

**From Consumer to Consumer-Provider:
A Narrative Analysis**

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This research is dedicated to the people who gave their time and their words in taking part. Their stories have now become a part of mine, for which I am very grateful.

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Abstract

Recent years have seen increasing recognition for new forms of offering 'mental health service,' both within the voluntary and statutory sectors. One example is the provision of support by those operating within formal 'peer support worker' roles. This 'peer support' is purportedly guided by principles of recovery, mutuality and recognition of the value of 'experiential knowledge.' In some settings, the employment context and the construction of peer support as an 'intervention' may have contributed to the 'professionalisation' of interactions between 'peers.' There is precedent in the peer support literature to suggest that this may pose challenges to peer supporters, called upon to maintain identities as 'service users' and 'workers.'

This study adopted a narrative approach to examining issues of identity in a group of eight peer support workers, employed across three different settings. Each was interviewed individually according to an open format, and transcripts were analysed in order to develop 'core narratives' of being and becoming a peer support worker. These narratives took progressive forms, and were similar in structure and theme to stories of recovery, stressing ideas of 'enlightenment,' 'restitution' and transformation in meaning of painful experiences. Additionally, participants ambiguously constructed peer support as 'normal human' / 'professional' relationships.

It was argued that peer supporters were engaged in constructing 'desirable selves' away from previous stigmatized identities, but also accounting for themselves as possessing 'authority over subjectivity' in line with their roles. The roles were said to lend sanction to stories about the self as recovered. It was suggested that ambiguity in role construction reflected ambiguous role definition in some contexts, in addition to a response to the 'professional' language of the interviewer. A key recommendation was that peer support projects should be supported to develop free of the imposition of mainstream models of helping.

Chapter 1: Assumptions underpinning the research

Social constructionism

This research will proceed within and be informed by a social constructionist paradigm, and therefore it is necessary to describe this at the outset. Burr (2003) suggests that social constructionist approaches can be characterized by a critical stance towards positivist and empiricist claims that observation of the world can result in the acquisition of knowledge representing things as they *really* are. To paraphrase Derrida (1976), reality *is* representation. This is a challenge to the idea that knowledges historically described as 'objective' and 'subjective' hold a different ontological status to each other. It is claimed that no human being has access to an 'objective' reality, since the means by which we come to generate and to define knowledge are culturally and historically relative. Rather, 'knowledge' and what constitutes 'knowledge' is constructed by people through the shared use of language.

Descriptions of this process are grouped by Burr into micro- and macro-accounts. The former are described as viewing social construction as taking place 'in everyday discourse between people in interaction,' (p21). The latter are defined by an emphasis on the constructive power of language as related to social structures, relations, institutionalized practices and the operation of material power. Reality comes to be fashioned by 'discourses,' or 'practices which form the objects of which they speak' (Foucault 1972), that regulate and define what it is possible to say and know about the world. Institutions (such as medicine) have exercised power by producing and defining what it is possible to know. As Burr suggests, these approaches need not be seen as mutually exclusive; at least theoretically, 'discourse' in the Foucauldian sense may arise from and influence situated interaction.

Reliability and generalisability

Within this paradigm, traditional understandings of 'reliability,' 'validity' and 'generalisability' common to clinical psychology research are not applied. By definition, the unique set of discursive conditions from which this research arose would preclude its reproduction by others. It is generalisable in so far as others that read it find something to recognize in it. Rather than seeking validity, I have sought 'authentication' of this account (Lincoln and Guba 1986) by participants.

Self-reflexivity

Walsh suggests that 'If human knowledge is co-constructed, then any research project must involve some degree of mutual exploration and discovery' (1996, p. 383). As Frank (cited by Etherington (2004)) has noted, 'As I tell you my own stories and those of other people, I am also telling them to myself and I am changed by them; as I listened to and wrote these stories down I had a chance to make sense of my own and other people's experiences in new and different ways' (p25). Through meeting with peer supporters and hearing their stories, I was perhaps thus engaged in the process of 'peer support' myself. I hoped to document the impact of this on my own sense-making through the inclusion of a personal journal (Appendix A), in line with an aim of exploring the practice.

Social constructionism and 'mental illness'

This study proceeds according to understandings of 'mental illness' informed by Foucault's (1974) genealogy of the concept, and of the rise of the 'disciplines' that pertain to work with the 'mentally ill.' In *Madness and Civilisation*, he claimed that the development of a discourse constituting mental illness arose out of a process of exclusion and control. In the context of the prizing of rationality during the Enlightenment, there was a drive to push 'unreasonable' elements out of society into

confinement. Along with the ideological reasons for doing so, ‘What made [this] necessary was an imperative of labour’ (Foucault, cited in Burr 2003). That is to say, individuals who were not afforded a productive role within the developing market economy were to be incarcerated. Doctors became involved in such institutions initially to attend to the physically sick, but over time the profession came to dominate them and to classify systematically the people within them.

Arguably, the concept of ‘unproductivity’ remains closely aligned with definitions and descriptions of ‘mental illness’¹. This concept is made sensible within the framework of capitalist, individualist discourse that is typical to Western democracy. Informed again by Foucault², Rose (1997) suggests that the ‘psy-professions’ have been integral to the definition of modern subjectivity as part of national programs ‘for the governing of increasing areas of social and economic life in order to achieve desired objectives,’ including ‘continuity, efficiency... public tranquility, moral virtue and personal responsibility,’ (p101). Through discourse, the domain of subjectivity was constituted as ‘a possible object for rational management, such that it became possible to conceive of desired objectives – authority, tranquility, sanity, virtue, efficiency and so forth – as achievable through the systematic government of subjectivity,’ (p102). This has given rise to ‘technologies of the self,’ or techniques for the conduct of relation with oneself, such as ‘knowing oneself’ or ‘mastering oneself,’ that are embodied in institutional practices such as psychotherapy.

In previous centuries, the authority underpinning regimes of self-regulating subjectification was theological. Rose suggests that the modern concept of scientific ‘expertise’ associated with the psy-professions ‘binds subjectivity to truth, and subjects to experts, in new and potent ways.’ I will return to further discussion of the concept of expertise below.

¹ Note for example the association between ‘depression’ and unproductivity in Layard’s et al.’s influential ‘cost-benefit analysis’ of improving access to psychological therapies (2007)

² Note Discipline and Punish (1977)

Chapter 2: ‘Consumers’ as ‘providers’ within a mental health context – concepts, definitions and descriptions

Definition and background

The term ‘consumer’ is here used to refer to someone who is in receipt of a mental health service; the term ‘provider’ is used to refer to someone who is employed in order to deliver such a service.³ Present and past consumers have sometimes been employed in professions historically associated with the provision of these services, such as nursing or psychiatry (Ghouri et al 2010). Nonetheless, this study is primarily concerned with the stories of individuals for whom experience of services is explicit in the description of their role as providers. This kind of provision has often been referred to as ‘peer support.’

Broadly, Gartner and Riessman (1982) describe peer support in this context as ‘social emotional support, frequently coupled with instrumental support, which is mutually offered or provided by persons having a mental health condition to others sharing a similar mental health condition to bring about a desired social or personal change’ (p. 443). This definition potentially covers relationships situated in a huge range of practices, including practical support or advocacy groups, mutual help groups and mentoring projects to name but a few.

It may be possible to refer to a continuum of ‘formalisation’ of the peer support idea. The history of producing settings and services to facilitate the formation of these relationships, with the express aim of improving ‘mental health,’ perhaps dates back to early therapeutic communities established in the 1940s. Mowbray and Moxley (1997) suggest that the idea of ‘mutual support’ influenced the development of psychiatric rehabilitation programs through the 1960s and 70s, which (in their emphasis on social support and work opportunities) reflected a ‘nascent movement

³ These terms follow those used in an anthology of research relating to ‘user-led’ initiatives in recovery services (Mowbray et al 1997)

to humanize the support of people with psychiatric problems' (p10). For policy-makers, interest in 'lay helpers' reflected recognition that demand for professional support would always outstrip perceived need. Also growing civil rights and anti-psychiatry movements produced groups of campaigning 'ex-patients,' a 'survivor movement' that began to develop their own support systems as ideological and practical alternatives to mainstream provision.

Social science literature from the 1960s onwards has supported and reflected these changes. The 'helper therapy' model (Riessman 1965) was suggested as an explanation for the benefits to both 'helpers' and 'helpees' in 'therapeutic' relationships. Research into outcomes associated with the provision of talking therapies variously found no significant difference between interventions provided by trained therapists and 'lay' providers (e.g. Durlak 1979; Christensen & Jacobson 1994). Periodically, there have been proposals to increase research and development of mental health service provision offered by those who have had direct experience of being helped in order to meet rising demand (e.g. Riessman 1965; Hattie, Sharpley and Rogers 1984).

History of user-led movements and peer support in the UK

As noted, the emergence of the peer support worker role in the UK was preceded and perhaps made possible by the development of a 'survivor movement' of ex- and current mental health service users. Charting the history of this movement may thus provide some context. Campbell (2005) suggests that protest against the mental health system has often been a driver for service user action, and that such protest has existed in some form since the creation of asylums in the 1800s. Organized service user groups began to emerge in the UK in the 1970s with The Mental Patients Union, proliferating through the 1980s until the foundation of the first national network of service users involved in action (Survivors Speak Out) in 1986.

Others followed, including National Voices and Mindlink, networks within national mental health charities Rethink and Mind.

Campbell goes on to propose that 'in broad terms, in 1985 service users were nowhere; in 2005 they are everywhere,' (p.74). Accordingly, the growing visibility and availability of activist and pressure groups made it increasingly possible for people to speak openly about diagnoses or living with distress, including mental health workers in senior positions. The possibility of and the demand for user involvement and consultation arose in tandem with this, to the point where service users are now involved in policy development and in leading research (for example, through the Service User Research Enterprise at the Institute of Psychiatry). Additionally, statutory service providers have been gradually moving towards a 'user-as-consumer' model, evidenced by emphasis on patient choice and personalization in policy (e.g. DH 2011)⁴. Increased visibility and vocalism of mental health service users has likely facilitated a view of them as consumers with contingent rights and expectations, who should therefore be involved in planning the services they receive.

Basset et al (2010) suggest that the experience of coming together in adverse circumstances (e.g. in hospital wards) or to campaign for alternatives resulted in opportunities for spontaneous or informal peer support amongst mental health service users. There was recognition in these settings that this support was part of the value of user networks, coupled with an ideological drive to explore alternatives to mainstream services perceived as unjust or inadequate. In the 1980s, groups were set up with the express purpose of affording members to meet and support each other. National networks of these groups, such as the Hearing Voices Network and MDF: The Bipolar Organisation, subsequently arose.

⁴ A movement towards giving those in receipt of services control over what those services consist of or where they get them from, often through the allocation of personal support budgets for them to manage and allocate themselves. See DH paper 'No Health Without Mental Health' (2011) for an example of this move in policy.

These organizations aimed to offer an alternative form of support, but to varying degrees they also offered an alternative ideology or view of distress. For example, the Hearing Voices Network is couched in a movement influenced by the work of Romme and Escher⁵, which proposes that the 'expertise of experience' should be given equal weight to professional and academic accounts of 'mental illness' (May and Longden 2010). Rather than conceptualizing the experience of hearing voices as indicative of underlying organic pathology, this movement emphasizes the normality of the experience as well as its potential as a carrier of personal and emotional meaning. Given this view, support groups are seen to afford the opportunity to engage with the experience of hearing voices, to identify patterns or meanings, to stimulate acceptance or normalization of the experience and to cultivate a positive identity associated with hearing voices (Escher 1993).

The combination of increased influence and visibility of service users coupled with the development of alternative ideologies to the medical model might be said in part to have influenced the development and adoption of recovery approaches within statutory services (Shepherd et al 2008). Consciousness of the possibility of recovery from 'mental illness' and a contingent policy shift towards greater inclusion for service users likely premised the development of 'user involvement development worker' or 'consumer advisor' roles within the NHS in the 1990s. Some of these additionally involved the direct provision of support (Relton & Thomas 2002).

Basset et al (2010) describe these roles as a precursor of current peer support worker positions.⁶ They describe the '1st National Conference of Survivor Workers UK' in 2000, organized in part to address the issues and experiences of those in these roles, as 'a clear and important acknowledgement that mental health workers have mental health problems,' (p.7). For them, this acknowledgement represented a developing recognition that 'service user expertise has something very useful to offer,' (p.8) reflected first in service user involvement in training and education and latterly in the implementation of formal peer support as part of statutory provision.

⁵ E.g. Romme and Escher (1993).

⁶ See page 18 for discussion of this role and its relationship to statutory service provision

Extent of current provision

Based on a national survey conducted in 2002, Goldstrom et al (2006) report that, in the US, consumer-led services and mutual support groups 'greatly eclipsed' the number of traditional mental health organizations. Repper and Carter (2010) report that 'peer support' has been slower to develop in the UK, though Wallcraft et al (2003) documented 318 user-led groups of which 79% purported to offer some form of mutual support.

Again, even practices that label themselves as offering 'peer support' might vary significantly in form. Davidson et al. (2006) suggest three broad categories, including mutual support in groups, participation in consumer-run programs, and the use of consumers as providers of services and supports. Within this latter group, they note the development of 'peer specialist' or 'peer support worker' roles, where current or previous consumers are required to undergo training in order to then provide what has been described as an 'expert' service to other consumers (Repper and Carter 2010), often in paid employment. In a sense this represents one end of a continuum of 'formalisation,' and has been developing in the U.S (Mowbray & Moxley 1997). This 'formal peer support' will be the primary focus of this study.

Describing formal peer support

The task of further exploring what formal peer support consists of is again made difficult by the diversity of forms and settings it is found in. Nonetheless, some general definitional principles have been described (e.g. Mead 2003; Clay 2005), endorsed by peer support workers in Faulkner and Kalathil's (2012) survey of UK voluntary sector peer support projects and described frequently in literature pertaining to peer support (e.g. Repper & Carter 2010). These shall be discussed below.

Recovery

Recovery has been described as the basic aim and ethos informing peer support (e.g. Mead et al 2001). This raises further definitional difficulty; Davidson and Roe (2007) have noted there has been little consensus on what recovery means in relation to 'mental illness.' Weaver, Randall and Salem (2005) have proposed a four-phase process model apparently unique to the mutual help context, though it possesses considerable overlap with other descriptions (e.g. Anderesen, Oades and Caputi 2003). It includes: a) mourning and grief (i.e. loss of hope); b) recognition and awareness (i.e. awareness of how mental illness disrupts life); c) redefinition and transformation (i.e. changing attitudes about mental illness and self, redefining expectations, generating hope) and d) enhanced well-being and quality of life (i.e. developing a positive sense of self and new approach to life, finding meaning and purpose).

Such visions of recovery don't seek to challenge the basic epistemological claims of a medical account of experience. Rather, they represent a re-focusing of aims away from symptom management and towards the development of an individually-defined 'good life.' In line with this view, it has been suggested that peer support facilitates such development through a) the provision of social support; b) the provision of practical, experience-based information (e.g. on living with symptoms); c) the efficacy of peers as role models for facilitating behaviour change through social learning and d) social comparison which results in the generation of hope (Salzer 2002).

Alternatively, social constructionist ideas about mental illness as a social phenomenon have given rise to narrative accounts of recovery (e.g. Mancini et al 2005). The development of a 'recovered' identity is said to result from the re-storying of experiences, away from the problem-saturated narrative (where these experiences are recruited into a tale about illness) and towards one marked more by meaning and wellbeing (where they are storied as part of the development of an

identity associated with this). Mead and Macneil (2001) refer to this process as the 'renaming' of experiences, suggesting that the culture of peer support provides a community within which this can occur.

Antze (1976) and Rappaport (1993) have further suggested that collective story-telling within this community shapes a local ideology which subsequently informs, frames and changes the self-narratives of people engaged in it. As Campbell (2005) has suggested, an alternative worldview is afforded. This is reminiscent of Myerhoff's (1982) description of 'definitional ceremonies,' or ritualized story-telling within groups which frame and indeed come to constitute the identities of the group and its members. White (1997) has described this process as the social performance and authentication of knowledge, and incorporated it into narrative therapy as 'outsider witness' practice.

In summary, differences in the way in which recovery is envisioned, whether individual or organizational, may impact on peer supporters' understandings of their role and of themselves within that role and also the form of the stories they share with others.

Reciprocity

Whether it incorporates a rejection of the medical model or not, peer support is generally said to represent a rejection of traditional methods of formal helping. Mead and Macneil (2004) describe these as a 'one-way process' which 'continues to maintain static roles of helper and helpee,' antithetical to the 'mutuality that most resembles community type relationships and allows us to move towards full citizenship' (p11). Relatedly, Clay (2005) claims that all peer support services share the 'peer principle' and the 'helper principle' as common values. The former emphasises the necessity of 'equality' and 'reciprocity' in relationships between 'peers,' with the capacity for learning constructed explicitly as bi-directional. The

latter proposes that 'working for the recovery of others facilitates personal recovery.' In line with this, studies purporting to evaluate the efficacy of peer support have examined and described benefits to both 'help-seekers' and 'providers' (e.g. Mclean et al 2009).

Michael White's critique of the 'one-way' account of therapeutic interactions⁷ might help to situate some of the ideas informing the practice of 'mutuality' in peer support. In his view, models of help in which one person is constructed as 'the object of the therapist's [expert] knowledges and practices,' where 'the ideal is for this person's life to change as an outcome of the therapeutic conversation while the life of the therapist remains as it was' reproduce a 'subject/object dualism that is so pervasive in the structuring of relations of power in contemporary western culture,' (p.128). Constructing lives as objects of professional knowledge and remediation facilitates the disciplining practices described in Chapter 1. Additionally, constructing one set of people as recipients of help and denying the possibility of mutual gain through relationship may contribute to the reinforcement of the kind of identity conclusions (e.g. of the self as inert or deficient) that bring people to seek support in the first place.

White also describes the construction of the help-seeker as 'other' where the likelihood of mutual influence through relationship is denied. Mead et al (2001) develop this idea, suggesting that a shared experience of social disempowerment leads people with experience of mental health service use to develop affiliations that build 'a strong sense of identity as a 'mental patient,' (p.7). They describe a contingent internalisation of 'otherness' that informs social relations, noting that 'we see ourselves in the role of the "mental patient" and learn to make meaning defined by the roles that keep us feeling hidden and separated from others,' (p.8). These roles are reinforced by and embodied in one-way constructions of helping relationships. In contrast, the explicitly mutual relationships of peer support offer an opportunity to find new ways of making meaning, practice new ways of being with

⁷ E.g. White (1997b).

others and of viewing self from the vantage of social power.

In practice, Mead et al allow that many factors can contribute to an imbalance of power in relationships (e.g. financial means, job titles, level of education, history of access to services). They suggest that peer support offers a means to talk about power dynamics, and therefore to break them down. In contrast to 'one-way' helping, there is a shared responsibility for maintaining fluidity between roles of 'helper' and 'being helped' that involves acknowledging these dynamics.

Experiential knowledge and expertise

In addition to the bi-directional learning of new roles and self-knowledges, Salzer (2002) has described 'experiential knowledge' as one element that is constitutive of the exchange in peer support. Borkman (1976) defined this as 'competence or skill in handling or resolving a problem through the use of one's own experience' (p447). This concept was originally developed as a response to the perceived hegemony of 'professional expertise' (Borkman 1990), and literature on the topic has attempted to define and establish a basis for the power of non-professional knowing. For example, people performing experiential knowledge have been understood as possessing 'referent power,' or social influence based on a sense of identification with another person (Powell 1990). This was contrasted with 'expert power,' which is derived from the perception that a person possesses technical expertise. Referent power was said to not be dependent on the perception of the influencing agent as more powerful or superior; experiential knowledge might be performed mutually or co-created.

In contrast professional 'expertise' is performed in a uni-directional or asymmetrical fashion as part of the practice of 'institutional talk' (e.g. Heritage and Drew 1992). My understanding of the use of the term 'expertise' is grounded in Berger and Luckmann's (1966) analysis of the social construction of institutions. It is claimed that one way in which an institutional practice is explained, justified and transmitted

from one generation to another is through the generation of theories that legitimate the practice in terms of a differentiated body of knowledge. Individual 'expertise' might thus be understood as a construction of a body of knowledge as specialized and that legitimates an institutional role. For example, in inventing and appealing to the Diagnostic Statistical Manual of Mental Disorders (e.g. American Psychiatric Association, 2000), the 'psy-professions' have established a basis for their own position as professional wielders of this knowledge (e.g. Rose 1995).

While some have referred to the formalisation of peer support as a process of 'legitimation' of skills and knowledge gained through experience of the use of mental health services (Mowbray & Moxley 1997), it might also reflect or support a process of 'professionalisation.' The provision of training might suggest that 'peer support' is a skill to be learnt and delivered. Relationships are usually structured according to a model of service provision, whereby some people are positioned as 'consumers,' some 'providers' (even if it is possible to talk about mutuality in these relationships, less palatable to mainstream professionals). Providers are employed by large organizations and paid, whereas consumers aren't. The basis of these discrepancies perhaps requires explanation, and so peers employed in support roles are described as 'further along their road to recovery' (Repper and Carter 2010, p4), though it is not always spelt out clearly how this is defined.

Some forms of evaluative study have perhaps supported a construction of peer support as 'expertise.' Rogers et al (2007) conducted a 'randomised controlled trial' (RCT) of a 'consumer-operated' peer support project, purporting to measure the effect on 'empowerment' for persons 'receiving' a peer support condition. 'Intensity of engagement in the intervention' (p787) was measured through monitoring of attendance rates. 'Significant, small and positive effects' were found overall. Another RCT has been conducted according to a similar design, measuring impact on hospitalization rates as an outcome (Solomon & Draine 1995). This kind of research has perhaps subsequently prompted policy recommendations that research aim to identify more and less effective forms of peer support (e.g. Naylor and Bell 2010).

Behind the description of peer support as an ‘intervention’ condition, there is the suggestion that it is a kind of thing that exists beyond the interactions of the particular people who deliver it, and that it is therefore possible to be more or less skilled at conveying it. This (in addition to the structural issues described above) might impact on the way in which ‘experiential knowledge’ is conceived, for example. Where the core relationship-specific idea underlying the ‘referent’ power of this knowledge is de-emphasised, it might come to represent a form of professional expertise, acquired and legitimated through ‘recovery.’

Peer support and ‘mainstream’ services

Formal ‘peer support’ projects may vary with respect to their relationship with ‘mainstream’ services. Some may operate ‘within’ or as a part of such services; others may be seen as supplemental (e.g. ward-visiting projects), still others as alternatives (e.g. crisis houses). Given this variety and the varying contexts in which groups may have originated, it is likely that their ideological foundations and the way in which ‘mental health’ or ‘recovery’ are understood likewise vary. As is arguably the case with other formal helping interactions (such as psychotherapy⁸), ideology may influence the form and content of peer support.

The ‘formal peer support worker’ role (akin to ‘peer specialist’ as described) has and is being trialled by the NHS, for example in Scotland (McClean et al 2009), Nottingham⁹ and South London.¹⁰ Philosophically, this development has been described as part of ‘a wellbeing and recovery-based mental health service model,’ aimed at promoting ‘empowerment’ and ‘wellness’ for both formal workers and persons referred to the service.¹¹ In the evaluation of the Scottish project, peer support workers were described as offering ‘hope’ of recovery, as providing a space

⁸ See Peräkylä et al (2008)

⁹ See <http://www.nottinghamshirehealthcare.nhs.uk/aboutus/latest-news/funding-boost-for-peer-support-worker-project/>

¹⁰ See <https://slamtwigops.wordpress.com/2012/08/20/the-s-h-a-r-e-project-a-new-peer-support-project-in-lewisham-still-some-places-left-for-taster-this-wednesday/>

¹¹ See <http://www.scotland.gov.uk/Publications/2009/11/13112054/5>

for disclosure without fear of judgment, as encouraging service users to take control of their recovery and as introducing new perspectives or strategies for wellness by using their personal experience as a precedent (McClean et al 2009).

In Faulkner and Kalathil's (2012) survey of voluntary sector 'peer support' projects, a focus on 'recovery' and the notion of 'expertise by experience' also seemed present in peer supporters' understandings of their roles, though a diversity of views on who counted as a 'peer' and what that support consists of were noted. Additionally, 'concerns were expressed about community, peer-led and informal approaches becoming subsumed' (p 34) by versions promoted by mental health services, with less formalized versions of peer support going unrecognized and unfunded. It was felt that peer workers within the NHS may struggle to maintain an alternative ethos and that the roles may privilege 'those who are already on their way to becoming 'professionals,' promoting a 'hierarchy' of peer supporters.

The preference of funding bodies for the RCT as a means of demonstrating value may result in the privileging of the 'professionalised' construction of peer support as described. This could have an impact on those required to fill formal peer supporter positions. Despite being called upon to form relationships based upon a principle of 'equality' (Mead and Macneil 2004), using personal experience to empathise with others (much as perhaps one might do in the context of friendship), the construction of their roles may introduce a certain ambiguity with regards to purpose or identity for people employed as peer supporters. This shall be explored further below.

Chapter 3 –Defining the current study

Issues of identity for providers of formal peer support

In comparison to the RCTs described above, qualitative research on peer support projects has variously involved descriptions of benefits to both ‘consumers’ and ‘providers’ (e.g. Ochoka et al 2006; Mclean et al 2009), although these are still framed as arising from ‘peer support’ as opposed to specific relationships. These benefits have included an increased sense of empowerment and independence, control of ‘symptoms,’ social support and the generation of hope (Davidson et al 2006).

Some research has focused more specifically on the experiences of those employed as formal peer supporters. Mowbray, Moxley and Collins (1998) interviewed 11 employed peer supporters, again describing benefits associated with the role such as financial reward, personal satisfaction, self-knowledge and the acquisition of vocational and interpersonal skills. They also noted some difficulties, including feeling unskilled in the role and sometimes finding it difficult to switch off from work. The theme of ‘boundaries’ was explored, with peer supporters stating that it was not always easy to know how and where ‘friendship’ could be separated from ‘peer support.’ A similar finding was reported in Coleman and Campbell’s (2009) evaluation of a peer support project.

There is perhaps an association here with the role ambiguity that I suggested above. Mowbray et al went on to suggest that there was a meta-theme in their data regarding peer supporters’ ‘changing sense of self,’ where new roles created ‘new conceptions of people’ and that peer supporters found themselves in a ‘gray area in which they were neither consumer nor professional,’ (p408). Relatedly, Miya et al. (1997) suggest that, ‘by adopting highly defined roles, professionals work hard to institutionalize and maintain [social] boundaries,’ that are responsible for constructing a boundary between the ‘ill’ and the ‘well.’ Having a role which

challenges this boundary can involve a difficult 'paradigm shift' away from the 'sick role' for the person in it and those around him helping to shape it, but that this may be a source of benefit.

Peer supporters may come from ideological contexts which emphasise a critical stance towards the provision of mental health services. Zipple et al. (1997) suggest that they may have the difficult task of balancing their consumer identity and their new professional identity, as 'consumers move from the role of being critics of the mental health system to being members of it' (p413). Alternatively, mental health services may provide a context in which people feel more free to discuss aspects of themselves or their experiences associated with mental health diagnoses. Salzer and Shear (2002) interviewed peer supporters who reported feeling able to 'be themselves' at work, and benefited from a sense of social approval of those selves associated with employment.

It has been suggested that further research into self-perception and identity would benefit understanding of peer support (Armstrong et al 1995). Questions of identity may be particularly pertinent within the social constructionist framework I have outlined above. If 'mental illness' involves being positioned by discourse as mentally ill on the basis of one's experiences, then for many within this tradition wellbeing is associated with a 'reframing' or a 're-ownership' of these experiences, essentially identity work (e.g. White & Epston 1990). Accordingly, the development of 'positive' identity away from a conceptualisation of self solely as 'ill' has been described as an aspect of 'recovery' and wellbeing (Brown & Kandirikirira 2007), with the willingness of others to accept this identity also described as important.

As yet, there does not seem to have been any research that solely and explicitly examines the construction of identity as a formal peer supporter. Some autobiographical accounts of moves from 'consumer' to mental health professional are available, without any analysis of themes or implications. Cavanagh-Daley (1997) described her decision to become a mental health worker as akin to finding

her 'calling,' making sense of her experiences as a service user: 'I had at long last found the purpose and meaning of life through the many doors and corridors of my own pain,' (p281). The concept of 'mental illness' as a permanent part of one's life or identity was a theme present in this account and another (Gallagher 1997), where it was supported by the idea of a 'predisposition' to mental ill health. Concerns about or negative experiences of disclosure to others and about the visibility of the conditions they hoped to keep 'invisible' were also expressed, with one person stating that she 'compartmentalized' her life and that mental health issues were not an appropriate part of her 'professional' sphere (North 1997).

The transformation of experiences through meaning making is well-documented in the narrative literature on recovery from trauma (e.g. Crossley 2000), but to what extent will peer supporters claim that this kind of meaning is made through their roles? Will peer supporters endorse 'mental illness' as a part of their identity as it is a part of their job description? What will be the self-construction of people who aren't able to keep 'mental illness' invisible? This study will aim to address some of these questions, according to a framework outlined below.

Social constructionist approaches to 'identity'

As noted in Chapter 1, a social constructionist position advocates that every element of our 'reality' is constructed through language. This includes the 'self,' which is conceived of as 'a description rather than an essence.'¹² The idea that we are largely autonomous 'I-s' carrying with us a set of internal traits which shape the way we respond to particular situations is said to be a particular rendering of experience shaped by available discourses.

To elaborate, Benwell and Stokoe (2006, p.29) suggest that a discursive view of identity can be realised as either 'a historical set of structures with regulatory power

¹² Benwell and Stokoe 2006, p31

upon identity' (which I shall call a macro-account) or as 'a discursive performance or construction of identity in interaction' (which I shall call micro-). Addressing the former of these, Burr (2003) describes identity as achieved through the 'interweaving' of 'threads' constructed through discourses available in a culture (such as those of age, gender, sexuality and so on). For each 'thread,' a limited number of discourses exist through which an identity might be achieved. For example, it might be argued that there are a limited number of discourses (perhaps relating to madness or spirituality) according to which one might be able to construct an identity that incorporates 'voice hearing,' and that each might prescribe a set of behaviours consistent or acceptable within that identity. They might also influence how one is treated by others.

On a micro- level, Butler (1990) has argued that identity is also performed; that is to say, that an identity is 'performatively constituted by the very 'expressions' that are said to be its results' (p33). What follows is the possibility that identity is something produced in interaction with others, perhaps even something relative to particular interactions. Proponents of 'discursive psychology' (e.g. Edwards and Potter 1992) have further described language as 'action-oriented.' Speech is produced as a series of social acts, performed according to the requirements of interactions in order to meet convention, justify versions of events or to maintain a credible stance according to the local rules of conduct. To these ends, social identities are claimed, resisted and put to use by speakers.

The narrated self

Social constructionist approaches to identity may seem to describe the person as multiple, fragmented and incoherent, possibly contrary to our own experience of ourselves as coherent over time. Yet, while Davies and Harré (1999) have claimed that 'what sort of person one is is always an open question with a shifting answer depending upon the positions made available within one's own and others'

discursive practices,' they go on to suggest that within those practices we make use of 'stories' in order to 'make sense of our own and others' lives' (p35). Similarly to Sarbin (1986), it is suggested that narrative form is used to structure our experience, our self-understanding and the accounts we provide to others. We may also live our lives according to the stories we tell about ourselves, and omit or embellish details in order to fit an overarching theme (such as the self as 'victim'). Bruner (1987) argues that individuals become the autobiographical narratives by which they describe their lives, planning futures consistent with their sense of the meaning of the past.

Crossley (2000) further describes the relationship between personal narratives and the wider social context in which they are developed. It is suggested that we draw on narrative structure and content provided by narratives we are surrounded by from birth, both present in the media and in cultural stories and myths. It seems to me that this conception of the kind of broad narratives that saturate culture shares many features with the term 'discourse' as it has been used in the above when describing macro-social constructionism. However, perhaps a difference is that 'master narratives' (to use Swan and Linehan's term) are not described as constructing the subject, but rather as available to the subject for their own relational construction during interaction with others.

Narrative researchers have made use of positioning theory (Davies and Harré 1990) to describe this process. By this view, culturally available 'master narratives' describe positions that are associated with 'structures of rights,' outlining a limited set of concepts, images, and ways of speaking and describing our behaviour that we take as our own. People are able to actively engage with these 'subject positions' by adopting, negotiating or resisting them. We are also able to 'position' other speakers through responses to their speech. For example, John may respond to Bob's remark as offering sympathy by taking up a 'victim' position (with its associated speaking rights).

Where identities are conceived of as narratives, it follows from a discursive or performative understanding that narratives might also be constructed and employed strategically, with the audience in mind (Riessman 2008). Freeman (2002) notes that 'this is not to claim that the intentionality of narratives is always conscious and deliberate.... Rather, the claim is simply that narratives, as sense-making tools, inevitably do things' (p9) – for example, to argue, justify or engage amongst other things. Elaborating on the 'performative' understanding of narrative function, Goffman (1974) has suggested that 'What talkers undertake to do is not to provide information to a recipient but to present dramas to an audience,' (p508). Identities are constructed in interaction in order to persuade or to present a 'desirable self.'

Applying these ideas to the present research, some relevant questions are raised. How might people make use of various 'master narratives' to construct an account of themselves as formal peer supporters? How might they story the process of becoming a peer supporter (and therefore how might this process have impacted on the performance of identity)? Given the importance of identity construction to wellbeing discussed above, I shall attempt to use these questions to explore the impact of holding a formal peer support role on identity.

Locating the aims of this research: relevance to clinical psychology

One reason for the apparent relative ubiquity of 'peer support' in the U.S as compared to the UK is that, given systemic differences in the provision of health services, the 'patient-as-consumer' concept is apparently more well-established in the former (Mowbray and Moxley 1997). This emphasis on choice has possibly resulted in the development of a wider 'market' of support options. Current UK policy is also heading towards an emphasis on greater patient choice (e.g. DH 2010). Direct payments to mental health service users to afford them to buy their own care have already been rolled out in some areas (Irvine et al 2011). A proliferation of alternatives to 'mainstream' help may follow.

Additionally the Department of Health (DH) White Paper 'No health without mental health' proposes 'radically changing the way that current services are delivered so as to improve quality and reduce costs' (DH 2011, p66). A King's Fund report explored ideas for achieving this and included the development of 'peer support' services amongst its recommendations (Naylor and Bell 2010). The employment of people with experience of 'mental ill health' to provide services designed to make use of their experience was one suggestion of the form this could take. In support of this, reference was made to an evidence base suggesting that peer support can reduce rates of psychiatric hospitalisation and demand for other services (e.g. Solomon 2004). The report proposes that 'considerable expansion in the number of peer supporters' may be necessary (p16).

The British Psychological Society's Division of Clinical Psychology, in its definition of the role and purpose of the clinical psychologist, has described 'working with issues and mechanisms to facilitate organizational change' and 'sustaining effective partnerships with a range of commissioners and delivery systems' as core competencies for the profession (Toogood 2010, p7). Additionally, it 'actively encourages all members to develop partnership arrangements with local service user and carer organisations' (p3). Given this, clinical psychologists could potentially be positioned as leads in the development of peer support as innovative service provision.

The current study aims to examine the construction of identity by individuals providing peer support within a formalised role, given that this form has recently been piloted in the NHS as described. To this extent, it may inform the policy and practice of clinical psychologists working with peer supporters or called upon to support the development of services that include them.

Chapter 4: Method

Narrative analysis

The arrival at a narrative framework with which to make sense of the question of 'identity' has come about in part through the influence of key proponents of the peer support approach, who have themselves adopted this framework as a means of understanding their work and who were involved in training many peer-support providers operating in the UK (e.g. Mead and Macneil 2004). This framework also provides a means of understanding the process of the research in terms of its impact on me as I join the storytelling and listening practice described by White (1997a).

The selection of a methodological approach with the identification and analysis of narrative as its focus seems therefore appropriate. Riessman (2008) outlines several approaches to 'narrative inquiry,' describing them as belonging to a 'family of methods for interpreting texts that have in common a storied form.' She goes on to quote Radley and Chamberlain (2001) in claiming that 'as a general field, narrative inquiry 'is grounded in the study of the particular' (p11). It is concerned with how and why accounts are constructed in context, for whom and to what end and with the cultural resources that are drawn upon in doing so. She also describes the preservation of extended accounts as units for analysis, contrasting this with the 'fragmentation into thematic categories' of other qualitative approaches. Her argument is that category-centred approaches 'eliminate the sequential and structural features that are hallmarks of narrative' (p12), and pose challenges to the honouring of the intentions of participants. Nonetheless, analysis moves from the particular towards broader commentary and the development of conceptual propositions.

Given the diversity of approaches which have fallen into this 'family,' it will be necessary to answer some key methodological questions relating to this research below.

How are narratives to be identified?

The multiplicity of responses to this question reflects perhaps the absence of a single meaning or definition for the term 'narrative' itself. Riessman (2008) describes a continuum of definitions ranging from the 'restrictive' social linguistic (where 'narrative' is said to refer to a discrete, topically-centred answer to a single question) through to those used within anthropology (where narrative can refer to the entire 'life story' of an individual or group). She locates working definitions utilized in psychological research between these, describing personal narrative as 'long sections of talk – extended accounts of lives in context,' differentiated from the discrete response as 'evolving [and] framed in and through interaction' (p6).

If stories evolve in dialogue and if narrative identities shift in response to the demands of talk (as suggested above), the question arises as to what criterion will be used to group speech together to form discrete units for narrative analysis. One response has been to attempt to define narrative as employing a common structure, and to code dialogue according to this structure. Within Labov's (1972) sociolinguistic approach, 'fully formed' narrative is said to begin with 'an orientation, proceeds to the complicating action, is suspended at the focus of evaluation before the resolution, concludes with the resolution, and returns the listener to the present time with the coda' (1972, p369). At the very least, to be considered as narrative he proposes that talk must contain clauses that are temporally ordered, and incorporate basic features such as characters, settings and a plot.

A major criticism of this approach is that the investigator might be involved in imposing a potentially arbitrary or value-imbued structure on speech that was not formed in such a manner, perhaps losing meaning and ignoring the function of 'deviant' utterances in the attempt to achieve good fit. Arguably, however, the application of any theoretical framework within qualitative research is a form of guided ordering, selection and reconstruction of peoples' speech. Even conversation analysis, which attempts to ground any sense-making in reference to the speaker's

words, could be said to employ implicit cultural understandings in accessing and categorising the meaning of those words. Any piece of research is possibly itself a story about others' experience, told with the incorporation of a certain set of rules about how one can talk about the world in a methodologically rigorous way.

Riessman (1993) acknowledges the idea that, in narrative analysis, 'the analyst's authorial voice and interpretive commentary knit the disparate elements together and determine how readers are to understand [the informant's] experience' (p30). For me, however, research in the power-sharing spirit of peer support means attempting a co-authoring of peoples' stories. Construction of 'core stories' (Mishler 1986) from conversational material will proceed according to a structural approach, in the hope that this produces a familiar aesthetic form with which to engage peer supporters in commenting on and contributing to the ordering/re-ordering.

Edwards (1997) suggests that focus on structure risks failing to address the way in which narrative and narrated identities are used in response to the demands of interaction (and as such may in fact be fragmented or fluid structurally). I will therefore also attempt to thematically organize points of conversational exchange between myself and participants in order to comment on this.

How are narratives to be constructed?

As Benwell and Stokoe (2006) note, social constructionist narrative work shares features with discursive approaches to research, in that it 'adopts a constructionist understanding of discourse, or narrative, as constitutive of 'reality.' Selves and identities are therefore constituted in talk,' (p.42). This framework arguably implies a different understanding of the process of 'interviewing' participants in research than might be employed as part of more positivist qualitative methodologies. If there are no 'attitudes' or essential identities to access through the use of focused questions, this process rather becomes a means by which two participants ('researcher' and

'participant') jointly construct narrative and meaning. With this in mind, Mishler (1986) has suggested that structured schedules be replaced by open conversations aimed at generating detailed accounts from a position of curiosity.

In exploring what this might entail, Speedy (2008) discusses the ethical positioning of the investigator as 'co-researcher' of participants' experiences, suggesting the use of interviewing techniques drawn from narrative therapeutic traditions (e.g. White and Epston 1990). From these she borrows the concept of 'landscapes of meaning and action,' describing the role of the 'interviewer' as asking exploratory questions in these areas in order to expand 'the conversation from that which is known and familiar towards that which it is possible to know' (p68). She describes attending to 'talk that sings' (or the use of metaphor or poetic description) in people's expression of their lives, suggesting that these be explored and developed. She also highlights the possibility of introducing reciprocity into research conversations, where the 'interviewer' might respond to emerging stories with their own thoughts and experiences as part of the process of meaning-making. The consistency of this approach with the principles of peer support discussed on page 12 recommends it in this instance.

While a narrative conversation of this kind might begin with an open-ended question related to the research topic at hand, 'narrative interviewing necessitates following participants down *their* trails' (Riessman 2008, p24). While this research is interested in how peer support workers manage identities, arguably questions that presuppose identity categories and/or identity as salient (such as 'how do you feel your identity has changed during the transition from 'consumer' to 'consumer-provider?') could introduce a frame for narrative that wouldn't otherwise be utilized. Instead, conversations will proceed from a more general invitation to talk about the process of becoming a peer support worker. 'Identity' will be examined as a potential framework for analyzing narratives that emerge.

Quality in narrative research

As noted, this research proceeds according to a social constructionist understanding of narrative, identity and its situated production. The research interview is viewed as a novel context in which narrative identities are uniquely performed, and uniquely co-constructed in conversation with the researcher. Therefore no attempts will be made to establish the replicability of findings or their generalisability over time, place and population. No efforts to access or represent an independently-verifiable 'truth' will take place; the social constructionist position precludes such a possibility.

As evaluative standards, then, positivist conceptions of 'validity' and 'reliability' have no use here. Spencer and Ritchie (2012) describe attempts to establish rules for assessing the *quality* of qualitative research, noting that the heterogeneity of methodological approaches and epistemological positions adopted within this school have complicated the adoption of a prescriptive framework. Nonetheless, they suggest applying some 'recurring principles that underpin concepts of quality' (p.229) as a guideline to appraisal. Research should attempt to make a novel *contribution*, to theory, practice, policy or to the lives of individuals. It should strive for *credibility*, through the adequate representation of claims and the use of evidence to support them as well as through validation via peer and/or member review. Finally, it should demonstrate *rigour*, through the use of reflexivity, through the auditability of research decisions, orientations and roles and through the defensibility of the rationale and method of inquiry.

Spencer and Ritchie also note the possibility of standards uniquely applicable to a given research method and epistemology. Arguably, a social constructionist approach to narrative research allows that the process and product of this research is itself narrative, a particular framing of a set of experiences. It might therefore be evaluated according to criteria that cross boundaries between 'art' and 'social science.' Speedy (2008) has suggested the following: transparency (or the provision of information about the process of the research); trustworthiness (or a

demonstration of plausibility and credibility); aesthetic merit; reflexivity; accountability (or a consideration of interests served by producing the research); impact (or whether it affects the reader); and contribution (to understanding of the human condition).

The present study will attempt to incorporate transparency, rigour, reflexivity and accountability through inclusion of the research diary (Appendix A), which will aim to document my position, attitudes and developing story through the course of conducting the research. Through this I will also aim to describe the manner in which the process of the research impacts upon me. Auditability will be established by providing sufficient contextual description of research decisions. Credibility will be aimed for by presenting representations of participants' stories to participants themselves for validation; broader commentary will additionally be checked for credibility, coherence and aesthetic merit by the examiners of this thesis. I will aim to contribute to an understanding of the process of peer support by exploring the particular experiences of a small group of people, and make tentative suggestions as to implications for policy and practice.

Procedure

Ethics

Ethical approval was gained from the University of East London Research Ethics Committee (see Appendix B). Participants were told that I would be investigating peoples' stories of becoming peer support workers, and informed of the form the write-up would take. A draft version of individual case studies and general analysis was sent to participants for comments and suggestions before consent was sought again to use these. All names and any potentially identifying information have been changed. I periodically emailed participants throughout the research in order to update them and to provide an opportunity to discuss any concerns. I informed them

at this stage that I felt I was benefiting personally from the research, and would reflect on this in the report.

Participants

The selection criteria for participation were that participants be currently employed as 'peer support workers' by an organization offering services to 'mental health service users,' that participants be of 18 years or older (so as to give informed consent), and that English was their first language (given that translation costs may be beyond the feasible budget for the project).

The people who took part were involved in varying forms of 'peer support,' recruited from different contexts in order to afford the opportunity to consider whether these contexts impacted on narratives of peer support. Nonetheless, all were in paid employment in the voluntary sector as peer support workers, and all had received training in peer support. Some contextualizing information about each person follows:

Linda is a 42 year-old White British woman. She described herself as experiencing a 'breakdown' in the mid-nineties, resulting in an extended period of 'clinical depression' during which she was unable to work. She underwent psychoanalysis within the NHS, and received hospital treatment for a long-term addiction during this time. She became a user of mental health day services, and through this was afforded the possibility of attending training in peer support around six years ago. Following that, she set up a peer support group with others who attended this training, which has since grown into a community day project. She is now employed to facilitate this group and project.

Jenny is a 38 year-old White British woman. She described herself as first being hospitalized in an acute psychiatric unit in her early 20s, subsequently spending all

of her 20s 'in and out' of hospital. She described herself as someone who hears voices, and that this was one of the reasons for her hospitalization. She was given the opportunity to attend peer support training around six years ago by a mental health worker. Subsequently, she has been employed as a peer support worker for five years, where she visits an inpatient psychiatric unit to meet with service users there as well as supporting people with mental health diagnoses living in the community to access facilities and activities.

Rhys is a 32 year-old White British man. He described himself as having had contact with mental health services since he was a teenager, having received treatment for addictions, 'depression' and anger over the intermittent years (including both pharmacological and talking therapies). He attended training to become a peer supporter about eight months ago, and has been subsequently employed to support individuals with mental health diagnoses in the community and in residential care units to access activities and to develop support plans.

Elaine is a 39 year-old White British woman. She described herself as having had contact with mental health services periodically since her 20s, including three episodes of 'clinical depression' involving stays in acute psychiatric wards. Her most recent admission was for 'post-natal depression' two years ago, following which she had ongoing contact with community mental health services. She attended peer support training about a year ago, and has been employed as a peer support worker for about four months. In this role she visits a psychiatric hospital in order to meet with and provide emotional support to clients there. Prior to this she also volunteered as a family support worker for about a year in a project that helped struggling families with young children.

Jane is a 45 year-old White British woman. She described herself as having had a 'breakdown' about six years ago, after a long history of 'unhappiness' since childhood due to difficult family circumstances. She received treatments for 'depression,' but described peer support as facilitating her recovery. She attended

training to become a peer support worker about eight months ago, and has been subsequently employed to support individuals with mental health diagnoses in the community and in residential care units to access activities and to develop support plans.

Martin is a 35 year-old White British man. He described himself as having used community mental health services since he was a teenager following impulsive and 'self-destructive' behaviour. This involved contact with psychiatric nurses and psychiatrists. He has been employed in mental health and support settings since his early twenties. He received training in peer support three years ago, and has worked as a peer support worker since then. This has involved supporting individuals with mental health diagnoses in the community and in residential care units to access activities and to develop support plans.

Robyn is a 32 year-old White British woman. She first had contact with mental health services eleven years ago, when she found herself feeling overwhelmed by the experience of hearing voices and experiencing other unusual perceptual phenomena. She was diagnosed with schizophrenia, and has subsequently received community psychiatric services and pharmacological treatment to date. She undertook training to become a peer support worker about eight months ago, and has been subsequently employed to support individuals with mental health diagnoses in the community and in residential care units to access activities and to develop support plans.

Sue is a 42 year-old White British woman. She first had contact with mental health services in her teens, subsequently spending much of her 20s and 30s 'in and out' of psychiatric hospitals with the aim of treating low mood, unusual perceptual phenomena, addictions and self-harm. She was given the opportunity to attend peer support training around six years ago by a mental health worker. Subsequently, she has been employed as a peer support worker for five years, where she visits an

inpatient psychiatric unit to meet with service users there and offer emotional support.

Recruitment

I contacted representatives from each of the participating groups to discuss the possibility of research and what it would entail and produce. I was invited to attend a meeting at each, attended by peer support workers. I explained the research procedure and rationale as well as some of my own history and context in order to qualify my interest in the area. People interested in taking part provided contact details, and I subsequently arranged individual interviews. Information sheets and consent forms were provided prior to conducting interviews (see Appendices C and D respectively). Participants were not offered payment.

Interviews

Eight face-to-face conversations took place in total, ranging in length from 45 to 65 minutes and recorded using a digital recorder. Time was provided at the end for questions. Conversations began with a request - 'Could you tell me how it was that you came to be a peer support worker' - and proceeded as described above. Because of the open-ended nature of this approach, the content of each varied somewhat but generally followed themes related to personal experience of mental distress and the impact of the job role. See Appendix E for some sample questions.

Transcription

Riessman (2008) quotes Mishler as suggesting that, 'because there is no universal form of transcription suitable for all research situations, investigators make

decisions...based on theoretical concerns and practical constraints including an investigator's perspective on the relationship between meaning and speech, specific aims of a project and relevant aspects of speech' (p28). Theoretically, this study proceeds from the position that accounts are co-constructed; therefore, both my words and those of participants were transcribed word for word. Nonlexical expressions were included, and notes were made as to the style in which speech was delivered (as these may have been incorporated into an analysis of performative function). See Appendix F for the transcription convention used, and Appendix G for a sample of the original transcript.

In presentation, speech was cleaned up during sections concerned with presenting 'core stories' in order to facilitate reading. It was preserved in its transcribed form for sections concerned with commenting on interaction.

Analysis

This proceeded through the following stages:

1. Reading and re-reading transcripts many times and annotating them with comments about themes and similarities;
2. Generating thematic categories and grouping these comments according to these;
3. Looking at points of interaction between myself and participants and commenting on then grouping these thematically;
4. Re-reading each individual conversation and attempting to generate a core story by a) noting contingency and temporal progression (Salmon 2008) in the telling of events; b) attempting to identify an abstract (where present) as a guide to the intended theme of the core story (Mishler 1986); c) noting recurring 'evaluative' themes throughout the conversation to, in Polkinghorne's (1988) words, accomplish 'emplotment' and to draw material

- into stories which were not told sequentially; d) utilizing Labov's (1986) structural elements as a framework for inclusion and presentation of material;
5. Applying concepts from narrative literature to comment on the content and structure of these stories;
 6. Drawing out issues raised in the stories that are pertinent to the research question.

Chapter 5: Narratives of being and becoming a peer supporter

The primary aim of the analysis was to describe characteristics of narratives constructed during conversations with participants about becoming a peer supporter. Taking a broad focus, there did seem to be some features common to nearly all if not all of the accounts. Each might have been characterized as 'progressive' (to use Gergen's¹³ term), moving the self towards a state characterized as more desirable. Sometimes the idea of a 'turning point' or 'cut-off' was employed to demarcate a separation between a previous and current state or self, well and less well. Previous 'mentally ill' identities were accounted for by: suggesting that they were conceptions of self that were produced as a result of being part of particular environments (such as 'the ward' with Jenny, an unstable home with Rhys); storying them as relatively undeveloped states (as with Jane and Robyn); or representing a misunderstanding of behaviour (Martin).

Progression was often associated with the acquisition of wisdom, skills or a new perspective to be shared with others. To this extent, I have likened tales to what has been referred to as the 'enlightenment' (Thornhill et al 2004) or the 'quest' narrative (Frank 1995) of illness and recovery. Here illness is seen as a context for producing 'epiphany' or gaining knowledge, which can then be shared with others, seen in narratives of recovery from 'mental illness' (e.g. Ridgway 2001).

Other accounts emphasized themes such as restitution, empowerment or the transformation of experience, also described respectively as forms of narrative of recovery from illness (Frank 1995), 'mental illness' (Parkinson 2003) or trauma (Tedeschi & Calhoun 2004). Despite differences in emphasis, accounts tended not to exemplify these forms but rather made use of elements from each to varying degrees. Therefore I have endeavoured to highlight similarities as well as differences.

¹³ Gergen and Gergen (1984)

Due to constraints of space, quotes have often been annotated, as signaled by ‘...’ I have as far as possible attempted to retain descriptions of their context.

Linda

I felt that the core theme of my conversation with Linda was one of restitution, a regaining of productivity and confidence that was lost through the course of ‘mental illness.’ This was storied as facilitated by peer support, which afforded validation from peers but also a validation of her skills. She began our conversation with a description of the loss of her business in the early 90s. This heralded the storying of a part of her life as thematically dominated by a ‘mental health issue.’ This was described in terms that suggested ‘stuckness,’ a lack of agency and indeed of value:

I got very stuck, very stuck, very.... Not knowing where I was going, feeling very helpless I suppose, sense of helplessness, no direction. And I think once you stop working and you’re out of that, your confidence goes down very very quickly. When you have got a sort of mental health issue, it’s so easy to like feel like you’re the worst of the worst, you know? You haven’t got any value or self-worth anymore, you feel trapped, isolated, under a deep tarmac of horrible stuff that you can’t move and you know the more you seem to try and move you just know you’re just getting more stuck. It feels like, in fact someone said once it feels like you’re in a swamp, and it was very very hard to get out of that swamp.

Linda was using mental health services at the time, and found other patients to be supportive. This provided a rationale for taking up training in peer support when the opportunity arose:

I was accessing day services and I found day services very useful because it was meeting other people with likeminded situation, able to share some of our problems ... An opportunity came along that there was some training for

service users across the whole of the country to ... learn about intentional peer support, [otherwise referred to as formal peer support]. I came back to the day centre with the other members, and said 'shall we give it a go?' which we did, three or so of us, actually give it a go and that's where the process started of our group. And it was really, really from the beginning it was just us sitting in a room, three, four, five, six of us talking about our experiences and our stories really ... and we realized we had to leave the day centre at some point, and we had to go and find our own room which we did.

Linda's descriptions of her activities following the training seemed to emphasise agency, for example in her repetition and underscoring of 'actually give it a go' and her use of the phrase 'which we did' to perhaps highlight the accomplishment of finding their own room. After this excerpt, Linda went on to talk about some of the beneficial changes that had occurred in people coming to the group. This seemed to further develop the contrast with that 'stuck' self with no value - the group that she had helped to set up had made a real difference to peoples' lives.

I asked Linda if she would expand her account of the transition between being under the 'tarmac' and deciding to take up the training:

I think sometimes someone can't tell you to do it, I think some and I am only speaking on behalf of me, things have to get worse and worse until they're unbearable, you know, that for me something within thought 'I can't be like this anymore, I can't...' ... It was like an energy or something, came out of me that wanted to burst out. It was just sort of like... part of it was me stopping that energy coming up by all the patterns of my thought patterns. Basically I had to do some work on myself, and I think the counseling, the therapy did help, it broke down some of those... the peer group was supportive, also the therapy helped because it actually looked at some of the patterns, but I think you can do that in peer support as well, because we've got proof of that in our group, that if you've got a supportive enough group, challenges can come up

.... Being in a peer group and sometimes saying in that peer group 'Well I think you think I'm this way' and they feed back to me and say 'Well I hadn't thought you were that way' or whatever, and you think 'Oh my god people aren't thinking the way you think they are.' That's what started me changing ... I've been validated. I needed to be validated I think.

It appeared that Linda made use of ideas with which to demarcate a separation from the 'stuck' self. One of these was an idea of saturation and crisis point – things got 'worse and worse' until they became 'unbearable' and there was a sudden shift – 'I can't be like this anymore.' Another was related to the accumulation of awareness, here of 'the patterns' that had held Linda where she was. This awareness was storied as emergent within relationships, both with a 'professional' therapist and with 'peers.' Notably, peer support was compared positively with 'professional' help here but also constructed as offering the same kind of thing.

Despite the use of ideas establishing a separation, Linda also seemed to emphasise continuity between selves or states in her use of the energy metaphor above. The implication seems almost to be that, even during the 'stuck' period, there was something positive inside her that was waiting to come out given the right conditions, or given an opportunity to be validated. Based on her narrative analysis of peoples' stories of choices of and decisions to change professional roles, Linde (1993) has suggested that any discontinuity in these stories required 'explicit treatment' in order to maintain coherence.¹⁴ It may be that these ideas served to manage the credibility (to borrow Goffman's¹⁵ word) of a shift from stuck to peer supporter.

The theme of validation through peer support and its link to value continued through Linda's account:

I think a lot of my life well I've been wiping myself away by critical inner voices or whatever so I think it's about hearing people say 'You did a good job on

¹⁴ For further discussion of 'coherence' and related ideas, see page 82.

¹⁵ From Goffman (1974)

that' you know, 'That was really well done,' you know, 'what you did made a difference to somebody.' ... Sometimes it's not just about being validated, it's also someone needs you, that you can do something the other way round ... it's not just about having something off of peer support, it's about giving something back and it's also the fact that you're needed. And I think we all need to be needed, you know, and in this project what it's done for me is I felt because I hadn't been a mother I felt needed.

Here being able to do a good job or being needed was associated with a selfhood that would otherwise be 'wiped away.' I wondered if her reference to motherhood served to locate this desire as something basically human. There was the implication that being a recipient of supporting services denied the possibility to 'do something [this] way round.'

I thought that the idea of restitution underpinned Linda's story, in that there was a kind of symmetry in losing the business but then finding and developing another enterprise in peer support. The activities associated with it provided a context with which to story the acquisition of various skills, above and beyond what she had as a businesswoman:

In my business I had a big issue with dealing with councilors and things, so I feared speaking to a town council or anything and because of peer group we had to access a grant. I had to go and see a town councilor. Again, a fear of the past, where I kept thinking to myself 'I'm finding it amazing every time I do try and face my fears, what a difference it is.' And I did go and meet this town clerk, and it was not at all what I expected, the outcome was completely different. ... So an old pattern's been broken down again, and that's what Shery Mead, [a popular proponent and provider of training in formal peer support], refers to as our worldview, how we see ourselves and how we think others see us ... It's making me learn skills I haven't learnt before, learn how to communicate better, I think that's the thing ... I'm getting a lot more from

life. I'm not hiding myself away, feeling this is what people think of me, because I'm able, if I do get a problem or an altercation I can actually face somebody now ... I never knew those skills before. Never knew them whatsoever, you know.

This development of skills and the idea of a change in how Linda sees herself and the world further enrich the narrative of progression away from the stuck self. I also wondered whether there was an allusion to a need for wider societal validation. She went on to develop the idea of a progressive change of self-view in terms of activity and a desire for activity:

I used to think there was not much out there when I was going through my depression, the world was empty, right? Now I haven't got enough time.. whoever .. why did they make it only a 7 day week? I actually feel like there's not enough time now in the week you know because I feel like I wanna do this, I wanna do that and I never felt that before. I used to think there's nothing on in my community. Well I couldn't see it. I couldn't see it. I mean, how could I see it if I couldn't even see me operating it.

Linda linked loss of employment with a loss of confidence in the first quote I reproduced here. Contextualised by the rest of her account, perhaps there is an implicit idea that skills (such as those one might evidence in employment) and being 'needed' are part of what makes a valued or valuable self. Here she seemed to establish her 'better' self particularly as productive and desiring to be productive, and I was reminded of the construction of 'mental illness' as 'unproductivity' described on page 8. I wondered whether, in her account, peer support activity offered a sort of sanction or evidence for a story about the self as now 'not ill,' a response to that conceptualisation of her experiences and a validation with respect to it.

Jenny

I needed to banish some demons from psychiatric units ... Like many people, I'd had years of quite horrendous experiences in psychiatric units and I think going and working on the ward for the last five years has kind of like as I say banished some demons, its been cathartic to actually go back as a worker gives me a different perspective to being in a psychiatric unit and I think that's really helped.

Jenny opened our conversation with this statement, which seemed to introduce several themes that continued throughout. 'The ward' was described as a demonic place, which implied a critique of 'professional' psychiatric care (later compared to what might be offered by peer support). Peer support itself was constructed as 'work,' establishing Jenny's status as a worker. This status along with the acquisition of a 'different perspective' were said to have helped her. She also positioned herself as part of a community of 'many people' who have had 'horrendous experiences in psychiatric units,' using this solidarity to add weight to her account of them as such and positioning herself amongst a group (later defined). Overall, her story seemed to emphasise the empowerment afforded by peer support, particularly to undo some of the wrongs perpetuated by mainstream mental health services. In this 'redress' element, it also shares features with the 'restitution' narrative form described by Frank (1993).

I went on to ask Jenny about the history of her decision to take up peer support work:

I didn't work. I've always done voluntary work you know always, right from the word go but I left uni at 22 and I was straight pretty much straight into psychiatric units, I spent all of my 20s in-and-out in-and-out in-and-out. Don't get me wrong, I had a good life, I mean I was with my now husband, we were having a great time together, it wasn't all doom and gloom. But I was in-and-

out in-and-out and in-and-out and it was very much like most people, especially with vis-a-vis the voice hearing, I'd hear voices, get put into hospital, the voices would go, I'd come out, the voices would come back, I'd go into hospital, the voices would go and it just went on like this, revolving door patient, in-out in-out in-out all the time. And I got to about thirty and I thought, hang on a minute, I want a child. I want to get married. I want kids. I want a job, you know, I don't wanna just spend all my life just in and out of psychiatric units.

In addition to providing a critique of 'professional care' on psychiatric units, Jenny seemed to move negativity from herself to her surroundings in her descriptions of a previous self. I heard her account here as co-presenting two identities. There was that associated with more 'normative' social roles, such as work, parenthood and marriage. There was also that constituted by interaction with 'the ward,' the 'revolving door patient.' A theme of mechanistic repetition and stuckness pervading the account of the latter might be said to have features in common with Linda's 'stuck' state. Unlike Linda though, Jenny storied this identity as local to her interaction with the 'unit' and not a reflection of herself or her behaviour; she has always been able to work, but dealings with the 'unit' gave her an identity that denied her autonomy. By doing this, a continuous, coherent self was established over roles as 'patient' and her current role as a 'worker.'

Jenny's use of the phrase 'I got to about thirty' here provided a premise for the progressive movement from one state to another. Jenny was able to realise and effect her own agency in the context of the changes in understanding that are common themes in cultural stories about maturation. This agency was storied in her use of the phrase 'hang on a minute' – it's as if she realises she has been pulled along by something, and can now choose to step away and fully claim what she has always been maintaining to some degree.

She further developed this idea in a description of encounter with a user-led organization, using the theme of acquiring new perspective:

And I came into contact with the hearing voices network ... and it kind of like made me look differently at my voice hearing. And my, in inverted commas, illness altogether. I started thinking hang on a minute, you know, I can still lead a great life, I can still achieve my goals and aims. You know, I don't have to keep going into hospital all the time. And now I think I can share that with people on the ward.

The sharing of expertise by a representative of a group of voice hearers is said to lead to a different view of 'voice hearing,' described as something she can now own as hers whereas previously it was recruited by others into the 'revolving door' identity. She immediately storied the impact of this by critiquing and separating from herself the 'illness' concept associated with the unit's view. The account achieved the construction of an alternative knowledge that provided access to a 'great life,' and established a premise for her own ability to 'share that' as a peer support worker. Her reference to the hearing voices network, in the context of the rest of her account, also helped to establish a 'critical survivor' identity shared by others. As she later said, 'I'm sort of an anarchist at heart.'

In its reference to a new perspective to be shared, Jenny's account might be likened to the 'enlightenment' narrative described above. 'Empowerment' came through as a theme more so in her descriptions of the benefits of peer support to her and others, here conceptualized as 'catharsis':

I don't mean cathartic in the sense of I've forgotten all the bad experiences I've had and isn't this place wonderful, I certainly don't mean that with catharsis. I just mean it's a process.. the anger's still there, but I guess with catharsis, perhaps what I'm trying to say is that you know I'm in a position to actually do something about these atrocities now.

I was struck particularly by what seemed to be descriptions of solidarity as 'doing something about these atrocities':

There was a situation on the ward the other day, one of the ladies on the ward said to one of the staff 'Oh can I go and get my washing out of the drier?' 'No, cos the room's locked.' 'Well, can't you unlock the room?' 'We haven't got time.' She got really aggressive, well not aggressive she was quite annoyed and angry about it. And the staff were just laughing at her. And I sat down, I said 'You know, that would annoy me, that would annoy me.'

Within the context of the rest of our conversation, one way to understand this small tale is that peer support has provided a frame by which Jenny can describe herself as having the power to sit alongside people and affirm their position in the face of the hostility of the ward. Compared to the times when she would 'get put into hospital' for 'hearing voices' by these staff, she is now in a position to offer a normalizing sanction of this woman's response to the ward situation. Resistance to pathologising labeling was alluded to in her substitution of the phrase 'aggressive' for 'annoyed and angry.'

This empowerment entailed an account of new differences in her relationships on the ward:

Power is always negotiated [in peer support]. Certainly going on to a psychiatric unit, you I suppose do have a certain amount of power cos you don't hold the keys, you haven't got the keys but you can come on and off the wards. You have that freedom, they don't. And I think sometimes that power is not such a bad thing, so long as it's negotiated. And I think I think traditionally in therapeutic in inverted commas relationships, there is no negotiation of power.

I wondered whether one challenge of the change in status for Jenny was the possibility that she might be associated with 'staff,' and that this needed resolving with her 'critical survivor' identity. Here she established the difference between peer support and other forms of support, perhaps to this end, and emphasized that she doesn't 'hold the keys.' Perhaps she was in the difficult position of maintaining allegiance to an ideology that, whilst supported by the peer support organization, was very different to that of the environment she was working in and its procedures.

Elsewhere, she tackled this by suggesting that there was nothing to reconcile, rejecting the idea that she should be defined by her role:

Its been a cathartic process ... communicating with staff perhaps in a different way than how I communicated with them when I was a patient on the ward. But having said that, I'm me. I'm not me the peer support worker, me the patient, me the voice hearer ... I'm no good with hats and jobs, I just see people as people.

I also wondered whether her accounts of solidarity and positioning of herself alongside others who had experienced poor treatment were also part of this 'reconciling.' When talking with her, I was thinking about this and I said that I had sometimes felt that my training was leading me to see myself as aligned to 'mental health services.' She responded thus:

It's not quite the same thing but I went to [a mental health] conference ... I actually sat with a mental health nurse and her clinical psychologist friend and we were fine. We got on really well. And if you'd have told me 10, 5 years ago that I'd be sat with a mental health nurse and a clinical psychologist feeling equal and valued and valuable, I would have said that wasn't possible. Cos when I got home, one of my friends who's more anti-psychiatry than I am, I text her and I said I've been coll.. I didn't say colluding, didn't say colluding, I

said I've been consorting with the enemy isn't it. Didn't say colluding, but consorting with the enemy.

I heard in this a reflection of the generally progressive theme of her account. There was an implicit description of a divide between 'mental health staff' and 'service user' premised on a sense of inequality and value. Supported by her role, new relationships and the context of the conference Jenny was able to give an account of herself as now separate from a time when she wasn't able to feel equal and valuable.

In the context of the rest of her account, this could also be read in this way: mental health staff denied me a sense of value in the past. I now have that sense. I have not become one of the oppressors, I am simply reclaiming something they took from me and that everyone should have. I'm not 'colluding,' but 'consorting' with them as equals since we are all 'people.'

Rhys

The following tales also storied progression, but in doing so they seemed to follow the structure of an 'enlightenment' narrative more closely. They constructed difficult early experiences as a premise for the acquisition of understanding, and suggested that this understanding was then to be shared with others. Rhys's account lent a particular redemptive spin to this enlightenment form:

I never sort of had much direction in my life or nothing until the past year or so, it's always been quite fucking chaotic, I mean I've lived in S., I was born and brought up, I lived in N., I've lived in C., I've lived in L., I've lived in D., I've lived in S.. And this is all in the last ten, twelve years, so it's like yeah everything's just been completely chaotic. And it's like you do wanna sort of

whats the word? Yeah it's just a case of giving it back, paying it forward to a certain extent.

Our conversation opened with this characterisation of a prior life as 'chaotic,' along with demonstration of the proof of this, in the description of moves around the country. This seemed to develop a premise for a certain resolution to his account – the idea of 'giving it back, paying it forward.' He elaborated on the specifically redemptive quality of this process:

I think at some point in your life, just before you die, even in your own mind, you're gonna judge yourself. There is gonna be some kind of judgment somewhere. And I know I've done a lot of nasty, filthy, scum-filled type things in the last thirty years. But I've got the next thirty years to make up for it.

Similar to Jenny, a break or turning point was signalled at thirty and highlighted by the symmetry between the 'last' and the 'next' thirty years. Something has occurred to turn the self that needs redemption into the redeeming self, and Rhys was largely involved in explaining this. He started by telling me about his earlier self:

To be honest, more than anything, when I was 16 I wasn't exactly what you'd class as a good boy.

I felt that, through his use of emphatic terms here ('to be honest,') Rhys was convincing me how unlike a 'good boy' he had been. His account initially moved through and focused on difficult relations with parental figures, drug use, crime and relationship problems, as if to establish this beyond argument.

Like preceding accounts, I also heard a kind of determinism and 'stuckness' in his descriptions of attempts to change his life during this time. Events that could be construed as major successes and breaks from a pattern (such as coming off speed) were mentioned, but were followed by accounts of returns to old ways:

I stopped with the speed after that. I have come off the wagon once or twice. I mean, I moved to Norwich with a girl called R., soon as I got up there, didn't have any money, new start, fresh start. Within three weeks I'd met someone that I needed to know and I was pushing weed, started growing it myself cos I was on a farm estate, started a nice little hundred and sixty plant crop tucked away in the woods. Just got in with the wrong crowd again.

A subsequent move to D. was described as 'the same thing again.' A later move to S. was storied similarly:

Within three weeks I was dealing, I was working, I got myself a job in a petrol station, started robbing that place blind for fags.

In his use of the phrase 'within three weeks,' I thought that in one respect Rhys was underlining a sort of inevitability associated with that time. In addition to his work and habitation pattern, he also talked in similar terms about repeatedly seeking sex outside of established relationships. His exploration of this also had a deterministic theme:

Only recently that I've realized that my mother was a sex addict, her father was a sex addict, and all the time I've been called all the bastards under the sun for what I'm doing by these people and technically I mean my thoughts are you know well surely that's fucking learnt behaviour.

Rhys's description of being called 'all the bastards under the sun' for 'learnt behaviour' seemed to move negativity from himself to his surroundings (as Jenny did in her account of the 'revolving door'), using this idea of determinism to resist a negative account of himself in the present. Potentially stigmatized habitual behaviour resulted from and was associated with the actions of *others* towards him in the past.

Furthermore, the 'only recently' here appeared to function as a way of recruiting this realization into an account of a change of direction.

In developing this change, further contrast was provided when a more agentive present self was storied, separate from and able to *choose* to resist 'old habits.' The fulcrum or point of change was described (in this context) as his move down to the town where he currently lives and began working as a peer supporter:

I moved down here and I got a point where I was told I had a sofa bed for 6 months, rent free, sort myself out. So rather than just do what I'd always done, come down here, walk into the next job and carry on it's not fucking, I mean I'd managed to give up the weed, managed to go through a marriage breakdown without getting fucked up. Just thought no, I'm not gonna get back into my old habits, I don't wanna do that anymore.

From this point, successes (such as giving up weed) were recruited into the story seemingly in order to develop an account of how this change was possible. Rhys also made use of the idea of a 'leap of faith':

So I mean I started looking, decided I was gonna take a leap of faith, I was gonna sign on for the first time in my life, I was gonna take some of my money back and I was gonna wait for the right job.

This colloquialism is perhaps associated with the idea of a blind jump into the unknown, suggesting a fundamental break between totally different states, one territory charted (and possibly habitual), the other new. Agency is implied but perhaps not in a way that is necessarily inconsistent with the idea of a 'stuck' past self because such a leap connotes a sort of impulsive change (as opposed to a planned, sequential transition, which may require more explanation in order to achieve plausibility). The allusion to spirituality perhaps serves to underline the

significance of the change, but perhaps also suggests a kind of higher intervention that might also serve to make such a turning point more convincing.

Rhys storied himself as responsible for this change, although not solely so:

I've always had problems on and off with depression, anxiety, anger management, drugs, anything. And it's like... sort of, since I moved here, everything's started to calm down, everything's started to balance out. Thanks to a bit of honesty within my family, I'm starting to figure myself out and starting to figure out why certain behaviour patterns have come in.

Here the nature of the change is again developed through the theme of self-discovery or understanding, which begins to answer the question of what the 'redeeming self' looks like. Self-knowledge and perhaps increased agency provided a premise for a form of expertise¹⁶ associated with Rhys's present self and work as a peer supporter:

I went around for counselling and it was one on one for anxiety and depression, group for anxiety and depression, then it was group for anger management, one on one for anger management, then it was drug counseling, all sorts. And it's all the same shit. How does that make you feel? I mean... shit! You know, there is no other answer to that question... shit! You know, they have no point of reference. I think it's beautiful to be able to sit with someone and have that point of reference. ... And I mean, if I can walk if I can do this for thirty years and I make a handful of peoples' lives better or change their perspective on life, surely that's enough. I mean when I was 16, something like this I would have jumped on board, just to have some kind of role model in me life. Or someone who basically understands.

¹⁶ As defined on page 14

As with many of the others I spoke to, Rhys seemed to contrast the kind of expertise he could offer favourably with that offered by mental health ‘professionals.’ The latter were described as comparatively unable to ‘understand,’ and presented as part of a repetitive sequence. The telling, in this respect, shared features with the telling of his ‘stuck’ period. In order to justify his claim of greater effectiveness, he was perhaps alluding to and using his own experiences as a form of authority: I should know what helps because I’m the kind of person who would once have needed help, and these ‘professionals’ were just part of what was wrong with my life.

Thinking again of Linde’s (1993) work as described above, here the significant move from ‘self needing redemption’ to ‘redeeming self’ was made more convincing by Rhys’s storying of a kind of continuity between these two. Looking back at his opening statement described above, it is notable that Rhys didn’t describe himself as ‘bad’ – rather, he constructed an identity as definitely not a ‘good boy.’ Perhaps his use of the phrase was ironic, a kind of critique of social conventionality. In this context, it’s possible to see another meaning to this phrase:

Within three weeks I was dealing, I was working, I got myself a job in a petrol station, started robbing that place blind for fags.

In addition to describing stuckness, his repeated use of this ‘within three weeks’ phrase could be understood as a demonstration of a kind of unconventional resourcefulness. This idea did seem to be present throughout our conversation, for example:

Where as most kids get taught stupid things at home, I learnt how to make money. By the time I was 12 she was finding tins of money by the house where I’d been nicking ladders off a building and doing window washing, stuff like that. Then I couldn’t be arsed with school, so I started pissing about at school, answering back and then gradually it just got fucking worse and worse and worse to the point of in my last week of school alone I took I herded 50

sheep through the main corridor during lunchtime, I took a motorbike through the school, I superglued every lock on the top floor including the French room with the French teacher inside a stock cupboard.

What Rhys seemed to be saying was that he had valuable skills which (in the context of the rest of his story) served him well later as a successful 'businessman' in the recreational drugs trade, but that he was never afforded an opportunity to apply them in a way that was socially sanctioned due to a poor fit with school. In part this undermined the basis for stigmatization of the earlier self. His story developed the idea that an understanding of his behaviour as 'antisocial' meant that he was called 'all the bastards under the sun,' whereas in other circumstances he might have been seen as possessing desirable traits and abilities. In this way, a stigmatized or negative former self was accounted for it in a way that established a basis for his present role, as someone who has something to pass on to others.

'Redemption,' then, seemed at least in part about recognition for Rhys or support for the developing alternative account of his earlier life. This was storied as associated with the peer support role:

Everything that's ever gone against me for a job in the past went for me with a job like this ... It was one of those things where I ended up ringing up <the employer> and saying 'Look I've got no experience at all in this kind of work but the position sounds interesting, you know, I'd like a crack at it but I'm not academic, I haven't got a shit load of qualifications behind me, is it is it actually worth me..,' I said, 'The criteria looks good, but is it actually worth me applying?' So like she said to me 'Well have you ever had a history of mental health?' It was 'Oh yeah I've had oh you know I've got that like, I've done me anger management, me group counseling, me one-on-one counseling, my anxiety, my depression, my drugs.' ... 'To be honest,' she said, 'I really, really recommend you fill in the application form. You sound like a strong candidate.'

Rhys described an interaction where he was encouraged to perform potentially stigmatized or stigmatizing elements of his life almost as qualifications. This understanding of them – as characteristics that might contribute to a desired identity as an employee in this field as opposed to a ‘problem-saturated’ identity (White and Epston 1990) – was storied as sanctioned, in that he described being told that he sounded like ‘a strong candidate.’ I shall return to this idea of ‘sanction’ in chapter 8.

Elaine

Elaine’s story shared features with Jenny’s in its description of acceptance, ownership and reframing of ‘mental health issues’ as something occurring through access to peer support. Progression was seemingly storied in terms of this shift in identity.

I’m one of these people like they say beware the smiling depressive, don’t they? You know. Cos I’m one of these people always that... but inside you feel like rotten.

Near the beginning of our conversation, Elaine introduced the idea of a mismatch between what she was able to present to the world and other aspects of her experience through the idea of the ‘smiling depressive.’ This idea of not showing difficulties was couched in a story about what had been acceptable within her family, but also what she had experienced as acceptable within various social circles:

My parents’ generation, they would never... it was always something you wouldn’t talk about. So... and also I had a negative reaction, good and bad reactions, I mean I had my anti-natal group of friends and one of them was quite... odd about it, you know, very odd about the whole thing.

She went on to explain that there were times when it had become impossible to hide difficulties, first in a work context:

I had previous mental health issues, I had clinical depression that sort of thing and I always hid it from work til it came to the point where I couldn't hide it from work and I had six weeks off and it got out at work and I was sort of pushed out the job really to be honest.

Then in the context of family life:

I'd sort of put my mental health issues behind me. I thought 'That's it, so I'm gonna choose what I want in life, I've got a baby you know, husband, baby, house' ... but then it broke down again and it wasn't anything that I could control.

Elaine constructed her 'mental health issues' here almost as an uncontrollable aspect to herself – something that she could try to 'choose' to separate from herself, but that eventually made itself known. This was storied as problematic for the maintenance of socially sanctioned roles (and perhaps the identities that might accompany them) – as worker, mother, house-owner.

Nonetheless, Elaine storied her most recent stay in hospital as resulting in a turning towards mental health, specifically the idea of working 'in' it:

I think this was a turning point for me. I thought.... I don't want to have to go back to what I did before, the career I did before. I want to end up either voluntary or paid or whatever, I want to end up working in mental health

I wondered how she would describe what had resulted in this 'turning point.' As noted earlier, her description of her time on the ward as a 'patient' involved a critique of the quality of care offered there, and I got the sense that this was partly what had

inspired Elaine to try to offer something different. Nonetheless, she also talked about the impact on her of meeting and forming relationships with other 'patients' whilst there:

You can spot somebody that you think 'ah I think I'm gonna'.. You sort of gravitate towards each other don't you? And there was maybe a little enclave of us, but they were so different to anybody I've ever met before.

In the use of the term 'gravitate' here, there is perhaps the implication that there was something inherently similar between Elaine and the other people she found on the ward that would draw them together. Additionally, the formation of an 'enclave' suggests a group of similarity or solidarity within a larger, different, possibly hostile group or environment. In the context of her description of ward staff as generally uncaring or even cruel, I took this to refer to the ward as controlled by the staff (as opposed to the atmosphere created by other 'patients').

Despite this identification, throughout our conversation Elaine seemed to describe both similarities and differences between herself and the others she met, though these differences were described wholly in terms of access to resources:

I had my husband, I had my parents, I had a lot of support around me. But when I went in, obviously a lot of people without any support outside at all. Outside or inside, and actually it's a really horrible experience inside as well. And I dunno I just felt a bit sort of like, not charmed but a bit sort of like 'God you know, actually, what would have happened if you really didn't have the support?'

This sense – of having another, separate, more stable life from that associated with the ward or perhaps even with 'mental health issues' – seemed to have consequences for Elaine's story about membership of this 'enclave' or identity.

When asked to describe those 'lovely people,' following a set of positive descriptions of her fellow 'patients,' she went on to say:

I sort of felt like I wasn't ill enough. Maybe I shouldn't be here, you know. These people have got really sad stories and hard lives and that sort of thing, and here I am in my ... cosseted suburbia... voluntarily putting myself in here, you know. So ... so maybe that, I dunno, maybe that sort of I should be 'putting something back into society.'

Despite questioning whether she was 'ill enough,' Elaine didn't go on to construct this difference between herself and others in terms of level of distress; this might have suggested that her account was demonstrating questioning of her use of ward resources. Rather, the difference is constructed in terms of choice, empowerment and access to something other than a hard life. What could have been described as the 'normal' life of suburbia is herein described as 'cosseted,' as if Elaine was demonstrating allegiance to norms associated with this group or identity. The phrase 'putting something back..' was delivered in an almost ironic or self-mocking tone, suggesting a parodying of this arguably suburban sentiment. Through parody, perhaps she further distanced herself from that position.

So, it seemed as if, in her account, Elaine had moved from a position of trying to sustain what could be described as a 'normal life' (but finding this difficult because of difficulties that she had to hide) to a position of critiquing 'normality,' and wondering whether she was in fact 'ill enough.' I wondered whether one facilitator of this, suggested in her account, was a change in the perceived desirability of a 'mental health' identity. Her descriptions of some of the people she met on the ward perhaps supported this idea, such as:

There was another girl who, you know, well she was a substance abuser really and had lots of suicide attempts cos of that. She had a terrible

backstory, you know, really really sad. And she was really... gentle, nice, lovely person. Probably quite scary to look at but nice and gentle.

I was reminded of Elaine's description of herself as a 'smiling depressive' in the incongruity between 'scary to look at' and 'nice and gentle' here. Elaine was perhaps engaged in a critique of assumptions about character based on superficial appearance, maybe (in the context of discussion above) more broadly on identity as related to social status. Later, seemingly in response to this idea of 'not being ill enough,' she went on to discuss the 'common ground' between herself and her peer support colleagues, and to describe them:

Really surprising people, where you would... shouldn't... you know... the way they look, what they do, that sort of thing and I always think you meet some really surprising people. People who... their views on life always... and how really nice they are really surprises you.

Here she described herself as surprised to discover that the people she met were 'really nice.' I wondered whether this also represented a reframing of identity associated with 'mental health issues' that allowed her to claim such. Her description of her own difficulties in the context of others' seemed to support this:

I don't think I could have done it without my husband and you know, a single mum going through that, I just put my hand up to them sort of thing. It's a horrendous experience. So I thought no, fairly open about it now. And like I say, I felt angry. I felt sort of 'no, stop sweeping it under the carpet all the time.' And it's this, I think the shame part of it makes you worse anyway, if you're sweeping it under the carpet you're making that person feel there's some sort of shame element to it.

Elaine here demonstrated respect for someone framed as surviving a 'horrendous experience' on their own, a positive re-storying of the 'mental health issues' label.

This seemed to establish a premise for her suggestion that denying mental health issues was actually what implied that they were shameful (rather than deserving of respect). She went on to describe the consequences for herself and others of an increased openness about her own experiences:

And in the end I tell people now and the amount of women I've met, mums who I've talked to and said 'Oh you know I've had post-natal depression and ended up in hospital with it' and they've just kind of went and said 'Oh god I'm feeling awful, what do I do?'

Like Jenny, the result of Elaine's new understanding and ownership of 'mental health issues' was described as the possibility of helping others. There was also an idea of restitution in the re-acquisition of a kind of social acceptability associated with employment:

I've had really negative experiences with employment, and I really did feel that I'd never work again ... But this has made me first time ever that I've put down that I've had mental health issues on a CV!

Jane

Similar to Rhys, my conversation with Jane elicited more of an autobiographical account, less engaged than Jenny's in the establishment of peer support generally vis-a-vis other services but effective in its storying of the development of a personal basis for helping others. She introduced the idea of progression towards a point or 'cut-off' early on in our conversation:

I think I had to come to a point in life where you can start to impart...what you know to people in a similar situation, hopefully that's what most appealed, I thought that was a state where I could probably use my knowledge and experience to help people.

This was explicitly linked to both her own self-development and subsequently the premise upon which she was now able to help others:

The last ten years has been a lot of transition for me, huge amount of change and transition, which in some ways rounded me off as a person and I was just in a better place where I could help people I think. For that sole purpose rather than to get something out of it. Cos I think sometimes if you're in a caring relationship, you want some sort of pay back I think. It sounds strange, but when you see that, you know some over-caring people want to be needed. I've gone beyond all that, come out the other side of a long... battle and my .. my history started with my dad being alcoholic so, I was already a bit of a head case before I started, you could say.

This transition was here storied as one from 'head case' to helper, during which Jane established that she has 'gone beyond' 'over-caring' to a 'better place.' The use of the 'long battle' metaphor almost implied a sense of gravitas associated with this change, that it was hard-won and drawn-out.

Jane went on to elaborate the description of an earlier time in her life as associated with an identity constituted by difficulty:

I was a battered wife, I came out of an abusive relationship, I ran away from my husband, it was very violent and I... soon afterwards I fell in love with this man, who was... I left my husband the day after my father died, he died of alcoholism and what happened was I didn't foresee this at all but I fell madly in love with this guy and it was an insanity, it is insanity but .. I was insanely in love with this, this man. But he was actually a personification of my dad, who had just died, it was me not letting my dad go. And this man did all the things to me that my dad did to me as a child. Abandonment, rejection, unreliability. He was a drunk himself, it transpired. And all these things, I was in this

relationship, I played out my childhood in the most horrible amplified ... And I just cracked up under the strain.

To the extent that each represents a statement about identity as defined by difficulty, Jane's description of herself as a 'battered wife' here is similar to her description of herself as 'a headcase' earlier. As with the accounts of other peer supporters described, the story of this time was developed using a theme of a kind of stuckness or lack of agency. Here this was introduced as repetitiveness in relationships, told as being treated by others in similar ways but also the use of the phrase 'playing out' perhaps suggests a deterministic framing of Jane's own behaviour. She also described her behaviour then as an 'insanity'; elsewhere during our conversation, she referred to herself as 'cracked up' or in 'a muddle' during this time. This further introduced the theme of irrationality, a theme that is possibly drawn from a wider cultural discourse about identities associated with 'mental health issues,' (e.g. Szasz 1997).

What I shall call the theme of 'saturation and crisis' was arguably present in the idea of 'cracking up under the strain.' I shall return to a fuller discussion of this idea below. It seemed as if this 'crisis' was the cut-off point in Jane's account.

The subsequent period was described by Jane as one involving the acquisition of knowledge. She described finding 'somebody on the internet, somebody that I could correspond with, had similar problems to me,' subsequently engaging in two years of 'intensive self-searching.' This process was said to be like:

Unwrapping, bit like pass the parcel I suppose. Passing this back and forth, we were unwrapping a layer each time. Probably finding gems in there, those little toys, keepsakes along the way of insight ... That's what got me there ... I was a helpful person before, but I didn't really have insight. But the knowledge I've gained from all that, I suppose in a way it was knowledge that

was there already, stuff you pick up, and we know really, and it was articulating it into writing.

Knowledge was here framed as something that resides inside oneself, 'there already' to be unwrapped in the context of a helping relationship. I was reminded of Rhys's and Jenny's allusions to potential in themselves, there to be realized or recognized as opposed to generated anew. Again I wondered if this provided some coherence to identities separated by the cut-off, whilst also representing resistance to stigmatized accounts of the self. In Jane's case, a contrast was drawn between 'knowledge' and her descriptions of her 'stuck' identity as associated with irrationality, perhaps representing resistance to this idea.

Like Jenny, Jane also made use of the concept of ageing in storying transition between states. Here she did so when describing differences between present and past relationships:

I was a little lost girl, a child with that one, the one that hurt me so much. But this second one, I'm an adult. And I approach him as an adult. It's a whole new different way of learning about things.

In the context of the preceding use of the concept of knowledge, it could be said that the use of the discourse of maturity assumes in the listener a shared understanding of its associations (of wisdom, of greater expertise) and invites him/her to enter into agreement. After all, to the degree that we are commonly subject to this discourse, disagreement would have possibly negative connotations for his/her own identity story.

Something that is perhaps also notable about Jane's account is that the idea of mutuality implicit in 'pass the parcel' might be contrasted with a more traditional view of professional-patient interaction. Despite perhaps previously borrowing from this discourse in describing herself as previously 'a head case,' Jane does not story

herself as subsequently having been 'fixed.' Rather, transition was said to take place with another but not entirely as a result of the action of other; personal agency and role in this transition is preserved. This account is perhaps more consistent with an identity storied as possessing a degree of expertise.

As a form of resolution to her tale, Jane described herself as able to act differently in relationships, almost like performing a different role on an old stage:

I'd reproduced my father in this man. And I reproduced the scenario. So when I started to help back and help people after this correspondence with this lady, I can do it from a position of knowledge. And funnily enough I got into a relationship a few years ago with an alcoholic ... But it's actually a quite healing relationship, we're very good friends ... I don't do that rescuing himself from drunkenness. I point him to the way. I think its been strangely healing in some ways. It's shown me that I'm together now, much more together than I was then.

In this I was reminded of Jenny's description of herself as benefiting from the ability to go back to the ward in a new role, and her ability to recruit this into a story about herself as different from a prior self. Here, Jane related this explicitly to the idea of recovery: 'It's shown me that I'm together now.' Again, peer support is storied as a form of sanction for a story of herself as recovered, and painful experiences as part of a positive current identity:

It makes you a more colourful person in life if you've had some sort of pain, it makes you a better person

Martin

Martin began our conversation with a critique of some elements of traditional mental health provision, outlining a lack of empathy as often typical of practice. He had

spent many years working in mainstream mental health settings, and much of what we discussed seemed to weave this theme into a chronological account of his history with services:

I sort of started using psychiatric services when I was about 13 cos I was truanting, so I was referred by my school and ... he meant well, he was a really nice guy, sort of child psychiatrist but it was just I felt the really pertinent questions needed to be asked were never asked, like why? Why is all this happening? It was more I felt a lot of skirting round issues really ... I was told as well that because I was quite overweight at that point that I should go on a diet and that would really solve my problems, which kind of triggered the eating disorder really. Um just stuff like that. I found it really appalling actually, again in retrospect you haven't got much of a voice when you're thirteen. And yeah I kind of disengaged with that quite quickly. Also I was probably about 16, 17, going to see my GP, was kind of finding my life quite unmanageable and again just this really dismissive clinical attitude of 'I just want to get you out as quickly as possible,' which I found really unhelpful. He asked me cos most all the root issue of my problems was sort of sexual abuse as a child so he just sort of just said 'Oh so were you abused as a child?' and that kind of really pushed really big buttons for me and I was like woah, meltdown time. And he couldn't really I think gauge why that had happened, so I just left and didn't go back with that really until yeah I was 18, 19. I just decided that erm cos my life was again just extremely chaotic that I thought well if I don't do something now, I'll probably die really, cos I was kind of you know extremely self-destructive behaviour. So I got it together enough to kind of get a voluntary job at the universities sort of supporting disabled students.

I perceived a familiar thread of repetition also running through this account and elsewhere in our conversation – presenting to services, receiving a disempowering response, disengaging, a period of 'unmanageability' or 'chaos', re-presenting. I was reminded of Jenny in her description of the 'revolving door' identity, although despite

initially framing professionals as negative Martin's account did proceed toward an eventual positive experience of help (see below). Also similarly, Martin seems to describe the ascription of identity by a powerful other (as 'overweight'), and that it was this that resulted in subsequent 'pathology' in the form of an 'eating disorder.' He performed the GP's frank question by lampooning a privileged, almost stand-offish tone. The effect on me was to underscore the theme of his relative powerlessness but also of distance between them, underwritten by professional status but also by class.

Martin did here ascribe arguably 'a-rational' traits to himself in his use of the terms 'unmanageable' and 'chaotic' – that is to say, traits that suggested his behaviour was not ordered or subject to rational thought, a description perhaps drawn from the construction of mental health difficulties discussed in Chapter 1. However, he storied himself as having had some capacity to 'get it together enough' to engage in the 'clean break.' Later 'clean breaks' were also described in terms of his own agency, consistently taking the form of 'saturation and crisis.' For example:

I was working at this place in B. at the time and I actually witnessed a member of staff hit one of the clients there, and I reported it and it was quite a big issue at the time and this .. and it caused me a lot of stress. Which turned out to be a good thing cos it meant I actually went and had another attempt at seeking some sort of treatment really. Cos I was functioning quite well at work but at home just not. And I was referred to a really good CPN actually, she was amazing. I think it was around that period that .. I see it as my pivotal sort of 'Ok I can get better.'

Rather than storying a single definitive 'cut-off,' Martin moved us through a series of saturation points that eventually culminated in a decision to become a peer support worker. In his descriptions of himself in the present, he did nonetheless draw comparisons with a previous self:

At the time when stuff is at its most intense ... I knew kind of what the cause was in a way, but I couldn't relate it to it ... But I think in retrospect I guess been my own investigations really, kind of could really understand why an eating disorder was ... useful, you know, kind of my self-harming was useful, you know. And I do view them as at the time as being useful cos, although not particularly healthy that's how I coped with abuse. I suppose for want of a better word it has made me feel less of an oddity.

For Martin, a distinction between selves is here storied in terms of understanding but also as a reframing of the possibly stigmatized 'eating disorder' behaviour as 'useful' and as a response to something negative outside of himself. In this reframing aspect it shares elements with Jenny's account; in terms of the delineation of a cut off along the lines of understanding, it also seems similar to most of the others'. This understanding was said to have been achieved through his 'own investigation,' perhaps providing a premise for establishing an alternative expertise associated with peer support (to be contrasted with the responses of services described earlier) but also emphasizing his own coping and agency.

As a kind of resolution to his story, Martin suggested that the knowledge he acquired from his experiences in a sense justified them. The theme of using this knowledge to help others also arose, in his description of faith that others could also recover from their difficulties:

I know [that it's possible for others to recover] because I've done it. And I'm still doing it. It's not like, 'Oh, I've done that now and I'm gonna move on.' I've found so far I have to keep working on myself, I have to keep working on stuff. It can be hard work, but it's hard work in its most positive sense ... Because of my life experiences, they're not something I'd particularly wish for but it's my life, I can't change that. But its given me the opportunity to actually go, my life doesn't have to be a certain way. I can actually choose, I can remake my life, I can choose it to be like I want it to be. I think if I hadn't been

in that place, I wouldn't of.. I suppose had the incentive to do that, you know? I can literally choose what I want my life to be, and I know I've got the capacity to put it in that direction if I wish. And I'm no different to anybody else so.. if I can do something, I know somebody else can do it too.

Robyn

I guess I could tell you a bit about the illness that I had. In 2001 I went to see a medium along with my mum and I remember her telling me about my grandmother. I was quite impressed by some of things that she picked up on. She said, 'Do you ever notice anything, her presence?' And I said, 'Yeah, sometimes, if I'm sort of chatting away to her I notice taps and bangs.' And she said 'That's really good, it means your grandmother's trying to communicate with you.' And I went home and I thought more about this and it seemed to me that she'd made a 2D world become like 3D. I was starting to notice things that I hadn't before and I would've been about twenty, that age. And for a few years I used to hear the voice of my grandma sometimes.

Despite opening her account of years preceding becoming a peer support worker by describing them as constituted by 'illness,' Robyn frequently employed descriptions that alluded to a spiritual understanding of her experiences. The first time that she began to notice unusual perceptual phenomena was described as 'a 2D world become like 3D, I was starting to notice things that I hadn't before.' From the outset, what might have been understood to have been pathological or stigmatizing – later said to have resulted in the ascription of the label 'schizophrenia' by a psychiatrist – was described as the development of an *extra* sense, or as supranormal.

What seemed different about Robyn's story was that she consistently described this sense as separate to herself, something she learnt to refine and not descriptive of her identity:

I sort of knew that what was happening to me was strange, so I was able to sort of think well this is going on but you know this is me, and that's a sort of separate thing really. I've been to see the psychiatrist and he's said to me I mean he diagnosed it as schizophrenia but he said usually when people have schizophrenia they think that the chair is talking to them and they will answer back and enter into a conversation. But I was saying 'well I'd hear the chair talking to me and I think well that's the chair talking, that isn't normal.'

Here Robyn described resistance to and separation from a diagnostic label by appealing to an idea of herself as consistently 'rational' perhaps and in touch with what is 'normal.' Her interaction with psychiatry was storied as relatively empowered. As with some of the other accounts, Robyn did describe a previous time in her life where the theme of uncontrollability and saturation / crisis arose, but it was a separated sense which had become 'out of control,' not herself:

That summer was basically the start of me hearing like getting more dreams and visions and hearing voices and it grew worse basically until it became out of control, until I'd get up in the morning and I'd have like feel like I had like seven people around me talking to me.

Progression was therefore storied in terms of her power to control this sense:

I mean to someone else they might think these spirits aren't real, they're your imagining. But whether they are or whether they're not they still have an effect on me. And I've had like several like useful messages and visualizations and pieces of advice from them and its helped me to have a bit of wisdom I suppose, which I want to share with other people? And that visualization I told you about, the three flowers,¹⁷ that was from a man called R. who used to be a friend of the family and he'd died? And he ..cos I used to find I was having visions.. I suppose I'll say that to me when you're communicating with spirit,

¹⁷ A mental image of three flowers unfolding that Robyn focused on in order to alleviate the sensation of being overwhelmed by voices.

it's a thought world, so if you think something it becomes true? And if you think something disturbing, obviously you get no reassurance at all and you become disturbed. And so that positive visualization was like a way of stopping my mind from going too far too fast and it was just enabled me to feel like peaceful.

Robyn was initially engaged here in resisting any attempt to undermine or marginalize her version of her experience by appealing to the validity of her personal reality – ‘others may not believe me but this is real to me,’ an unassailable position. She then went on to demonstrate a kind of expertise based on this system of explanation – statements about the ‘thought world’ seemed authoritative, a sense that was underlined by Robyn’s use of the term ‘obviously’ when explaining its principles. Elsewhere in our conversation, Robyn had explained that she had learnt a technique involving focusing on ‘three flowers’ in space, and that she had received this in a dream from a family friend who had passed away. Here she explicitly linked this to her ability to control her mind, demarcating a cut-off from the state she had described earlier. Such ‘useful messages’ were framed as having been conducive to ‘wisdom,’ which she wanted to share with others. In her appeal to spirituality in constructing this, I was reminded of Rhys in his reframing of an ‘ill’ identity as ‘unconventionally skilled.’ This possibly provides a basis for skill in the peer support role whilst precluding any challenge to credibility posed by ‘illness.’

‘Poison into medicine,’ ‘walking proof’ and Sue’s account

As a resolution to her tale, Robyn offered the idea of being able to find a positive use for something seemingly negative:

I spent months of feeling ill, you know, years of being on tablets and that actually came to something.

Based on words that Martin used, I came to describe this as the 'posion into medicine' idea, which was present in many of the peer supporters' narratives. With Jane, I saw this in her claim that 'pain' makes one a 'better person,' occurring in the context of her wider attempt to resist a stigmatized account of her identity:

It makes you a more colourful person in life if you've had some sort of pain, it makes you a better person. You're not, not so black and white maybe. Cos you're... colour about you I suppose. You're more unique.

With Jenny, I found it in her claim that peer support provides a positive use for the anger she feels at the way she was treated by ward staff:

I don't think you can live with hate in your heart so that's one of the things that peer support helped me with is moving beyond the hatred and actually doing something positive and channelling the anger into doing something good.

With Elaine, I found it in her discussion of the benefits that being employable as someone who explicitly used mental health services could bring:

To think that something kind of... that at the time was so horrible could actually benefit you, you think well... you know... sounds a bit Pollyanna I suppose, sounds a bit 'oh everything's going to be fine' cos it's never, for some people it never is fine is it? It never, it never is. But it's trying to find something positive out of it.

Of all the accounts, Sue's reiterated this idea the most, and it was more prominent as a theme than the 'enlightenment' narrative described up until now. It seemed present right at the outset of our conversation:

I was a revolving door patient for 20, 25 years in the services, 30 years discharged about a year and a half ago. Peer support is one of the biggest

things that keeps me well. I can sit downstairs at times waiting for whoever I'm working with to turn up and I have butterflies and I'll be thinking 'Hope they don't turn up, hope they don't turn up' and then I can go home but.. 99% of the time, even if I've wanted not to go to work that day, I've felt better by the time I come away. And it really does help keep me well.

Looking first at some of the similarities with the other accounts, Sue here established a contrast between an earlier 'stuck' identity associated with the 'revolving door,' and the wellness that is associated with peer support. As with Jenny, this was contextualized within a critique of the quality of 'professional' care on the acute ward where she had once stayed as a patient and now visits as a peer supporter. This poor 'care' was strongly implicated as a driver in her decision to become a peer supporter, which took place after Sue had had a particularly 'chaotic' stay on the ward:

I saw people who were really really suffering, people would be sitting there streaming tears and the nurse would just walk straight past them, wouldn't consider saying 'Would you like a chat?' or even 'I'll make time for a chat later' if they're busy now ... [A mental health worker] had been on at me for years to get involved with user-led activities and I was always convinced I'm not well enough, I can't do that kind of thing, I'm not prepared to take any kind of responsibility, I can't do this. But yes that day I said yes and ... I was desperately nervous [going on to the ward for a long time], but once I'm sitting down just talking to someone or listening to someone... People don't get the chance to tell their stories and all doctors want to know the bare facts and it's often the little things that matter to someone most.

Like some of the others, Sue again described a transition into a role where she is able to offer what 'matters most,' contrasting with what was not provided by ward staff and perhaps reminiscent of some of the themes of redress or undoing of past wrongs highlighted above. Like Jane, Sue here described herself before peer

support as thinking she was 'not well enough,' again using her role to story a kind of cut-off from a previous self that believed this.

Later in our conversation, the peer support role was in itself associated with the idea of recovery:

The Trust talks the talk with recovery but once you get past that ward door, it goes out the window, you know... 'What tablet are you giving me?' 'Oh the doctor's decided, you just take it.' They talk about looking after your own medication, understanding your own medication, they talk the talk of recovery but they don't practice it whereas we're walking proof that it can and does work.

Developing this further, recovery was storied as evidenced by but also as a premise for the provision of peer support:

It's so stressful being on that ward and by our very being there and leading the lives we live we can share our stories, or parts of it where it's relevant, and say 'Yes I was like that and I'm not now and you know the whole notion of once a patient always a patient or once a service user always a service user just isn't the case.'

Consistent with the 'enlightenment' narrative, Sue did suggest that some of her earlier experiences as a 'patient' provided a premise for skills that she could offer as a peer supporter, above and beyond those offered by 'doctors and nurses':

I'm tagged the cutting expert in our little team, different people have different areas of expertise where they're the best one to talk to that person but, you know, cutting has saved my life. I'm sure it's saved plenty of other peoples' lives and stopped them actually taking their life by relieving the pressure

through cutting but yes, cutting's not the problem. It's a symptom of the problem and again doctors and nurses don't see it that way.

The main thrust of Sue's account however developed the idea that the role itself and what it represents was said to be the source of benefit to others – the idea that it's possible not to be literally and conceptually bound forever by the ward and the disempowering identity attached to being a patient there. As Sue said:

We can offer hope, you know, we don't say oh you know this is you, you'll be in and out of here for the rest of your life. I was told I'd be in and out of there for the rest of my life and I'm not you know and.. we can offer hope, above anything else we might offer on the ward we offer hope.

This idea was present in what some others said too. Martin also described having to keep well so that he feels able to demonstrate wellness and inspire hope in others, in the context of working openly as a survivor of childhood sexual abuse with other survivors:

You kind of really have to walk your talk? ... You're not giving good service, you're not being a peer cos you're not doing your own stuff to get your own life in order. If you're not doing that and you don't know something works, you can't sell that to somebody and say you know this is what I've done, dadadada, and its really worked for me, I don't know how it'll work for you but it's a possibility. And I think it's something really empowering, about being able to say to somebody 'you can change this.'

Sue, Martin and Jenny also described a political element to this demonstrative capacity of the role. As Jenny suggested in this context:

My happiness is my revenge.

Returning now to the 'poison into medicine' theme, given the slightly different emphasis of Sue's account, painful experiences of the past were mostly not described as providing a basis for expertise, but rather the process of providing peer support was said to involve a reframing of unpleasant experiences as worthwhile. What was perhaps alluded to in Sue's descriptions of herself as nervous during her work was the possibility of justifying or give meaning to that distress – that it was worth enduring it, that enduring it is given some purpose through being able to help others. This idea was developed:

After years of being very much on the receiving end of everybody's attentions, it's good to feel that you're doing something positive, it's good to feel that you've got something to offer, and it's a wonderful way of putting those thirty years of suffering to good use and to turn it on its head and in some way make someone else's stay on that ward a little easier than maybe it would have been.

This theme of 'usefulness' was reminiscent of Linda's reference to being needed. Here, the peer support role provided a context with which to story difficult experiences as something to 'use,' perhaps in contrast to their potential recruitment into a story about 'thirty years of suffering' or 'the revolving door patient.' While for Rhys it was acceptance as a peer supporter that started this reframing, for Sue being able to 'use' her experiences impacted on her identity through the implication of 'usefulness:'

We lead our lives, happy lives, contented lives, productive lives, we're needed, we're useful.... You can cry, you could laugh, you can have a good life, which didn't dream possible when that first time you're diagnosed and told you've got x, y or z. You think the world's coming to an end and it hasn't.

Chapter 6 - Constructions of the peer support role

'Expertise by experience'

As noted, to varying degrees the narratives present in these accounts appeared to establish the peer support role as associated with a more 'recovered' state. Given this, personal experience relating to recovery was arguably constructed as a form of expertise, sometimes said to be more valued and valid in working with others than professional training.

There were various ways in which this 'expertise' was described. For example, as touched upon above, Sue's personal experience of cutting was storied as affording insight into its nature, with a contrast drawn immediately between what is available to 'doctors' and 'nurses.' This insight afforded access to practical strategies that could be passed on to others:

When I see youngsters come in and they're cutting maybe their neck, or their arms, or their legs ... I'm not going to turn round and say to someone 'Don't cut!' because cutting can often be a way of saving your life, which the staff can't see but cutters can. Cut somewhere underneath a swimming costume ... I know at their age I couldn't see a future, but ... cut under a swimming costume, cut so you don't have to live with the scars.

Additionally, several people talked about peer support as the generation of hope in others, that this hope was part of what helped others. The ability to story personal experience of recovery then was perhaps described as a kind of expertise, in that it was said to lend unique ability and authority to peer supporters in generating hope. Martin developed this idea, suggesting that generating hope in this way was beneficial to both parties in peer support:

I think kind it's something really empowering, about being able to say to somebody 'You can change this, you do not have to have your life like this, it

can change and you know you've got all the capacity to do that already, it's just finding it a little bit.' Although you know you're talking to directly to that person, you know your own mind is absorbing that. It's very empowering and it's just a real buzz to kind of know, intrinsically know without doubt that the person in front of you can change their life in the way that they wish to rather than going 'Ohh just give them some medication, I don't know what that person's gonna do, they've been on that for years, uggghhhh, right I'm off.'

What seems implicit here is that Martin and Sue (and Rhys earlier) were able to use their status as 'service users' to make a claim for 'intrinsic knowledge' of what helps, reminiscent of Berger and Luckmann's¹⁸ definition of expertise as 'specialised knowledge.' In comparison to the discourses of 'evidence' and 'statistical significance' that are employed to establish the legitimacy of the psy-professions' claim to specialized knowledge, this argument seems to run along the lines of 'I am one of the people who these professions are supposed to help, whose 'expertise' is ultimately legitimated by the extent to which they are able to help, and I am saying actually that I am in a better position to know and to deliver what helps.'

Establishing the authority of personal experience, in a sense, represents a critique of the basis of power relations between 'staff' and 'service user' (where power relations are described in terms of who controls what is knowable about a thing and how it is known¹⁹). This further serves to undermine the basis for a pathologised understanding of that experience apparently generated by 'staff.'

Peer support as a choice of profession

A consequence is that peer support thus framed shares features with a 'profession' in Berger and Luckmann's sense, a conceptualization supported by the context of

¹⁸ From 'The Social Construction of Reality' (1966), see discussion in introduction

¹⁹ E.g. Burr (1995)

employment and training (or indeed perhaps this conceptualization is prompted by that context). I was interested in examining the extent to which participants brought ideas associated with professional roles to their descriptions of themselves as peer supporters.

As alluded to by my quoting of Linde's work above, features of the peer supporters' accounts shared commonalities with accounts of professional choice. In her study, participants were apparently involved in establishing that good reasons exist for a choice of profession in order to generate coherent narratives²⁰. She claimed that 'character' (or rooting explanations within an essential description of the self) was 'one of the most powerful types of adequate account for choice of profession' (p129). She described this as informed by cultural individualist discourse privileging individualist personal agency.

Within this framework, peer supporters' development of personal history narratives possibly functioned to situate current roles as causally related to the past. This seemingly established a kind of credibility with regards to subsequent decisions to become a peer supporter, as well as a basis for expertise.

Additionally, several people referred to an interest in mental health problems or a tendency to help others as longstanding, often in terms that seemed to construct this as a character trait and often towards the beginning of their accounts. For example, Linda's account, in its reference to training and formal volunteering, seemed to establish a 'professional' credibility in addition to an explanatory character-based causality:

I'd joined Samaritans, I was very interested in counseling, I'd always liked person development groups and I always had an interest in all that and I trained as a counselor so that was running alongside my interest of people. I've always been very much interested in people.

²⁰ For further discussion on the need for coherence in narratives, see chapter 8.

For Elaine, peer support had seemed to facilitate the development of a positive ‘user identity.’ She storied this identity as something she used in her occupation, and as connected to membership of a valued group who shared it. She described concerns that she was ‘not unwell enough’ to work as a peer supporter, linking experience of mental health problems to ‘credibility’ in this role. Elaine’s opening account of ‘character’ perhaps aimed for a different kind of credibility to Linda:

I’ve just always been really interested in mental health, always been really interested in it. I mean I’ve had three previous episodes of clinical depression, I’ve had hospital instays and that as well, been an inpatient.

I wondered if this opening statement involved listing experiences with depression and hospital as qualifications of a kind – premises for adequate expertise as a peer supporter and for group membership, both of which were characterized by personal experience of mental health difficulties.

Ambiguity in the construction of professional status

Descriptions of peer support, perhaps unsurprisingly, tended to construct it as ‘work’ across the accounts. Some peer supporters seemed to try to establish peer support as ‘professional’ but different from other helping ‘professions.’ Looking back at the quote from Martin on page 69, there is perhaps some ambiguity in his statement:

You’re not giving good service, you’re not being a peer

‘Service’ provision perhaps taps into ideas about ‘professionality’ associated with a human services model, whereas ‘being a peer’ perhaps belongs to a realm of discourse about a different kind of relationship. Jenny explicitly attempted to define the difference:

I mean there's some people, I don't know if this is professional or not, if this is peer or not, you don't actually have to like people to do peer support work. But some people you are gonna connect with perhaps better in inverted commas than other people. But it's not it's not.. I think what I'm trying to say is that peer support is.. you can be friendly but it doesn't mean these people are your friends as such. It's a different relationship.

She seemed initially to be engaged here in managing an impression of herself as 'professional' by qualifying what she was about to say with 'I don't know if this is professional or not.' Perhaps she was concerned that her audience would question this. Like Martin she then immediately went on to state 'if this is peer or not,' as if correcting herself, positioning herself rather as someone concerned about a different kind of status or relationship. Nonetheless, she then claims that 'you don't actually have to like people to do peer support work.' There is the implication that peer support is 'work,' perhaps then subject to contingent ideas about 'professionality.' A separation is then constructed or reinforced between 'friendliness' and 'friendship,' perhaps in order to qualify peer support as work.

There are similarities in Elaine's description of pressure associated with meeting expectations around 'professionality' – that an ordinary activity becomes a pressurized one when it is constructed as something that requires training:

You're not just talking to your friends or lending an ear to a friend, you are actually moving on to into a little bit of a more professional role which you've had the training for. You think 'Am I up to this?'

Despite their apparent framing of the peer support relationship as a kind of 'professional' relationship, Martin, Jenny, Elaine and Linda were also involved in what I came to refer to as 'humanising helping,' a form of normalizing or perhaps 'de-professionalising' help. Linda referred often to her peer group as like a family:

Peer in a way means to me a family, friends that have come together that want to share experiences together and want to tell each other their stories of their lives over a period of time to support one another

In the context of a critique of the 'care' offered by ward staff, Elaine made a claim for the value of non-expert human acknowledgement:

[Peer support is] getting past all that and then sort of getting into an environment where you can talk to people. Cos they're not really asking for expertise, it just really wants someone just to think they're here.

Jenny conceptualized traditional forms of professional help as mechanical and impersonal, contrasting this with peer support as a normalized human relationship involving love:

I think that's what's wonderful about peer support. It's not stale. When you see psychiatry, you know right off, they go 'here's a script,' it's all very stale and 'yeah, yeah.' ... When it's pure peer support and you're getting on really well, love comes into it. Not love for that person but love and respect, you know, there is that element of love that comes into it. Showing people love, you know?

At several points in our conversation, Jenny also mentioned that she was 'no good with hats and jobs, I just see people as people.' I thought that she was generally involved in a kind of 'de-professionalising' of help and helping relationships (while retaining the idea of 'pure peer support'). This seemed more explicit in Martin's account:

I found it a bit strange <that you can't use your own life experiences when talking to others> cos I think good treatment for want of a better word works

when it's done on a human level, like human to human. Not omnipotent perfect 'I've had no problems in my life' clinician to somebody who's had it hard. That really struck me, I suppose, that gulf between humans.

I will discuss this ambiguity below, and return to the issue in chapter 8.

Chapter 7 - Reflections on my role in constructing narratives

The co-construction of 'professional'

Given the discursive view of narrative described earlier, it's important to note that I would have had a role in shaping the form and content of the conversations I had with peer supporters (Riessman 2008). Therefore, one possible reason for the 'ambiguity' in descriptions of peer support as 'professional' was my use of language. Unknowingly, I inconsistently and unconsciously invited people to account for themselves as 'professionals.' Note for example this short exchange with Jenny:

Sam: Sounds like one of the ways that you use your own experience is to build rapport with people, so when you meet them for the first time..

Jenny: We talk about first contact in the manual as being quite important, yeah

Here I support a construction of experience as a thing to be used in order to do something associated with 'professional' relationships, described using the jargonistic word 'rapport.' Jenny responded with her own use of a kind of jargon ('first contact') and an appeal to an authoritative basis for her 'practice' ('the manual'), perhaps as if now having to account for herself when positioned as a 'professional' by this kind of question.

Consider also this longer exchange with Elaine, which came at a point where I had led our conversation towards an idea of using her personal experiences as a peer supporter:

Sam: I'm wondering whether your experiences kind of feed into the way that you are with the people that you..

Elaine: How I actually am

Sam: Whether they feed into your work I guess

Elaine: I hope so, I hope so. But erm my sort of big thing is.. 'am I ill enough?' you know, I haven't got schizophrenia or, you know.. to me they sound more heavy duty than post-natal depression or clinical depression.

Here my conceptualization of peer support as 'work' perhaps prompts or reinforces an idea of 'experiences' as to be discussed or understood in the same way that work experiences might be framed. This idea was explored further when I asked Elaine what qualities were needed to be a good peer supporter. This felt subsequently like the kind of question that might be asked at a job interview. Elaine's response suggested that 'experience of mental health issues' lent her credibility in her role, comparing this to other 'professional' roles that might also require holders to account for their positions:

Elaine: I think you need some sort of experience of mental health issues. I'm not sure if it has to be on the ward or not, but I think some sort of mental health issues.

Sam: What's so important about this kind of experience?

Elaine: I think it's a credibility thing, personally. Mind you, I mean not all psychologists or psychiatrists have had mental health issues have they but.. I think with peer support it's a bit different, and I think it might be a bit of a credibility thing.

As Mead and Macneil (2004) have suggested, 'it is the medical model that has given us language, self-definition, an interpretive framework and a notion of what it means to 'help'' (p8). Certainly for myself at times, it was difficult to find language about

helping that didn't reconstruct this kind of model, which possibly invited peer supporters to respond with language that did the same.

Storying progression

Overall story form may also have been influenced by my interactive style. To begin with, the way that conversations were opened may have framed a 'before' and 'after' structure to peoples' accounts, with peer support as the fulcrum. While this would not necessarily account for their progressive quality, consider also this excerpt from my conversation with Elaine. I remember being struck early in this first conversation by what I thought to be an emergent property of her tale – the idea of a 'turning point.' Looking back at it, it seems that this idea can't be characterized quite so cleanly:

Elaine: I mean I've had three previous episodes of clinical depression, I've had hospital instays and that as well, been an inpatient. So erm, I just thought .. d'you know.. I think this sort of was a turning point for me, I thou.. I . I don't want to have to go back to what I did before, the career I did before, I want to end up either voluntary or paid or whatever, I want to end up working in mental health

Sam: Hmm-hmm, hmm

Elaine: I want to work in the care sector and, I , and then this course came up, and I met somebody who had done this course, this course came up and I did it. And I just really like doing it. I really like doing it, I really like going on to the ward, I really like the people you meet, I just like... it opens your eyes, really.

Sam: Hmm

Elaine: Just, you know, puts you in touch with people and you get to know people you'd never.. you'd never meet, you know. So that's really.. where I come from

Sam: Right

Elaine: And I.. ye

Sam: So sounds like you had some, you kind of had some interest for a while in mental health

Elaine: Yeah

Sam: And that being on the ward was a turning point, do you think?

Elaine: Yeah

Elaine: Yeah it was, yeah yeah. I thought the erm.. this is on, on record haha oh the care on the ward was atrocious to be honest, I thought it was terrible.

Again, while Elaine did seem to bring the idea into the conversation, it was also the thing that I chose to pick up on and develop and in a sense perhaps reinforce. There could be a number of reasons for this. Booker (2004) has suggested that critical events are common to culturally familiar story structures. It may be that I was engaged in communicating and co-developing the 'tellability'²¹ of a particular story form according to a possibly shared familiarity. Another idea is that my training in 'talking therapy' has encouraged me to participate in conversations in a way that encourages the development of 'progressive' narratives (Gergen and Gergen 1984) and the separation of self from 'problem-saturated' states (White 2007) away and separate from apparently less desirable states. These ideas are interestingly not mutually exclusive.

²¹ See discussion below

Chapter 8 – Discussion

Impact of different settings and/or ideological differences

Each conversation that I had as part of this research felt different from the others, with its own unique themes and emphases. The demands of space preclude a detailed examination of individual particularities in favour of a development of broad similarities and difference. Looking at them through a ‘wide focus’ lens, there did seem to be some broad patterns. Sue, Jenny, Elaine and Martin all had direct experience of staying or working on psychiatric wards. My conversations with them all contained a strong element of critique of institutional care, with staff and service user almost framed as belonging to opposite and sometimes antagonistic ‘sides of the fence.’ Although establishing peer support as preferable to professional interventions was also present in Rhys’s account (and to an extent Robyn’s), it seemed particularly strong in these stories. Sue, Jenny and Elaine had movingly reported disempowerment and neglect as patients on the ward they were now visiting, which may have informed their construction of their roles as now empowered, but I also wondered about the extent to which the power dynamics in the inpatient environment supports a construction of ‘them’ and ‘us.’

Rhys, Jane, Martin and Robyn’s accounts shared an extended autobiographical format that perhaps resulted from their recent production of their ‘stories’ as an activity within their organization. Perhaps storying a basis for their skills as peer supporters reflected some of the challenges of being sent into new environments in a new role. Jenny, Sue and Linda had all been peer supporters for many years; noticeably, their accounts tended not to develop the ‘enlightenment’ idea so much, in that their accounts spent less time establishing a basis for skills to offer through peer support based on personal insight and understanding. Perhaps this was because they felt more established or validated in what they brought as skills, and felt less need to demonstrate this. Additionally, Linda’s role (as someone who had developed a service herself and now employed to facilitate it) was different to that of the others

(as people employed to deliver a defined service within an organization), and perhaps afforded more scope for the validation of a broader range of skills rather than those relating purely to insight around mental health.

Narrative form

Beyond these differences, I have suggested that there were commonalities between accounts that arose from constraints on the production of narrative. As Gergen (1994) suggests,

‘It is largely because of existing narrative forms that ‘telling the truth’ is an intelligible act. If the narrative fails to approximate conventional forms, the telling becomes nonsensical. Thus rather than being driven by facts truth telling is largely governed by a fore-structure of narrative conventions’ (p189).

He goes on to argue that, whilst there is no reason to claim that there should be an absolutely limited number of tellable narrative forms, ‘due to the exigencies of social co-ordination, certain modalities are favored over others in various historical periods’ (p195). It may be reasonable to expect to find commonality in the form that peoples’ stories take when confronted with particular kinds of tasks in particular contexts, making use of the assumed common cultural knowledge of the listener in structuring what is tellable.

Some features of peer supporters’ tales may have reflected conventions of modern storytelling. For example, Booker (2004) describes the ubiquity of a movement from increasing ‘tension’ to sudden ‘liberation’ as a common device. There seemed to be an analogue in the use of the ‘saturation and crisis’ motif, for example in the stories of Jane, Linda and Martin, or in the idea of ‘turning points’ present in Elaine’s, Jenny’s and Rhys’s accounts.

Gergen and Gergen (1984) have also emphasized the importance of 'coherence' to the tellability of stories about the self. Their suggestion is that, to be coherent, narratives must 'select and arrange events in such a way that the goal state' (perhaps in this case, the attainment of a credible peer supporter identity) 'is rendered more or less probable' (p25).

I have already alluded to coherence in referring to Linde's (1993) criteria of adequate causality and continuity. Perhaps in accounting for themselves as credible helpers, many peer supporters storied the acquisition of their roles as causally issuing from their character or history, making use of culturally familiar narrative forms to establish the plausibility of a move from consumer to provider. Features of the peer supporters' narratives may have represented attempts to manage any apparent discontinuity between these two states. Many accounts tended to story the continual persistence of positive traits in the self that weren't recognized or fully realized earlier in life, which may function as a premise for taking up peer support roles. Linde also describes a 'strategy' of treating discontinuity as a sequence, where one state leads to another. The various uses of the idea of maturation described above might be understood in this way, or as a method of distancing the self from a previous state (i.e. there is no discontinuity because I am now a different person to who I was before, and am able to do different kinds of things).

Recovery stories

More specifically, I have argued that all accounts shared thematic and structural features that made them recognizable as versions of progressive 'recovery' stories. These similarities may have been dictated by the 'tellability'²² of particular forms of this story; that is to say, seen as the 'rhetoric of self-change'²³, the stories here were convincing perhaps because of their familiarity. In listening I was often reminded of Campbell's (1968) 'monomyth,' a basic pattern found in many narratives from

²² Livesey (2002)

²³ Frank (1993)

around the world. Its basic structure moves the protagonist out of 'ordinary life' and through trials (with the aid of a helper) towards the abyss, where transformation occurs and s/he is able to return in order to share wisdom gained. Some stories (such as Jane's and Robyn's) seemed in particular to make use of this kind of format, even emphasizing the role of guides through difficult times (in Jane's internet friend, and in Robyn's family friend who contacted her in her dream). McAdams (1988) has described his 'redemptive' narrative, which moves an individual through suffering to an enhanced state and a consequent drive to improve the world in some way, as basic to American culture (and prevalent in media).

In short, peer supporters may have drawn on or been influenced by wider culture in constructing stories about their lives. Additionally, it's possible that they were influenced by local culture – that is to say, stories about peer support that are present within the organizations to which they belong or the training they received or indeed local familiarity with the kind of recovery narratives referenced earlier. Perhaps the existence of peer support as a practice has been made possible by the cultural familiarity of narratives such as that describing the 'wounded healer' (e.g. Merchant 2011).

Construction of a desirable self

Given the performative view of narrative and identity proposed on page 21, a relevant question may be 'what was the function of the telling of these stories in this fashion?' Answering this would require a consideration of the audience to whom they are speaking. In this case, the immediate audience was myself, a research interviewer and trainee 'psy-professional' who also attempted to position himself as a 'service user.' There was also an implicit wider audience for the research, including potential funders of peer support services and mental health professionals.

The progressive quality of the narratives may thus have represented a desire to show peer support in a positive light, again transforming potentially stigmatized selfhood ('service user') into a position of authority (someone who can say what works) and productivity (someone who provides something useful). The credibility of this position would potentially be called into question by some accounts of 'service use' – that is to say, that mental illness impacts on the ability of persons to take rational positions and represent experience 'truthfully.' Arguably then, peer supporters' narratives also did the job of establishing them as 'desirable selves' (Goffman 1974), moving them away from times in their life when they might have been disbelieved. These times were storied as less-developed forms, misunderstandings, the results of circumstance.

Perhaps all 'recovery' narratives must do some form of accounting for 'illness,' because the term itself suggests a response to illness or indeed a response to wider society's conceptualisation of certain experiences as constitutive of illness. Constructing a narrative of recovery might be seen as an interactive, social task of first accounting for and acknowledging the possible views of the audience before rhetorically developing an alternative view.

Rose (1996) has described a set of presuppositions concerning the contemporary self: '[it] is to be a subjective being, it is to aspire to autonomy, it is to strive for personal fulfillment in its earthly life, it is to interpret its reality and destiny as a matter of individual responsibility, it is to find meaning in existence by shaping its life through acts of choice,' (p151). I was struck by the way in which these informed the stories reproduced here. Personal agency was storied and managed carefully; I wondered whether participants' use of the idea of 'stuckness' in association with periods of illness (e.g. in descriptions of repetitive patterns that were difficult to break, in actual use of the metaphor in Linda's case) served in part to contrast the current self as agentive. An association of selfhood with agency might support the idea that current gains are down to self or the realization of self, previous difficulties down to circumstance (most notable in Rhys, Jenny's and Jane's accounts).

Construction of expertise

Another way of seeing it is as reflective of an underpinning theme of self-actualisation. Within the context of peer support, selves moved towards greater productivity (Linda), empowerment (Jenny), moral reformation (Rhys) and mastery of innate abilities (Robyn). In particular, the idea of 'self-knowledge' was often emphasized. These ideas are all recognizable as forms of authority over subjectivity, examples of 'technologies of the self.' As Rose (1997) suggests, these 'are always practiced under the actual or imagined authority of some system of truth and of some authoritative individual,' (p29). Rather than appealing to scientific expertise, peer supporters may have utilized other powerful cultural narratives to construct a basis for their own authority over subjectivity. The concept of 'experiential-' or 'self-knowledge' may have roots in religious tradition.²⁴ It is possible that peer support as a movement (and its appeal to its own expertise) reflects or is made possible within the context of cultural critique of technical or scientific hegemony, at least within the field of the 'personal,' and may reflect the next phase of mental health provision according to these philosophical changes.

This 'expertise-establishing' quality of their accounts may have been prompted by performative requirements of the interview setting. Perhaps peer supporters felt required to account for themselves in roles as formal helpers of others in 'mental distress,' or to construct their roles as comparable favourably to the 'psy-professions' on their own terms. Perhaps in doing so, some were constrained by what was 'tellable' about paid mental health positions, whilst also trying to critique the 'professional-patient' dynamic by humanizing helping (hence leading to some of the ambiguity described).

²⁴ Again, note parallels with shamanic tradition, but also debates re: the direct authority of personal religious experience in the Christian tradition (e.g. Schleiermacher 1799).

Sanction

There is a circularity to the system described above: peer supporters have used the authority of their own experience to claim that self-knowledge is integral to 'recovery,' and self-knowledge is the basis of that authority. Nonetheless, their roles might be seen as providing a form of sanction of this authority, and that there is a reciprocal relationship between roles and narratives: that is to say, roles require stories to justify them, but the roles also sanction those stories.

According to the narrative view of identity, telling a story of recovery might constitute *being recovered* as an identity. As Riessman (2003) notes, 'We 'become' the stories through which we tell our lives' (p7). If the definition of mental illness is an operation of social power, it follows that being 'recovered' is also a social status (as some of the allusions to power differences between 'patient' and 'staff' in peer supporters' accounts suggested). As Burr (2003) suggests, 'We are dependent for our identity upon the willingness of others to support us in our version of events,' (p145) and indeed I'd argue that we are dependent for our social status on the complicity of others with it.

I was struck by Sue's suggestion that peer supporters were 'walking proof that recovery can and does work.' Relatedly, Rhys described performing potentially stigmatizing elements of his story as qualifications in the context of a conversation about employment. Elaine described the benefits of being able to put that she had had mental health issues on a CV now. Being employed (and therefore 'productive') represents a change in social status and power, but being employed as a peer supporter – as someone whose job explicitly involves being 'more recovered' from mental health difficulties (Davidson et al 2006) – represents social sanction of individual recovery stories, already convincing and familiar in form because of the cultural ubiquity of the 'enlightenment' idea. As suggested particularly in Sue's account, one implication of this is a change in the meaning of painful experiences,

both in the present and past, which has been associated with greater wellbeing (e.g. White & Epston, 1990; Tedeschi & Calhoun, 2004).

I wondered whether roles constrained the kinds of stories that could be told as well as sanctioning them. To the extent that peer support roles are associated with recovery, perhaps participants were (at least in this context) limited to talking about their experiences as part of recognisable stories about recovery and helping. Although the possibility of mutual support in peer relationships has been neglected in this study, I wondered whether those who felt the need to inspire hope through use of 'recovered' identities sometimes found it hard to story current or past experiences that didn't fit so easily into this format. Sue's example notwithstanding, did they feel the pressure to 'look well' at work?

Challenges in peer support

Defining the peer support role

As noted, participants were apparently ambiguous in their construction of peer support relationships as 'professional' or 'human.' One way of understanding this is that there is an inherent ambiguity in the 'peer support worker' role. It is framed to some degree as a profession, with training and payment and a title, all things commonly associated with membership of one. However, the core activity of the role is described as forming relationships based on shared experiences, not dissimilar to friendship as commonly understood.

Members of the psy-professions have perhaps helped to establish themselves as professionals by separating off the personal from 'therapeutic relationships' through the construction and publication of institutionally-standardised 'boundaries.'

Psychologists for example are not 'friends with a psychology degree' partly because of the performative context in which 'clinical' relationships are conducted, but also because they do not routinely disclose information about themselves or hope for

help from those they 'see' (ideas associated with friendship). As Heritage and Drew (1992) describe, this is also reflected in an 'asymmetry' in speaking rights which is typical and constitutive of institutional talk. Arguably it is partly this interactive asymmetry that constructs the professional helper as a professional.

Peer supporters, however, are expected to be mutual in the context of their helping relationships. The ideology their roles arose from has generally rejected 'professional' forms of help based on asymmetrical speaking or support. If trying to account for themselves as employed helpers (to 'professionals' or possibly 'professional' audiences at least), this perhaps leaves them in the difficult position of trying to construct a new kind of professional role without making use of some of the established definitional characteristics that would make such an account 'tellable.' It is therefore unsurprising that peer supporters have sometimes struggled to find words to describe how 'peer' relationships are different from friendships, both here and elsewhere (e.g. Faulkner & Kalathil 2012).

Managing consumer and provider identities

In keeping with previous peer support research (e.g. Mowbray, Moxley & Collins 1998), Jenny's account appeared to present the challenge of accounting for herself as both 'user' and 'staff' to professionals and other 'users' and maintaining her 'critical survivor' identity whilst working within an institution she despised. 'Humanising helping' perhaps served to make the co-management of 'user' and 'staff' roles easier by collapsing the expertise-based distinction between 'consumer' and 'provider,' and helped to provide a sense of something consistent (an identity as a human being entering human relationships) over various roles.

An interesting contrast might be drawn with Robyn's account. For her there appeared to be nothing to reconcile because she did not appear to endorse an

identity associated with being a 'user.' In this excerpt, she was responding to a question about how it felt to interact with staff as a colleague now:

Robyn: It is different, but you just have to step back in time and remember how it felt to be when you were a service user really.

Sam: So it sounds like you feel like.. that isn't who you are anymore, you've become something different...

Robyn: Well I still am a service user in that I still receive care from the psychiatrist ... so I wouldn't say I don't feel like that anymore, no.

Here it was me who endorsed the idea of an identity associated with use of mental health services, in my use of the phrase 'isn't who you are' in reference to her 'service user' descriptor. She went on to define 'service user' as referring literally to whether one is actually using services. She didn't seem to utilize a 'user identity' in any way.

Robyn's response was to perhaps establish her credentials in the face of what could be perceived (but wasn't intended) as a challenge to them, emphasizing what she is still doing to qualify her for the 'peer' element of her role. Nonetheless, looking back to her story, it was notable that she also didn't account for or critique any 'negative' version of a user identity and so perhaps just didn't see mental health service use as defining her in any way.

Essentialising

Despite Robyn's example, I wondered whether one possible consequence of peer support is a kind of essentialising of 'mental health difficulties.' To the extent that peer supporters use an identity as 'service users' in their work and must work within

contexts where this has particular implications based on a medical model, there is perhaps a sense in which they are tied to an understanding of their experiences as mental health issues or themselves as partially defined by service use. I was reminded of literature in which some peer supporters described feeling a need to get out of the world of mental health altogether and find other identities (e.g. Schön et al. 2009).

Relatedly, I wondered whether peer support may promulgate the 'recovery-as-enlightenment' story to the extent that opportunities for self-definition are restricted. Despite the benefits to peer supporters of association with a 'professional' role, constructing 'mental health difficulties' as a kind of thing for which one needs specialist skill or experience to work with could be counter-productive. It is arguably this construction that marks people with history of contact with services as different, and serves to exclude them from other forms of work.

Through the reflections above, I thought of Faulkner and Kalathil's (2012) report of concerns amongst peer supporters that alternative ideologies might struggle in mainstream settings. Though it seemed as if, by their report, the peer supporters I met did a good job of standing their ideological ground in their approach to working with 'professionals' or ward residents, it is possible that it would be easier to 'humanise' helping interactions in settings where there are fewer connotations associated with what it means to be 'staff' or a 'service user,' as perhaps suggested by Linda's description of her peer group as 'family.'

Further research

'User identity'

As noted, in conversations with peer supporters as part of this study it appeared that there were differences in the extent to which 'service user' identities were endorsed. Those accounts where storying a positive 'user' identity did seem to be a strong

theme (i.e. Martin, Jenny, Elaine) also tended to be those where narrators had direct experience of psychiatric acute units, where 'staff' and 'user' were constructed as on either side of a 'fence' and where there was a strong critique of 'professional' care. Martin went on to suggest that asymmetrical disclosure in helping relationships reinforces an idea of separation between 'humans:'

Even in the best places there's still ... a gulf between people, a professional boundary and ... for me, I think it just gives the message that ultimately it's like 'Yes you are different, you are different to me.' Yeah, it's like an invisible wall, kind of it's like you stay on that side and I'll stay on this side, on the well happy side and you can stay on that side ... It doesn't really give scope for people to actually move forward.

This reminded me of social identity theory (Tajfel and Turner 1979) and the idea of definition of an in-group identity with respect to an 'out-group.' Further research might explore the development of 'user' identities, perhaps within the dynamic of institutions or related generally to a sense of 'other-ness' to the mainstream. Is this sense brought to and/or developed in ward settings, and only there? How does it relate to other issues, i.e. class or minority stress?

Different settings

Because of recruitment difficulties, this study didn't include peer workers employed as part of NHS trusts. Useful research may examine issues of identity for this group, perhaps as a comparison with peers working in a totally user-led service.

Mutuality

In its focus on the identities and work of people employed as peer supporters, this study neglected this important aspect of peer support, descriptions of which were

present throughout peer supporters' accounts. Future research might incorporate a similar approach but include those referred to peer support services, noting the impact on their identity of this role or of relationships formed.

Relatedly, it is interesting to note that mutuality is often spelt out with research on both parties in helping relationships between 'service-users' (e.g. Mclean et al 2009). In comparison, there is a paucity of research into the effects of developing 'therapeutic relationships' for psychologists and other mental health workers. It's possible that this disparity helps to convey a kind of implicit denial of the possibility of mutual influence in 'professional' relationships, contributing to the division between 'well' and 'unwell' described above.

Implications for policy / practice

Given the caveats to generalisability described in Chapter 4, suggestions made as to the implications for policy and practice arising from this study are necessarily tentative. In line with other research (e.g. Mowbray et al 1998), participants here described personal benefits associated with their employment in formal peer support roles. In particular I have argued that the development of positive identities has been supported by the explicit acknowledgement of 'mental health difficulties' as affording useful experience to bring to valued positions. Formal validation of this experience may additionally impact on the attitudes of mental health professional colleagues towards service users and what is possible for them (e.g. McLean et al 2009). Participants here also described the power afforded by these roles, providing opportunities to impact on and influence the practice of staff around them in statutory settings and (through their ability to report poor practice) to facilitate a greater degree of accountability.

Nonetheless there may also be drawbacks associated with the promulgation of the formal peer support worker role in the NHS. Where people are employed and

trained, they may find themselves having to account for themselves as professionals, whether to other staff, researchers or service users. Subsequently constructing professional expertise as associated with and arising from recovery may be problematic. There could be contingent organisational and personal pressure on individuals to 'stay well' (Chinman et al 2006), and peer supporters may find it difficult to story a recurrence of distress in a way that is consistent with these positive new identities.

Another possible consequence of this 'professionalisation' is that some people in peer support relationships come to understand themselves as 'service users,' others 'service providers.' This may carry with it the attendant difficulties described in Chapter 2, as well as pressurising interactions for those in the latter group²⁵, limiting the potential for the mutuality that is said to be unique to peer support. Furthermore, any beneficial empowerment associated with a formal or professional peer support role may be minimized by a relative disempowerment with respect to other professionals, through lower wages or influence or access to progression (noted as concerns raised by peer supporters in Mowbray et al, 1998).

Mental health professionals need to remain mindful of the possibility that their involvement in the development of peer support, whether through research or policy, has involved implicitly or explicitly exporting their own models of what it means to help. Rappaport (1993) has suggested that there is a tendency to conceptualise mutual help organizations as alternative treatments (as opposed to communities of people engaged in meaning-making, described as an essentially 'human' activity). On a macro-level, it could be argued that the application of an 'outcome research' model to peer support has helped to construct it as some kind of 'intervention.' The adoption within the NHS of a model of peer support based on the provision of a 'service' by trained 'para-professionals' (to use Barker and Pistrang's (2002) term) perhaps suggests the influence of organizational discourse on the conceptualization of what is possible. On a more micro-level, the present research has perhaps shown

²⁵ See quote from Elaine and discussion on page 84.

that even well-meaning individuals trained in the use of 'professional' language can, through its use, inadvertently 'professionalise' the kind of human interactions that take place between 'peers' and invite peer supporters to account for themselves as professionals.

Given some of the reflections above, it's possible that, consistent with Faulkner and Kalathil's (2012) suggestion, peer supporters may be more free to offer genuinely alternative models of understanding and support for distress in contexts where they have complete control over what is offered and how. For example, Mead and Macneil (2003) describe the provision of a peer-run 'crisis house' as an alternative to acute psychiatric hospitalization, run on principles of community, mutual learning and shared responsibility for safety. While some 'peer workers' in this context are paid and trained, perhaps an organisational culture that emphasises payment for time rather than professional expertise is more possible outside of hierarchical mainstream settings such as the NHS and may result in a different construction of the peer role.

Other voluntary sector peer support projects (e.g. Positively UK²⁶) operate in an organisational context that frees up a transparent fluidity of roles, challenging the static 'helper/helped' distinction in line with the ethos described in Chapter 2. People are able to progress through levels of responsibility and organisational involvement over the course of their time with the project in a way that might not be possible where the availability of roles is limited by funding and rigid criteria for banding. Clinical psychologists may serve the development of these projects by using their training as social scientists, providing support (if desired) to peer supporters in developing novel forms of research with which to evaluate them.

Finally, it appeared from this study that the social sanction of a story that transforms 'mental health problems' into skills may be an aspect of the benefit of peer support

²⁶ See http://www.positivelyuk.org/personal_stories.php

work. Rather than developing a story that limits the scope of these skills to working with others in mental distress, campaigning efforts to address stigma associated with mental health issues could stress the strengths associated with living through and managing difficult experiences, useful not just in the mental health field. Constructive work with employers to this end might open up the possibility of 'putting mental health problems on a CV' next to some of the other considerable skills that this group of peer supporters had. Current work towards raising awareness of the presence of distress at all social levels may complement such a policy.

Chapter 9 - Critical Review

Methodology

In his review of three texts purporting to study the individual 'illness narrative' through narrative inquiry, Atkinson (1997) has critiqued a tendency therein to privilege those forms of experience that are rendered sensible by narrative or that take a narrative form. Furthermore, he locates the focus on the individual's autobiographical narrative within a cultural tendency towards the 'Romantic celebration of the individual subject' (p.335). The different ways in which narratives are used socially, by social actors in social contexts, are thereby neglected.

In the case of the present study, it is arguable that only those aspects of identity or experience that could be told as narrative (whether by participants or by myself) were included for analysis. Further, the process of identifying a 'core narrative' around which to structure analysis of peoples' speech excludes any material not consistent with this form. This potentially poses problems for the credibility of the research, as Spencer and Ritchie (2012) note a general consensus amongst qualitative researchers that the process of establishing such credibility involves demonstration of an attendance to negative cases or alternative explanations. The analytic result perhaps also presents a 'cleaned up' version of speech and identity use, a view of participants' identities as 'coherent' that results from an assumption that narratives be coherent.

Relatedly, in using narrative forms to make sense of peoples' speech, the analyst is perhaps involved too strongly then in importing an interpretation of what is there. As noted in chapter 4, Riessman (2008) suggests that narrative analysis, whilst grounded in a study of the particular, moves towards broader commentary and aims to make links with existing work. This involves particular assumptions on the part of the analyst about the kind of wider literature that would be relevant in storying others' speech and its apparent form, in this case predominantly a focus on the illness narrative corpus. Some (e.g. Schegloff, 1991) have argued that this process

reflects the political and ideological motives of the researcher, at the expense of attending to what is demonstrably relevant to participants in the moment-to-moment social use of 'identity.'

Additionally, a focus here on the individual autobiographical narrative as produced in the research interview potentially neglected important aspects of the social phenomenon of peer support. Relevant questions as to how peer supporters use narratives in interaction with other supporters, with those they are called on to support and with staff in statutory settings must therefore remain recommendations for further research.

Procedure

Due to the time constraints and word limit associated with this research, I made the decision to meet only once with each peer supporter. Riessman (2008) has suggested that some people might not want to develop a lengthy account of their lives with a stranger, or that it may not be possible to narrativise a breadth of experiences in one session. Furthermore, a very broad opening question such as the one I asked may not have been as easy to respond to as more targeted, chronological questions about a life story. She has recommended ongoing meetings, in conjunction with the use of a 'life history grid' to aid this kind of specificity.

Simply inviting people on one occasion to talk to a stranger about how they came to be a peer supporter might have produced a context that elicited safer 'work'-oriented accounts as opposed to grounding the transition more in personal history.

Additionally a focus on the individual narrative, while pragmatic, was likely to have resulted in neglect of its relationship to the narrative culture of each peer support organization. An ethnographic approach, conducted as a member of such a community over an extended period, might have afforded a more comprehensive description of these narratives and their reciprocal development.

Analysis

The lack of investigation into the relationship between local culture and peer supporters' narratives was one major omission of the analysis and approach. Simultaneously there was arguably insufficient attention devoted to the unique features of each individual account, due to space constraints. Sections of transcript were extracted from conversations with a view to exploring similarities and producing a 'meta-narrative,' perhaps reflecting a bias in qualitative research for this approach. These sections might have been thought about differently and the individual thematic, performative or purposive differences between them developed to a greater degree if they had been considered within the contexts of each whole account. They may have been presented as richer narratives; as it stands, more space is dedicated to my own (albeit in the Appendix).

Another consequence was that I was involved in paring down and summarizing individual stories to a greater extent than I might otherwise have been, increasing my influence on the structuring of each re-told narrative. Barthes (1977) has suggested that 'narrative analysis is condemned to a deductive procedure, obliged first to devise a hypothetical model of description... and then gradually work down from this model towards the different narrative species which at once conform to and depart from the model' (p81). My analysis began with the assumption that conversations would produce something recognizable as 'narrative'; this immediately imposed structure on what was re-told, even before a narrative type was suggested.

There is even a kind of circularity in then utilizing concepts such as 'coherence' to explain this structure (e.g. coherence involves establishing causality in stories; we know this because coherent stories incorporate causality). Linde's study recruited sociological commentary and cultural precedents to explain why this should be the case for people interacting in this society, and to a lesser degree I employed this method in attempting to account for constraints in narrative production here. Nonetheless, to what extent is it possible to suggest that everyone belongs to the

same 'culture' and is influenced by it in the same way? To quote Garfinkel (1967), we may not be 'cultural dopes' but 'rule users' who do not simply follow cultural plots in storying our lives but adapt, resist and selectively appropriate these. A more fine-grained analysis might have examined each individual way that this was accomplished.

Relatedly, as I have argued, it is likely that I was also involved in shaping narratives and influencing the performative function of responses through my interactions with the peer supporters. Given constraints, it was difficult to balance devoting space to presenting participants' 'core narratives' as integral units (suggested as distinctive of narrative analysis by Riessman (2008)) with space for the micro-analysis that such a discursive approach would prescribe. Through inclusion of a reflective journal, I hoped to allude to the mutual influence of my understanding of my own experiences on my thoughts about the stories of others. However, given more space, I would like to have examined this in a more transparent way looking in detail at my interactive contributions during conversations and linking aspects of my story to analytic conclusions.

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Appendices

Appendix A - Research Journal

A starting point

*'Nothing is capsulised in me on either side of town.
The streets were never really mine,
Not mine,
Not mine these glamour gowns.'*

From 'The Boho Dance' by Joni Mitchell (1975)

Not for the first time, I've found it hard to know where to put myself. By setting this story apart from the others that make up this research I could be implying that, as named author and researcher, my tale is to be seen as fundamentally independent from those that I have sought out. This could be seen as a claim that the process of telling some of one's own stories is an entirely separate activity from the production of a research text, a dubious claim indeed! Doubtless everything about the way that I have constructed it, from the epistemological stance I've taken to the manner in

which I conducted myself during 'interviews' with others, has been informed by the tales I tell and perform about an idea I refer to as 'me.'

Perhaps some would believe that this separation reflects a rather deistic position I have assumed as a researcher, isolated from and yet basic to the reproduction of others' stories. This certainly would not reflect my understanding of the impact that carrying out this project has had on 'me' thus defined.

On one level, I have included it here for practical reasons relating to word count. However, it also seemed aesthetically preferable that it be readable as a whole story in and of itself, presented with its own structure and performative context rather than dispersed throughout another text with which it has a co-creative or intertextual relationship. I have left conclusions about that intertextuality to the reader.

So, in terms of performative context, this account was created in order to produce several things: a) a disclaimer for any reader hoping for 'objectivity'; b) a point of reference with which the reader might consider any claims made; c) a blurring of the boundaries between the 'personal' and the 'professional,' which seemed in my mind to be in the spirit of the peer support movement; and d) a record of the experience of receiving a form of 'peer support' through my conversations with peer supporters. It was produced chronologically, which is to say that both beginning and end pieces were created before beginning and towards completing the research respectively. Other entries were written subsequent to the events from which they arose.

My original account of a journey from consumer to consumer-provider

When I was sixteen, I moved out of a disintegrating home into a hostel for homeless young people, runaways, wastrels, wronguns, whatever. Notably, the carpets were the same as they had at school. I hated school. There were eight rooms, and each rarely had the chance to become particularly acquainted with its occupant as a

'three-strikes' drugs / violence policy was fairly consistently applied. I lived there for one and a half years.

I was initially terrified by my surroundings, but gradually struck up friendships with my 'peers,' fellows with whom I had little in common save a sense of shared social status. At this point, I had a mere two 'parasuicide' attempts to my name, a community psychiatric nurse and some contact with psychiatry. My closest compatriot there, a girl who had been sexually abused by her stepfather and who was also having sex (sometimes unwanted) with a senior social worker who worked with us and one of the hostel staff, had been 'sectioned' several times by the time I met her. She was 18. Her arms and legs were covered in scars, some around a centimeter wide.

The hostel was frequently chaotic and tragic. I remember coming home from school one day and immediately having to grab and attempt to restrain a fellow resident as he rushed towards another with a knife. I remember finding a friend covered in blood after she had put cuts in her arms needing 42 stitches. I remember rooms being smashed up, holes punched in walls, a period when smack started being dealt into the place and my stuff started disappearing. But incredible as it may sound, I felt a strong sense of solidarity with most and was fond of nearly everyone, seeing them as unique people who I'd never otherwise have met and respecting them for their difficulties.

Most importantly, I felt they could understand something in me or an experience I was having that few else could. We would sometimes sit and make up jolly songs together about killing ourselves, joke about my psychiatrist who couldn't remember my name when he was trying to hypnotise me or the nurses who told us to 'keep still or you might die' when we were having our stomachs pumped ('Anyone might think that's the fucking idea!'). I began to cut myself and take more overdoses. My psychiatrist got more opportunities to get my name wrong. Eventually I too was admitted voluntarily to a psychiatric ward, though I was allowed to leave quickly

because I had found it even more scary than home. Still, I felt almost as if I had earned my badge of honour. I displayed it and its accompanying story both to my friends ('I have one too!') but also to staff ('I have one – Do Something!'), many of whom I hated and loved like they were my parents.

And it was a badge that gave shine to difference I think. I felt so different to others of my age at school, painted Snow White together in my mind, belonging to some hermetic suburban slumber. I started to imagine that my 'crap life' was sat on one pan of a set of cosmic balance scales, to be gradually levered upwards as the image of myself and my peers as someday using these experiences to save the world formed on the other. I guess I wanted some way to feel that life would be fair to the people I knew.

Despite the 'same boat' solidarity, I felt keenly aware that I was the only resident of the hostel in fact going to school, studying towards my 'A' levels, hoping to move out and pursue something else. I think to balance this sense of vulnerability that the idea of 'not-belonging' to any group brought, I went about making myself an indispensable confidant, comforting newcomers, accompanying overdosees to hospital. I remember one time when staff had failed to calm someone down after a fight, and I had approached her and she had talked with me. She said she had done so because I knew 'what it's like.' I was never sure I did.

In those days I had a feverish fear-driven work ethic, and I managed to secure the grades I needed to get into Oxford in order to 'get out.' I arrived with livid scars marching up my forearms. I rolled my sleeves up and set about telling confrontational stories about 'meat wagons'²⁷ and psychiatric medication to the intelligent, liberal and mostly middle-class people I met. I thought most seemed unsure how to respond. Nonetheless I made friends, and while I drank increasingly heavily and took antidepressants and continued to feel separated from others, in many ways I thought I had slammed the door on the strange world of 'mental health.'

²⁷ A police van

I guess I had access to different kinds of social sanction, though I now struggled to care about grades and employment as much as I had once striven to care about medications and psychiatrists survived.

Three years of a degree, a year of uncertainty after a degree, a year of living abroad and the death of a parent later I was back in my hometown, wondering what to do next. I had had no contact with anyone from the hostel days for all of this time. Unexpectedly I bumped into someone I had lived with then, and subsequently met with several others. They seemed to me now desperately unhappy, were drinking heavily, were unemployed, were still periodically admitted to psychiatric hospital or patched up in A and E. While in most ways I was not much better off, I had material prospects and a set of experiences that I felt set me apart from them even further. I hadn't had any contact with 'proper' mental health services for many years. I felt guilty, sad, disconnected but also desperate to escape what I saw as the magnetic pull of that life.

University again seemed like the answer. I thought that, in order to bid a final farewell, I should draw the ultimate line and attempt to construct the life I would have led had I not experienced the troubles of my teens. I applied and was accepted onto an MPhil programme. At the last moment before confirming my place, I changed my mind. I had had what I considered at the time to be an epiphany; that any attempt to forget was doomed to failure, and that rather I should try to forge myself with my experiences and use them in some way to help others. In this way, I felt that I could find purpose in turning something bad into something good. Those old cosmic balance scales had really stuck.

First I applied for and was offered a job in the hostel. I was instructed that under no circumstances was I to tell any of the residents that I had once lived there, and attended 'boundaries' training that encouraged a kind of mental and practical separation from the teenagers who reminded me very much of myself and my friends. Looking back, this was a strange position to be in. It appears that I was

reinforcing the idea of separation from my 'unwell' self by identifying with the idea of 'staff' who, for all of their abuses, had perhaps represented 'wellness' in their otherness. And yet, I had physically put myself back into *that place*, which to me represented everything about me that I associated with 'illness.' Was this a familial tie or 'survivor's guilt'?

Over years and many jobs in the social care field, though I wobbled a lot I thought that the general direction of my life was towards greater stability and happiness. I was more financially secure, I had friends who I didn't support. I became convinced that helping others live with and recover from their difficulties had helped me to recover from mine. I thought that having to find hope for people whose troubles I could relate to lent me hope for myself. I felt that every time I helped someone to explore alternative views of themselves, I was rehearsing an alternative view of myself. In my work I had a real incentive to 'stay well' by looking after myself, so that I could be of use to others. From this and from some research I had done with users of mental health services who had valued peer support, I began to develop an interest in this movement, which had just started to take off in the NHS in Scotland.

But by this point I was well on the way towards applying to become a clinical psychologist. I remember laughing knowingly when I first read David Smail's 'The Origins of Unhappiness.' There was a point where he described individuals being told in this essentialised way that they would make 'natural' psychologists, that old question 'Are you the kind of person who your friends tell their troubles to?' Well yes, I was, for all of the reasons I have described! But I wasn't some kind of passive troubles receptacle, I actively reeled them out of my friends, that was the kind of relationship I was used to. Additionally, as Smail wrote, I was interested enough in people not to ignore them when they were talking.

So I was told that I would be a 'natural' and I bought it and sold it. However, whilst I pressed ahead towards this goal I was also beginning to develop serious doubts about the ability of statutory mental health services to adequately address the

suffering I encountered daily. I worked for a time in a crisis team in an impoverished inner city district of London, and in visiting people at home I encountered what for me was grave poverty, deprivation and threatening conditions. I began to wonder how it was that these people could be described as 'mentally ill' when their environments were so hard.

I had also been deeply affected by the suicide of a woman with whom I had spent a little time. She was someone who had been frequently referred to the crisis team over many years, and who had had a long history of hospital stays. I had been asked to compile a case history for her, patching together some kind of chronological story from the tomes of notes that she had acquired like barnacles over the years. As I did so, I formed with great sadness a picture of someone who had had abusive relationships with parents, then other adults in relationships. Someone who had become a nurse, perhaps in order to live out some aspect of being cared for in caring for others. Someone who had entered a relationship with mental health services which seemed to mirror that with her parents, where those services had responded to her distress by harming her to more and more extreme degrees with powerful medications and ECT. Someone who could seemingly not see anything beyond this crushing pattern and had eventually killed herself.

I thought angrily at the time that services had killed her by perpetuating abuse, that here was a dynamic in which relatively powerful people needing to 'care' in order to be successful or to get paid or to manage what society has described as 'risky' had been parasitic upon someone's suffering. I began to have serious doubts about my decision to work in this field. I was troubled by what I perceived to be the one-way nature of what was offered, that often it was the system and professionals that seemed to gain from interactions with 'service users' – financially, in terms of status, in terms of support and development.

But I still went into training, lured by what a friend had called 'the good breast' of the NHS, with its now precarious-seeming promises of lifelong security. These doubts

stayed with me though. Furthermore, in my first clinical placement, I felt for the first time to be a part of and aligned with 'the mental health establishment.' As a support worker, I felt in a sense it was still my role to offer a kind of solidarity with the people I worked with, people I thought of as 'my kind of people' despite our different backgrounds. As a trainee psychologist, I felt an imposter in the land of the oppressively 'well,' heading out of my cosseted therapy room to net butterflies, categorising their 'problematic typologies' from my position of non-disclosure and strength, then sending them back to their lives in a haze of psycho-ether after fifty minutes were up.

It seems no surprise to me now that around this time, after a brief crisis I found myself back under the auspices of psychiatry, back with an identity with which I was more familiar. I found the experience of assessment and diagnosis so damning and disempowering this time that my resultant anger, both for myself and for others who I imagined experiencing the same thing, drove me back into continuing with training with the idea that I could offer an alternative. What I was left with, however, was a sense of exposure. I felt ashamed of my diagnosis, my troubles, and feared that even the slightest glimmer of 'messiness' would bring the forces around me down on me like gannets on a sardine. At best, they would realise I was an imposter and chuck me out of their group.

Which leads me thematically up to this point, where in writing this piece I am perhaps rolling up my sleeves at university once more, though hopefully not so angrily. Where, in seeking out the experiences of peer supporters as opposed to clinical psychologists who have experienced mental distress (imagining there are many), I am perhaps seeking out old solidarities and comfort in old identities again. Nonetheless, in sharing my story, I hope to in part challenge the binary of the 'well' treating or researching the 'unwell' that in my view pervades clinical psychology literature. This is of course a deeply personal aim.

Meetings with peer supporters

Meeting in the countryside

As soon as I sat down with the group of peers in the community centre, I felt almost totally relaxed. Almost as soon as the meeting ended, I was thinking to myself 'if that had been a group of psychologists, a group of nurses, a group of strangers pulled off the street I would have been shaking, my voice would have been tremulous.' Why was that?

Was it because that particular context is so familiar to me? I remember attending a group for distressed teenagers when I was 14, 15 or so. I think my CPN arranged it. We would sit in a circle every week and chat to each other and draw on clipboards. I remember doing things like 'expressing anger' with red felt tip pens. I thought everyone was much more exciting than me, they had dreadlocks and were variously in a lot of trouble with school.

I think actually the content was irrelevant. The feeling that I can still remember now was a sort of feeling of ... safety? To start with in that group as a kid I was so scared that I couldn't speak or look anyone in the eye, but everyone there was kind of on the bottom of the heap in one way or another so no-one had anything to prove really by being nasty. As I spent more time there I grew to really like everyone, but also in a way their coolness infected me a bit – I was part of their group, so I was an exciting rebel too, not just an unwanted body.

Back in the present, was it like coming home then? Did I feel like I was with 'my people?' Even though I knew nothing about them, and I'm not sure at all how they saw me. It felt like loosening a belt, being somewhere where people were talking about having to do and say the right things to get what you need from psychiatrists and I could say 'Yes I've felt that.' And with that then came anger at 'the other' – mental health professionals who were still impeding my life by not letting me be

myself at work. For making me feel ashamed of my bouts of sadness and happiness or my occasional fear of people, for making me scrutinize all of my behaviour for potential sources of concern. And guilt at being one of them.

Is it that sense, that deep deep sense, of somehow being other to people who represent the 'normative' majority – other and less, the object of scrutiny and rejection? That in this group I wasn't 'other'? How ludicrous to say this when I have so many of the things that represent society's approval – a well-paid job, a degree, somewhere to live, a *credit card* for goodness sake! And yet, it's how I still make sense of what I feel all these years later.

Meeting by the sea

Again, meeting with the peer support rep today to discuss the research, there was no sense of fear or unease – none of what I might feel talking to someone who didn't have 'peer' in their job title I guess. I think it's because I assume automatically that if I do anything strange she'll understand, if I'm nervous she won't think I'm inadequate or unprofessional, if I can't form my sentences precisely she won't frown at me or think 'this person shouldn't be working.' Her job title tells me that she has experienced all of these things herself, even if she hasn't. She would never judge me, even if she does. At least, I think that's it.

We talked a lot about our thoughts on what was wrong with The System and I felt inspired by her sensitivity and the 'common sense' of her approach to being with people in pain. I could also relate to a lot of what she was saying in her description of peer support work. In particular, she described wondering sometimes whether she had been 'ill' enough to qualify for her position, as she had not ever had a hospital stay. This made me think of not feeling as if I belonged in either camp, as my life was now too easy for me to be able to say that I could relate to a lot of 'service

users' on their level but I still had a diagnosis and was using services, which made me feel like I wasn't really 'a professional.' She described herself at one point as feeling as if she was positioned in the middle, between consumers and providers, and that she had always sided with the 'underdog.' I nodded.

But even here, in this conversation where it seemed like there was a lot of common ground, I thought that I noticed that we were speaking slightly different languages. Her accounts of her work situated much about it in the realm of the comparatively everyday human – the benefits of being a listening ear, someone who could acknowledge emotions. I was introducing terms such as 'reflective' and 'transparent' without even thinking about it, seeped as I had been in the clinical psychology school of linguistics for two years plus. I was psychologising her experiences almost totally unconsciously, though hopefully in this instance not from a position of power. It did make me *wonder* (to use that ubiquitous chocolate digestive of the clin psych argot) whether part of this sense of separation between the worlds of provider and consumer was a bit like the separation between countries, reinforced by different ways of speaking.

Nonetheless, I came away feeling really good. For want of a less clichéd expression, I didn't feel alone.

Rhys

Spending an hour with Rhys reminded me so much of the guys I used to live with back when I was a teenager. For me it felt good and nostalgic to laugh at tales of drug-fuelled theft of police cars, to enjoy the kind of gallows humour that I so closely associate with those days.

In some ways I think that being able to laugh together at the painful was one of the things that I valued most about those times, at it perhaps signified a sort of shared

understanding and a lack of fear of what the other person had been through. It was the opposite of the silent awkwardness and subject-changing that I encountered at university. It was the most normalizing thing that you could hear, a laugh. It's something that, in what has felt like the serious and rarefied atmosphere of clinical psychology, I miss a lot.

Rhys made me think of the kind of person that I always looked up to and wanted to be like when I was a teenager, I think: properly irreverent to convention, fearless and genuinely resourceful. I reckon you could have dropped him on the moon and he would have been growing and selling weed to Clangers within three weeks. His tales of pragmatic rackets and the trouble they had brought made me think of one of the characters of Sin City, about which there was a line:

Most people think Marv is crazy. He just had the rotten luck of being born in the wrong century. He'd be right at home on some ancient battlefield swinging an axe into somebody's face. Or in a Roman arena, taking his sword to other gladiators like him. They would've tossed him girls like Nancy back then.

Miller (2005)

Not that I thought Rhys would have enjoyed those things. More that his skills were not valued or rewarded by society because of the time and place he found himself in.

Past the charismatic telling, though, and the tale itself was often sad to me. I think because it emerged in such a story-like way, it really made me think of how I had performed my troubles story time and time again to various mental health professionals, generally hoping for something like drugs or therapy or time off school or work. How, in a sense, I had become that story through its repetition.

Jane

Jane mentioned a few times during our meeting that she was the child of an alcoholic, and I wondered whether she did this partly to show some kindness and solidarity with me, also raised by one. There was a moment where 'I' became 'we' in her descriptions of the patterns of behaviour she saw herself as experiencing as a result of that history. And, while I didn't feel that I was looking at myself when we were talking, there was a lot in what she said that was familiar.

That moment had the effect that I didn't feel alone or uniquely 'wrong' because of some of the difficulties with relationships that I have been challenged by over the years. Jane's disclosure of her experiences also seemed to endow her with a kind of authority in my mind. What seemed funny is that I have always railed against the idea of experiential authority, that I can know how another person might and should act if I have experienced something similar. But this wasn't how I experienced Jane at all – telling me about her life provided the equivalent of a kind of theoretical rationale for the lessons she described having learnt. To use Elaine's word, the telling of those parts of her life gave her words a kind of credibility.

Something that she said really stuck with me, and I've been thinking about it often since we met. She had described difficulties managing boundaries in relationships over the years, which was something I could relate to but had not really thought of in this way until recently. When describing managing boundaries in peer support relationships, she had talked interchangeably about managing boundaries in her personal life, which I took to imply that she didn't really see a difference between the 'personal' and the 'professional' in this respect. I had never before seen things in this way – 'boundaries' was to me a word very much belonging to the world of work, referring to such things as not giving presents to clients and ensuring you finished therapy on time. Now as a result of this conversation, it had become something else, a word which referred to a relationship skill in any sphere. It occurred to me that I couldn't hope to help people to develop this skill effectively if I couldn't demonstrate

it myself, that developing it would mean working towards developing it in my personal life.

And then I started to think about how this ‘personal’ and ‘professional’ divide implied something strange – that you could learn, demonstrate, and in a sense teach interpersonal skills through academic rigour and that one could therefore potentially apply them perfectly. I thought that ‘therapeutic’ relationships traditionally conceived often give people no safe place to practice the *negotiation* of boundaries, which is a skill that I’ve needed so many times in the world and not had, because the boundaries are decided by the worker. For me, for much of my life I’ve only known two roles really – help or be helped. Helping was associated with ‘well’ and so that’s where I tended to put myself.

I thought I knew what it meant then when peer supporters had talked about feeling a responsibility to work on their own recovery, because of the explicit mutuality of what they were doing – that you couldn’t help each other if you didn’t work on things yourself. Many ‘professionals’ it seemed usually have no such motivation or encouragement to develop in this way – raising personal issues on my training course almost felt like a taboo at times, certainly exposing.

I wondered then whether there would ever be a point where one was skilled enough or well enough to purely help others and never need help yourself, and if so how one would decide this. I thought that this idea was contingent on the medical construction of recovery as a fixed and teleological state. Perhaps ‘recovery’ is relational in this sense, always learning and changing through being in relationship.

Robyn

Listening to Robyn speak, I thought about how skilled she seemed in her descriptions of managing personal relationships as part of her job. Much of what

Robyn was saying seemed equivalent to the kinds of things that psychologists say about relationship dynamics, about meeting people at their level, about gauging and responding to an individual's needs based on their presentation (but without the jargon). It's a testament to the rhetorical power of 'professional training' in convincing you that it's necessary that I wondered to myself 'Where did she get these skills?'

One thing in particular that she said stuck with me. In response to a question about 'being on a level' with peers she met, Robyn had started to talk about meeting new people in this context as being a bit scary. I thought she implied that this would be the case for all human beings, and I silently agreed. But even more interesting, I heard her as implying that 'looking at someone from a superior perspective,' as she put it, arose in response to fear of other people. I wondered how much 'distancing' professional boundaries used in this way were a form of protection against this fear, a fear that is stoked by the cultural dehumanization of people with mental health diagnoses.

I was also affected a lot by her response to a question about whether she saw herself as a 'service user.' To her, it seemed as if the use of this term as an identity category was really unusual – she responded by saying she was because she still used services, but there was nothing of the connotations for allegiance or group membership that I heard in other accounts and which resided in my telling of my own story.

I was left with a sense of the strangeness of defining myself in part according to the clinics I had attended over my life.

Martin

Martin had reportedly spent much of his life working in mental health, and had seemingly come to many of the same conclusions that I had: that helping others

inevitably benefited yourself, that hearing yourself performing hope for others you saw as similar introduced a kind of hope for yourself. This felt validating, to have a sense that I wasn't the only one who had had these thoughts.

His description of having been on 'both sides of the fence' also rang familiar with me. His critique of the divide created between the 'omnipotent well' and the 'service user' really made me think about how this divide had power at its heart, and was related to so many other power relations in society – middle class professionals giving valium to working class patients, White British nurses sectioning Black African guys in London. I came out wondering whether this was one of the reasons why I had felt uncomfortable and separate in predominantly middle class psychology teams, that I had crossed sides in some kind of Marxist scenario.

Martin also led me to think a lot about the categories of 'well' and 'unwell' and how my own decisions (about what I pursued in life) had in a sense been made on the basis of this kind of categorization of self. I took much of what he said as critiquing this division – that we are all human and that much of what is taken to signify the 'unusual' or the 'disordered' is a response to unusual or disordered circumstances. I wondered whether, had I not seen myself as previously 'unwell' in my life, as an 'oddy' (to use Martin's word), I would have felt the need to justify or make sense of this through becoming a helper.

But then, as he described it, his experiences had allowed him to see people with diagnoses as something other than a label, as individual and human and not part of some homogenized group defined purely by being 'other.' As he had been part of this group and had known people within it, he couldn't see things this way. The same homogenization also held for conceptualizations of staff as the omnipotent well. Perhaps his commitment to peer support, to being open about his experiences, was about showing that people on 'both sides of the fence' were human. Since thinking about this, when relevant I started to talk about my experiences during meetings at

work, even if it felt difficult. As Martin suggested, I started to feel a sort of social responsibility to do so.

Linda

My conversation with Linda was preceded by feelings of admiration, as she had managed to accomplish so much with so little in the way of resources it was almost as if she had secret conjuring powers. I had visited some months before to see the day centre that she had set up, organized, run, promoted and developed into a supportive community, giving people a place to use skills that they never knew they had. There was a beautiful symmetry in this story – that by working towards helping others, she had found a way to demonstrate skills herself and receive the validation she needed.

I was really struck by her description of her group of peers as akin to a family. Like many other things that arose during this research, it made me think about the concept of narrative communities and the social enterprise of meaning-making. Linda and her peers had perhaps recreated something human that has been generally lost in our society, a forum for collectively making sense of experiences. I also thought about how, in the large and dispersed social groupings of modern life – the football fan groups, the online game players, the pop music appreciators – it perhaps takes a spectacular achievement to feel like one has a recognized and valued role or function or a part to play in a greater whole. Perhaps in Linda's group, it didn't take so much for any member to feel this.

I also thought a lot about what it was that united people there, what brought and kept them together as a group. Linda had suggested that it was a shared experience of feeling fragile, of knowing what it is to feel fragile. I wondered whether coming to the group was almost a permission to *be* fragile if that's how you felt. Perhaps 'shared experience of mental health problems' in peer support doesn't literally refer to having

had the same experiences, but rather means or signals a shared permission to talk about the painful or the unusual or anything else that you fear would not fit the script in everyday social interaction.

Jenny

Throughout my conversation with Jenny, I was very worried that I was putting her on the spot. Sometimes my questions came out in a way that sounded like they belonged at a job interview, whereas I wanted her to feel like I was on her side. I think basically I really didn't want to be aligned to 'professionals' who had done a lot of wrong by her, from the sounds of things. But actually, in looking back at my use of language later, I came to realise just how saturated with 'profession-speak' it had become.

This reminded me of a friend saying to me once 'you sound like my CPN, you have that way of speaking.' When she said that, I was mortified.

I wonder whether I felt like this because Jenny positioned herself so strongly amongst a community of people who had survived and suffered, and I didn't really feel like I had had it hard enough recently to be part of that anymore. It triggered some of the guilt of feeling like I had abandoned my peers in the hostel, that I was colluding with evil services that had abused by training as a psychologist. Perhaps because of those feelings, I read more into this 'allegiance' theme than there was when analyzing her account.

What I did love, though, was her stories of her peer support work which (because of the focus of the analysis) didn't get much airtime here. She talked about 'being part of each others' journeys,' of learning about herself through the relationships she forms, the close and supportive network she had built with other peer supporters and of sometimes falling asleep on a bench together with a chap she visits who is stuck

in hospital. She described these relationships as being about 'showing love' to people. Me, with my cynical and analytical tendencies, I tried to get her to talk about what this meant, which I felt ashamed of after. I think she meant exactly what she said. Carl Rogers might have called it 'unconditional positive regard' to make himself and therapists sound more important and professional, but she just called it what it was in everyday terms.

When I had gone away and thought about it a bit, this poem by Galway Kinnell came to mind as perhaps being about what she was saying:

*The bud
stands for all things,
even those things that don't flower,
for everything flowers, from within, of self-blessing;
though sometimes it is necessary
to reteach a thing its loveliness,
to put a hand on its brow
of the flower
and retell it in words and in touch
it is lovely
until it flowers again from within, of self-blessing;
as St. Francis
put his hand on the creased forehead
of the sow, and told her in words and in touch
blessings of earth on the sow, and the sow
began remembering all down her thick length,
from the earthen snout all the way
through the fodder and slops to the spiritual curl of
the tail,
from the hard spininess spiked out from the spine
down through the great broken heart*

*to the blue milken dreaminess spurting and shuddering
 from the fourteen teats into the fourteen mouths sucking
 and blowing beneath them:
 the long, perfect loveliness of sow.*

Elaine

Elaine was the first person I met with to ‘interview.’ I was nervous, but I soon found myself nodding eagerly along to what she was saying. There seemed to be so many things that I could relate to. I came to expect this more in later conversations with other peer supporters because of this.

If there were a kind of mental equivalence table set up in my brain, it would look a bit like this.

| Elaine | Me |
|--|--|
| <p>What would have happened to me if I hadn't been supported by my husband and parents?</p> | <p>What would have happened to me if I hadn't done well at school?</p> |
| <p>I met people I'd never have met otherwise in hospital and it changed my view of life</p> | <p>I met people I'd never have met otherwise in the hostel and it changed my view of life</p> |
| <p>Am I ill enough to be able to be taken seriously by people who have had apparently harder lives and more serious diagnoses than me?</p> | <p>Am I ill enough to be taken seriously by people in a peer support context? Am I well enough to be taken seriously by people in a clinical psychology context?</p> |

| | |
|---|--|
| Feeling bad for coming from 'cosseted suburbia' when interacting with friends who had seemingly had harder lives. | Feeling bad for having moved myself into comfortable middle-classhood whilst friends from harder times remained in a similar position. |
| Experiencing a sense of common ground with other peer supporters | Experiencing a sense of being understood and accepted by people who have seen a part of life that perhaps most haven't |

Of course, there is nothing really on this table that is exactly the same, and there were many things about Elaine's account that were different from anything I've experienced. But the sense of identification, to use a jargonistic word, did seem to produce in me a sense of solidarity.

Afterwards I wondered whether similarity between stories allows them to influence each other more easily. I thought of how, in music and art, self-recognition (in what the artist was saying about themselves) seemed initially to draw me to something before changing or challenging my view. Had Elaine told me that she had spent most of her life as a nun and had recently discovered, through prayer, that it was ok to be open about mental health difficulties, I think I would have explained this to myself as having occurred due to the fact that she is a fundamentally different kind of person to me. Because this outcome was a plausible development in Elaine's actual told story, given the similarities to mine it was a plausible possibility there too.

I left my meeting with Elaine feeling as if I had finally been shown some unseen thorn that had been troubling me for years: feeling as if I had had to hide something from others at work, which they might discover at any time and denounce me for, which seemed so obvious to me so often, had caused me a lot of distress.

Sue

Sue mentioned quite early on in our chat that, if she was able to make someone's stay even a little better, it would be her reward for being on the ward, that turning something bad into something good was the most satisfying thing. I felt like I was going to cry, which is not usual for me.

Maybe it was because I was moved by Sue's warmth and bravery. I couldn't believe that, after all she had seemingly suffered on the ward, down to the removal of any right to knowledge of and control over her own body, the removal of her right to feel as distressed as she felt there, she had chosen to go back to help others. I thought about myself and how I had always worried and stewed about the possibility that, by remaining in mental health work, I had never escaped that way of seeing myself – that even my sense of what it meant for me to be valuable was framed by that binary between helper and helped, that I had only moved to the other side of the chess board and not off the board altogether. Sue had seemed to take such genuine satisfaction in her work, despite physically being back in that place.

But she had said at the beginning that the main reason why she does peer support is that it's good for her. She was careful to emphasise in her story that she gained a lot from peer support as well as gave a lot to it. I think that one reason why I had been so moved by her choice of words was that sense of being rewarded for something awful tapped into a key desire for me – the desire to be given a hug and told 'I'm so sorry that happened to you, but you're ok. There's nothing wrong with the person you are.' Perhaps lots of people feel this, perhaps we all go about finding it in different ways, whether through material success or through relationships. I was just struck by Sue's description of giving and getting back, of seeing someone she had helped ward in the street and being given a hug that both people were receiving.

Revisiting my story

I think since being a teenager I had a sense of being 'different' in some way. I suspect I was hardly alone in this; alienation seems to be a common theme in art purporting to describe our over-populated, individualist, secular times. I figured I stood out to others, and not in a good way. I wonder now whether 'standing out' is very much a matter of where and with whom one comes to stand.

I think it was this existing story of difference that was embellished by contact with mental health services and my move into the hostel, that these things became woven into the major theme of my character. Every subsequent patch of unhappiness got recruited into this story, another badge on my sleeve to mark me out. Against whom though?

There was also perhaps a sense that difference had to be accounted for in some way or explained, in the same way that unusual events prompt a search for explanation. Becoming a professional helper perfectly explained why I had been a mental health service user, an oddity. But what if, as the old woman in *Candide* suggests, there is not a single person in the world without troubles. Why should my troubles necessitate any attempt to account for them, above and beyond a story about being human?

When I had my own crisis, it seemed to me at the time that I had two choices: I try to proceed as if none of what had happened to me had happened, step into the shoes of a kind of parallel me leading my intended unimpeded life. Or I accept that they had happened, to accept that they would always frame my identity, be core to who I was, and that therefore they had to be involved in everything I did and everywhere I put myself.

Sat in the house where I grew up, my head full of the songs of that time ringing loud after the death of my mother, it's not difficult to see why I chose what I chose. But I think now that there was at least a third choice, waiting patiently in a cupboard

somewhere to be brought out and put on. That in some ways I had had a rocky ride, but that did not make me *fundamentally* different from everyone else. That those experiences would be part of how I am written, but not all. That it was a confluence of culture and time that led me to come into contact with such a thing as a 'mental health service,' that the sense of otherness I partly acquired there was not something intrinsic to me or stable or fixed or constant or permanent or applicable to every area of my life. That I did not have to account for my experiences in some way by turning them into something good unless it gave me joy and satisfaction to do so.

But perhaps I am one of the lucky ones – because I have acquired some of society's tick boxes, I'm freed up to tell my story in this way. I've been given the chance to find other identities for myself through work or education or opportunity. Now when I listen to 'The Boho Dance,' Joni is singing me something new from what she has always sung; that I did not 'belong' on either side of town, but perhaps that nobody ever fully belongs or ever fully doesn't because being in one place or another is more a matter of geography and history than identity. That perhaps apart from those things, the people on both sides aren't so different – it's just a matter of where they find themselves, or where they are put.

Peer support

Looking back on my meetings with peer supporters, I always wanted to position myself alongside them in our conversations. Perhaps this desire has influenced the way that I have told the tale of this journal, and influenced the way that I have found myself re-storying my experiences.

Within a positivist framework, this might be referred to as bias, a subjective influence on the reporting of genuine truth. Having critiqued the basis for such a truth, I would instead suggest that this desire may be part of the therapeutic 'effect.' Many times I have met with detached professionals, who have offered up stories on why I am like

I am for me to accept, with varying degrees of usefulness. But (as I felt at the time) why would I want someone who presents themselves as powerful, approved-of, different-to-me and separate to be right about my life? Admitting this was to feel 'less than' to one's bones – that privilege afforded not only the right to freedoms I didn't have, but also the ability to tell me who and what I was (and, in the cases of some of the peer supporters here, why that meant they would never be free themselves).

With the peer supporters, I wanted to listen to and believe their stories of recovery and success, because to the extent that they demonstrated the human similarities between us, if those stories were true for them they could be true for me. To the extent that I found things to relate to in their human experiences, their stories could potentially be our stories.

Appendix B – Ethical Approval and Change of Thesis Title Confirmation

Ethics approval was originally granted to the study according to its original title, but with the design and procedure as described in Chapter 4. The title was subsequently changed to better reflect the content and direction of the thesis (see confirmation letter below).

ETHICAL PRACTICE CHECKLIST (Professional Doctorates)

SUPERVISOR: Ken Gannon

ASSESSOR: Lynne Dawkins

STUDENT: Samuel Wintrip

DATE (sent to assessor): 06/02/2012

Proposed research topic: Reciprocity and the construction of expertise and expectation in formal peer support relationships

Course: Prof Doc Clinical Psych

- | | |
|--|-----|
| 1. Will free and informed consent of participants be obtained? | YES |
| 2. If there is any deception is it justified? | N/A |
| 3. Will information obtained remain confidential? | YES |
| 4. Will participants be made aware of their right to withdraw at any time? | YES |
| 5. Will participants be adequately debriefed? | YES |
| 6. If this study involves observation does it respect participants' privacy? | NA |

7. If the proposal involves participants whose free and informed consent may be in question (e.g. for reasons of age, mental or emotional incapacity), are they treated ethically? YES
8. Is procedure that might cause distress to participants ethical? NA
9. If there are inducements to take part in the project is this ethical? NA
10. If there are any other ethical issues involved, are they a problem? NA

APPROVED

| | | |
|-----|----------------------------------|----|
| YES | YES, PENDING MINOR CONDITIONS | NO |
|-----|----------------------------------|----|

MINOR CONDITIONS:

REASONS FOR NON APPROVAL:

Assessor initials: LED

Date: 10th February 2012

RESEARCHER RISK ASSESSMENT CHECKLIST (BSc/MSc/MA)

SUPERVISOR: Ken Gannon

ASSESSOR: Lynne Dawkins

STUDENT: Samuel Wintrip

DATE (sent to assessor): 06/02/2012

Proposed research topic: Reciprocity and the construction of expertise and expectation in formal peer support relationships

Course: Prof Doc Clinical Psych

Would the proposed project expose the researcher to any of the following kinds of hazard?

- 1 Emotional NO
2. Physical NO

3. Other NO
(e.g. health & safety issues)

If you've answered YES to any of the above please estimate the chance of the researcher being harmed as: HIGH / MED / LOW

APPROVED

| | | |
|-----|-------------------------------|----|
| YES | YES, PENDING MINOR CONDITIONS | NO |
|-----|-------------------------------|----|

MINOR CONDITIONS:

REASONS FOR NON APPROVAL:

Assessor initials: LED

Date: 10th February 2012

Please return the completed checklists by e-mail to the Helpdesk within 1 week.

SCHOOL OF PSYCHOLOGY

Dean: Professor Mark N. O. Davies, PhD, CPsychol, CBiol.



**School of Psychology
Professional Doctorate Programmes**

To Whom It May Concern:

This is to confirm that the Professional Doctorate candidate named in the attached ethics approval is conducting research as part of the requirements of the Professional Doctorate programme on which he/she is enrolled.

The Research Ethics Committee of the School of Psychology, University of East London, has approved this candidate's research ethics application and he/she is therefore covered by the University's indemnity insurance policy while conducting the research. This policy should normally cover for any untoward event. The University does not offer 'no fault' cover, so in the event of an untoward occurrence leading to a claim against the institution, the claimant would be obliged to bring an action against the University and seek compensation through the courts.

As the candidate is a student of the University of East London, the University will act as the sponsor of his/her research. UEL will also fund expenses arising from the research, such as photocopying and postage.

Yours faithfully,

Dr. Mark Finn

Chair of the School of Psychology Ethics Sub-Committee

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The University of East London has campuses at London Docklands and Stratford
If you have any special access or communication requirements for your visit, please let us know. MINICOM 020 8223 2853





Samuel Joseph Wintrip

15 May 2012

Student number:0933903

Dear Sam

Notification of a Change of Thesis Title:

I am pleased to inform you that the School Research Degree Sub-Committee has approved the change of thesis title. Both the old and new thesis titles are set out below:

Old thesis title: Reciprocity and the construction of expertise and expectation in formal peer support relationships.

New thesis title: From Consumer to consumer-provider: a narrative enquiry

Your registration period remains unchanged. Please contact me if you have any further queries with regards to this matter.

Yours sincerely,

A handwritten signature in black ink that reads 'James J Walsh.' The signature is written in a cursive style with a period at the end.

Dr James J Walsh
School Research Degrees Leader

cc. Mark Rapley

Appendix C – Information Sheet

INFORMATION SHEET

You are being asked to participate in a research project, but before you decide it is important for you to understand why this research is being done and what it will involve. Please read this information sheet carefully. Please take your time to decide whether you want to take part in this research.

Who is the researcher?

- Sam Wintrip is studying towards a Professional Doctorate in Clinical Psychology at the University of East London. Producing and writing up a research project such as this one is necessary in order to gain the qualification required to work as a clinical psychologist.
- He has conducted some other research before. If you are interested, see http://www.casweb.org/polari/news/item?item_id=939712
- His email address is: u0933903@uel.ac.uk. He can be written to at :

Sam Wintrip, Professional Doctorate in Clinical Psychology, School of Psychology, University of East London, Water Lane, Stratford, E15 3LZ.

Aims and objectives of the research project

- This project aims to look at how peer supporters understand their roles and decisions to become a peer supporter. There is already some research that seems to show that these kinds of relationships are beneficial to those involved. Understanding how people think about these relationships might help to describe what it is about them that is helpful (or sometimes difficult).

Participants of the research project

- The project would involve people who are currently working as peer supporters for an organisation which provides this service.
- Participants would be 18 or over.
- Participants would use English to communicate. This is because the researcher would struggle to analyse conversation in a language that isn't English, and interpretation or translation can sometimes subtly change the meanings of what people say and therefore the findings of the study would be affected.

What is involved?

- If you were interested in taking part, the researcher would contact you or meet with you to answer any questions you might have.
- We would then arrange a time to meet together, probably at the organisation where you work if this is convenient. The researcher would interview you broadly on the topic described above. The interview would last from 45 minutes to 1 hour. It would be recorded with a digital recorder.
- The researcher would then give you the chance to discuss what the experience of doing the interview was like.
- The researcher would then type up the conversation and think about the themes that arose in the discussion, and whether there are general themes across different interviews.

Are there implications of my participation or any hazards/risks involved?

- Some people don't like being recorded, which is totally understandable. Therefore it's important that you know that if at any time you don't feel good about taking part, you are absolutely free to change your mind.

- For example, even if you decide after the recording has been made that you're not actually that keen on taking part anymore, you can tell the researcher (or someone who can let him know) and the recording will be destroyed.
- Taking part or not taking part will have absolutely no effect on your involvement with the organisation which arranged this supportive relationship, or on any service you receive from them.

Confidentiality

- The researcher will ensure that the digital recorder with your interview on remains in a locked cabinet, to which only he will have access. Any paper transcriptions will also be kept similarly, and will not include your name.
- Computer files of the recordings will be stored with passwords in a password-protected computer owned by and only accessible to the researcher.
- Any contact details kept for you will be stored separately from recordings and transcripts, and will not include your name – only a pseudonym known to the researcher.
- Any potentially identifying information (e.g. your name, where you live, anything you say in your support session which might give a clue as to who you are) will not be given in the write-up of the research.
- An anonymised transcript of your interview will be kept for five years in case someone has a question about the research. It won't be put to any further use without your permission. Any other information collected from you (e.g. any contact details) will be shredded.

Who sees the report?

- Firstly, you get to see it before anyone else does to make sure you're happy with it.
- The final report will be seen by examiners at the University of East London.
- It will be sent to the organisation which arranged your peer support if they request it, but anything that might identify you to them will have been removed from the report.
- It might also be published in an academic journal.

Further contact

- If you have any worries or concerns about taking part in this project that you don't feel that you can discuss with the researcher, you can contact his supervisor whose details are:

Dr Ken Gannon, Professional Doctorate in Clinical Psychology, School of Psychology, Water Lane, Stratford, E15 3IZ

Appendix D – Consent Form

CONSENT FORM

Title of project: From consumer to consumer-provider: A narrative inquiry

Name of researcher: Sam Wintrip

Instructions

Please put your initials in each box if you agree with the content of the paragraph above, otherwise cross the box.

I have read the information sheet about the research project in which I have been asked to participate and have been given a copy to keep. The nature and purpose of the research project have been explained to me and I have had the opportunity to discuss the details and ask questions about this information. I understand what is being proposed. The procedures in which I will be involved have been explained to me.

I understand that my involvement in this study, in particular data from this research, will remain strictly confidential. What will happen to the data once the research project has been completed has also been explained.

I understand and hereby consent that quotes from my interview may be used anonymously in the write-up of this research project and any future publications.

I hereby fully and freely agree to participate in this study, which has been fully explained to me.

Having given this consent, I understand that I have the right to withdraw from the study without disadvantage to myself, without any impact on services I may receive from the NHS or other organisations, and without any obligation to give a reason.

Participant's Name

Participant's Signature

Researcher's Name

Researcher's Signature

Date

Appendix E – Interview Schedule

As noted, beyond opening with ‘Could you tell me how it was that you came to be a peer support worker,’ interviews proceeded without a pre-determined structure but rather aimed in principle to be responsive to the interests and direction of participants. A sample list of the general kinds of questions that I asked from several different interviews follows:

‘What has been the impact of [change or life event described by participant]?’

‘Has this experience changed or affected the way you see things?’

‘How have you come to develop [ability or knowledge described by participant]?’

‘What do you mean by [unusual word or metaphor used by participant]?’

‘How were you able to [make a change or utilize an ability described by participant]?’

‘What was different about [a event or change described by participant as important or transformative]?’

As people talked about being peer supporters, I also asked more specific questions about their views with regards to their roles:

‘You described using your personal experience when working as a peer supporter. Could you tell me in what way you use this experience?’

‘What does the word ‘peer’ mean to you?’

‘Do you see a difference between the peer support role and some of the other roles on the ward?’

Appendix F – Transcription Convention

Potter and Wetherell (1987) note that, ‘for many sorts of research questions, the fine details of timing and intonation [in conversation] are not crucial, and indeed they can interfere with the readability of the transcript, particularly when dealing with extended sequences,’ (p.166). This study aimed to produce a case-based narrative analysis incorporating extended segments of speech, analysed more or less holistically and in terms of form rather than micro-procedural processes. Clarity and readability were therefore primary concerns when approaching transcription, leading to adapted use of the simplified system adopted by Banister et al (1994).

| | |
|------------------------|------------------------------|
| (.) | pause |
| (..) | pause two seconds or greater |
| xxx | untranscribable |
| <laughter> | laughter |
| <u>word underlined</u> | emphasis |

Neologisms and nonverbal utterances were reproduced phonetically in original transcripts, but removed from all extracts in the main body of the text for the sake of clarity apart from those which presented dialogue between myself and participants (e.g. pp. 86-89). These extracts additionally employed a simplified system to denote simultaneous speech by two people adapted from Jefferson (1984):

Sam: And that being on the ward was a turning point, do you think?

Elaine: Yeah

Appendix G – Samples of Original Transcripts

Extract from conversation with Jane

Well, it was just a case of at first seeing the job advertising, advertised and I thought that appeals to me. And in fact I thought... it's pretty much what I'm doing already, in a funny sort of way. With with people... that I've been associated with over the last few years. Not necessarily... In a good way, I think I had to come to a point in in life where you can start to impart... what you know to people in a similar situation, hopefully that's what most appealed, I thought that was est a state where I could probably use my knowledge and experience to help people. So that was the initial thing that that led me there ha

So you said it was something that you felt you were doing already

Hmm yeah um I'm a very helpful person, some people call it co-dependent and I think I've got I've gone beyond that, I've learnt the pitfalls of co-dependency or whatever... that embraces, that term, but I've I've always been a quite caring person, very empathetic empathetic person. Erm, I've always attracted... Erm, for lack of a better word, oddballs in to my life that I've that've kind of (feed me) I suppose. Erm, and I went for the last um ten years has been a lot of transition for me, huge amount of change and transition, which in some ways rounded me off as a person and I was just in a better place where I could help people I think. For that sole purpose rather than to get something out of it. Cos I think sometimes if you're in a caring relationship, you want some sort of pay back I think. It sounds strange, but when you're see that, you know some overcaring people want to be needed. I've gone beyond all that, come out the other side of a long... battle and my... my history started with my dad being alcoholic so, I was already a bit of a head case before I started, you could say. So.. does that answer that question?

Yea yeah. So

In a nutshell I felt I'd arrived at a place where... I could be of some support to others, without getting anything in return if that makes sense. I don't know if that does, but it can do sometimes. Um,

You were saying something about being able to use your your experiences to help other

Day of act as desired to do this
wherever
able.
again think
idea of a break
from something
before
linear progress
has no goal
about trying to
experience

about the day of the job, my being a stable
aged identity, an expression of a stable
identity
strongly necessary as a good thing
idea of imparting knowledge "fed up with
his ideas progressive idea of maturity - fed up
or associated with welfare? or recovery!
wanted more? - wanted leaders
able hearts and again reaching
politicised about this - had reaching
through the idea of progression - demonstrated
to help that H
is the case

Helper role as demonstrating
welfare or associated with
wellness, but also idea of practicing
roles.
part of upward transition is
power as ordinary / things left no desire to get
replaced out - respect
particulars (not will
career)
as welfare with
respect to "co-dependency"
but some have
phased, in how do
front of competing
Dad alcoholic
we had use
Married
Co-dependent
New I am this
" - out the other
side.

