Given the focus placed on social support by Factor One this was surprising. The factor participants need to consider the context in which mental health services are provided and ensure that the concepts that are viewed as important are delivered in a setting that is appropriate. It was also noted that Factor Two participants endorsed statements that related to levels of support from different sources. As well as valuing attendance at Growthpoint they endorsed statements relating to medication, psychological therapy and seeing a counsellor more than other factors. This may be indicative of a group that requires higher levels of support and may indicate persons who are in acute phases of illness.

What could account for these differences between factors?

- 1) There may be a completely separate perception of recovery based on experience. The client group have an experiential perspective of living with distress and mental health issues. It may be that their experiences have led them to endorse the use of medication as a way to alleviate symptoms. Or

they may be entrenched in mental health services and it's just become the normal thing for them to take medication.

- 2) This difference may also be affected by belief and attitudes of trainee psychologists developed during clinical training. The majority of trainee clinical psychologists attended a training course where the development of a critical perspective was encouraged. As such trainees may be more sceptical to the claims made about the efficacy of medication and by nature of their professions would endorse interventions that focus on psychological and social intervention over medical intervention.
- 3) A demographic explanation could be the age difference between the cohorts. The mean age of the Factor One cohort was 29.60 years old compared to 46.75 years old for Factor Two. As such there may be a different view of medical professionals based upon this generational difference. The older cohort may be more deferential to the opinion of medics than the younger cohort
- 4) If the analysis had been run using only Growthpoint attendees, the result of the analysis would have been exactly the same for those participants left in the model. Effectively we would have been left with a 2 factor model rather than a 3 factor model, as the correlations and euclidean distance between each of the remaining participants would be exactly the same.

Given the results of the analysis a number of service delivery recommendations can be made:

- 1) Consideration may be given to providing psychological support to the Growthpoint project. At present there is no psychological input, although support workers within the project do create an environment that is sensitive to individual people's needs.

- 2) “Psychology in the Real World “approach may be beneficial. For example, a group discussion on the role of medication may be helpful to Factor Two participants who endorsed the use of medication.
- 3) Acceptance and Commitment Therapy may be integrated within the project. Potentially participants from Factor Two may benefit as they seem particularly isolated. Groupwork or one to one sessions may be beneficial.
- 4) However, it may be that the introduction of such support may change the dynamic within the Growthpoint community. Perhaps people would feel that a more structured form of support is the antithesis of what is provided at Growthpoint?
- 5) Given the disparity between the trainee perspectives and service-user perspectives more training on the concepts of the recovery model is required.

For any proposed changes, both service-users and professionals need to be involved in the design of recovery focused services in a spirit of co-production. Key to this is the element of choice as to where and how services are provided and what treatments are on offer. This idea of co-production helps to redress the traditional power imbalance that has existed between client and professional within services. McDaid (2012) describes this situation as professionals being “on tap” and not “on top” within a service. Another important point is the need for professionals to really listen to the experiences of people. Professionals need to understand the experiential perspective of people in relation to their personal understanding, aspirations, goals and knowledge about their journey of recovery.

Researcher

It is important to understand the relationship between the researcher and the research in terms of the development, implementation and interpretation of the research project. The research was undertaken by a single researcher who adopts a subjectivist epistemology. Therefore, although objectivity remains a goal to which the

researcher aspires, it is acknowledged that we cannot separate ourselves from what we know and what we bring to the research process. As such it may not be possible to remain objective within the research setting although this would always be the aim of the researcher.

Limitations

The three factor solution only explains 41% of the variance with four people not loading onto any of the factors. Therefore it is acknowledged that only tentative interpretations can be drawn from the results. It was also acknowledged that the sample was predominantly from the same ethnic group. Exploring recovery with different ethnic minorities may identify any differences in approaches to recovery and would help service provisions for those from different cultural backgrounds.

The trainee clinical psychology sample was predominantly from one university. A larger cohort of trainees from different universities may have provided a different perspective.

One potential limitation of the study is that it didn't provide a breakdown of the trainee psychologist participants in terms of their year on the programme or training in the recovery model. This would have been of interest and may provide a rationale for future study.

Another potential limitation relates to the inapplicability of Growthpoint items in the Q-sort in relation to trainee clinical psychologists who may not have experience of the Growthpoint project. The validity of those items and other terms in the Q-Sort including "my", e.g. "my sexuality" may have led to a degree of ambiguity for some participants completing the sort. However, from a methodological view it is acceptable to use terms like "my" within the Q-Sort statements. Indeed, for each statement sorted it is a subjective viewpoint from the individual that we seek in the model. And in relation to specific statements about Growthpoint or other community projects it is also acceptable within the Q-Methodology to subjectively rate statements about items that you have no objective knowledge about. Stenner & Watts (2012) contend that Q-Methodology can use any set of stimulus objects and be able to place them in an order of personal salience.

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Paper3: Reflective Paper

“The reflective mirror of recovery: Using personal experiences in the reflective process”

A Q-Sort Study: service user and trainee psychologists’ perspectives of recovery in a community-based project.

Heather Wood

Word Count: 3,267

“The reflective mirror of recovery: Using personal experiences in the reflective process”

Abstract

The importance of reflective practice is discussed in relation to professional standards in Clinical Psychology. Concepts relating to reflective practice are introduced and the Atkins and Murphy (1994) Models of Reflective Practice is reviewed. Using this model as a framework, the author uses a narrative approach to compare her experience of recovery from diabetes to the experience of recovery from mental health problems. The author uses Q-Sort methodology to compare factor viewpoints that emerged from the Q-Sort analysis and combines this with the model of Reflective Practice.

Introduction

It is a requirement of the Doctorate in Clinical Psychology programme at the universities of Staffordshire and Keele that trainees complete a reflective paper as part of their thesis. This is in line with the Health & Care Professions Council (HCPC) and British Psychological Society (BPS) whose guidelines highlight the importance of reflective practice for psychologists in terms of supervision, continued professional development and clinical practice. The Division of Clinical Psychology goes further and they define the requirement of being a Reflective Scientist-Practitioner as a key competency for clinical psychologists;

“Reflective practice is also promoted through an effective use of supervision and collaboration with service users and other colleagues in setting goals and monitoring progress. Importantly, the clinical psychologist will also be aware of the importance of diversity, the social and cultural context of their work, working within an ethical framework, and the need for continuing professional and personal development.”

As such it is important for clinical psychologists to utilise reflective practice in clinical and research settings. In general terms, reflective practice can be defined as a

process of learning from experience towards gaining new insights into one's self and practice (Finlay, 2008).

The concept of reflective practice has been further defined by Schön (1991), who makes a distinction between reflection-in-action (thinking while doing) and reflection-on-action (after-the-event thinking). The former can include the self-awareness of bodily sensations, emotions, experiences and cognitions as they occur during a reflective episode. Whereas, reflection-on-action is understood as a process to consciously review, describe, analyse and evaluate past practice or experiences with a view to gaining insights into improving future clinical practice. In doing so a reflective practitioner may draw upon multiple forms of prior knowledge including psychological theory, epistemological knowledge, their own social status (gender, class and ethnicity), self-narratives, personal values and the multitude of personal experiences that inform their autobiographical story. As such, first order episodes of reflection-in-action become the object of second order processes of reflexivity-on-action (Dallos & Stedman 2009).

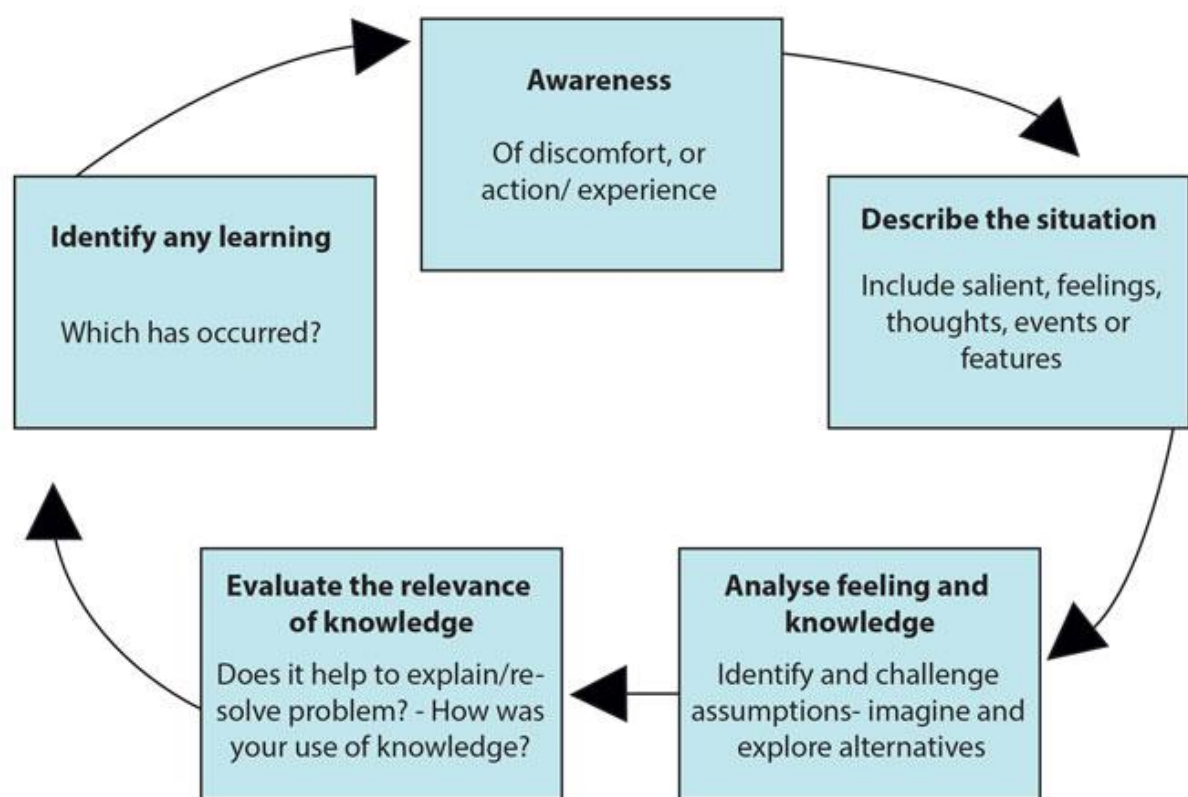
Schon (1991) contends that development of reflective practice skills are a form of “professional artistry” and that as these clinical skills develop they allow a practitioner to act both intuitively and creatively in clinical settings. Both personal reflections “in-action” and the subsequent reflexivity “on –action” allow practitioners to revise, modify and refine their expertise.

Models of Reflective Practice

A number of models have been developed to aid in the process of reflective practice. They provide a framework for thinking reflectively that can be especially helpful for new or inexperienced practitioners when learning how to think reflectively. Atkins and Murphy (1994) developed a model that progresses through a step-by-step thinking process. The initial phase is identifying an awareness of an action or experience that may give rise to uncomfortable thoughts or emotions. The next step is to describe the situation, thoughts and feeling that accompany that event or experience. This is

followed by an analysis of the situation and identifying alternative ways of thinking or acting. Next, an evaluation of the event or experience is encouraged to help develop a solution to the problem. Lastly, by integrating the output of this step-by-step process, new ways of thinking and practising can be developed. They contend that the progression through description, analysis, evaluation and integration is the key to developing reflective practice skills.

Figure 1: Atkins and Murphy Model of Reflective Practice (1994)



While such models provide a framework for reflective practice, Dallos & Stedman (201&) also contend that reflexivity can be a creative, artistic and playful activity that utilises more than a person's acquired academic knowledge. It should encompass aspects of our self, our values, our personal experiences and it is these uniquely personal aspects of reflexivity that can lead to new insights and thinking "outside the box".

Aim of the Reflective Paper

The process of carrying out a research project for the Doctorate in Clinical Psychology course is a long and arduous process. Some of the key tasks include, developing a research idea, reading papers and books, carrying out a literature review, applying for university peer review, developing a methodology for an empirical paper, applying for NHS ethical approval, applying for NHS trust approval, developing the materials required for an empirical paper, running focus groups, giving presentations, collecting data, analysing data, learning new methods, writing a thesis, re-writing a thesis and recognising that for a time, your life revolves around a thesis! It is a long and demanding journey, and this is by no means a definitive list. And running alongside, everyday life goes on.

And sometimes, things don't go to plan. In the personal journey of my thesis I have had many personal setbacks that have impacted on the research process. These have included family bereavements, difficulties at work, periods of stress and periods of illness. By far the greatest impact was being diagnosed with Type II Diabetes in June 2014, some two months before I was due to hand in my thesis. This had a major impact on me at both a personal and professional level. It impacted on my ability to complete my research thesis and for a long time it impacted upon my physical health. At that time, I felt like I was embarking on another journey, one of recovery from my diagnosis of diabetes. The irony was not lost on me that my research project was looking at perspectives of recovery from mental health problems. And I soon realised that the experiences I heard described by the research participants mirrored my personal experiences I was having in regards to my recovery from diabetes. Not one to miss an opportunity, I decided that this had the potential to provide material for my reflective paper.

In the spirit of Dallos & Stedman (2009), I decided to be playful with my reflective account. Using the Aitkens & Murphy Model of Reflective Practice as a framework, I reflect upon how my personal experiences from recovery in diabetes mirrored the experiential perspective of recovery from mental health problems reported in the Q-sort study. In addition, the impact that this has had on the research process is discussed.

Awareness of Discomfort / Action / Experience

I first became aware that something did not feel right in my physical health in the Spring of 2014. I had suffered from a family bereavement and it was a difficult time for me and my family. At the same time, I was on clinical placement in Shrewsbury whilst still living in Manchester. As a result I had a lengthy commute each day to get to work and was feeling extremely tired when I got home at night. However, many of my friends and colleagues on the Doctorate in Clinical Psychology course reported that they were similarly tired. It was after all the final year of clinical training. As the months moved on my levels of tiredness seemed to be increasing and I noticed everyday tasks were becoming more difficult. I needed to stop off for a nap on the way home from work as I was so tired. I stopped seeing friends and going to the pub quiz because I had no energy. Reading books and academic papers became a real toil as I found it hard to concentrate. I became frustrated at the pace at which as I was working as I had a huge workload and a thesis to complete yet progress was painfully slow. Eventually, I went to my GP and they investigated the cause. The results of blood tests revealed that my blood sugar levels were 26.9mmo/L instead of the normal levels of 4 – 5mmo/L. Not only had I developed Type II diabetes, but my blood sugar levels were massively high. Indeed the lab had requested another set of blood tests as they thought they may have got the first test wrong because they were so high. This explained the extreme fatigue I had been experiencing as my body was not converting the food I consumed into energy that could be used by my body – my insulin intolerance meant that energy was being retained in my blood in the form of blood sugars and I was effectively “running on empty” as my GP put it. So in June 2014, fresh with a diagnosis of Type II Diabetes I began on my own journey of recovery.

In April 2015, I decided to write this reflective paper to detail how this journey seemed to reflect the experiences of people who were recovering from mental health problems whom I had seen as part of this research project. The empirical paper in this study had reported a three factor model that revealed three different viewpoints related to recovery from mental health problems;

The first factor reflected the views of trainee psychologists and was summarised as “Understanding ourselves better and receiving social support are the keys to recovery in mental health”. The second factor reflected the views of service-users and was summarised as “Attending Growthpoint and taking my medication are the keys to recovery in mental health. But I don’t need much interaction with others”. The third factor was a shared trainee and service-user viewpoint. “Attending Growthpoint, looking to the future and getting involved in new activities are the keys to recovery in mental health”

I had recognised that many of the Q-Sort statements reflected issues, feelings and emotions that I had encountered in my journey towards recovery. Therefore I decided that I would complete the same Q-Sort as those participants had done but from a perspective of recovery from diabetes rather than recovery from mental health issues. I was curious to see which of the three factors identified in the main study would best reflect my personal experience of recovery. Therefore I entered my completed Q-Sort into the database and re-ran the analysis of the data. The loading for my Q-Sort was as follows;

P24 Factor 1 = 0.1149 Factor 2 = 0.6421X Factor 3 = 0.1429

As can be seen above, my Q-Sort was significantly loaded on Factor 2.

Therefore my personal reflections on recovery from diabetes were more closely matched to those of the service-users who were representative of Factor 2.

“Attending Growthpoint and taking my medication are the keys to recovery in mental health. But I don’t need much interaction with others”

Describe the Situation – Including Thoughts and Feelings

Salient events and key features

In the empirical study, the Factor Two viewpoint was the one that was most related to a medical discourse. Attending Growthpoint and feeling part of the Growthpoint

community were the two most important statements that were endorsed by the service-user group. And I can relate to the importance of peer support as I found great value in attending the Manchester Diabetes Patient Group and will speak more of this later. However, in the early stage of recovery my thoughts and feelings were dominated by a medical discourse. The service-user group also reflected the importance of medication in the recovery process. Finding medication that works and taking medication regularly were highly endorsed statements. This mirrored my own experience. I was beginning to learn of some of the long term consequences of living with diabetes. There is an increased incidence of heart disease, retinal damage, problems with podiatry, problems with decreased circulation and a host of potential long term complications. As such, finding medication that works and taking medication regularly were very important to me.

Other statements that were highly endorsed by the service user group related to a reduction in symptoms for mental health problems. Feeling happier and being able to concentrate and remember things were important to the group. Once again, I could relate to this and the idea of being able to concentrate and feeling less frustrated were statements I highly endorsed. For me these items related to my social and academic functioning. There was also a realisation that my physical health had to take priority over other things in my life. This is reflected in the service user group where Factor Two participants were less likely to be in employment or at college than other factor participants. Although I was in employment, I could empathise with the view that immediate health concerns were more relevant than work or occupational concerns. That was a difficult thing for me to come to terms with and in consultation with the university and my research tutor I was given an extension for the hand-in of my thesis.

Another aspect of commonality related to accessing services. The Factor Two participants were more likely to access multiple levels of support from mental health services, medication, Growthpoint, Psychological Therapy, and Support Worker. I found myself in a similar situation as a diagnosis of diabetes automatically triggers a number of associated appointments in relation to podiatry, retinal scans and visits to the diabetes clinic.

Analyse Feelings and Knowledge Relevant to the Situation

I remember the thoughts and feeling I had at that time related to a fear of failure in my academic work, becoming frustrated that I could not work at previous levels of intensity and feeling upset that I wasn't enjoying the research process as it had become more of a task than a joy.

There were also feelings of fear and anxiety relating to the long term consequences of diabetes. I knew that I didn't have enough knowledge or experience in relation to diabetes. The practice nurse was able to give me information and leaflets. However, the reliance on medical advice and medication was not something I was fully comfortable with and I felt that control was somewhat out of my hands and I sometimes felt a degree of hopelessness. This is perhaps a difference to my situation than those in Factor Two who felt it was less important that they had a choice in the treatment they received.

A major turning point for me was attending the Diabetes Patient Support Group in Manchester. I could see the value of this in the same way that service users see the value in Growthpoint. It was really important to discuss this common perspective with other people. In particular, it was good to meet someone else who had very high blood sugar levels as this clinical feature tends to bring additional issues. For example it requires higher levels of oral medication that can be a gastric irritant. It was great to get some tips on how to deal with that particular issue.

Gaining access to a peer support group was a really powerful moment. Having access to an experiential perspective was a different kind of knowledge and a different kind of emotion was evoked. Before I felt quite alone and afraid in dealing with those issues. And then suddenly, not only were other people feeling those same concerns, but there were dealing with those issues and dealing with them successfully. This brought about the realisation that if those people could deal with these issues, then so could I.

Evaluate the relevance of Knowledge

So what was so powerful about gaining new knowledge and perspectives?

Firstly, there was the idea that knowledge is power and by developing my own understanding of diabetes and treatments, I was less reliant on the medical professionals. I'm not sure why this is so important to me, but it certainly ties in with my views on self-efficacy and feelings of self-worth. I think the process of receiving a diagnosis and being reliant on others had a negative effect on those aspects of my identity. Although these issues were not specifically covered in the Q-Sort questions, I would hypothesise that a similar emotion may be present in the service-user population.

Another, powerful outcome of the reflective process is gaining new meaning of the process of recovery. There is an idea that recovery should be all or nothing and a complete cessation of symptoms is the end point of recovery. However, my own experience has taught me that this is not the case. Diabetes is likely to be a lifelong diagnosis and I am likely to need medication for the rest of my life. But that does not mean that I need to be a passive recipient of treatment. I can make the relevant lifestyle changes to help control this condition. I have started to make those changes and there have been some significant improvements. A similar viewpoint was more relevant in Factor One and Factor Three participants in the main study. Hope for the future and developing personal strengths were seen as being important statements for those groups. It seems to me that when people are past the initial stage of illness and the immediate symptoms are under control then a process of reflection is easier to begin. For many of the participants in Factor Two it may well be that they have severe and enduring mental health problems and their focus is dealing with the immediacy of those issues. And perhaps the views put forward by those in Factor One and Factor Three are more optimistic in how they look to the future.

Certainly the results of my personal reflections are that I feel more positive in relation to the future and I feel better equipped now to deal with problems related to my diabetes than I did previously.

Identify any learning that has occurred

I've found the reflective process to be an interesting one. There are obvious methodological problems in entering my Q-Sort data into the main analysis when I'm answering the question in relation to diabetes and not mental health. However, in the spirit of Dallos & Stedman, and being playful with reflective practice it has provided a useful "rule of thumb" to measure how my experiences measured in comparison to others.

I think reflecting on my personal experiences in this way has given me a better understanding of what recovery may feel like for a service-user. It's difficult to determine how other people may feel when they have common experiences, due to the subjective nature of feelings and emotions. But I think there has been enough commonality in the Q-Sort statements to believe that reflections on my own thoughts, feelings and emotions in my journey of recovery may give an insight into the thoughts, feelings and emotions that service users may experience in relation to their experiences of recovery from mental health problems. This type of experience is described in the research literature on reflective practice.

Chinn (2007) highlights the importance of personal reflexivity and acknowledges that for therapists "her own agendas, experiences, motivations and political stance contribute to what goes on in work with clients". The therapist's subjective perceptions of interpersonal power and inequality are viewed as important aspects both of personal reflective and reflexive processes. As such, an awareness of our own relational position could easily be triggered in the moment of therapeutic engagement and can provide an important point of reference for looking back over the therapy.

As such, I have found this to be a valuable exercise in using reflective practice to better understand my own, and others, journey of recovery.

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Appendices

Appendix 1A) Journal Instructions for authors

Author Guidelines

Instructions to Authors

The Journal of Community Psychology is a peer-reviewed journal devoted to research, evaluation, assessment, and intervention. Although review articles that deal with human behavior in community settings are occasionally accepted, the journal's primary emphasis is on empirical work that is based in or informs studies to understand community factors that influence, positively and negatively, human development, interaction, and functioning. Articles of interest include descriptions and evaluations of service programs and projects; studies of youth, parenting, and family development; methodological studies for the identification and systematic alteration of risks; and protective factors for emotional and behavioral disorders and for positive development. The journal also publishes the results of projects that inform processes relevant to the design of community-based interventions including strategies for gaining entry, engaging a community in participatory action research, and creating sustainable interventions that remain after project development and empirical work are completed.

Authors are required to follow the APA Publication Guidelines. Authors must state explicitly that appropriate ethical guidelines on human and animal (where applicable) have been followed and that the work was reviewed and approved by an institutional review board (IRB) according to NIH regulations relating to research involving human subjects. Authors must also identify any actual or perceived conflicts of interest in their conduct of the research reported in their submission.

Types of manuscripts: Three types of contributions are considered for publication: full-length articles, brief reports of preliminary and pilot studies that have particular heuristic importance and, occasionally, commentaries on conceptual or practical issues related to the discipline's theoretical and methodological foundations. Typically, empirical articles are approximately 30 pages including tables, references, etc.; brief reports cannot exceed 12 pages; and commentaries should not, in general, exceed 20 pages. All material submitted will be acknowledged on receipt, assigned a manuscript number, and subject to peer review. Copies of the referees' comments will be forwarded to the author along with the editor's decision. The review process ranges from 12 to 16 weeks, and the journal makes every effort to publish accepted material within 12 months.

Manuscript submission: The Journal of Community Psychology has adopted an online submission process, available at mc.manuscriptcentral.com/jcop

Format of submitted material: All copy, including references and captions, must be typed double-spaced. An abstract of 150 words or less is required for articles and brief reports.

Style: Authors should follow the stylistic guidelines detailed in the Publication Manual of the American Psychological Association, Sixth Edition, available from the American Psychological Association, Washington, DC. References should also follow APA style.

Title Page: The title page should contain the complete title of the manuscript, names and affiliations of all authors, institution(s) at which the work was performed, and name, address (including e-mail address), telephone and telefax numbers of the author responsible for correspondence. Authors should also provide a short title of not more than 45 characters (including spaces), and five to ten key words, that will highlight the subject matter of the article. Please submit the title page as a separate document within the attachment to facilitate the anonymous peer review process.

Figures: Figures should be professionally prepared and submitted in electronic TIFF or EPS format (if possible) along with high-quality printed hard copies. Good glossy black and white photographs are required for halftone reproduction. Figures should appear at the end of the manuscript, after the text.

Reprints: Reprints of articles may be ordered from the publisher when the corrected proofs are returned. Authors should return the Reprint Order Forms with the proofs.

Guidelines for Electronic Submission

Software and format: Microsoft Word is preferred. Refrain from complex formatting; the Publisher will style your manuscript according to the Journal design specifications. Do not use desktop publishing software such as Adobe PageMaker or Quark XPress. If you prepared your manuscript with one of these programs, export the text to a word processing format. Please make sure your word processing program's "fast save" feature is turned off. Please do not deliver files that contain hidden text: for example, do not use your word processor's automated features to create footnotes or reference lists.

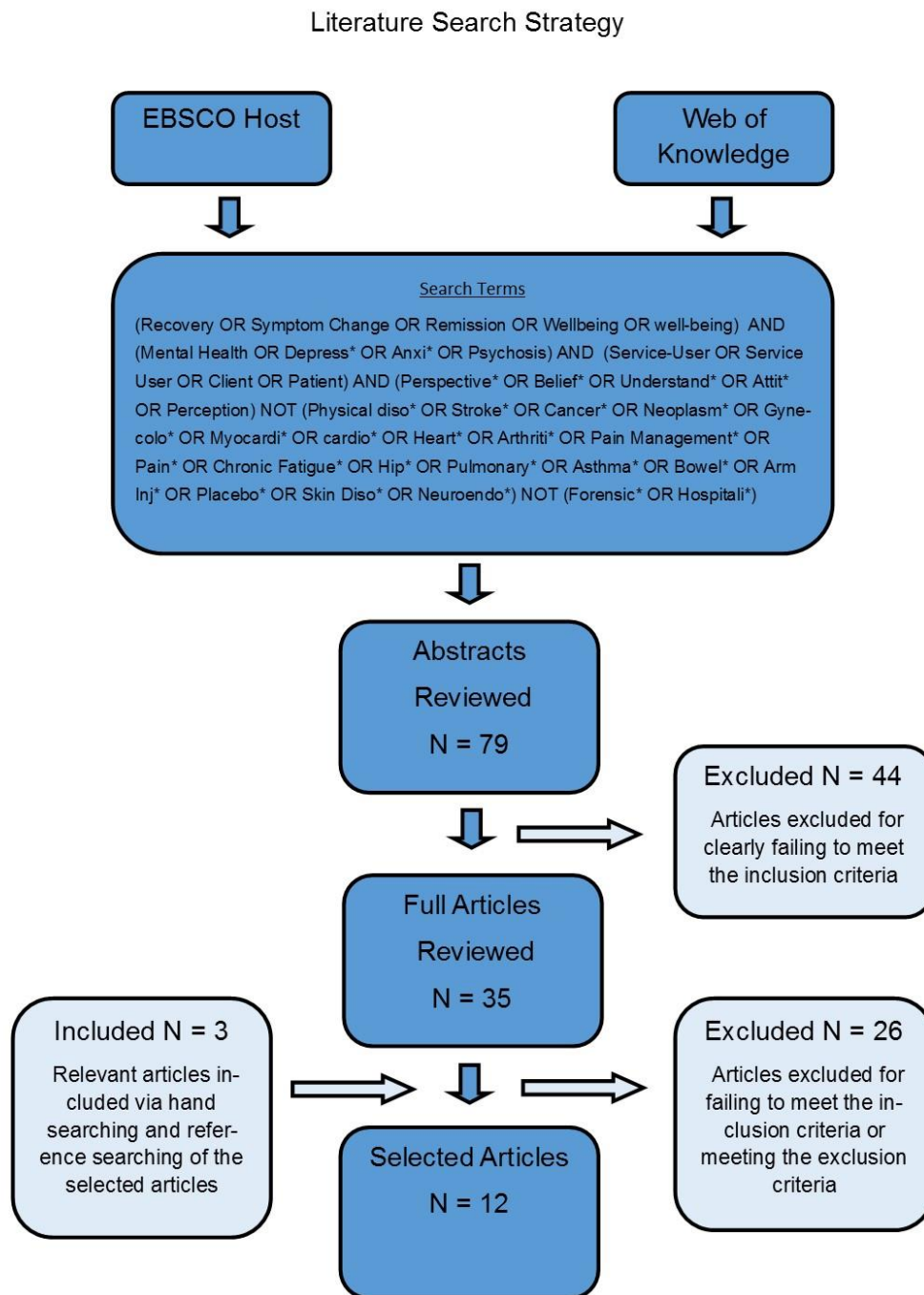
Illustrations: All print reproduction requires files for full color images to be in a CMYK color space. If possible, ICC or ColorSync profiles of your output device should accompany all digital image submissions.

Software and format: All illustration files should be in TIFF or EPS (with preview) formats. Do not submit native application formats.

Resolution: Journal quality reproduction will require greyscale and color files at resolutions yielding approximately 300 dpi. Bitmapped line art should be submitted at resolutions yielding 600-1200 dpi. These resolutions refer to the output size of the file; if you anticipate that your images will be enlarged or reduced, resolutions should be adjusted accordingly.

File names: Illustration files should be given the 2- or 3-letter extension that identifies the file format used (i.e., .tif, .eps).

Appendix 1B) Flowchart for literature search strategy



Appendix 1C) CASP Example

CASP Master Document

Paper 1	Paper 1 Wood et al. Exploring service user perceptions of recovery from psychosis: A Q methodological approach.
Methodology	Q method approach. Sample N = 40.
Findings	Analysis revealed four distinct perspectives in relation to recovery: Collaborative Support and Understanding. Emotional change through social and medical support. Regaining functional and occupational goals. Self-focused recovery.
Themes	<p>1. Collaborative Support and Understanding This factor (N = 8) consisted of people who felt that positive collaboration and engagement with others was key to the recovery. They were positively motivated to overcome that experiences and accepted help from others to achieve this. One participant stated "I viewed my experiences as very negative but when I viewed it as a positive I felt a lot better and recovered a lot quicker and I accepted all the help I could" this script tended not to focus on the negative aspects of having a mental health problem. For example statements relating to shame and embarrassment, unpleasant experiences, and how much I dwell in my experiences were not considered important.</p> <p>2. Emotional change through social and medical support. This factor (N =10) comprised of people who considered emotional stability through support and treatment as a key factor to recovery. The affective impact of having psychosis, i.e. the emotional impact was prioritised over psychotic symptoms themselves. People were concerned about his experiences affected their happiness, levels of depression, contrasting the red of others, and how their experiences affected the relationships. A factor exemplar stated "I don't have nearly the same amount of the motion as I did and I am trying to find it" "my illness has left me depressed and can be quite frightening when I hit a low my parents and my main support when I hit a low" This group did not find the psychiatric characteristics of symptoms or occupational aspects of any importance. They considered the amount of alcohol and drug use that worse is my experiences, my living arrangements as a result of my experiences, the amount to which my voices of inside my head compared to outside my head, how loud my voices are, my belief that my experiences come from my own mains, how positive I view my experiences, my ability to find work as a result of my experiences, were not important.</p> <p>Factor 3: Regaining functional and occupational goals. This factor (n=9) consisted of people who considered functional and occupational goals as the key to their recovery. It was important to this group to regain life functioning and aspects that hindered this process were considered important to change in recovery. For example statements like how my experiences affect the quality and amount of sleep I get, my ability to find work as a result of my experiences, how my experiences affect my relationships with friends and loved ones, my living</p>

	<p>arrangements as a result of my experiences, my ability to look after myself, how vulnerable I feel as a result of my experiences were all seen as important.</p> <p>One factor member stated "I feel as though I've gone downhill, I've lost everything, job, house."</p> <p>This group did not find it in terminal cognitive aspects to be important. Statements like how withdrawn I am as a result of my experiences, how empowered I feel over my experiences, how unpleasant my experiences voices are, how often my experiences happen, how my experiences alter my ability to control my own thoughts, how much support I get from other service users, were not seen as important.</p> <p>Factor 4: Self Focused Recovery</p> <p>This factor (N=5) consisted of people who were internally focused on recovery. The aspects they found important involved the self and feelings of isolation. This group felt persecuted and unsupported by services and felt they could only be dependent on themselves for recovery. They found factors such as how my experiences affect my personal freedoms and rights, how withdrawn I am as a result of my experiences, how my experiences affect my men at the end concentration, how positive I view my experiences, how much I've dwell on my experiences, how much religion/spirituality was involved with my experiences. A participant from this factor stated "because I feel people give me no support" statements such as how loud my voices are, the amount to which I think about harming myself as a result of my experiences, how helpful I feel psychological therapies are with my experiences, the amount to which my voices are inside my head compared to outside my head, how active I wasn't seeking help with my experiences, read amongst the least important factors.</p> <p>Five participants left additional feedback outlining how the phone completing the questionnaire and how useful the Q sort was in helping understand that experiences. For example "this research has enabled me to reach deeper into some of the questions asked of me" "I found the research very helpful" "I have found this exercise quite helpful and I hope it is helpful to others especially patients nurses and doctors" "found test easy and it opened my eyes further to understanding about my diagnosis, it helped me further"</p> <p>The correlations between the factor scores indicated no overlap between factors. This suggests there are different aspects of recovery from psychosis and that these are not necessarily linked to alleviation or removal of symptoms and highlights the idiosyncratic nature of people's recovery.</p>
Strengths	Service user them to lead in the design and implementation
Weaknesses	The factor solution only explains 36% of the variance with eight people not loading onto any of the factors. Therefore it is acknowledged that only tentative interpretations can be drawn from the results. It was also acknowledged that the sample size where predominantly from the same ethnic group. Exploring recovery with different ethnic minorities with identify any differences in approaches to recovery and would help service provisions for those from different cultural backgrounds
Comments	The most endorsed items by service users support previous literature regarding important aspects of the company. For example, "how much support I get from loved

	<p>ones" and "how my experiences have affected my relationships with friends and loved ones" where deemed important and these are consistent with those reported previously. (Including paper hand search one and hand search three)</p> <p>Changing personality was also identified as an important factor that occurred during the company, perhaps similar to the team identified by pitting colleagues of "Rebuilding Self" identified in Pitt et al and this may highlight the themes of having hope and positivity in recovery identified another research</p> <p>The four factor solution provides an interesting insight into recovery and the different types of recovery sales. For example the factor related to collaborative support and understanding highlighted the importance of positive thinking appropriate support and understanding from others in recovery from psychosis. Interestingly the participants are loaded onto this factor had the shortest duration of psychotic experiences. This may indicate that a positive outlook may be associated with a shorter service history and this would support the idea of early intervention and detection in recovery.</p> <p>The factor related to emotional change through social and medical support highlights a group of people who want to tackle the affective impacts of having psychotic experiences such as reducing distress and levels of depression. There has been increasing emphasis placed on a mortal distress and psychosis with some new therapies aiming to focus primarily on this area. Therefore this factor highlights that some people may need to focus on emotional distress rather than the actual psychotic symptoms.</p> <p>The third factor of regaining functional and occupational goals illustrates the importance of regaining social roles and social integration within recovery. This group emphasise the importance of acknowledging social integration and the impact of stigma within psychological therapy. This supports the idea that social ranking may play an important role in facilitating recovery from psychosis. Furthermore this recovery style seems to support the distinct factors outlined by Neal et al 2009 who stated that interpersonal recovery is a vital process that has value in the external world.</p> <p>The factor relating to self focused recovery highlights that people who described approach to recovery as individual. This group do not value external support and solely place importance on internal factors. Interestingly people who loaded onto this factor had the more symptom experience. A link has been highlighted between people with severe than enduring psychotic experiences and negative service experiences which is an important issue to overcome in recovery. Therefore it is always important to assess service users previous relationships with services and to be mindful of the impacts this can have on the recovery style.</p>
Q Sort Statements?	See page 10 for list of statements. Many are psychosis related but relevant.

Appendix 2A) Journal Instructions for authors

Manuscript Submissions

The primary mission of *Operant Subjectivity: The International Journal of Q Methodology* is to foster understanding of subjectivity through presentation of original research, theoretical and philosophical critique, and methodological clarification. An anonymous peer-review process assists the Editor and Editorial Board to select manuscripts for publication. The journal is committed to the ideas and concepts of Q methodology as enunciated by William Stephenson (1902–1989) and, while not precluding alternative viewpoints, encourages contributions compatible with this commitment. Manuscripts should be submitted to the Editor via electronic mail. Submissions are assumed to be original work for publication not under consideration elsewhere.

Brief Instructions for Authors

Ordinarily, manuscripts should be 6,000 to 12,000 words in length, accompanied by a 150 to 200-word abstract. Authors should follow the style of the 6th edition of the *Publication Manual of the American Psychological Association* (APA 6th; 2009). All copy should be typed, double-spaced in Times New Roman 12-point or similar font.

Manuscripts should include a cover sheet with the title, author's name, address, phone number, and email address, along with a brief biographical statement (2–3 sentences). Ordinarily, the submitting author's email address will be used as a contact address for communication from the editors, and will be published with accepted manuscripts. If the article was authored by more than one person, coauthors' names, phone numbers, email addresses, institutional affiliations, and biographical statements should also be included. However, to assure appropriate blind review, the author's name and identifying information should NOT appear in headers, footers, reference lists, or other portions of the manuscript text. Information that would identify the author should be replaced with the word "Author" in lieu of the author's name or identifying information.

Place references, tables, and figures at the end of the manuscript. All tables and figures should be included in the electronic file. Use centred brackets to indicate the approximate place of the table or figure in the text. Use Word to draw tables when possible. Do not add shading, remove or change the appearance of gridlines, or vary the type size or appearance in the table. It is preferable to avoid footnotes. Use only one space after a period (full stop). References must be presented in APA format. *Operant Subjectivity* accepts manuscripts using British or American English spelling and grammar.

Specific Guidelines for Applied Research

'Applied research' refers to reports of a study in which Q methodology was used. The best applied research is of interest to readers of *Operant Subjectivity* when it shows contributions from the study of subjectivity to knowledge in new topic areas. Stephenson frequently argued that Q could be useful where other (often objective) research was found wanting. Here are some additional guidelines and some exceptions to the above that should be considered when developing an applied research manuscript. To be accepted, the paper must make an original contribution to understanding of subjectivity in its substantive topic area (such as teacher training or hospice care). If it also makes an original contribution to Q methodology as a methodology (such as demonstrating a new technique with non-verbal Q sorting or an innovation in comparative research design), it is not considered solely applied research and the guidelines below need not be followed in every detail.

Readers are knowledgeable about the basics of a Q-methodology study. For such readers, papers must supply information on the important parameters of the research design, implementation and analysis. Do not include routine explanations of the methods used (such as is required for a non-Q audience), diagrams of the sorting grid or similar basic information.

Applied research articles will normally be between 3,000 and 4,000 words. These articles will be peer-reviewed along the lines of the guidance in this section. By emphasizing the contribution to the study of subjectivity in the application for Q methodologists, authors may be able to publish a second paper from the same study in a disciplinary journal (without contravening the conventions of academic publishing). The disciplinary paper would reverse the emphasis, by explaining the Q study in detail, and providing specialist-specific discussion on the substantive value of the findings.

A suggested format for such papers follows (headings tailored by authors):

- Introduction
- Literature Review: a brief consideration of the salient literature in the applied area, in order to situate the Q findings in their context. (Check: would subject experts agree with your context-setting?) If other Q studies have been done in related areas, these should be summarized, and the continuing gap in understanding highlighted. From your review, a non-specialist reader needs to see why specialists might find the study of interest.
- Research Design: a brief description of the parameters of the design (including the research question or purpose, numbers of items and sorters, sorting condition [face-to-face, online, email], information about follow-up interviews, significant loaders per factor, software, methods of factor extraction and rotation, and correlations between factors).
- Findings: a presentation of the factor interpretations, in a manner that makes full use of the factor array. Do not simply report a few high - or low - scored items, or paraphrases of them. Normally only one table will be needed, showing the factor array. However, the text itself should convey the salient information.
- Discussion: a brief section on how the study has advanced understanding of subjectivity in the applied field.
- Conclusion: a summary statement of the insights gained and how they have advanced knowledge of subjectivity in the applied field.

Appendix 2B) Peer review letter from Keele University



RESEARCH AND ENTERPRISE SERVICES

10th July 2013

Heather Wood
Clinical Psychology Professional Doctorate
Faculty of Sciences – Science Building
Staffordshire University

Dear Heather,

Title: A Q Sort Study: Service-User and Trainee Psychologists perspectives of recovery in a community based project

The above project was initially awarded a grade 2 but following assessment of your revisions the project now has received final approval from the Independent Peer Review Committee and can be submitted for ethical approval. Please find attached the peer review comments and accompanying letter for the above project. LREC requests that all peer review proforma/s are sent along with your LREC application form. Although this project has been deemed appropriate based on scientific merit, you may wish to incorporate the reviewer's constructive comments to strengthen your protocol.

Management approval

You should arrange for all relevant NHS care organisations to be notified that the research will be taking place, and provide a copy of the REC application, the protocol and this letter.

All researchers and research collaborators who will be participating in the research must obtain management approval from the relevant care organisation before commencing any research procedures. Where a substantive contract is not held with the care organisation, it may be necessary for an honorary contract to be issued before approval for the research can be given.

Clinical trial of a medicinal product

Please remember that, if your project is a clinical trial of a medicinal product, MHRA approval is required. You must submit a request for a clinical trial authorisation under the Medicines for Human Use (Clinical Trials) Regulations 2004. Further details can be found at <http://www.mhra.gov.uk/home/groups/l-unit1/documents/websiteresources/con2022633.pdf>

If you have any queries, please do not hesitate to contact Hannah Reidy on 01782 733588.

Yours sincerely

Professor A A Fryer
Chair – Independent Peer Review Committee

Enc

CC R&D Office, UHNS

Research and Enterprise Services, Keele University, Staffordshire, ST5 5BG, UK
Telephone: + 44 (0)1782 734466 Fax: + 44 (0)1782 733740

10th July 2013

Chair
NHS Research Ethics Committee

Dear Sir/Madam

Investigator : Heather Wood

Name of study : A Q Sort Study: Service-User and Trainee Psychologists perspectives of recovery in a community based project

Please find attached the peer review of the above project.

The Independent Peer Review Committee has graded this project at level 1 and therefore can proceed for ethical review without any revision.

We have informed the applicant that although this project has been deemed appropriate based on scientific merit, they wish to incorporate the reviewer's constructive comments to strengthen their protocol.

We have also stressed to the applicant that the Independent Peer Review Committee is NOT linked to or a Sub-Committee of the Local Research Ethics Committee and that you may identify ethical issues of your own.

If you have any queries, please do not hesitate to contact Hannah Reidy on 01782 733588.

Yours sincerely

Professor AA Fryer
Chair – Independent Peer Review Committee

Enc

CC R&D Office, UHNS

Research Project Details	
Project title	A Q Study: Perspectives of recovery in a community project
Name of principal investigator	Heather Wood
Institution of principal investigator	Student: Staffordshire University / Keele University

The important or relevance of the problem to be addressed in relation to either or both of:

- a) The particular field of research as a whole

- b) The value of this research for health or social care

On both accounts a valuable area of research to seek patient perspectives of treatment strategies for conditions and diseases and also to compare to the views of health care professionals

The quality and relevance of the background information provided

Good overview given in the background. Some information on health care professionals perspectives on management of such conditions would have made it even more complete, to complement the views of the patients/users

Design, methods and strengths and weakness of the proposed plan of investigation

Overall the design and means of analysis was logical but there were a few gaps in the presentation of this data. The methods were clearly described for the service users but not so for the selection of the clinical psychologists and what they would have to do in this study. You mentioned a focus group for the service users briefly but then it did not show as being part of the study flow chart which it should do. Will the clinical psychologists have a focus group as well? The patient information leaflets is designed to be read by the service users what about the clinical psychologists and will you have a separate consent form for the two groups. This just needs to be refined and clarified more precisely to avoid any confusion

The quality of analysis provided (statistical or qualitative, as appropriate)

Fine

The capacity and expertise of the research team in the context of the proposed study

Fine

Appropriateness of resource requirements

No problems

General feedback (indicate major areas where changes will be required, indicate whether any weaknesses indicated in any of the above categories are major or minor areas of concern)

The areas mentioned above about clarifying the methods for both groups involved in this study needs to be made clearer and adjustments to information leaflets and study flow charts also need to be made. At the moment it is no clear enough what the psychologists will be expected to do in this study and if they too will have a focus group and if not why not.

Assessment of Merit

Grading	Description	Please tick
1	Proceed without any revision. Project may be submitted for appropriate NHS/University approval and then to either the Local or the Multi-Centre Research Ethics Committee.	
2	Minor amendments or Further information required. Revise project according to reviewer(s) recommendations. Document to be checked by Internal Committee Member prior to Chairman's approval to proceed.	X
3	Complete major revision required. Principal Investigator to discuss outcome with Centre/Programme Director and agree plan to complete substantive revision of the project (with support as agreed). Resubmission will need to be reviewed and approved by Internal Committee Member, prior to Chairman's approval to proceed.	
4	Reject on the basis that the project has major scientific flaws	

Appendix 2C) Indemnity certificate from Keele University



23rd July 2013

VERIFICATION OF INSURANCE

TO WHOM IT MAY CONCERN

We act as insurance brokers to the above client and in this capacity can provide brief details of their current Professional Indemnity policy

Insured	Keele University, Keele University Science Park Ltd and Keele University Science and Business Park Ltd.
Insurer	RSA Group
Period of Insurance	1 st August 2013 to 31 st July 2014
Policy Number	SA13328793
Limit of Indemnity	£5,000,000 for each claim and in the aggregate in respect of all claims first made in any one period of insurance with one automatic reinstatement of the limit to provide an additional £5,000,000 of cover in the aggregate if the first £5,000,000 is exhausted. In respect of claims made against the Insured in the USA or Canada the Limit of Indemnity is restricted to £1,000,000 in the aggregate in any one period of insurance, with no automatic reinstatement.
Excess	£25,000 each and every claim

This document is provided for information only and is subject to Insurers policy terms, conditions, limitations and exclusions. Cover may also be subject to cancellation provisions and warranties.

LOCKTON COMPANIES LLP

4th Floor Higham House, New Bridge Street West, Newcastle upon Tyne NE1 8AN
Tel: 01912613077/ Fax: 01912613060
www.lockton.com

A limited liability partnership registered in England & Wales at The St Botolph Building, 138 Houndsditch, London EC3A 7AG. Company number: OC353198
Authorised and regulated by the Financial Conduct Authority and a Lloyd's Broker
A list of the designated members and individual members of Lockton Companies LLP is available for inspection at the registered office

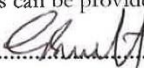


The issuance of this document does not make the person or organisation to whom it has been issued an additional insured and confers no rights upon the recipient, nor does it modify in any manner the contract of insurance between the Insured and Insurers.

Lockton does not accept any liability or responsibility to any Third Party in respect of the information provided nor do Lockton have any obligation to advise any changes to or cancellation of the insurances described.

This letter shall be governed by and shall be construed in accordance with English law and the courts of England and Wales shall have exclusive jurisdiction.

We trust that this information is sufficient for your purposes however, should you require additional detail this can be provided upon agreement from our client.

SIGNED.......... DATED: 23rd July 2013

PRINT NAME: George Smith

For and on behalf of Lockton Companies LLP

Appendix 2D) NHS approval - NRES Committee South Central - Hampshire B



Health Research Authority **NRES Committee South Central - Hampshire B**

Level 3 Block B
Whitefriars
Lewins Mead
Bristol
BS1 2NT
Telephone: 01173421334

11 July 2014

Ms Heather Wood
Clinical Psychologist in Training
North Staffordshire Combined Healthcare Trust
Staffordshire & Keele Doctorate in Clinical Psychology
Science Building, Leek Road
Stoke-on-Trent
ST4 2DF

Dear Ms Wood

Study title:	A Q Sort Study: Service-User and Trainee Psychologists perspectives of recovery in a community based project.
REC reference:	14/SC/1137
Protocol number:	N/a
IRAS project ID:	128468

The Proportionate Review Sub-committee of the NRES Committee South Central - Hampshire B reviewed the above application on 10 July 2014.

We plan to publish your research summary wording for the above study on the NRES website, together with your contact details, unless you expressly withhold permission to do so. Publication will be no earlier than three months from the date of this favourable opinion letter. Should you wish to provide a substitute contact point, require further information, or wish to make a request to postpone publication, please contact the REC Manager Miss Natasha Bridgeman, nrescommittee.southcentral-hampshireb@nhs.net.

Ethical opinion

On behalf of the Committee, the sub-committee gave a favourable ethical opinion of the above research on the basis described in the application form, protocol and supporting documentation, subject to the conditions specified below.

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

- 1) Please provide a separate consent form for the participants from Growthpoint and for the trainee clinical psychologists
- 2) Please ensure that the term 'participants' is used consistently throughout the PIS and not interchanged with the term 'patients'.
- 3) Please check the PIS for typographical accuracy.

Recommendation

- 1) Recommend that researchers consider registering study on a public database

You should notify the REC in writing once all conditions have been met (except for site approvals from host organisations) and provide copies of any revised documentation with updated version numbers. The REC will acknowledge receipt and provide a final list of the approved documentation for the study, which can be made available to host organisations to facilitate their permission for the study. Failure to provide the final versions to the REC may cause delay in obtaining permissions.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission ("R&D approval") should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.

Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at <http://www.rdforum.nhs.uk>.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of approvals from host organisations.

Registration of Clinical Trials

All clinical trials (defined as the first four categories on the IRAS filter page) must be registered on a publically accessible database within 6 weeks of recruitment of the first participant (for medical device studies, within the timeline determined by the current registration and publication trees).

There is no requirement to separately notify the REC but you should do so at the earliest opportunity e.g. when submitting an amendment. We will audit the registration details as part of the annual progress reporting process.

To ensure transparency in research, we strongly recommend that all research is registered but for non-clinical trials this is not currently mandatory.

If a sponsor wishes to contest the need for registration they should contact Catherine Blewett (catherineblewett@nhs.net), the HRA does not, however, expect exceptions to be made. Guidance on where to register is provided within IRAS.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Ethical review of research sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion").

Summary of discussion at the meeting

Suitability of the applicant and supporting staff.

The Committee asked for clarification of whether you were part of the therapy team at Growthpoint or just part of the research team.

You confirmed that your involvement at Growthpoint was purely in a research role. You stated that you were employed as a Clinical Psychologist in Training by North Staffordshire Combined Healthcare Trust, who fund Growthpoint, and as such you were involved in the provision of therapy in other parts of the trust. However, with regards to Growthpoint, you were simply carrying out this research project.

Approved documents

The documents reviewed and approved were:

Document	Version	Date
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Keele Indemnity Certificate]	1	23 July 2014
Non-validated questionnaire [Q Sort Grid Example 2 July 2014]	4	02 July 2014
Other [HW GCP Certificate]		24 October 2012
Participant consent form [Trainee Consent Form vers 3 June 2014]	3	01 June 2014
Participant consent form [Client Form vers 3 June 2014]	3	01 June 2014
Participant information sheet (PIS) [PIS Vers 3 June 2014]	3	01 June 2014
REC Application Form [REC_Form_02072014]		02 July 2014
Referee's report or other scientific critique report [Approval Letter Keele University]	3	10 July 2013
Research protocol or project proposal [Protocol Vers 3 June 2014]	3	01 June 2014
Summary CV for Chief Investigator (CI) [CV H Wood]		
Summary CV for supervisor (student research) [CV Dr H Combes]		07 February 2012
Summary, synopsis or diagram (flowchart) of protocol in non technical language [Study flowchart vers 3 June 2014]	3	01 June 2014

Membership of the Proportionate Review Sub-Committee

The members of the Sub-Committee who took part in the review are listed on the attached sheet.

There were no declarations of interest.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for

Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical reviewReporting requirements

The attached document "After ethical review – guidance for researchers" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The HRA website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

Feedback

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website <http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/>

We are pleased to welcome researchers and R & D staff at our NRES committee members' training days – see details at <http://www.hra.nhs.uk/hra-training/>

With the Committee's best wishes for the success of this project.

14/SC/1137	Please quote this number on all correspondence
-------------------	---

Yours sincerely



Dr Giles Tan
Vice-Chair

Email: nrescommittee.southcentral-hampshireb@nhs.net

Enclosures: List of names and professions of members who took part in the review
"After ethical review – guidance for researchers" [SL-AR2]

Copy to: Ms Nicola Leighton Ms Laurie Wrench, North Staffordshire Combined Healthcare Trust



Health Research Authority

NRES Committee South Central - Hampshire B

Attendance at PRS Sub-Committee of the REC meeting on 10 July 2014

Committee Members:

<i>Name</i>	<i>Profession</i>	<i>Present</i>	<i>Notes</i>
Mrs Angela Iveson	Oncology Research Nurse	Yes	
Dr Karl Nunkoosing	Principal Psychology Lecturer	Yes	
Dr Giles Tan (Vice-Chair)	Consultant Psychiatrist	Yes	

Also in attendance:

<i>Name</i>	<i>Position (or reason for attending)</i>
Miss Natasha Bridgeman	REC Assistant

Appendix 2E) NHS approval - NRES Committee South Central - Hampshire B



Health Research Authority

NRES Committee South Central - Hampshire B

Level 3 Block B

Whitefriars

Lewins Mead

Bristol

BS1 2NT

Telephone: 0117 342 1384

23 February 2015

Ms Heather Wood
Clinical Psychologist in Training
North Staffordshire Combined Healthcare Trust
Staffordshire & Keele Doctorate in Clinical Psychology
Science Building, Leek Road
Stoke-on-Trent
ST4 2DF

Dear Ms Wood

Study title: A Q Sort Study: Service-User and Trainee Psychologists perspectives of recovery in a community based project.
REC reference: 14/SC/1137
Protocol number: N/a
IRAS project ID: 128468

Thank you for your letter of 15 February 2015. I can confirm the REC has received the documents listed below and that these comply with the approval conditions detailed in our letter dated 11 July 2014.

Documents received

The documents received were as follows:

Document	Version	Date
Covering letter on headed paper		15 February 2015
Participant consent form [Service User CF]	3	01 June 2014
Participant consent form [Trainee Psychologist]	3	01 June 2015
Participant information sheet (PIS) [Service User PIS]	4	01 July 2014

Approved documents

The final list of approved documentation for the study is therefore as follows:

Document	Version	Date
Covering letter on headed paper		15 February 2015
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Keele Indemnity Certificate]	1	23 July 2014
Non-validated questionnaire [Q Sort Grid Example 2 July 2014]	4	02 July 2014
Other [HW GCP Certificate]		24 October 2012
Participant consent form [Service User CF]	3	01 June 2014

A Research Ethics Committee established by the Health Research Authority

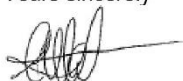
Health Research Authority

Participant consent form [Trainee Psychologist]	3	01 June 2015
Participant information sheet (PIS) [Service User PIS]	4	01 July 2014
REC Application Form [REC_Form_02072014]		02 July 2014
Referee's report or other scientific critique report [Approval Letter Keele University]	3	10 July 2013
Research protocol or project proposal [Protocol Vers 3 June 2014]	3	01 June 2014
Summary CV for Chief Investigator (CI) [CV H Wood]		
Summary CV for supervisor (student research) [CV Dr H Combes]		07 February 2012
Summary, synopsis or diagram (flowchart) of protocol in non-technical language [Study flowchart vers 3 June 2014]	3	01 June 2014

You should ensure that the sponsor has a copy of the final documentation for the study. It is the sponsor's responsibility to ensure that the documentation is made available to R&D offices at all participating sites.

14/SC/1137	Please quote this number on all correspondence
-------------------	---

Yours sincerely



Libby Watson
REC Manager

E-mail: nrescommittee.southcentral-hampshireb@nhs.net

Copy to: *Ms Nicola Leighton*
Ms Laurie Wrench, North Staffordshire Combined Healthcare Trust

Appendix 2F) R&D approval – North Staffordshire Combined Healthcare Trust

RESEARCH AND DEVELOPMENT DEPARTMENT

Trust Headquarters (Lawton House)
Bellringer Road, Trentham, Stoke-on-Trent, ST4 8HH
Telephone: 01782 441687/651 : Fax: 01782 441637/624
Email: r&d@northstaffs.nhs.uk : Twitter: [@nschtresearch](https://twitter.com/nschtresearch)

06 March 2015

R&D Ref: CHC0099/RD

Heather Wood
Staffordshire University
Leek Road
Stoke-on-Trent
ST4 2DF

Dear Heather

Study Title: A Q Sort Study – Perspectives of Recovery in a Community Project

Chief Investigator: Heather Wood

Sponsor: Keele University

I can confirm that the above project (R&D application) has been reviewed and given NHS Permission for Research by the Research & Development Department for North Staffordshire Combined Healthcare NHS Trust, and the details have been entered onto the R&D database.

I note that this research project has been approved by South Central Hampshire Research Ethics Committee [Ref. 14/SC/1137].

NHS permission for the above research has been granted on the basis described in the application and supporting documentation. The documents reviewed were:

Document	Version Number	Date
Protocol	3	01.06.2014
Study Flowchart	3	01.06.2014
Patient Information Sheet : SU	4	01.07.2014
Consent Form: SU	3	01.06.2014

The research Sponsor, Chief Investigator, or the local Principal Investigator at a research site, may take appropriate urgent safety measures in order to protect research participants against any immediate hazard to their health or safety. The R&D Office should be notified of any such measures, the reasons for the action and any further action required. The R&D Office should also be notified within the same time-frame as that of the research ethics committee and other regulatory bodies.



R&D-TMP-001

Chairman: Mr Ken Jarrold CBE

Chief Executive: Mrs Caroline Donovan

Working to improve the mental health and wellbeing of local communities

 [@nscht1](https://twitter.com/nscht1)

www.combined.nhs.uk

Version 4.1 (03/12/2013)

Page 1 of 2

Approval by the R&D Department therefore assumes that you have read, understand and agree to comply with the following:-

- ❖ Research Governance Framework (www.doh.gov.uk/research)
- ❖ ICH Guidelines on Good Clinical Practice
- ❖ Data Protection Act 1998
- ❖ Mental Capacity Act 2007
- ❖ Medicines for Human Use (Clinical Trials) Regulations 2004
- ❖ Human Tissue Act 2004
- ❖ All applicable Trust policies & procedures

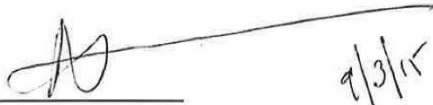
In line with these requirements, may I draw your attention to the need for you to provide the following documentation/notifications to the R&D Office throughout the course of the study, and that all amendments (including changes to the local research team) need to be submitted to, and approved by R&D, in accordance with IRAS guidance:-

- ❖ Annual Progress Report (form sent by this R&D Office)
- ❖ End of Study Declaration Form (available via IRAS)
- ❖ End of Study Report (produced by the Chief Investigator)
- ❖ Changes to study start and end dates
- ❖ Changes in study personnel

Please note that this NHS organisation is required to monitor research to ensure compliance with the Research Governance Framework, and other legal and regulatory requirements. This will be achieved by random audit conducted by this department.

I would like to take this opportunity to wish you well with your research. If you need any further advice or guidance please do not hesitate to contact us.

Yours sincerely



Dr Richard Hodgson
Associate Director for R&D

Copies to:
H. Combes, Academic Supervisor
N. Leighton, Sponsor rep.
Dr D Okolo, Clinical Director



R&D-TMP-001

Chairman: Mr Ken Jarrold CBE

Chief Executive: Mrs Caroline Donovan
Working to improve the mental health and wellbeing of local communities

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Version 4.1 (03/12/2013)

Page 2 of 2

Appendix 2G) Q-Sort statements

1 Having fewer symptoms of a mental health problem	26 Support from other service users
2 Feeling less depressed	27 Support from family or loved ones
3 Seeing a counsellor or therapist	28 Having help in a crisis
4 Being able to concentrate and remember things	29 Feeling part of the Growthpoint community
5 Feeling happy	30 Realising I'm not the only one who feels this way
6 Medication helps me feel less anxious or depressed	31 Learning to join in on groups
7 Having a say in the medication I take	32 Learning about mental health conditions
8 Finding medication that works	33 Sharing stories and experiences with other people
9 Being able to live without medication	34 Developing hope to achieve goals in the future
10 Taking my medication regularly	35 Meeting people who are role models and manage their own recovery
11 Attending Growthpoint	36 Realising that life is full of ups and downs
12 Meeting new people	37 Understanding my past helps me understand things now
13 Taking part in social activities	38 Religion or spirituality
14 Being in employment or education	39 A reduction in self-harm
15 Learning new skills	40 My sexuality
16 Being able to make decisions for myself	41 Quality of sleep
17 Feeling positive about the future	42 Living arrangements or accommodation
18 Understanding myself better	43 Problems with benefits or social services
19 Understanding how my mental health problems have changed	44 Other peoples attitudes towards me
20 Finding new meaning in life	45 Stigma related to mental health
21 Building on my own strengths	46 Challenging peoples attitudes about mental health
22 Attending mental health services	47 Understanding my legal rights
23 Learning to trust other people	48 Having a good relationship with a support worker
24 Being in a relationship	49 Psychological therapies
25 Having someone to talk to about my problems	50 Feeling less angry and frustrated

Appendix 2H) Q-Sort distribution grid



(Version 3: June 2014)

A Q Sort Study: Perspectives of Recovery in a Community Project

It is part of the Q-sort methodology that the sort statements are developed as part of the research process. Therefore although Q is a widely used research method, there are no standardised Q-sorts used in the methodology and each q-sort is unique and individual to each study. Some example statements that we would ask people to rate in the order they think is most important would be similar to the following:-

Example 1) Having peer support or friends at Growthpoint is important in my recovery.

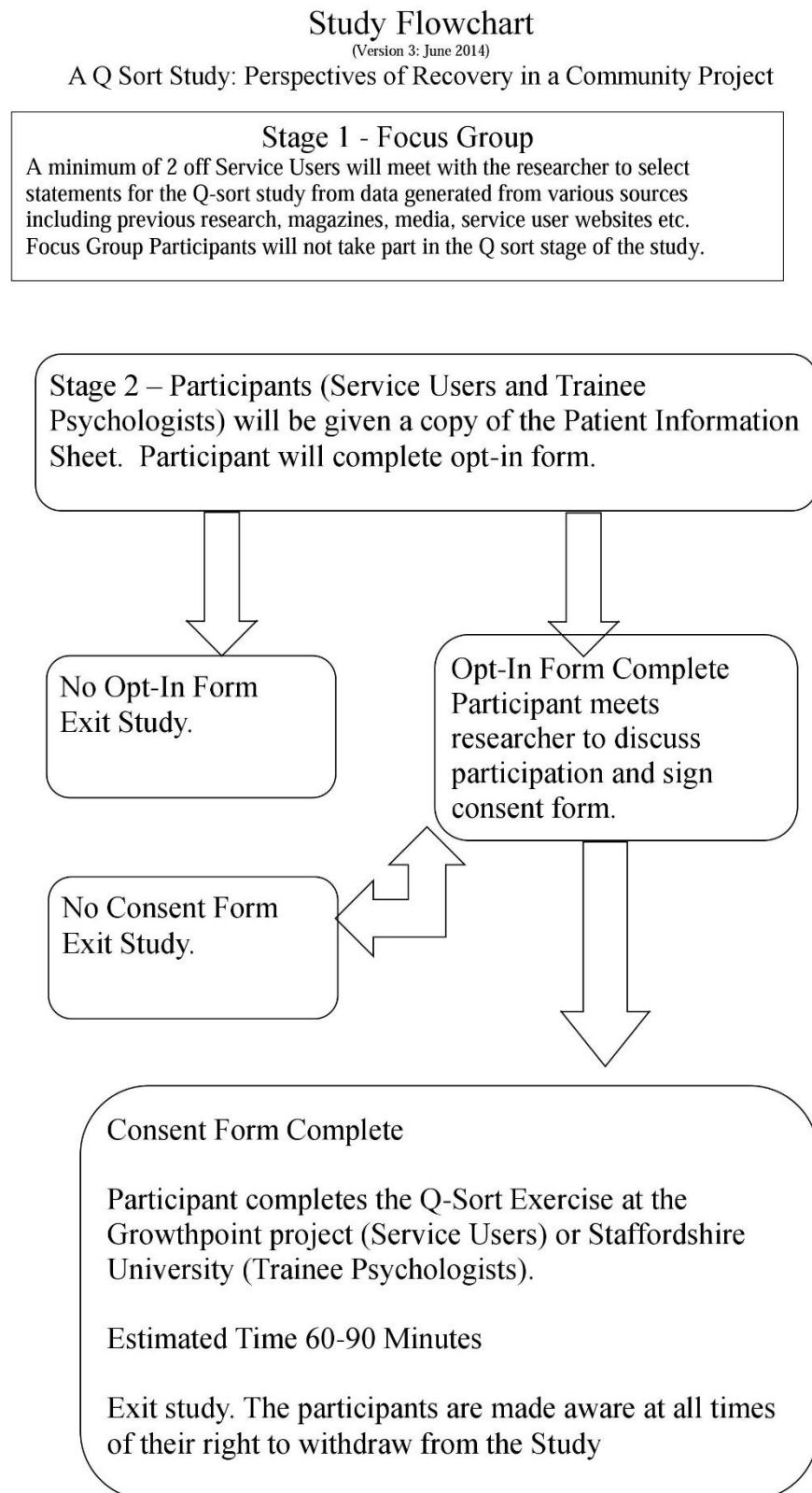
Example 2) Taking medication is important in my recovery.

Example 3) Having counselling is important in my recovery.

Participants would be asked to rate these statement on a Q-Sort grid, and this allows analysis of which factors are seen as important in the recovery process. An example grid is shown below:-

[illegible]

Appendix 2I) Participant Study Flowchart



Appendix 2J) Participant Information Sheet



PARTICIPANT INFORMATION SHEET FOR SERVICE USERS

Version 4/JULY 2014

Project Title: A Q Sort Study: Perspectives of Recovery in a Community Project

Introduction

You are being invited to take part in a research study. The study is being carried out by Heather Wood of Keele University / Staffordshire University as part of the award of a Doctorate in Clinical Psychology.

Before you decide to participate it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part. Thank you.

1) What is the purpose of this investigation?

We hope to learn more about how service user's attendance at the Growthpoint project has helped people to cope with the mental health problems which they may be experiencing currently or in the past.

2) Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason. For service-users a decision to withdraw at any time, or a decision not to take part at all will not affect your continuation of using the Growthpoint project.

3) What will I do in the project?

We would need to see you for about 60 minutes. During this time we would give you a number of cards, each of which has a statement written on it. The statements relate to experiences of mental health problems in a community setting. We would ask you to rate which experiences relate most highly to you and to sort the cards on a grid to show which statements are most relevant to you and which are most important in recovery from mental health problems.

4) Why have I been invited to take part?

We would like people who have experienced mental health problems and who use the facilities at Growthpoint to take part in the study. We would like to know more about your experience of using Growthpoint.

5) What are the risks in taking part in the study?

We do not foresee there being any risks in taking part in the study.

6) What happens to the information in the study?

All information that is collected about you during the course of the study will be kept strictly confidential. We will replace participants name with an anonymised participant number to ensure that individual participants cannot be identified. The principal investigator will be responsible for the security of personal data and will hold the information on a secure, encrypted and password protected computer.

Contact for further information:

Contact Heather Wood via email at h.wood@keele.ac.uk

Clinical Psychology Professional Doctorate
Faculty of Sciences – Science Building
Staffordshire University
Leek Road
Stoke-on-Trent
ST4 2DF

OPT – IN SLIP: Please Detach Here.

I am interested in taking part in the study and agree to be contacted by the researcher to discuss my participation in the study. Please return the opt-in slip to the STR Worker at Growthpoint or contact Heather Wood using the contact details above. Thank you.

Name:

Contact Number:

Signed:

Date:

**PARTICIPANT INFORMATION SHEET
FOR TRAINEE PSYCHOLOGISTS**

Version 4/JULY 2014

Project Title: A Q Sort Study: Perspectives of Recovery in a Community Project

Introduction

You are being invited to take part in a research study. The study is being carried out by Heather Wood of Keele University / Staffordshire University as part of the award of a Doctorate in Clinical Psychology.

Before you decide to participate it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part. Thank you.

1) What is the purpose of this investigation?

We hope to learn more about how service users' attendance at the Growthpoint project has helped people to cope with the mental health problems which they may be experiencing currently or in the past.

We are also asking the same questions to a number of trainee clinical psychologists. We would like to know how the trainee psychologists think a project like Growthpoint can help people who have experienced mental health problems.

Comparing the similarities or differences in the views of service-users and trainee psychologists may help us in a number of ways. Finding out what service users and trainee psychologist think about community projects like Growthpoint may inform us how these services are provided in future. And it could help to improve the training of clinical psychologists by highlighting differences in viewpoints about recovery between service-users and trainee psychologists.

2) Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason.

3) What will I do in the project?

We would need to see you for about 60. During this time we would give you a number of cards, each of which has a statement written on it. The statements relate to recovery from mental health problems of mental health problems. We would ask you and to sort the cards on a grid to show which statements you believe are most important in recovery from mental health problems in a community mental health setting.

4) Why have I been invited to take part?

We would also like to know how trainee clinical psychologists think community mental health projects like Growthpoint, or similar community mental health projects, can help people in the recovery process.

5) What are the risks in taking part in the study?

We do not foresee there being any risks in taking part in the study.

6) What happens to the information in the study?

All information that is collected about you during the course of the study will be kept strictly confidential. We will replace participants name with an anonymised participant number to ensure that individual participants cannot be identified. The principal investigator will be responsible for the security of personal data and will hold the information on a secure, encrypted and password protected computer.

Contact for further information:

Contact Heather Wood via email at h.wood@keele.ac.uk

Clinical Psychology Professional Doctorate
Faculty of Sciences – Science Building
Staffordshire University
Leek Road
Stoke-on-Trent
ST4 2DF

OPT – IN SLIP: Please Detach Here.

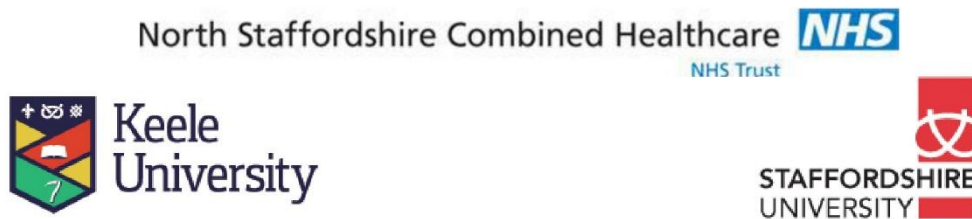
I am interested in taking part in the study and agree to be contacted by the researcher to discuss my participation in the study. Please return the opt-in slip to Heather Wood using the contact details above. Thank you.

Name:

Signed:

Date:

Appendix 2K) Consent forms



Patient Identification Number for this trial:

Consent Form – Growthpoint Service Users

(Version: 3 June 2014)

Project Title: A Q Sort Study: Perspectives of Recovery in a Community Project

Name of Researcher: Heather Wood

Please initial box

1. I confirm I have read and understand the information sheet dated.....
(version.....) for the above study. I have had the opportunity to consider the
information, ask questions of a member of the research team and have had these
answered satisfactorily. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at
any time without giving any reason. ☐
3. I understand that relevant sections of my data collected during the study, may be
looked at by individuals from the research team, at Keele/Staffordshire
Universities, where it is relevant to my taking part in this research. I give
permission for these individuals to have access to my records. ☐
4. I agree that the researchers, who are employed by the NHS Combined Healthcare
Trust, can access my referral to the Growthpoint service and my health records
relating to current or past mental health issues. No information that can identify
me as individual will be used from these records. ☐
5. I consent to my comments about the Q-sort being used in the study. No
information that identifies me will be used from these comments. ☐
6. I agree to take part in the above named study. ☐

Participant's Name

Date

Signature

Researcher's Name

Date

Signature

Patient Identification Number for this trial:

Consent Form – Trainee Psychologists

(Version: 3 June 2014)

Project Title: A Q Sort Study: Perspectives of Recovery in a Community Project

Name of Researcher: Heather Wood

Please initial box

1. I confirm I have read and understand the information sheet dated.....
(version.....) for the above study. I have had the opportunity to consider the
information, ask questions of a member of the research team and have had these
answered satisfactorily. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at
any time without giving any reason. ☐
3. I understand that relevant sections of my data collected during the study, may be
looked at by individuals from the research team, at Keele/Staffordshire
Universities, where it is relevant to my taking part in this research. I give
permission for these individuals to have access to my research records. ☐
4. I consent to my comments about the Q-sort being used in the study. No
information that identifies me will be used from these comments. ☐
5. I agree to take part in the above named study. ☐

Name of Participant Date Signature

Name of Researcher Date Signature

Appendix 2L) First sort grid

Most
Important

Neutral

Least
Important

Appendix 2M) Q-Sort instructions

Q-Sort Instructions (Version 1 – April 2015)

Thank you for agreeing to take part. The research question we want to answer is as follows;

“Which of these statements is the most or least important in recovery from mental health problems?”

- Each of the cards contains a statement that can relate to recovery in mental health problems.
- Based on your own experience of mental health, we hope to find out which of these statement is most important to you.
- Each card needs to be placed on the grid in front of you. The columns to the right of the grid are where the most important cards are to be placed, and those statements are rated at (+5) on the grid. The least important cards go on the left hand side and those statements are scored as (-5).
- The cards placed in the middle may be those statements that you feel neutral about.
- I'll ask you to begin by first sorting the cards into 3 piles. The statements you think are “most important”, those statements you think are “least important” and those statement you think are “neutral”.
- Next I will ask you to pick your two most important cards and place them in the far right hand column. We will then proceed to fill in the rest of the grid based on which statements you think are least or most important. Three cards would be placed in the +4 column as next most important and so on.
- Please feel free to move the cards between columns until you are happy that the grid reflects your point of view.
- If you have any questions, please ask me.
- When you have completed the Q-Sort I will ask you to complete a short questionnaire.

Thank you again for taking part!

Appendix 2N) Post Q-Sort questionnaires



Demographic Questionnaire

Version 4/Dec 2014

Project Title: A Q Sort Study: Perspectives of Recovery in a Community Project

Name of researcher: Heather Wood

Participant Number:

Please answer the following questions:

Name:

Date of Birth:

Have you ever accessed mental health services in the past? If yes, please give brief details of the type of support you received and the duration of that support?

Supplementary Questionnaire

Version 4/Dec 2014

Project Title: A Q Sort Study: Perspectives of Recovery in a Community Project

Name of researcher: Heather Wood

Participant Number:

Thank you for completing the Q-Sort. Please answer the following questions;

What other factors do you think are important in recovery from mental health problems?

What do you think of Growthpoint or other community mental health projects?

How did you find taking part in the research?

Any other comments or suggestions?

Appendix 2O) Correlation Matrix

Appendix 2N : Correlation Matrix

Sort	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23
1	100																						
2		100																					
3			100																				
4				100																			
5					100																		
6						100																	
7							100																
8								100															
9									100														
10										100													
11											100												
12												100											
13													100										
14														100									
15															100								
16																100							
17																	100						
18																		100					
19																			100				
20																				100			
21																					100		
22																						100	
23																							100

Significant correlations are highlighted where r +/ - 0.37 or greater. (Watts and Stenner 2012)

Appendix 2P) MDS Euclidean Distances

Appendix 2O) Multidimensional Scaling – Euclidean Distances

	Distances																						
	P1	P2	P3	P4	P5	P6	P7	P8	P9	P10	P11	P12	P13	P14	P15	P16	P17	P18	P19	P20	P21	P22	P23
P1	.000																						
P2	1.182	.000																					
P3	1.154	.694	.000																				
P4	1.295	.427	.549	.000																			
P5	1.520	1.079	.451	.806	.000																		
P6	.570	.922	.711	1.031	1.087	.000																	
P7	.680	.521	.767	.688	1.191	.613	.000																
P8	.610	.733	.924	.807	1.307	.739	.264	.000															
P9	.766	1.358	.902	1.271	1.083	.633	1.017	1.001	.000														
P10	.875	1.115	.848	.909	1.016	.892	.807	.686	.669	.000													
P11	.933	.980	.451	.804	.828	.632	.796	.837	.586	.501	.000												
P12	1.335	.870	.520	.485	.539	1.075	.924	.963	1.053	.673	.566	.000											
P13	1.572	.913	.559	.896	.653	1.035	1.171	1.389	1.332	1.406	.966	.981	.000										
P14	1.655	.953	.874	1.109	1.077	1.130	1.249	1.503	1.578	1.687	1.273	1.327	.432	.000									
P15	1.492	1.117	.584	1.073	.614	.934	1.236	1.429	1.129	1.346	.855	1.032	.343	.648	.000								
P16	1.034	.499	.894	.887	1.331	.760	.572	.823	1.355	1.321	1.127	1.242	1.004	.879	1.140	.000							
P17	1.542	.552	.632	.613	.865	1.100	.977	1.204	1.491	1.379	1.065	.919	.474	.547	.784	.779	.000						
P18	.755	1.007	.884	1.208	1.263	.323	.788	.961	.903	1.212	.916	1.323	1.040	1.016	.950	.693	1.124	.000					
P19	1.257	1.268	.972	1.418	1.218	.738	1.222	1.423	1.130	1.535	1.105	1.462	.860	.805	.692	1.003	1.133	.535	.000				
P20	1.075	.392	.722	.743	1.149	.724	.565	.828	1.284	1.240	1.004	1.088	.823	.746	.977	.193	.601	.695	.942	.000			
P21	1.508	.719	.400	.589	.512	1.039	1.019	1.211	1.292	1.205	.840	.683	.340	.673	.576	.973	.346	1.127	1.095	.780	.000		
P22	1.365	1.040	.922	1.256	1.213	.847	1.138	1.381	1.354	1.605	1.194	1.436	.692	.473	.699	.768	.856	.636	.399	.698	.926	.000	
P23	1.344	.724	.732	.951	1.060	.849	.945	1.203	1.366	1.462	1.089	1.205	.529	.332	.689	.566	.521	.735	.690	.439	.568	.356	.000

Appendix 2Q) MDS Co-ordinates

Appendix 2P) Multidimensional Scaling Co-ordinates

Final Coordinates			
	Dimension		
	1	2	3
P1	-.787	.556	-.016
P2	.017	-.089	.563
P3	.006	-.277	-.105
P4	-.105	-.464	.399
P5	.088	-.637	-.364
P6	-.273	.372	-.181
P7	-.403	.155	.378
P8	-.664	.118	.392
P9	-.646	.092	-.608
P10	-.841	-.312	-.112
P11	-.390	-.234	-.317
P12	-.295	-.685	.011
P13	.562	-.239	-.155
P14	.795	.072	.035
P15	.448	-.150	-.466
P16	.107	.394	.477
P17	.471	-.274	.309
P18	-.048	.603	-.165
P19	.383	.539	-.475
P20	.156	.231	.386
P21	.350	-.434	.026
P22	.569	.452	-.133
P23	.504	.210	.119

Appendix 2R) Z-scores and corresponding ranks

Factor Scores with Corresponding Ranks

		Factors						
No.	Statement	No.	1		2		3	
1	Having fewer symptoms of a mental health problem	-0.67	37	1.97	3	-1.52	48	
2	Feeling less depressed	0.70	13	0.25	18	0.92	11	
3	Seeing a counsellor or therapist	-0.83	39	0.11	21	-0.46	33	
4	Being able to concentrate and remember things	-0.52	34	0.95	9	0.34	20	
5	Feeling happy	0.04	26	1.46	6	0.95	10	
6	Medication helps me feel less anxious or depressed	-1.65	48	0.61	12	-1.38	46	
7	Having a say in the medication I take	0.69	14	-0.91	42	-1.15	43	
8	Finding medication that works	-1.10	43	1.67	5	-1.23	45	
9	Being able to live without medication	-0.60	35	-0.62	38	-1.03	41	
10	Taking my medication regularly	-1.32	47	1.77	4	-1.09	42	
11	Attending Growthpoint	-0.42	31	2.53	1	1.30	7	
12	Meeting new people	-0.45	32	-0.44	34	0.62	14	
13	Taking part in social activities	-0.20	27	-0.25	29	1.04	9	
14	Being in employment or education	-0.67	36	-1.43	47	0.44	18	
15	Learning new skills	-0.88	40	-0.60	37	1.31	6	
16	Being able to make decisions for myself	0.46	19	1.32	7	1.55	3	
17	Feeling positive about the future	0.85	10	0.47	13	1.53	5	
18	Understanding myself better	1.73	2	0.09	23	-0.17	28	
19	Understanding how my mental health problems have ch	0.79	11	0.35	15	-0.56	35	
20	Finding new meaning in life	-0.90	41	-0.35	32	0.44	17	
21	Building on my own strengths	0.76	12	0.63	10	1.60	2	
22	Attending mental health services	-1.18	44	1.11	8	-0.43	31	
23	Learning to trust other people	0.04	25	-0.97	44	0.28	21	
24	Being in a relationship	-1.81	49	-0.39	33	-1.16	44	
25	Having someone to talk to about my problems	2.19	1	0.32	16	0.61	15	
26	Support from other service users	0.15	23	-0.32	31	1.18	8	
27	Support from family or loved ones	1.33	7	0.10	22	0.26	22	

		Factors			
No.	Statement	No.	1	2	3
28	Having help in a crisis		1.46 4	0.25 17	0.09 24
29	Feeling part of the Growthpoint community		0.57 17	2.01 2	2.18 1
30	Realising I'm not the only one who feels this way		1.33 6	0.63 11	0.16 23
31	Learning to join in on groups		-1.92 50	-0.93 43	0.66 13
32	Learning about mental health conditions		-0.33 29	0.06 24	-0.72 38
33	Sharing stories and experiences with other people		1.02 9	-0.23 28	-0.36 30
34	Developing hope to achieve goals in the future		1.63 3	0.13 20	1.54 4
35	Meeting people who are role models and manage there		-1.04 42	-0.69 39	0.61 16
36	Realising that life is full of ups and downs		0.22 21	-0.30 30	0.08 25
37	Understanding my past helps me understand things no		1.41 5	-0.77 41	-0.82 39
38	Religion or spirituality		-1.28 46	-1.78 50	-2.02 50
39	A reduction in self-harm		0.62 15	-1.65 49	-1.74 49
40	My sexuality		0.32 20	-1.60 48	-1.49 47
41	Quality of sleep		0.48 18	-1.38 45	0.05 26
42	Living arrangements or accommodation		1.26 8	-0.71 40	0.68 12
43	Problems with benefits or social services		0.18 22	-0.57 36	-0.44 32
44	Other peoples attitudes towards me		-0.35 30	-1.41 46	-0.36 29
45	Stigma related to mental health		0.58 16	-0.08 25	-0.61 36
46	Challenging peoples attitudes about mental health		-0.72 38	0.13 19	-0.49 34
47	Understanding my legal rights		-1.28 45	-0.56 35	-0.85 40
48	Having a good relationship with a support worker		0.08 24	0.37 14	0.43 19
49	Psychological therapies		-0.51 33	-0.23 27	-0.66 37
50	Feeling less angry and frustrated		-0.30 28	-0.12 26	-0.07 27

Appendix 2S) Factor Q-Sort Values

Factor Q-Sort Values for Each Statement

		Factor Arrays			
No.	Statement	No.	1	2	3
1	Having fewer symptoms of a mental health problem		-2	4	-4
2	Feeling less depressed		2	1	2
3	Seeing a counsellor or therapist		-2	1	-1
4	Being able to concentrate and remember things		-1	3	1
5	Feeling happy		0	3	2
6	Medication helps me feel less anxious or depressed		-4	2	-4
7	Having a say in the medication I take		2	-3	-3
8	Finding medication that works		-3	4	-3
9	Being able to live without medication		-1	-2	-2
10	Taking my medication regularly		-4	4	-3
11	Attending Growthpoint		-1	5	3
12	Meeting new people		-1	-1	2
13	Taking part in social activities		0	0	3
14	Being in employment or education		-1	-4	1
15	Learning new skills		-2	-2	3
16	Being able to make decisions for myself		1	3	4
17	Feeling positive about the future		2	2	4
18	Understanding myself better		5	0	0
19	Understanding how my mental health problems have changed		2	1	-1
20	Finding new meaning in life		-2	-1	1
21	Building on my own strengths		2	2	5
22	Attending mental health services		-3	3	-1
23	Learning to trust other people		0	-3	1
24	Being in a relationship		-5	-1	-3
25	Having someone to talk to about my problems		5	1	1
26	Support from other service users		0	-1	3
27	Support from family or loved ones		3	0	0

Factor Arrays

No.	Statement	No.	1	2	3
28	Having help in a crisis	4	1	0	
29	Feeling part of the Growthpoint community	1	5	5	
30	Realising I'm not the only one who feels this way	3	2	0	
31	Learning to join in on groups	-5	-3	2	
32	Learning about mental health conditions	0	0	-2	
33	Sharing stories and experiences with other people	3	0	-1	
34	Developing hope to achieve goals in the future	4	1	4	
35	Meeting people who are role models and manage there o	-3	-2	1	
36	Realising that life is full of ups and downs	1	-1	0	
37	Understanding my past helps me understand things now	4	-2	-2	
38	Religion or spirituality	-4	-5	-5	
39	A reduction in self-harm	1	-5	-5	
40	My sexuality	1	-4	-4	
41	Quality of sleep	1	-3	0	
42	Living arrangements or accommodation	3	-2	2	
43	Problems with benefits or social services	0	-1	-1	
44	Other peoples attitudes towards me	-1	-4	0	
45	Stigma related to mental health	1	0	-1	
46	Challenging peoples attitudes about mental health	-2	1	-1	
47	Understanding my legal rights	-3	-1	-2	
48	Having a good relationship with a support worker	0	2	1	
49	Psychological therapies	-1	0	-2	
50	Feeling less angry and frustrated	0	0	0	