Exploring support group efficacy for individuals recovering from depression.

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ABSTRACT

Using narrative analysis, the objective of this study was to discover, how individuals, recovering from depression, narrate their own experience of support groups, through the use of storied accounts. Individuals in recovery need to find ways to tell stories about themselves which can create opportunities for change and healing (McKenzie, 2009). This qualitative study moves away from the traditional medical model, as the patient is now the expert, rather than the clinician. To explore these accounts and experiences, six participants who have previously suffered with depression, were narratively interviewed using a semi-structured guide. Applying Crossley's (2000) method for narrative analysis, three core themes were uncovered: narrating mental adversity & isolation; alleviating isolation & re-establishing connection and a reflexive journey of positive inward self-exploration. The overall analysis suggests that experiences of attending support groups can actually facilitate the recovery from depression, promote optimism and create opportunities for positive change.

KEY WORDS:	NARRATIVE ANALYSIS	DEPRESSION	SOCIAL RECOVERY	AFFILIATION	ISOLATION

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Introduction

Prevalence of mental health in the UK

It is now considered that 1 in 4 people will experience some kind of mental health problem over the course of a year, with mixed anxiety and depression being the two most prominent disorders in Britain (Mental Health Foundation, 2015). The highest incidence of mild mental illness is among the 50-54 years age group, with only 19% of people aged 16 or over, ever reporting their symptoms (British Psychological Society, 2015).

In terms of susceptibility of being treated for mental health problems, women are said to be more vulnerable than men. At least one in two people will experience depression at some point in their life. At any one time, mental health problems affect 10% of 5 to 16 year olds. However, in adulthood at any one time, anxiety and depressive disorders affect 17% of individuals, living in England (McManus et al, 2009). Depression alone, affects between 8-12% of the UK population in any one-year (Mental Health Foundation, 2015).

Social recovery

Recovery in a social setting is now seen as a vital step, in coping with and recovering from mental illness. Social support can be defined as, *'information from others that one is loved and cared for, esteemed and valued, and part of a network of communication and mutual obligations'* (Seeman, 1996). Studies in to social support have found that there can be physical health benefits e.g. reduced likelihood of illness and faster recovery when illness does occur (Holahan, Moos, Holahan, & Brennan, 1997; Stone, Mezzacappa, Donatone, & Gonder, 1999).

Social capital refers to features of social organisations like, social networks, shared norms, trust, reciprocity and participation in community life. Communities' rich in social capital have been described as socially cohesive, cooperative and caring, with evidence to suggest that, high social capital correlates with positive health outcomes (Putnam, 1995).

More recent studies in to social recovery have emphasised the importance of attending to social isolation. Simonds, Pons & Stone (2014) set out to investigate

whether or not social recovery is relevant in adolescents suffering with anxiety and depression. Thematic analysis of 9 semi-structured interviews revealed that, services should attend to social isolation/exclusion and emphasise support for positive future aspirations.

Social exclusion refers to those groups who are excluded from certain spheres of social life. "*Individuals or groups are socially excluded if they are denied the opportunity of participation, whether they actually desire to participate or not"* (Barry, 2002: p.16). Social exclusion overlaps with many other concepts such as, poverty, deprivation & social capital. Sayce (2001) extended previous definitions, to relate more directly to people with mental health problems, focusing specifically on the impact of both impairment and societal responses. She argued that for mental illness social exclusion has more explanatory power than poverty or related concepts, in that it focuses attention on the non-material disadvantages that result from the discriminatory responses of others and institutions.

A study by Parr et al (2004) discovered similar themes in their account of social exclusion and inclusion, of people with mental health problems, living in Scotland. "Inclusion" denotes relations and practices that people with mental health problems perceive to signify their positive involvement in and counting to a local setting. In contrast, "exclusion" denotes more negative prospects that involve rejection, avoidance and distancing from other community members, such that individuals are "made different" through more or less deliberate social actions reinforcing their problematic mental health status (Parr et al, 2004: p. 405).

Subsequently, researchers have been continuously analysing and trying to measure the development of social recovery. Marino (2015) explored the social aspects of recovery as reported by individuals with lived experience. A qualitative study, using thematic analysis, of data from focus groups with 41 individuals in recovery, he found that three meta-themes emerged, community, self-concept and capacity, with participants speaking about common human needs to belong, contribute, and have hope for one's future. The findings converged with results of consumer-led research, which emphasise the importance of overcoming the impact of illness on the self and social context.

Social affiliation

The need for affiliation is an expression propagated by McClelland (1961), which he describes as an individual's need to feel a sense of involvement and belonging within a social group. Mental health difficulties like depression, create obstacles for people seeking this need for affiliation, as these individuals' are often misunderstood in modern day society because of the negative stigma surrounding mental health. People with adverse mental health say that the social stigma attached to ill mental health and the discrimination they experience, can exacerbate their difficulties and make it harder to recover (Mental Health Foundation, 2016).

People with a high need for affiliation require warm interpersonal relationships and approval from others who they have developed a strong social connection with. In reference to a support group environment, people who take part actively create a push towards a sense of achievement and satisfaction for the individual and the group as a whole (McClelland, 1961).

DeWall et al (2011) studied the concept of 'belongingness' in much more depth, explaining an individuals need to belong as part of evolutionary history. As belongingness is a core component of human functioning, social exclusion influences many cognitive, emotional, and behavioural outcomes including personality expression. As a result, if a sense of belongingness is absent this can massively affect and reduce, an individual's recovery rate from mental illness.

Sonnenberg et al. (2013) conducted a longitudinal study, investigating gender differences in the relationship between depression and social support in later life. Respondents without a partner in the household, with a small network, and with low emotional support were more often depressed, with men showing higher rates of depression than women, and a high need for affiliation was associated with depression in women but not in men. Low social support and a high need for affiliation were related to depression in later life, with men being more vulnerable for depression than women. Taking in to consideration the serious consequences of depression, especially in older people, it is crucial to identify the persons with low social support and a high need for affiliation, and to help them to increase their social support or to adjust their needs.

Social rank within these affiliation systems has also been linked to depression (Gilbert, 2006). Irons and Gilbert (2005) discovered that between adolescents both affiliation and social rank measures are associated with depressive symptoms (Irons & Gilbert, 2005). Furthermore, social rank measures arbitrated the relationship between affiliation and depressive symptoms among insecurely attached adolescents (Irons & Gilbert, 2005). Similarly, compared with their non-depressed counterparts, depressed individuals reported engaging in more negative social comparisons, perceiving themselves as inferior, and displaying more submissive behaviors (Gilbert, Allan, & Trent, 1995).

Deserting traditional medical practice

The entire notion of social recovery is continuously diverting away from the traditional, 1 to 1 clinician facilitated recovery. Support groups bring individuals with similar experiences of mental illness together to address shared concerns and promote recovery (Davidson et al., 1999). The structured social interactions typical of these groups can help individual members become less isolated and adopt positive, active, and socially valued roles.

Beehler, Clark & Eisen (2014) conducted a study to characterise and compare participant's experiences of peer-facilitated versus clinician-facilitated recovery groups for veterans with mental illness. Qualitative data from 24 interviews with veterans, who participated in mental health recovery groups, led by peer or clinician facilitators, were analysed. Participants experienced both peer and clinician facilitators as helpful in promoting recovery, though they appeared to do this in different ways. Depictions of clinician facilitators ranged from extremely negative to extremely positive, although reports of peer facilitators were all moderately positive.

The main focal point of this research is the narratives the participants use, to tell their story and share their experiences of recovery. A study looking at narratives of natural recovery, through the use of a social inclusion experience programme, found that participants described core success factors corresponding to well-known recovery elements, such as recognition, supportive relationships, motivation, meaning, positive coping, self-esteem, confidence and hope (Kogstad, Agdal & Hopfenbeck, 2014). Participants described one effective factor of recovery, as the leader's ability to create a good group atmosphere.

Ridge and Ziebland (2006) attempted to understand how people comprehend depression and recovery by analysing 38 patient narratives. One reoccurring narrative evident in the analyses was adopting a recovery attitude and using recovery tools which are available, for example, counselling, sharing peer stories and re-writing their story from a negative one in to a positive journey. There is a growing recognition of the importance of patient narratives, not only in describing experience, but also in revealing how patients make sense of their world (Lewis, 2011).

It is important to view recovery as defined by the patient and patient narratives are integral to this, enabling healthcare professionals to understand what really matters to the individual. Also these narratives help to ascertain how best to encourage and empower patients in their recovery (Craig, 2008). Examining patient's narratives provides a pathway to explore their illness experience (Hyden, 1997). Individuals in recovery need to find ways to tell stories about themselves that create opportunities for change and healing (McKenzie, 2009).

Interventions

A number of organisations helped to obtain the data each being independent adult mental health charities, located in the North West of England. The charities however, were parts of national, well recognised, mental illness organisations. Their main ambitions are to work towards a society whereby, people who experience mental distress are supported with their recovery and are free from stigma and discrimination, whilst being empowered to reach their full potential.

They deliver high quality appropriate services such as, group support, 1 to 1 sessions, drop-ins, leisure activities and post-treatment aid by facilitating their re-establishment in to society. The charities are able to continue their great work through a small number of registered employee's, volunteers and generous public donations.

Research objectives and aims

The overarching aim of this research was to discover, how individuals, recovering from depression, narrate their own experience of support groups, through the use of storied accounts. In particular, the research will focus on:

- How individuals have storied their own personal change over time, therefore, providing an insight, in to individual perception on support group efficacy
- The narrative tone used to convey these personal accounts, to see if experiences of group work, are overall optimistic and positive occurrences.
- Exploring social recovery and how diverging away from traditional 1 on 1 practice can be more beneficial in the long term.

Methodology

Philosophical underpinnings

Carter & Little (2007) argue that epistemology is the study, theory and justification of knowledge, it is an examination of 'how we make knowledge'. Various social constructivist approaches prevalent in contemporary psychology e.g. postmodernism, discourse analysis, have failed to adequately highlight the importance of experiential and personal dimensions of human experience (Crossley, 2000).

Social constructivist approaches are very much individualistic and draw heavily on the 'self' or 'subject' (Potter & Wetherell, 1987; Nash, 1990). The 'self' is studied only in terms of the individual discursive acts, which perform various social activities, resulting in subjective experience being so context-dependent, there seems to be little beyond personal psychology. The 'subject' is often reduced to a mere grammatical shell empty of meaning and completely depersonalized. Consequently, this study avoided being individually bias and adopted a social constructionist approach in order to discover, what support groups offer and how they contribute to an individual's experience of recovery.

Ontology is concerned with the nature of social reality, the kinds of things that exist, the conditions of their existence and the relationships between these things (Dillon & Wals, 2006; Ramey & Grubb, 2009). The two contradicting sides of the ontological framework are 'realism' and 'relativism'. Relativists begin talking about the social construction of scientific knowledge, social structures and truth. Whereas, their realist counterparts complain of 'ontological vandalism' (Sayer, 1997; p. 477) and

begin hitting the furniture to demonstrate the undeniable solidity of reality. As a result, the research that was conducted took a critical realist ontological stance, challenging the solidarity of realism and investigating the fluidity of recovery in a social existence.

Taking a narrative approach

Narrative psychology believes, similar to postmodernist and discourse, that language is the tool for construction of reality, knowledge and experiencing the self. '*The aim of narrative psychology is therefore to study the language, stories and narratives which constitute selves and the implications and permutations of those narratives for individuals and societies'* (Crossley, 2000: p. 40).

However, narrative psychology differs as the approach tends to be more grounded in the attempt to comprehend the specific experiences undergone by individuals. It is concerned with retrieving that subjectivity by narrowing its attention on the lived experience of the individual, thus, being vital for understanding social recovery within a support group environment.

As a result of the epistemological and ontological stance adopted by the study, the aim was to obtain rich qualitative data from each participant, allowing the researcher to gain a deeper understanding of the narratives and subjective experiences the individual's will be conveying. Therefore, the qualitative data was collected using a semi-structured, narrative interviewing technique.

Narrative interviewing (NI) encourages and stimulates the participant to tell a story of some significant event within their life, narrative, deriving from the Latin word 'narrare', which means to report/tell a story. Stories can be utilised in many different ways, to entertain, make people laugh, cry and even scare and disturb. However, in some instances, stories may also be used to mend people when they are broken, heal when sick and even move individuals towards psychological fulfilment and maturity (McAdams, 1993, p. 31).

Schuetze (1977) stated that the basic idea of NI is to reconstruct social events, from the informant's perspective. Personal narratives enable the researcher to gain an insight in to specific aspects such as, the narrative tone e.g. are experiences of

support groups and their recovery conveyed in an optimistic or pessimistic manner, and dominant themes which run throughout the story (Crossley, 2000: McAdams, 1993). It is a critique of the traditional question-answer scheme, allowing the participant to freely talk about their experiences and also minimizing how much influence the researcher has on the data (Bauer, 1996). Henceforth, being the ideal technique to gather an individual's perspective on both, support group efficacy and social recovery.

Recruitment

Participants for the study were collected through opportunity sampling, from a small number of mental illness charities in Stockport, North West England. A recruitment poster was designed and put on display throughout various buildings and facilities these charities share (see appendix 7). The researcher recruited a total of 6 adults, all over the age of 18, 3 males and 3 females.

Prior to the study taking part every individual received both an information sheet (see appendix 2) and a consent form (see appendix 3). This ensured that participants were, fully aware of what the study involved and give their signed consent that they are happy to take part. Therefore, remaining within the ethical guidelines of deception and informed consent.

Whilst the interviews were taking place, the researcher had a small set of interview questions to help structure the narrative along the way and prevent any speechless moments from occurring (see appendix 4). The interview began with a few warm-up questions to make each participant feel at ease and finish with some cool-down questions, leaving the participant in a positive frame of mind. The interviews themselves were recorded through an audio recording device on a laptop, allowing the researcher to stay fully engaged and prevent missing any vital information through taking notes.

On completion of the interviews, each participant received a closure form (see appendix 5), ultimately thanking them for their participation and giving them the researcher's contact details if they had any further questions or would like to find out the results of the study. Interviews were then transcribed for analysis, once data from

all 7 participants had been collected. Finally, the audio recordings were destroyed, deleting all data, ensuring privacy and confidentiality.

Participant information

Table 1
Relevant participant information

NAME	AGE	RELVEANT INFORMATION
Linda	30's	Fibromyalgia, Depression, Anxiety
David	50's	Depression, Anxiety, Panic Attacks
Chris	30's	Bipolar, Depression
James	40's	Asperger's Syndrome, Depression
Victoria	50's	Depression
Catherine	50's	Generalised Anxiety Disorder, Depression

Pilot study

A pilot study was included (Linda) in order to test the interview questions and allow the researcher to become familiar with the interview structure. A pilot study can be used in two different ways, it can refer to so-called feasibility studies, which are "small scale versions, or trial runs, done in preparation for the major study" (Polit et al., 2001). A pilot study can also be the pre-testing or 'trying out' of a particular research instrument (Baker, 1994) and in this studies case it was the pre-testing of the interview questions. Therefore, this was advantageous to the research as it enabled any potential faults to be highlighted and thus corrected.

Ethical considerations

Ethical approval for this study was applied for through the university ethics (see appendix 1) and external gatekeeper (see appendix 6), recognising the main guidelines that need to be addressed. A signed consent form was obtained (appendix 3), indicating their readiness to take part, their permission to be audio-recorded and their data to be used. Also within this consent form, the individual's right to withdraw was addressed.

Prior to the study-taking place, participants were given an information sheet (appendix 2), which fully explains what the aims and content of the study are, making certain no individual is being deceived or harmed. These are the necessary steps to ensure the study sticks to the British Psychological Society's (BPS) ethical code of conduct, integrating the main principles of respect, competence, responsibility and integrity (BPS, 2009).

However, ethical considerations should not just be accounted for at the start of the research, but should be adhered to right up until the final moments and even after publication of the research. Punch (1986, 1989) acknowledges such issues, for instance, stress in the field situation, research fatigue, confidentiality, harm, privacy and identification.

As a result, ethical support and consideration is an on-going process, not just for participant, but researcher as well e.g. safety, not working alone with participants. A closure form following the study will be provided, thanking the individual for participation and informing them of the researchers contact details, e.g. email address. This then allows the participants to contact their researcher for further support and builds rapport between the researcher and participant.

Approach to analysis

The analysis started as soon as the interviews were being transcribed and was sustained throughout the reading and re-reading process, analysing more meticulously every time. Understanding the content and complexity of meanings produced in the autobiographical interview situation is crucial. As a result, the influence of the researcher needs to be recognised as they create, interpret and shape the entire research process (Crossley, 2000).

The approach focuses on individual's personal experiences of recovery, within a social setting, and the way in which this story is told. McAdams (1993) identifies three elements of a personal narrative, which are considered as important features to study; narrative tone, imagery; and themes. As previously mentioned, the study is analysing narrative tone, to see whether participant's experiences of social recovery, are conveyed optimistically or pessimistically, this perhaps the most pervasive feature.

People use images to create meaning and make sense of the self, within their narratives, using metaphors and symbols. The essence of metaphor is understanding and experiencing one kind of thing in terms of another (Lakoff & Johnson, 2003). However, this creation of imagery is highly dependent on upon raw materials available in our culture e.g. language, stereotypes, social norms.

Dominant themes that occur throughout the transcripts were also investigated to see what is important to the person and what motivates them throughout their lives. McAdams argues the two most important themes are, power, the need for agency, and love, the desire for connection. Themes are considered to be more ostensive when we experience our identities as 'in crisis'. For example, when suffering with depression and carrying the negative stigma of having a mental illness the person may describe themselves as being 'isolated' or 'trapped'.

Analysis and Discussion

This next section presents the 3 dominant themes that were used in narrating participant's experiences of support groups and how they storied their own personal development.

Narrating mental adversity & isolation

During the preliminary stages of the interviews, each participant reflected on their experiences of ill health and how they initially managed their symptoms, by being reluctant to confront and challenge their illness. For example, during the interviews participants drew on the imagery of 'bottling up' their problems and feelings, until eventually it became too much.

"*I would just bottle it up and up, until in the end I sort of blew…"* (David, 129)

"*I have been through a lot of pain, I have blocked my emotions and feelings, I just didn't want to entertain them…"* (James, 148)

"I don't share very well, my feelings, I tend to keep everything inside until I think I have dealt with it and then let it go… I don't like asking for help I

suppose… Then eventually it all builds up and I go off the edge a bit."
(Victoria, 5-6, 10, 14-15)

Through their storied accounts participants illustrate themselves as in denial and unable to cope with their fluctuating mental health. It is suggested that inhibition of trauma-related thoughts, feelings, and behaviours requires psycho- physiological work, which places cumulative stress on the body in the long term (Pennebaker & Francis, 1996). Inhibition is thus an active process which increases the risk of both physical illness and mental distress (Ellis & Cromby, 2011). By only giving vent to specific emotions that the participants feel are safe, acceptable and not overwhelming, perhaps, this allows for an acceptable sense of self to be preserved and unhindered.

The analysis also revealed a narrative of having a lack of control and the participants storied themselves as simply, passive victims suffering with this domineering illness. A sense of learned helplessness (Seligman, 1975) develops, as repeated exposure to the illness causes a cognitive shift, whereby becoming compliant, is less cognitively demanding than resisting the illness. For example, during the interview participants said:

"… I was hospitalised… that would of sent me over the edge." (Chris, 108 & 217)

"It took over me, pouring with sweat and everything. I panicked, had to get out, got out of the shop and from there it stopped me…" (David, 104)

The way in which Chris constructs himself as being hospitalised, demonstrates that he feels his mental health is out of his control, for example, external factors, that are responsible for putting him in hospital. Also the metaphor David uses to describe his experience, suggests he associates his illness as being a separate entity, disconnected from his identity and out of his control.

There are many closely associated symptoms linked with depression and one common contributing factor is the feeling of isolation. Social isolation is defined as "a state in which the individual lacks a sense of belonging socially, lacks engagement

with others, has a minimal number of social contacts and they are deficient in fulfilling quality relationships" (Nicholson, 2009, p. 1346). When reflecting back on their thoughts and feelings participants often narrated a feeling of isolation and a sense that nobody else would understand them, or be able to help them. For example:

"…I think I lost a lot of people that I thought were friends during my mental health problems and now from being somebody that people used to invite to a party, without being horrible, not being big headed, if I wasn't going or said no, they would be like why aren't you going, its not going to be the same without you, to people never bothering ringing me." (Catherine, 247-251)

"… you feel very isolated and on your own and you're just thinking these things, that nobody else is experiencing it…" (Linda, 73-74)

These quotes from Catherine and Linda reflect the narrative theme of isolation by demonstrating and reinforcing the current negative stigma surrounding mental illness (Mental Health Foundation, 2016). In relation to McClelland's theory (1961), this will have detrimental effects on their motivation, with low motivation being a key indicator of someone suffering with depression e.g. not wanting to get out of bed, talk to anybody, even shower or wash themselves. Linda narrated a similar experience of low motivation:

"I was in bed doing things like brushing my teeth because I physically couldn't move or get up…" (Linda, 41-42)

Social, psychological and medical research have all demonstrated conclusively that there is a direct correlation, between the degree to which a person feels connected to others, and their physical and mental health e.g. increased likelihood of depression, longer recovery times from illness or injury and significant increases in chronic illnesses, such as cancer and heart disease (Blazer, 2005; Nicholson, 2009; Cruz et al., 2016). It is obvious that isolation is a common metaphor used to describe experiences of mental illness, however, there is no consensus in the research that is available regarding the relationship between depression and social isolation. Blazer

(2005) states that frustration well in stating that depression has a "clear, but not obvious relationship" with social isolation (p. 497).

Alleviating isolation & re-establishing connection

As the interviews progressed, participant's began to reflect on their transition from being isolated, to then taking control of their illness and rebuilding social connections which had previously broken down. For example, participant's often narrated feelings of relief when they finally crossed the first hurdle of attending their first support group.

"Really positive, I would definitely advise people to do it. It really, my experience was scary, it was the unknown, it was finding out things about myself that I didn't realise. Finding out other people were feeling the exact same. They didn't have the same illness, nobody on the course had the same illness, but we were all feeling the same feelings. I just found it really really useful." (Linda, 63-67)

"But when you sit down and you're with a group of people and your talking about it, sometimes there is words coming out of your mouth that you didn't even realise you were thinking… It is a release because once you have said it out loud, you can face it up to it." (Victoria, 196-190 & 199-200)

"Its been really positive, you know you come here and its probably, what I would say, my sort of people. People that I have got more in common with that have had a depressive illness." (Catherine, 229-231)

All the interviewee's narrated a feeling of relief when they realise, they are not the only people suffering from mental health difficulties and how the shared knowledge and experiences at these support groups, can be extremely beneficial in their recovery. As previously mentioned, Putnam (1995) describes groups and communities rich in social capital as socially cohesive, cooperative and caring, with supporting evidence to suggest that, high social capital correlates with positive health outcomes.

Crossley (2000) argues that narrative tone is the most pervasive feature of a personal narrative in adulthood and is conveyed in both the content of the story and the manner in which it is told. Each storied account began to change as all the participants started to discuss their future in an optimistic narrative tone, this being a clear contrast in comparison to when participants were pessimistically constructing their past. Participants reflected on how their connections with other group members encouraged their journey to recovery and how their support groups acted as a secure base whereby they could explore and regain an active sense of self.

"I would say that support group, the first one, I call it, you fell off a cliff and you're at the bottom on the beach or whatever and that support is like the first anchor point, you've sort of got your hand on it, your still flat on the floor but you have got your hand on one point and you can tap and put the rope round so its always sort of, even though you might slip down, you have always got that rope. If you do fall you have got this anchor point. So all of the support groups even now, that's how I look at them. You might slip off one of them but there is always another one below you." (David, 228-234)

This quote from David is a perfect portrayal of the imagery he uses to describe his own personal experiences of group networks. He describes himself as being at the bottom of a cliff when he started this journey, but each support group he attends acts as an anchor point up this cliff, preventing him from falling straight to the bottom. The metaphorical language he uses highlights his optimistic outlook on his current situation, using words such as 'anchor' and 'rope' to emphasize the strong connection he feels with his support networks.

A reflexive journey of positive inward self-exploration

The modern self holds within it two different kinds of reflexivity, one being 'self-exploration'. Self-exploration doesn't stand back from bodies, thoughts, feelings and desires, instead it encourages to explore these dimensions in order to establish identity; we have to 'search for ourselves' (Taylor, 1989). Each and every storied account provided, narrated a positive transformation of the self, catalysed through experiences of support groups.

"The difference is, more confident, more energised, more energy kind of thing. I look at life more positively. I have been planning for the future a bit more. I take one day at a time, I do a list every night, with what I want to do the following day and I do it and just tick it off when I have done it, then its gone. If I have to put it on to the next day because I haven't done something, but as long as I have done 80% of that list I am alright. Bit of structure. So more structure to my life and also hygiene has gone a hell of a lot better." (James, 172-178)

"I'm a lot more positive, if I do have a low mood, I know how to get myself out it, I know the avenues to go down, the positive thinking strategies to use. I can use all the information now when I am at home, rather than having to go to the groups because I remember it all and I have all the books, so I can go back and look. But yeah I find I am dealing with my depression and my illness a hell of a lot better than I was before the group and during the group because I know the ways I can get myself out of it, I think that is the huge, huge thing." (Linda, 121-127)

Taylor (1989) argues that the kind of questions troubling people in modern day society centre around 'the meaning of life', 'the meaning of self' and 'where we are going'. These existential dilemmas of 'loss', 'emptiness' and 'meaninglessness' dominate our age and differ dramatically from previous civilisations (Crossley, 2000). These two quotes demonstrate the opposite end of this dilemma and show the substantial impact support groups can present and how, through social recovery, an individual can explore and modify their own sense of self and self-worth.

During the latter stages of the interviews participants reflected on how they have changed right through their journey of first experiencing mental illness, up until the present day. Every individual told a positive story of total transformation, from where they once were, to where they are now.

"I have totally changed because before I was always thinking of saving a little bit of money for when you retire or 2, 3 years from now. Now its day to day

now. I appreciate everything, its not all about money, its about quality of life." (David, 301-303)

"…it was pleasant at the beginning, horrendous in the middle, tough towards the end, 12 months down the line, it was amazing, it really was. At the time I didn't think at all it was helping, but now I realise it has helped." (Victoria, 205-208)

These findings correspond with previous research conducted by Marino (2015) who found three meta-themes of, community, self-concept and capacity, with participants speaking about common human needs to belong, contribute, and in particular having hope for one's future. The research also emphasises the importance of achievement in overcoming the impact of illness on the self and social context. This sense of overcoming the impact of illness is best summarised in a quote by James:

"Greatest achievement so far, is coming through the issues I have come through in my life... I just see myself standing on a mountain, I don't know what that's about but I just like I have achieved something." (James, 38-40)

The birth of a new practice

The overall analysis clearly demonstrates that experiences of support groups and recovery in a social setting, are highly beneficial to an individual recovering from mental illness. When fusing together the three dominant narrative themes, it highlights the transformation from an isolated, helpless mental state, to an energised and empowered positive state of mind. The main suggestion from this research is that through the use of social recovery and storied accounts, people can empower themselves and can create opportunities for healing and change, thus providing further support for previous research (Craig, 2008; McKenzie, 2009).

One unique factor of this study, is how all the participants story time and how the narrative theme changes in conjunction with time. All the participants constructed a clear story with a beginning, talking about the past, a middle, discussing the present and an end, considering the future. The narrative tones in which these stories were told, gradually developed from a pessimistic past to an optimistic present and future.

Therefore, answering one aim of this research and showing that experiences of support groups, are on the whole, positive experiences.

This research can be vitally important for future professional practice as it emphasises the importance of providing space for individuals to narrate their stories and an alternative pathway for them to explore their illness. This relates back to another aim of the study reinforcing the idea that diverging away from traditional 1 on 1 medical practice, and adopting alternative methods like narrative psychology, can actually be more beneficial in the long term.

Reflexive analysis

Experiencing first hand the effects of depression in my close family life, provided the stimulus for me to become engrossed with a piece of research related to depression. Since the start of these experiences I have been fully determined to learn more about the illness and currently work alongside those who are suffering. I have immersed myself in local charity work, providing support in group drop-in sessions, one to one support and even helping with fundraising events.

Once my research proposal had been approved, I was keen to absorb myself into the mechanics of the study. I had chosen a methodological framework which I felt comfortable with and which reflected my moral standpoint on the issue. I wanted to ensure that participants had as much freedom to tell their stories as possible and didn't at all hold back in what they were telling me. According to Gelissen (2012) the method is not only created to suit the needs of the researcher, the method should be structured and altered around the participants.

Prior to conducting or starting any research, I believed that having as little influence as possible on the interview process and on the data, would yield far better results. However, I was quick to realise that little influence was impossible to achieve and I was very much a major of part of the research process. Nevertheless, this did not reduce the reliability of my project, as the interview process allowed for a rapport to develop with myself and the participants collectively constructing their personal narratives.

From the very beginning of my research, I knew I was using the qualitative approach, as I wanted to make sure that the personal constructs the participants were narrating, became the central focus of the entire project. Therefore, the quantitative approach was not suitable, as it would not have enabled me to achieve this.

Before conducting my first interview, I experienced a mixture of emotions. I was nervous and anxious as it was the unknown and something I hadn't been a part of before, but at the same time I was excited and intrigued at what I was going discover. Conducting these interviews has not only increased my confidence but it has enabled me to develop a skill that will be essential in future professional practice.

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