**Title: Using lived experience to develop a personal narrative workshop programme in order to aid mental health recovery**

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**Abstract**

**Background**

According to Slade’s Personal Recovery Framework (2009), mental health recovery involves developing a positive identity, reframing experiences, developing self-management and valued social roles.

**Aim**

This study explored how developing a personal narrative can support mental health recovery through reframing and developing a more positive identity. This paper provides an overview of the study’s three phases and the resultant Personal Narrative Workshop Programme.

**Method**

Phase 1 involved developing and analysing my own recovery narrative using autoethnography.Phase 2 used Participatory Action Research (PAR) to explore the experience of other service users, with co-researchers recruited to two focus groups. Six co-researchers continued into Phase 3 (three cycles of PAR) to develop the workshop programme.

**Results**

An eight-session workshop programme was co-produced and fully documented.

**Conclusions**

Developing a narrative is not benign: it can involve reliving trauma; and dealing with the ‘voice of others’ in our narratives can be difficult. As a result, the workshop programme aimed to provide a supportive environment, promoting collaboration and validation. Methodological issues resulted from the complexities of using a PAR approach, and on the multiplicity of roles for the researcher.

**Declaration of Interest**

No interests require declaration.

**Key Words**

Lived experience, personal narrative, co-production, workshop programme, mental health recovery, autoethnography.

**Introduction**

Recovery tools such as WRAP - Wellness Recovery Action Plan (Copeland, 2013) and Recovery Star (Mental Health Providers Forum, 2013) are widely used in developing self-management, community links and valued social roles.

The aim of this research was to explore the premise that the supported development of a personal narrative can aid mental health recovery through the process of reframing and attributing meaning to lived experience (Moen, 2006, Chase, 2013), and by supporting the development of a more positive identity (Slade, 2009).

**Background**

## Recovery model framework

Following a systematic literature review of models and descriptions of personal recovery, Leamy et al. (2011) developed a formal and empirically-based Conceptual Recovery Framework which described three key interlinked domains:

1. Recovery Processes: connectedness; hope and optimism about the future; identity; meaning in life; and empowerment (CHIME).
2. Characteristics of the recovery journey. Existing recovery models and conceptual frameworks (e.g. Andresen et al., 2003, Slade, 2009) were mapped onto the trans-theoretical model of change (Prochaska and DiClemente, 1984) using the theoretically linear pre-defined headings of: pre-contemplation; contemplation; preparation; action; and maintenance and growth.
3. Characteristics of the recovery journey suggested that the recovery process is not straightforward.

Slade (2009) suggested that a spiral process was a better description of the recovery process. In his model, Slade described four tasks of recovery:

**Box 1: Four Tasks of Recovery (Personal Recovery Framework, Slade, 2009):**

1. To develop a positive identity.

2. To reframe the mental illness.

3. To develop self-management with a consequential reduction in the reliance on professional support.

4. To develop valued social roles through engagement in familial, work and social activities.

This research drew on both Slade (2009) and Leamy et al. (2011), as well as on the follow-up work of Bird et al. (2014) - who reported on the validity and relevancy of this framework for clinical and research purposes.

***Narrative***

Within a social world, narrative is fundamental to sense and world-making processes (Bruner, 1987, Polkinghorne, 1988, Moen, 2006, Chase, 2013). Narratives can be temporal, multi-voiced social constructions, which are dependent on individual values and cultural practices. There is no one ‘true’ narrative but a range of alternative possibilities (Bruner, 1987) offering a ‘transformative’ possibility (Atkinson and Delamont, 2006).

Within any given cultural context, illness has physiological, psychological and social meaning, with implications for an individual’s sense of self and identity including: a sense of loss and grief; uncertainty; economic and temporal loss; and an element of shame and being hidden. Factors such as: the medical model environment (perceived power/powerlessness); illness chronicity; type and ‘acceptability’ of illness (schizophrenia versus cancer); public and personal stigma (Goffman, 1963); employment and social inclusion; and relationships and roles that are played (the ‘patient’ or the ‘victim’) may contribute to the illness narrative. The meaning that an individual ascribes to their illness is essentially an attempt to restore order and understanding (Kleinman, 1988, Frank, 1995).

The individual may become the diagnosis so that the ‘me/it’ integrates (Slade, 2009) –seen as a depressive rather than someone who experiences depression. The illness identity can also become a badge of honour – such as ‘mental health survivor’. Many people fight to hold onto their ‘illness identity or sick role’ because it brings with it the security of what is known.

For others, developing a personal narrative may contribute to breaking free from the ‘illness or sick role’. Frank (1995) suggested that narratives could help repair the damage done by illness and the environment of illness, ‘the way out of the narrative wreck is telling stories’ (p. 55). There is a sense that self and identity could be rediscovered through narrative. If illness experience dislocates identity (our past does not predict our present), narrative could have the potential for integration of the past, present and possible futures.

***Autoethnography***

As a methodology, autoethnography is embedded in postmodern philosophy and is linked to the growing debate about reflexivity and voice in social research (Wall, 2006). Wall (2006) considered whether ‘autoethnography is less of a method and more of a philosophy, theoretical underpinning, or paradigm, aimed at restoring and acknowledging the presence of the researcher/author in research, the validity of personal knowing, and the social and scientific value of the pursuit of personal questions’.

Ellis et al, (2011. p.2) suggested that ‘as a method, autoethnography combines characteristics of autobiography and ethnography’. Autoethnography implies that a narrative is being used for a purpose beyond simply telling a story. In autoethnography, there is a significant element of reflection and reviewing lived experience: using hindsight; ‘epiphanies’ or times of ‘existential crises’ (Ellis, 2009).

The process of autoethnography contextualises personal experiences within existing cultural practices and shared experiences. This may support better understanding for both insiders (cultural members) and outsiders (cultural strangers) (Ellis et al., 2011). This could result in making personal and social change possible for more people. As a form of personal narrative, autoethnography (Sparkes, 2002, Ellis, 2004, Ellis, 2007, Ellis, 2009) has been used to describe lived experiences and/or recovery: living with bulimia (Tillmann-Healy, 1996); surviving child sexual abuse (Fox, 1996), schizophrenia and mental health recovery (Deegan, 1987, Deegan, 1988).

However, autoethnography is not without its critics. For example, there are concerns that autoethnography appears unwilling to follow traditional social science research conventions – exemplified by a lack of fieldwork, sample size and not using any control group (Fine, 2003, Delamont, 2009).

### Narratives and Mental Health Recovery

There appeared to be limited literature on the process of developing a personal narrative and how it could support recovery (Dent-Brown, 1998, Dent-Brown and Wang, 2004, Lysaker et al., 2010). Literature focused on the results of the process –using the content of personal narratives to identify recurring themes of recovery such as: regaining identity (Wisdom et al., 2008, Scottish Recovery Network, 2011); agency (Holm and Severinsson, 2011); and the familial/socio/cultural context (Kalathil, 2012).

**Methodology**

*Research Paradigm and Perspectives*

A narrative inquiry perspective which described multiple research approaches was used as the over-arching methodology for this research (Chase, 2013). Pragmatism (Chase, 2013) guided this research and an interpretative bricoleur approach (Denzin and Lincoln, 2013a) was used to interpret the emergent data. A thematic approach (Riessman, 2008) was used to analyse the narrative in each phase (Braun and Clarke, 2006), drawing on different paradigms - such as Postmodern, Constructivist and Feminist (Denzin and Lincoln, 2013b).

### Phased Approach

The research comprised three phases: Phase 1 used autoethnography to explore the factors involved in the process of developing my own personal narrative. As shown in Figure 1, this informed the participatory action research (PAR) focus groups of Phase 2, which explored the narrative development experience of the co-researchers. Finally, the emerging analysis and reflection of the autoethnography and the focus groups informed the development of the personal narrative workshop programme in Phase 3.

**Figure 1: Phases and Methodologies used in this research**

***Ethics Approval***

Ethics approval was not required for Phase 1, but was Phases 2 and 3. Ethical approval was gained (University of Southampton ethics system (ERGO) (phase 2. 12626 and phase 3. 22294). In Phase 2, co-researchers consented for their data to be used in the study at the start of the focus groups. In Phase 3, the co-researchers were re-consented for each PAR cycle (3 times in total).

**Phase 1: Exploration and Understanding of Self (using Autoethnography)**

I believe that I exemplify mental health recovery in practice. Within my mental health ‘career’ (Kleinman, 1988), I have received care in primary, secondary and third sector services. I received multiple therapies, alongside ‘my personal recovery journey’ (Pilgrim and McCranie, 2013) – an individual process of learning and growth. From 2010-2013, I was an ‘expert’ service user within an NHS mental health trust. In this role, I developed my recovery narrative (also called a recovery story) and delivered this testimony of successful recovery (Frank, 1995) to staff, other service users and at conferences.

Autoethnography was chosen for Phase 1 to explore, first-hand, the experience of personal narrative development. This involved developing a new version of my mental health recovery narrative as a series of 54 vignettes, under the title ‘From the Edge of the Abyss to the Foot of the Rainbow’. The vignettes were then sequenced and categorised into three sections: The Hopeless Narratives; Beginning the Long Assent Narratives; and the Thriving Not Surviving Narratives. This process was described in more detail in an earlier paper (Robertson et al., 2017).

## Findings

Braun and Clarke’s (2006) six-phase thematic analysis approach was used to analyse the data generated from the autoethnography vignettes, in terms of both content and process. In particular, the thematic analysis considered the data in relation to the Conceptual Recovery Framework (Leamy et al., 2011, Bird et al., 2014). Themes (Table 1) were generated from the data in an inductive and reflexive manner, rather than using the data to fit a pre-existing range of themes (to match a theory).

**Table 1: Autoethnography (Content and Process) Themes**

|  |  |  |
| --- | --- | --- |
|  | **Themes** | **Sub-themes** |
| 1 | Context | Background, places, time and my narrative |
| 2 | My Journey | Recovery journey |
| 3 | Impact of my illness | Impact of mental illness; internal and external world |
| 4 | Identity | Sense of self, stigma and roles we play |
| 5 | Relationships | Son, husband, relationships, family and external drivers |
| 6 | Emotions and behaviours | Emotional response and suicide |
| 7 | Power and control | Power and control; expectations |
| 8 | Communication and voicing my narrative | Communication, voice and sharing my narrative |
| 9 | Lessons learnt | Positive changes in me, on-going tensions and reflections |
| 10 | Reflections on my process of writing autoethnography | Revisiting trauma, creating distance and my writing process |
| 11 | Creating vignettes | Writing the vignettes, collaborations and making connections |
| 12 | Methodology | Autoethnography as method |
| 13 | Reflections on the process of Others | Reflections on the possible process of other’s |
| 14 | What I have learnt as a result of writing my vignettes | What have I learnt? |

The key themes of: identity; relationships; communications and voicing my narrative; lessons learnt and what I have learnt; and reflections on my process and the process of others were the starting point for discussion within Phase 2 focus groups.

***Discussion***

Over a period of three months, I wrote vignettes that described memories of my lived experience. Vignettes - ‘short and incomplete’ snapshots - seemed appropriate, as much of my mental health lived experiences felt chaotic, piece-meal and lacking any sense of coherence (Frank, 1995, Robertson et al., 2017). I used memorable quotes and statements (that other people had said to me – in effect the voice of others within my narrative) as a starting point. Examples included: *‘Play the game – stop being challenging’* (Vignette 15, February 20013); *‘You are worth saving’* (Vignette 28, 2004-6);and *‘You’ve found your voice’* (Vignette 47, July 2013).

Writing was an emergent and fluid process. The first vignette written was *‘I don’t know who you are anymore!’* (Vignette 12, June 1996). In terms of someone else noticing my distress, this marked the recognisable start of my mental health difficulties. From this point, the vignettes were written in no particular order. Initially, I had some quotes that I thought would become vignettes (and had planned to write them up first), but as the writing process progressed more memories and therefore quotes emerged. Having written a number of vignettes, I realised that I had not included any positive experiences. This did not reflect my lived experience. This reflective process enabled the writing of the ‘what I have learnt’ and the ‘epiphanies’ parts of my autoethnography.

**Phase 2: Exploration and Understanding of and with Others (Two Focus Groups using Participatory Action Research)**

***Focus Groups***

The co-researchers in this research were all mental health service users who had systematically developed a personal narrative for a range of reasons (such as staff training and public events). Purposive sampling was used, given that the target population was small, with specific characteristics, experience and knowledge (Goodman and Evans, 2010). A convenience strategy of contacting service users who had developed their personal narratives (recovery stories) was used.

The 11 co-researchers represented a diverse geographic, cultural and social mix. Within the group there were three male and eight female co-researchers. Different UK regions were also represented, as were differences in age, marital status, familial structures, educational attainment and occupational status. The group was transdiagnostic – with lived-experience of schizophrenia, bipolar, borderline personality disorder, major depression, anxiety, OCD and other complex conditions. They were also a mix of primary and secondary care service users, as well as some that had experience formal detainment within psychiatric services.

Their experiences were explored in two parallel focus groups. As the research strategy of this study was emergent and formative, it was important that the focus group discussions were flexible. Themes generated from the autoethnography (Phase 1) were made available to be used as prompts, if required. In each focus group, the discussion flowed with little need for facilitator input.

## Findings

Table 2 is a summary of the themes and sub-themes that emerged from the focus groups.

**Table 2: Focus Group Themes**

|  |  |  |
| --- | --- | --- |
|  | **Focus Group Themes** | **Sub-themes** |
| 1 | Recovery – Political, Social and Cultural Context | Social, political and cultural context and value of recovery as a concept |
| 2 | Narrative Content | Personal narrative v recovery narrative; language of recovery and narrative content |
| 3 | Narrative Form | Media and value of storyboard |
| 4 | Timing | Time as context; recovery cycle and continuum of wellness |
| 5 | Developing Narrative | Process of developing a narrative; value of developing a narrative; value to self; constraints on developing narrative; reframing and editing narrative |
| 6 | Process of Sharing Narrative | Sharing narrative with others; peer narratives and telling our narratives is a political act |
| 7 | Impact of Sharing Narrative | Value of sharing narrative; being believed and contribution to recovery |
| 8 | Working with Others | Commonality of experience; group dialogue and co-production |
| 9 | Sense of Self | Sense of self |
| 10 | Making Sense of… | Growing understanding |
| 11 | Other Voices in Narratives | Family and peer group |
| 12 | Phase 3 Workshops | Where to locate workshops? |

***Discussion***

There were subtle differences between the importance and emphasis that the co-researchers placed on the internal and external aspects of their narrative development process. This seemed to highlight a distinction between the narrative being developed for personal use or for public sharing. For example sharing their narrative (which involved processes such as editing), being heard by others through providing testimony and potentially making a difference to others appeared to be more important for some. Sharing seemed to involve aspects of explaining behaviour to others (including close family) and being heard and believed. Besides being transformative (Frank, 1995), sharing their narrative could also be seen as a political act contributing to systemic change (Ellis, 2009). For others, narrative development was felt to be more of an internal process – making sense of and reframing their own lived experience and starting to ‘have conversations with ourselves’.

Another difference was the relative importance given to the inclusion of other people’s voices (especially close family) within their narratives. To share their narrative involved sharing parts of the narratives of others (Ellis, 2007, Ellis, 2009). Given the interconnectedness of social relations, this issue was not easily rectified. It appeared to require continual editing of the narrative depending on the situation and the audience.

Similarly, there appeared to be different degrees of co-production within narrative development. There seemed to be a clear distinction between professional or peer input – the latter being very important for some of the co-researchers. Professional input appeared to take place within a clinical, medical model setting (with its inherent power dynamics and imbalances) often as part of a therapeutic alliance. Peer input was described as being based on the sharing common lived experience. This was felt to be empowering (as examples of testimony), which reduced an individual’s feelings of isolation and other negative feelings about themselves. For others, the development of their narrative appeared to be a very individual and internal process, with little professional or peer input. It seemed more about the individual making sense of their lived experience, changes to their identity and finding their own voice (Leamy et al., 2011). It may also be a reflection of where they were on their personal journey.

**Phase 3: Development of Workshop Programme (One Focus Group using Participatory Action Research)**

***Co-Researcher involvement***

For Phase 3, seven co-researchers were recruited from those who took part in Phase 2, to one focus group that met three times (over three months) using PAR cycles (le May and Lathlean, 2001). The aim was to create a workshop programme framework model, complete scheme of work and a set of underpinning session plans.

Phase 3 required more co-researcher time input and active participation in developing the workshop programme. Each cycle built on the work of the previous one and involved the production of material and documents for the personal narrative workshop programme. The workshop considerations that emerged from Phase 1 and 2 themes (Table 3) were used to guide the focus group discussions.

**Table 3: Phase 3 Workshop Considerations**

|  |  |
| --- | --- |
| **Issue** | **Workshop Considerations** |
| Group Setting | - The value of developing a narrative within a group setting as opposed to one to one |
| Timing | - Begin the process of developing their narrative when people are ready  - Allow adequate time to develop narrative  - Time to share and be heard within the group |
| Media | - Working with peers to choose a suitable media e.g. written, art, photography or performance |
| Facilitator | - Peer co-facilitation |
| On-going peer support in workshops | - Supporting people to get started  - Level of peer support within and outside the workshops (for peer facilitators and participants) |
| Narrative development | - Inclusion of work around the process of narrative development.  - Work on the concept of recovery  -Supporting peers to develop a coherent/ structured narrative out of what they might have already produced |
| Using narrative | - Work on editing narrative for different purposes  - Using narrative in different settings |
| Relational ethics | - Explore how peers could include the narratives/voices of intimate others within their narratives |
| Resources | - Adequate resources and facilitation  - Access to other media |
| Location | - Where?  - Safe space |
| Workshop Participants | - Narrative development may not be appropriate at a particular time |

***Findings – the development of the Developing a Personal Narrative Workshop Programme.***

Discussions in all three cycles focused on the following key themes: why develop a personal narrative; framework and model; structure of workshop; workshop education and content; participants; workshop facilitation; and PAR process and facilitation of the focus groups. These themes resulted in the development of the framework model (Box 2), complete with scheme of work (Table 4).

**Box 2 The Framework Model (underpinning principles)**

It is believed that the process of developing a personal narrative can contribute to mental health recovery. The key aim of the workshop programme is to facilitate individuals to develop their personal narrative in a supported environment.

The workshop programme will be peer-led, co-produced and co-delivered. At least one of the co-facilitators will be a peer who has experience of developing their own narrative. It is expected that the second co-facilitator (whether a peer, a professional or carer) will have an interest in mental health and narrative development and may also have lived experience.

It is hoped that the workshop programme will be community located rather than being exclusively tied to a healthcare authority or specific organisation. It is hoped that this will encourage participation from a wider range of individuals.

The structure of the workshop should follow the workshop programme but be flexible and not too prescriptive. The workshop programme will be made up of 8 sessions (each 2.5 hours long). Workshop content should be based on the aims and objectives of the developed scheme of work and the session plans. Whilst the workshop programme can be considered to be therapeutic, it is not clinical therapy.

Participants should be able to choose the media for developing their narrative, thus supporting expertise, interest and agency.

There should be an open approach to participation in the workshop programme. Participants will not need to be referred by mental health services or be formally ‘labelled’ as service users. It is hoped that the workshop programme will eventually be co-attended too. The workshop programme has not been designed for a formal assessment or diagnostic tool.

There is no formal ‘timing’ requirement for participating in the workshop programme. For example, individuals do not need to be free from services or accessing services to participate. The timing principle is when individuals consider themselves ready to undertake the process of their personal narrative development.

**Table 4: Workshop Programme Scheme of Work**

|  |  |
| --- | --- |
| **Title** | **Developing A Personal Narrative Workshop Programme** |
| **Aim** | A practical, peer-led workshop programme that will support participants (service users) to develop their personal narrative. |
| **Objectives** | * Consideration of participants’ rationales for wishing to develop their personal narrative * Exploration of important theoretical issues underpinning mental health recovery and personal narrative development * Exploration of important factors associated with personal narrative development: keeping safe and boundaries; relational ethics; different media; what is included and what is left out * Exploration of different possible personal narrative development frameworks - such as: Tree of Life, timelines and storyboards. * Opportunity to work on their personal narrative within a supportive environment * Opportunity to share their personal narrative with others. * Opportunity to discuss their process in developing and sharing their personal narrative * Consideration of issues such as the on-going development of their personal narrative and signposting for further support |
| **Session Overview**  **(Guideline)** | It is important that the delivery of the Workshop Programme is flexible and is able to reflect: co-facilitator skills, local conditions, participant needs and resources.  Every session should have:   * group check-in and check-out * ice-breaker * session introductions and recaps |
| **1.** | **Introduction and Getting to Know Each Other**   * Overview of the Workshop Programme * Initial consideration of why participants have signed up for the workshop programme |
| **2.** | **Why Bother Creating a Narrative?**   * What is hope and what is recovery? * Fundamentals of narrative – What? How? Why? For Whom? |
| **3.** | **Mechanics of the Narrative – ‘bits and bobs’**   * Different media in personal narrative development * Different narrative development frameworks |
| **4.** | **‘Plain Sailing and Stormy Seas’ – the ups and downs of creating and sharing your personal narrative**   * Sharing their personal narrative with others * Who is the audience? |
| **5.** | **‘Playtime’ – doing it!**   * Work on personal narrative within a supportive environment |
| **6.** | **‘Tinker Time’**   * Continue working on personal narrative |
| **7.** | **‘Show and Tell’**   * Sharing and listening to personal narratives (or parts of) |
| **8.** | **‘Reflection and Celebrating’**   * Discussion of individual’s process of developing and sharing their personal narrative * What to do with the personal narrative now? * Feedback to each other * Showcasing |

***Discussion***

It was apparent throughout the three cycles that there were multi-layered processes occurring. The Phase 3 focus group task of developing the workshop programme involved discussing higher order considerations such as framework model, aims of workshop, workshop structure and participants. There was also the essential practical task of building workshop content.

This practical layer was further layered with PAR and focus group process issues: how decisions were made; the flow of the discussion; disagreements and consensus; co-researcher anxieties, interests and passions; the co-researchers different levels of knowledge, experience; and contribution. A further layer of co-facilitator expectation was also added to this. For example the importance of co-production, of the free flow of discussion, of having space for consensus, disagreement and wonder (all important factors in choosing PAR as methodology) were key. Yet at the same time, there was a pragmatic awareness of achieving the practical aims (developing the workshop programme) of Phase 3 in the time allowed.

Timing was felt to be a crucial factor in developing a personal narrative. This research highlighted a number of questions such as:

* Is there a ‘right’ time to start the process?
* Is there a particular stage of recovery that developing a personal narrative is more suited for?
* Should developing a personal narrative be a one-off exercise or part of an on-going part of an individual’s recovery process?

The analysis suggested that different aspects of the personal narrative could be tackled at different times.

**Reflections and Conclusions**

***Reflections***

The development of the workshop programme resulted from the emergent and iterative process. Each phase was a complete piece of research in itself, with rationale, methodology, method, results, conclusions and reflections documented and fully discussed. Each phase then informed the next phase. The pragmatic design that was outcome-focused underpinned the whole study, yet much of the richness and learning of the research came from the methodological challenges and the underlying individual and group processes.

Ethical considerations were key factors in both the design and implementation of this research. These ethical issues included: working with vulnerable co-researchers (Lathlean et al., 2006); my welfare as the autoethnographer; anonymity within a focus group setting; the multiple roles of the researcher; and relational ethics (how to include the narratives of others within our own).

Ethics approval had not been required for my autoethnography in Phase 1. However, ‘developing and analyzing my autoethnography was visceral. It highlighted aspects of my process (and the likely process of others) and raised many unresolved dilemmas’ (Robertson et al., 2017). As a result, this part of the study would have benefitted from a similar level of ethical scrutiny as was required for Phases 2 and 3.

***Multiple Roles***

During this study, I was the researcher, focus group co-facilitator and co-researcher. Whilst PAR was chosen as a methodology because there is an attempt to have more equal power dynamics, the reality does not always match the aim. My status as researcher and academic (including my expectations for the study), and holder of the ‘knowledge of narrative’ ensured my socialised and internalised power was a key factor in how the focus groups progressed.

Given my insider perspective, co-facilitating and analysing the focus groups (Phases 2 and 3) was challenging. The emergent data and themes were not just academic data. There was an emotional connection and response, which linked to my lived experience and Phase 1 autoethnography. Facilitating the focus groups was complex. There was a tension between maintaining objectivity and neutrality as the researcher whilst at the same time knowing and having on-going relationships with a number of the co-researchers.

At times, I had difficulty allowing the co-researchers time and space to explore what they were being asked to do (including deciding on the underpinning philosophy and framework of the programme) and the decisions that I wanted them to make (and the need at times to be pragmatic). The PAR process produced additional richness to the output, but was balanced by the slower process of achieving it. However, there was an important modelling parallel - participants will need time and space to develop their narratives within the workshop programme.

**Original Contribution to Mental Health Research**

This study offers valuable insights into the process of developing a personal narrative and the potential contribution to an individual’s recovery through growing agency, understanding, reflectivity, social connectedness and a separation of the ‘it/me’ identity (Slade, 2009, Leamy et al., 2011, Bird et al., 2014). As a result, the workshop programme has been carefully developed to support participants to develop, reframe their experiences (Frank, 1995) and potentially share their personal narratives with others.

The workshop programme (including underpinning Model and Framework, Scheme of Work and Session Plans) developed in this study was an innovative and unique peer-led practical programme. The workshop model and framework is based on both service user and clinician co-facilitators (and other stakeholders). This has important implications for the delivery of the workshop programme.

The lived experience, understanding and insight that emerged from my autoethnography and the co-researchers narrative process, was fundamental to the development of the workshop programme. The emergent data built upon the theoretical basis of narrative; its purpose and value. This combination, in addition to the workshop programme itself, is a significant contribution to mental health research.

This study has also made a significant contribution to the body of knowledge in terms of autoethnographic and PAR methodology. Key factors such as: ‘loss of and regaining voice’; relational ethics (Ellis, 2004, Ellis, 2007, Ellis, 2009); the on-going nature of narrative development (Robertson et al., 2017); the ‘insider’ perspective and competing roles; the benefits and costs of reflexivity; and what we ask of co-researchers (especially in relation to PAR cycles), whilst adding to the academic and research debate are all unresolved tensions and considerations. In raising, discussing and reflecting on these tensions, this study has not only added to the body of knowledge in terms of a greater understanding of the process of narrative development and the innovative development of the eight week workshop programme, but also contributed to discussion of the research process itself (especially as I could be defined as ‘vulnerable’ too (Robertson et al., 2017).

**Putting the Workshop Programme into Practice**

This PhD study was an exploration of the process of narrative development, which culminated in the development of the workshop programme. As the study progressed (especially in Phase 3), the needs of developing and implementing the workshop programme (both philosophically and practically) required a more balanced consideration of who could deliver the programme. It was acknowledged that clinicians could also have lived experience and service users could be clinicians too – and that both groups actually had so much to offer the programme (carers too). A crucial requirement was an interest in narrative development work. The key concern was location and ownership of the programme (fear that the NHS taking the programme over could affect participation and availability) rather than maintaining the ‘us and them’ boundary.

The workshop programme has been developed using a collaborative peer-led psychosocial approach and would potentially fit within a non-clinical, therapist-led setting; a guided self-help environment and/or a psycho educational setting such as Recovery Colleges, Wellbeing Centres or community groups (as long as key principles of a safe and supported group environment can be assured). It is not a formal educational programme and it does not fit within the traditional medical model - it is not intended as a tool for diagnosis, formulation or treatment.

It is intended that the implementation (including pilot), full evaluation of the programme and rollout will be carried out as post-doctoral research.

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