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An investigation of experiences of reading for mental health and well-being and their relation to models of bibliotherapy

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Abstract

Bibliotherapy is the use of imaginative or self-help literature as an intervention for mental health problems. It aims to provide psycho-social support and treatment and is used with individuals or in a group. Bibliotherapy has come to prominence in the UK over the past decade. Bibliotherapy schemes mainly operate in partnership between the public library and the NHS.

Previous research on bibliotherapy has focused on the quantitative effectiveness of the intervention or anecdotal report of individual successes. Evaluation of current schemes and qualitative investigation of the views of those experiencing bibliotherapy have been neglected in previous research, providing the rationale for this thesis. The thesis argues that because there have been shortcomings in previous research, there are differences in the understanding between those managing bibliotherapy schemes, and those using the schemes.

The thesis has a dual research design; it critically analyses the emergence of the main models of bibliotherapy in the UK, deconstructing them using an Actor-Network Theory framework. Document analysis, interview data, and descriptive statistics contribute to these findings. Analysis concludes that the focus of these models is not always user-centred, with other factors driving the implementation of the intervention e.g. cost-effectiveness and health policy requirements. The type of text used is a key element of the intervention.

The thesis also takes a qualitative, ethnographic approach based on Interpretive Interactionism to investigate the experiences of people with mental health problems who use bibliotherapy. Data was collected via an interview and observation study. It concludes that there are diverse uses of bibliotherapy. Building on the gaps between the application of bibliotherapy and the experience of using it, the central finding of the thesis is the emergence of four user-centred models of bibliotherapy, focused on the outcomes of bibliotherapy rather than the text used. These proposed models reflect the emotive, escapist, informational, and social outcomes of using bibliotherapy as a form of support for mental health problems.

Acknowledgements

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Abbreviations used

ADHD – Attention Deficit Hyperactivity Disorder
ANT – Actor-Network Theory
BDI – Beck Depression Inventory
BME – Black and Minority Ethnic
BoP – Books on Prescription
CBT – Cognitive Behavioural Therapy
cCBT – computerised Cognitive Behavioural Therapy
CPN – Community Psychiatric Nurse
DCMS – Department of Culture, Media and Sport
DCMS Wolfson Fund – Department of Culture, Media and Sport Wolfson Public Libraries Challenge Fund
DH – Department of Health
DSM – Diagnostic and Statistical Manual for Mental Disorders
DSM-IV-TR – Diagnostic and Statistical Manual for Mental Disorders, 4th edition, text revision
EBP – Evidence-Based Practice
FtF – Feel the Fear and Do It Anyway [self-help book by Susan Jeffers]
GIR – Get Into Reading
GP – General Practitioner (family doctor)
HADS – Hospital Anxiety And Depression Scale
IAPT – Increasing Access to Psychological Therapies
ICD-10 – International Classification of Disease and Related Health Problems, 10th revision

LHIRI – Liverpool Health Inequalities Research Institute
LIS – Library and Information Science
MeSH – Medical Subject Heading
MRC – Merseyside Reading Communities
NHS – National Health Service
NICE – National Institute of Health and Clinical Excellence
NSFMH – National Service Framework for Mental Health
OCD – Obsessive-Compulsive Disorder
OPP – Obligatory Passage Point
OSSA – Overcoming Shyness and Social Anxiety [self-help book by Gillian Butler]
OT – Occupational Therapist
PALS - Practice Activity and Leisure Scheme
PCT – Primary Care Trust
PLR – Public Lending Right
PTSD – Post-traumatic Stress Disorder
RAYS – Reading and You Service
RCTs – Randomised Controlled Trials
SSRIs – Selective Serotonin Reuptake Inhibitors
TAU – Treatment As Usual
TRO – The Reader Organisation
WAG – Welsh Assembly Government

Chapter One: An Introduction to Bibliotherapy for Mental Health Problems

1.1 Introduction

This thesis investigates the emergence of current models of bibliotherapy in the UK and presents a qualitative analysis of the use of reading as a therapeutic technique to help people with mental health problems. Bibliotherapy is the use of written materials (fiction, non-fiction, or poetry – typically in book form) as psycho-social support or psycho-educational treatment. Further definitions will be discussed in section 2.2.1. Bibliotherapy schemes have been offered in UK public libraries since 2001 and are typically run in partnership with health care providers. Surveys reveal that librarians play a significant role in managing these schemes (Hicks *et al*, 2010). The aim of the schemes is to provide access to selected materials, which will have a positive impact on mental health conditions.

In the UK, the costs of mental health problems are among the highest in health care, estimated at £105 billion per year (DH, 2011). The social costs of poor mental health are also high (Shaw and Taplin, 2007). Government health policy emphasises the importance of information provision and a life course approach to tackle mental health problems (DH, 2009b; DH, 2011). Non-medical interventions including psychotherapy are increasingly popular (Priest *et al*, 1996). However, there are currently shortfalls in the availability of these non-medical interventions (Clark *et al*, 2009). While some progress has been made in improving access to psychological therapies, futher investment and staff training is still required (Clark *et al*, 2009). Bibliotherapy can contribute to improving the outcomes of mental health treatment in line with these policies. It is also highly cost-effective, as discussed in section 2.2.5 (Bower *et al*, 2001). There is thus significant interest from the health sector in the effectiveness and application of bibliotherapy.

As explored in section 2.2.1, different models of bibliotherapy exist. There are currently three main models of bibliotherapy used in the UK, applied throughout the country with some variations. One model, Books on Prescription (BoP), provides a list of recommended cognitive behavioural therapy (CBT)-based self-help books to access and use as psychological treatment. CBT practitioners view mental health problems as illnesses to be treated. The second model, Get into Reading (GIR), operates groups which read aloud and discuss selected fiction and poetry; the third, the Reading and You Service (RAYS), is similar, but focuses on individual or group

discussion of poetry and fiction and other therapeutic activities, including creative writing. These models have a social understanding of mental health problems, providing psycho-social support.

The emergence of these three schemes was influenced by developments in health policy, though there has been no previous research into the links between policy and practice. The schemes were designed in response to policy decisions. This top-down design of the schemes does not take into account these service user perspectives and so the qualitative analysis in this thesis is particularly important to establish whether bibliotherapy schemes do meet the needs of those with mental health problems. There has also been a lack of independent evaluation of the schemes. In particular, there has been little qualitative research analysing the experience of using bibliotherapy. Thus, there is a need to examine service user perspectives on bibliotherapy schemes. Identification of these gaps in the evidence base builds on Brewster's (2007) work. This thesis will engage with both policy and practice, analysing these identified gaps in the evidence base about the current use of bibliotherapy in UK public libraries.

Bibliotherapy schemes have achieved widespread popularity, with over one hundred local authorities operating a scheme, and this study makes a timely contribution to updating knowledge about current practice (Frude, 2008; Hicks *et al*, 2010). Understanding the motivations for implementing bibliotherapy schemes will identify the strengths and weaknesses of the schemes. Analysis of the qualitative data collected about bibliotherapy schemes will influence future implementation of bibliotherapy schemes and improve the accessibility and usefulness of bibliotherapy schemes. The thesis also contributes to debates about the relationship between health policy and the appropriateness of treatments. While bibliotherapy schemes have met with some success and popularity, the thesis proposes four outcome-based models of using bibliotherapy to replace current definitions, and their impact need to be considered in service design and delivery.

1.2 Research questions, aims and objectives
Following on from the identification of the need for the research, the aim of the study was defined – to investigate experiences of reading for mental health and well-being (in formal bibliotherapy schemes and as independent therapeutic reading) and to compare experiences to current models of bibliotherapy. As the majority of bibliotherapy schemes in the UK operate in the public library, an analysis

of the role of the public library will be inherent throughout the thesis. To achieve this aim, appropriate methods were identified – outlined in chapter three – and five objectives were established. These were:

1. To critically review existing literature on bibliotherapy.
2. To investigate current practices of bibliotherapy in the public library in the UK, focusing on three main models.
3. To explore the experience of reading and public library use for people with mental health problems, through observations and interviews.
4. To understand factors that affect engagement with bibliotherapy schemes through observation of bibliotherapy groups and interviews with group members and facilitators.
5. To relate the findings of the observation and interview studies to current practices of bibliotherapy and existing literature on bibliotherapy.

Building on these aims and objectives, three research questions were proposed:

- How do people with mental health problems use reading as therapy, both in formal bibliotherapy schemes and independent of these schemes?
- How did the three main models of bibliotherapy in the UK emerge?
- What is the relationship between bibliotherapy schemes and the use of reading as therapy by people with mental health problems?

These research questions shaped analysis throughout the study, and will be revisited in chapter seven, which concludes the thesis and addresses implications for theory, practice, and future research.

Having introduced the topic of bibliotherapy, the problems with current research and gaps in the evidence base, and the importance of conducting this research on bibliotherapy in relation to policy and practice, the chapter will now turn to the specific rationale for this study.

1.3 Research rationale

To clarify, the gaps in the evidence base presented above – which will be explored in further detail in chapter two – can be summarised as:

- a lack of independent evaluation or in-depth investigation of the rationale behind recent bibliotherapy schemes in the UK;
- an absence of qualitative studies engaging with experiences of using bibliotherapy.

Influenced by ethnographic research, as discussed in chapter three, section 1.3 explores my background, allowing the reader to situate the aims and objectives of the research project in their context. As Denzin (2001: 32) states, 'interpretive research begins and ends with the biography and the self of the researcher.' A reflexive, self-aware approach to data collection and analysis – again, explored in chapter three – is beneficial to a qualitative, ethnographic study, as it contextualises analysis and 'introduces accountability' (Gobo, 2008: 299). Broom *et al* (2009) emphasise that the individual biography of the researcher is important to the data collection.

Aside from the gaps in the literature identified above, I have identified three main stimuli for this study. Firstly, I became aware of bibliotherapy schemes serendipitously, while looking for a Masters dissertation topic investigating the potential social benefits of public libraries. I encountered Clarke and Bostle's (1988) *Reading Therapy*, which piqued my interest in the topic. Secondly, my professional experience outside of the sphere of Library and Information Science (LIS) work has involved work on mental health, encompassing employment with a disability consultancy company; a counselling service; and voluntary work for a telephone listening service similar to the Samaritans. Finally, on a more personal level, I have experienced a number of depressive episodes throughout my life, and been treated with both medication and talking therapies. My own experience, recognising the contribution of reading to my own well-being, influenced my decision to investigate interaction between people with mental health problems and reading.

As Lucock *et al* (2007a: 796, italics in original) highlight, 'the terms *service user* and *researcher* are not… mutually exclusive.' I acknowledge that my personal experiences may influence analysis; nevertheless, as Rose (2008) discusses, prior experience can be beneficial as having a personal investment in the research can be seen as ultimately inevitable. Thus acknowledging the 'standpoint' of the researcher is to be encouraged and not avoided, and is key to Interpretive Interactionism, as discussed in section 3.2.3 (Denzin, 2001). The research project is thus located as a study emerging from gaps located in current research, designed in accordance with the principles of an interpretive, ethnographic standpoint, and grounded in personal and professional experience.

1.4 Thesis structure

To achieve these aims and objectives, the thesis presents a two-part study; firstly, the emergence of the three main models of bibliotherapy is explored. An ethnographic study discussing the experiences of the use of bibliotherapy is then presented. The thesis takes a reflexive approach to conceptualise bibliotherapy and therapeutic reading, gathering locally situated and diverse understandings of the term. As the analysis contrasts current service provision with individual experiences, the ethnographic approach of Interpretive Interactionism was identified as a suitable framework to facilitate this comparison (Denzin, 2001). A mixture of methods was used to gather data about the three main models of bibliotherapy, including analysis of documents, five interviews, and descriptive statistical analysis of an existing data set. Interpretive Interactionism does not present an approach to investigating the emergence of services so a supplementary approach – Actor-Network Theory (ANT) – was adopted to analyse this data (Callon, 1986; Latour, 2005). Twenty-seven interviews with people with mental health problems and sixteen observations of bibliotherapy groups were used to gather data about the experience of using bibliotherapy as a form of support for mental health problems. Denzin's (2001) six stage process (outlined in chapter three) was used to analyse this data, which was then contrasted with the ANT analysis of the public presentation of the schemes.

Chapter four addresses the development of three UK bibliotherapy schemes, outlining the reasons for their emergence, including the fulfilment of policy objectives. Chapter four also explores the relationship between Evidence-Based Practice (EBP) and the wider implications for health policy. The relationship between bibliotherapy schemes and health policy means that some models are not flexible or able to be responsive to the needs of service users. The sector – education, health, or libraries – from which the bibliotherapy scheme emerged played an important role in determining the texts used in the intervention.

As chapter five shows, there are four ways in which participants used reading to help them manage their mental health. In contrast to service provider perspectives, these uses were outcome focused. Outcomes included emotional engagement, distraction and escapism, information, and social support, and participants often used more than one method to help them cope. Understandings of those using bibliotherapy and those providing bibliotherapy services differed, with service providers more focused on the type of text used, and service users concerned about the outcome of

the intervention. Factors affecting engagement with bibliotherapy schemes are also established in chapter five, focusing on the contextual relationship between reading and mental health problems. Bringing together the findings in chapters six and seven, a number of implications are discussed. Of primary importance is the finding that current models of bibliotherapy do not meet all the needs of people with mental health problems. There is thus a gap between service provision and service user experiences.

Thinking about the structure of the thesis in terms of the objectives presented in section 1.2, objective one will be fulfilled by chapter two, which contains a two-part literature review. The first part outlines the emergence of bibliotherapy and evidence for its effectiveness, and the second contextualises bibliotherapy in terms of current constructions of mental health. This will be followed by chapter three, containing a discussion of the research frameworks, methods, research design and pilot study. In line with objective two, current practice will be reviewed in chapter four, presenting an ANT analysis of models of bibliotherapy and tracing the emergence of the three approaches to bibliotherapy summarised in section 1.1. Chapter five will present the findings from the interview and observation studies detailed in objectives three and four, and finally chapters six and seven will discuss and relate the findings of the study to current practices and literature, as detailed in the final objective.

Summary

The chapter has introduced several important concepts for the thesis, outlining bibliotherapy and presenting the research questions, aims and rationale. Lucock *et al* (2007b: 636) comment that looking at the service user experience 'brings a perspective to research that could not otherwise be achieved.' Exploring the service user perspective of people using bibliotherapy schemes focused the aims and objectives of my research. When considering the use of bibliotherapy, it is essential to relate these service user experiences to another previously under-explored area – the relationship between bibliotherapy schemes and health policy. A dual research design, using ethnographic methodological approaches to analyse participants' viewpoints and ANT to analyse the emergence of policy and procedures, was adopted with Interpretive Interactionism used to discuss the relationship between public policy and private experience.

Chapter Two: Literature Review

2.1 Introduction

Chapter two reviews the interdisciplinary literature surrounding bibliotherapy, and is split into two parts, following this introduction which also contains a brief discussion of terminology. The search strategy for this literature review is contained in appendix one. The first section examines the emergence of bibliotherapy, tracing its history from its coinage in 1916 to current research. The effectiveness of bibliotherapy is also addressed, firstly in terms of the clinical effectiveness of self-help bibliotherapy interventions, then focusing on creative bibliotherapy in terms of reader response and literary theory. The role of public libraries in supporting bibliotherapy is considered, incorporating issues of social inclusion and partnership working, before the current NHS policy context is presented. The second part contextualises bibliotherapy in a wider body of literature about the construction of mental health problems. The effects of symptoms, culture, and gender are examined, and issues including the medicalisation of society and stigmatization are raised, reflecting the research objective investigating socio-cultural factors affecting experiences of bibliotherapy.

2.1.1 Experiencing bibliotherapy: a note on terminology

Initial constructions of the research design intended to undertake data collection solely with people with depression, as will be discussed in section 3.3.2. However, contact with bibliotherapy groups and individuals who volunteered to participate in the project established that those finding benefit in bibliotherapy had a diverse range of diagnoses, including anxiety, obsessive-compulsive disorder (OCD), bipolar disorder and schizophrenia. While – as will be explored in greater depth in 2.2.3 – self-help bibliotherapy is recommended for anxiety and depression, there has been little research conducted on the use of bibliotherapy by people with other mental health conditions. Thus, there was novel value in exploring the available experiences of people with varied diagnoses, rather than limiting the sample using this criterion. The change in scope, coupled with a recognition that to give someone a diagnosis is to medicalise their condition, meant that the concept of 'mental health problems' was adopted as an umbrella term.

 The study is an interdisciplinary one, drawing on discourses from librarianship, medicine, health and social care, psychology and sociology; and there are a number of different terms traditionally used in different disciplines to describe participants.

For example, people can be conceptualised as patients, mental health consumers, customers, patrons, or clients. Each term is specific to a discourse and reflects a socio-politically charged perception. The three main current models of bibliotherapy use different terms – BoP service providers call service users patients; RAYS uses the term clients; and those facilitating GIR refer to beneficiaries. Typically, the library discourse defines people as service users, and investigates how the user fits in to the life of the library. In my research, the aim is to see how public library services fit in to the life of the service user, but it was felt that the term itself was still of use.

Drawing on R. D. Laing's critical conceptualisation of psychiatry, it is recognised that any terms may be inadequate to define and diagnose mental health problems but a term must still be used to ensure communication is possible (Brown and Harris, 1978: 19). My previous professional experience established that 'service user' is a term often preferred by people with disabilities, including mental health problems, as it is associated with choice and respect and is used within the social model of disability (Abberley, 1987). For clarity, then, it was seen as appropriate to refer to people who use bibliotherapy schemes and other mental health services as service users.[1]

The use of the definition adopted by some service users themselves acknowledges that despite the value-laden nature of all terminology, a term must still be found to use. However, as Trivedi and Wykes (2002: 468) discuss, such terms cannot be neutral and 'generally reflect a particular context or political perspective.' During data collection for the research project, I found that some participants rejected the term 'service user' and discussed possible alternatives with them. These preferred terms also contained political or socio-cultural connotations which sometimes did not fit with the ethos of the study. For example, referring to all participants as 'psychiatric system survivors' – one participant's preferred term – would raise questions, as it contains an implicit criticism of mental health services. This note on terminology illustrates the problematic nature of language and how it can never be considered to be a transparent, neutral phenomenon that simply reflects society; yet, language is all that is available to describe society, and thus must be used (Aitchison, 1981).

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[1] While service user has been adopted as the main term of reference throughout the thesis, chapter four – which focuses solely on BoP – refers to patients to avoid confusion in discussion of current health agendas e.g. patient choice.

Having established these parameters for the thesis, this chapter now presents part one of the literature review, looking at the history of bibliotherapy and current assessments of its effectiveness.

2.2 Bibliotherapy – emergence and effectiveness

Research on bibliotherapy has examined its use for various conditions and client groups. A sizable body of research has investigated its use for children (Allen Heath *et al*, 2005; Doll and Doll, 1997; Raingruber, 2004; Rapee *et al*, 2006); and for issues such as occupational stress (Kilfedder *et al*, 2009); career guidance (Amundson, 2006); parental competence (Hahlweg *et al*, 2008); and alcoholism (Apodaca and Miller, 2003). The purpose of this section is to focus on the use of bibliotherapy for adults with mental health problems like depression and anxiety, first considering the historical context of bibliotherapy.

2.2.1 A brief history of bibliotherapy

One of the main misconceptions about bibliotherapy is that it is a new phenomenon (Morrison, 2008; Tivnan and Curzon, 2008). While the delivery of formal schemes in public libraries has developed over the past decade, bibliotherapy has a much longer history. As a term 'bibliotherapy' was coined by the American Samuel McCord Crothers (1916), though usage of the word has undergone some refinement since its original definition.

Some scholars and practitioners refer to the custom of using a phrase over the door of ancient libraries, usually translated as 'medicine for the soul,' as bibliotherapy (McDaniel, 1956). Englishman Samuel Tuke and Americans Benjamin Rush and John Minson Galt are also credited with early bibliotherapeutic work, advocating reading in the asylum in the nineteenth century (Weimerskirch, 1965). Whether these practices are regarded as bibliotherapy in anything more than its loosest definition is open to debate. Most aspects of bibliotherapy are still under discussion – over the past century, there has been little agreement as to what constitutes bibliotherapy and how best to deliver it. Throughout the late twentieth century, there was still ambiguity; for example, about the role of the librarian and the physician in the treatment regime (Jack and Ronan, 2008). There was no clarity as to who had responsibility for choosing therapeutic texts, and who was actually the 'bibliotherapist'. This dispute has not yet been resolved, and the role of the librarian in health care information and advice still causes concern (Harris *et al*, 2010).

World War One and its aftermath shaped bibliotherapy as a discipline, with McDaniel (1956: 586) observing that bibliotherapy is 'a hospital library baby of World War I'. Conditions like shell shock increased demand for psychological treatment in the hospital (Bourke, 2000). Throughout the 1920s and 1930s, hospital libraries were appreciated for providing books to distract and inspire (Ireland, 1934; Peterson-Delaney, 1938). While such work cannot be seen as bibliotherapy per se, enthusiastic librarians including Sadie Peterson-Delaney increased the profile of the subject (Peterson-Delaney, 1938).

Bibliotherapy developed further with the publication of the first academic thesis on the subject (Shrodes, 1949). Shrodes (1949: 138-9) theorised that literature had four conceptual effects on the reader; identification, projection, catharsis (or abreaction) and insight. Her work was influential in explaining the psychological impact of literature, and while her theoretical approach was predominantly Freudian, her work contributes to modern models of bibliotherapy. Interest in bibliotherapy grew throughout the 1960s and 1970s, mainly in North America, and while bibliotherapy was originally utilised with hospitalised adults, there was a shift toward using books with children. Interest peaked with a special issue of the journal Library Trends (Tews, 1962) and again with the publication of Rubin's (1978a; 1978b) texts on the subject.

Rubin (1978b: 4-5) defined three different types of bibliotherapy, reflecting mental health care before the advent of community care initiatives. These were:

- Institutional bibliotherapy – using books with individuals in the mental institution, with the aim of information, recreation, and re-socialisation.
- Clinical bibliotherapy – using imaginative literature in groups, either in the institution or the community, to encourage insight and behavioural change.
- Developmental bibliotherapy – using imaginative and didactic literature with people who do not have any form of mental health problem, to maintain mental health.

Since the 1970s, there has been a move towards the deinstitutionalisation of mental health care, and community care has become the norm. The approaches defined by Rubin (1978b) no longer have practical significance. However, they illustrate the changing nature of definitions of bibliotherapy in line with changing attitudes and approaches to mental health treatment.

It is argued here, as elsewhere – for example, Cohen (1994) – that no clear, agreed definition of bibliotherapy emerges from the literature or practice. The Medical Subject Heading (MeSH) for bibliotherapy defines the term as 'a form of supportive psychotherapy in which the patient is given carefully selected material to read' (National Library of Medicine, 2009). The MeSH term provides a concise yet limited definition, but does not engage with the recent UK practices of bibliotherapy discussed in this thesis. Therefore, definitions used in this thesis will be based on previous research conducted with public librarians in the UK (Brewster, 2007). These concepts represent a synthesis of models from recent literature; reflect current practice in the UK; and were reinforced by the pilot study for the thesis (see section 3.4). These definitions will be used to structure discussion of bibliotherapy throughout the thesis.

- Creative bibliotherapy – the use of fiction and poetry in a formal scheme, aiming to work with individuals and groups to promote better mental health. Current practice focuses on the group experience more than the individual, mainly to ensure effective use of time and resources. Creative bibliotherapy groups can be modelled on a traditional reading group paradigm, a reading-aloud model, or a mixture of the two, sometimes specifically focused on poetry. Some creative bibliotherapy schemes focus on a specific booklist, while others emphasise the diversity of reading tastes. Social interaction and group dynamics are also important considerations.

- Informal bibliotherapy – the everyday use of reader development, promotions, and librarians' experience to connect public library users with books that may improve well-being. Again, there is a social dimension to informal work, as library staff form working relationships with library users, often basing their recommendations on personal knowledge of materials previously enjoyed. Public library staff felt that their everyday work was bibliotherapy in practice, especially in geographical areas with no formal creative bibliotherapy scheme.

- Self-help bibliotherapy – the use of non-fiction self-help books, often recommended by medical practitioners, to provide practical help. Self-help bibliotherapy usually operates in a formal scheme, and BoP booklists are used to suggest suitable materials. Books are usually based on a CBT approach and differentiated from widely available, low-quality self-help resources. The person

'prescribed' a book is expected to work through a text without further support from medical practitioners (All definitions expanded from Brewster, 2007).

Several concerns should be raised regarding the literature on bibliotherapy, including quality, age, and practical applicability. Previous research can be easily separated into anecdotal evidence, and quantitative Randomised Controlled Trials (RCTs) measuring improvements in mental health using psychological tests. The RCT approach investigates the contribution of reading a specific text to statistically significant clinical improvements in defined mental health problems; RCTs do not discuss the experience of reading the texts. By contrast, the anecdotal pieces are written by therapists, sharing their personal experiences of working with clients in therapy. They concentrate on the improvements to life conditions, and do not provide any systematic evidence of benefit. Problems with the quality of the research literature have been cited as explanation of why bibliotherapy has not found widespread acceptance in modern UK health care (Dysart-Gale, 2008). Recent studies have aimed to rectify this, but can be variously criticised for a lack of methodological rigour, doubts about impartiality, small sample sizes and little critical analysis (Grundy, 2005; McKenna, 2010; Hicks *et al*, 2010; Billington *et al*, 2010). The majority of these studies predominantly looked at service provider perspectives and were focused on questions of service delivery and evaluation, rather than gathering an in-depth perspective on experiences.

Other concerns include the North American bias of much research. Geography has led to a great necessity for self-help materials in the USA and Canada, as the continent's vast rural areas are long distances from treatment centres. While location can also be an issue in the UK, such as rural Scotland, these geographical factors have an impact on the practical application of research. Another relevant North American phenomenon is the contrast between the UK's socialised medicine and the USA's health insurance system. In a system of health costs, self-help is a cheaper option that may be preferred by service users. Much research into bibliotherapy was written in the 1970s and 1980s and requires some interpretation to be applicable to a modern world in which community care is the norm (Prior and Carman, 2008). Following on from this introduction to the concept, the next sections will discuss considerations of the effectiveness of bibliotherapy in relation to recent health initiatives.

2.2.2 Effectiveness of bibliotherapy: interacting with psychotherapeutic resources

Research highlights that people with mental health problems may prefer self-help strategies such as bibliotherapy to more traditionally allocated care. For example, Clarke *et al* (2006) examined barriers to traditional care that can be removed by self-help, observing that people can feel stigmatized by seeking treatment from health providers. Cuijpers (1997: 141) concluded that the use of books might be a less stigmatizing method of accessing therapy. Non-pharmaceutical treatments may also be preferred (Priest *et al*, 1996). The National Institute for Health and Clinical Excellence (NICE) observes that GPs and patients prefer psychological interventions such as talking therapies to medication for depression (NICE, 2004c). However, these interventions often have limited availability and long waiting times (Clarke *et al*, 2006).

Delivering self-help solutions can increase the accessibility of treatment; Mataix-Cols and Marks (2006: 78) state that 'self-help approaches have the potential to help many more patients who would otherwise remain inadequately treated or untreated.' Frude (2004a) adds a number of advantages of self-help over medication, including patient acceptability and the immediate effects of self-help treatment. A preference for independent self-improvement – the 'do-it-yourself' option – has also been established (Clarke *et al*, 2006: 289). Mains and Scogin (2003) conclude that the large number and varied subject matter of self-help books is indicative of high consumer demand for – and thus potential acceptability of – self-help. However, they urge the application of empirical evidence and clinical judgement when considering whether or not to recommend these titles to service users.

Further advantages to using bibliotherapy to deliver psychotherapeutic treatment have been observed in clinical trials:
- Clients can work at their own pace
- Minimal supervision is needed
- No geographical barriers to treatment
- Cost-effectiveness
- As with psychotherapy (and as opposed to medication), bibliotherapy provides coping skills and lifestyle strategies
- Potentially less time-consuming and intrusive than face-to-face therapy
- Promotion of self-support and empowerment
- Increased choice of treatment

- Focus on management of long-term conditions

(Reeves and Stace, 2005; Richards, 2004; Scogin *et al*, 2003)

Richards (2004) identifies several advantages for service providers, including cost-effectiveness and the associated benefits of early intervention. The effectiveness of bibliotherapy has been established in accordance with the criteria ascribed by proponents of EBP (NICE, 2004d). Meta-analyses, critically appraising the clinical effectiveness of bibliotherapy for depression and anxiety, reach broadly positive conclusions. Marrs' (1995) meta-analysis of bibliotherapy use for selected conditions found that there was a significant effect size. Similarly, Gregory *et al*'s (2004) meta-analysis looking at cognitive bibliotherapy for depression found favourable outcomes for bibliotherapy. Den Boer *et al* (2004) reviewed self-help in terms of group support and bibliotherapy, finding that the evidence base was sporadic for both, but that the effectiveness of bibliotherapy was equal to brief psychological intervention. An RCT by Salkovskis *et al* (2006) examined the provision of treatment as usual (TAU) for depression in primary care in comparison with TAU and self-help. The study found no significant differences in terms of clinical improvement between the two arms of the study; though patient satisfaction increased for those who were allocated to self-help as well as TAU. Gellatly *et al's* (2007) meta-analysis concluded that the use of self-help interventions, typically in the form of bibliotherapy, was significantly effective when the self-help was guided by a therapist. The study also found that CBT techniques were of greater benefit and effectiveness than other forms of self-help intervention (Gellatly *et al*, 2007). Cuijpers *et al*'s (2011) most recent meta-analysis found a 'small but significant' effect size for self-guided self-help, administered without contact with a therapist, but the majority of studies included were conducted with online materials.

Recent research has considered methods of delivery for CBT resources. McKenna *et al* (2010) commented on the delivery of computerised CBT (cCBT) for mental health problems, listing several advantages to using book-based therapy, including the need for access to IT equipment and IT skills for cCBT; the portable nature of books, which increased accessibility; the low cost of books; and the convenience of the provision of bibliotherapy materials in the public library. Williams and Chellingsworth (2010) found similar advantages of books over cCBT, countering these with the caveat that low levels of literacy can be a problem with books that may be overcome using simple cCBT interventions. Williams and Martinez (2008) expressed surprise that there are more 'credible high-quality outcome studies' that support bibliotherapy than cCBT.

Developments in online resource provision mean that trials of cCBT resources have only become widespread in recent years, contributing to this lack of evidence. Nevertheless, patient preference for books over cCBT has been widely discussed (Clark *et al*, 2009; Williams and Chellingsworth, 2010). Similarly, patient preferences for bibliotherapy have been favourably compared to face-to-face therapy (Floyd *et al*, 2004; Wollersheim and Wilson, 1991).

Bibliotherapy can be used throughout a treatment programme. As White (1995: 90) states, 'if waiting lists cannot be eliminated, approaches which offer some help to patients while they sit on a list would be of value.' Looking at bibliotherapy as a precursor to treatment provides an example of its use in a practical, NHS context. Bibliotherapy can be used autonomously; as an adjunct to therapy or medication; or as a form of continuing support following psychotherapeutic treatment (Kenwright, 2010). Bibliotherapy may be useful for particular groups. Studies have focused on self-help bibliotherapy for older adults, recognising that life changes in older age can contribute to symptoms of depression, while older adults are less likely to use mental health care facilities (Choi and Morrow-Howell, 2007). Floyd *et al* (2003; 2004; 2006) found that the use of bibliotherapy for older adults provides evidence of a continued improvement of measurable outcomes after two years.

The self-help bibliotherapy model is thus established as effective. Questions regarding the specific resources to be used in this model have not, however, been addressed. While there have been some published studies testing commercially available products – for example, David Burn's *Feeling Good* and Bouman and Visser's *Dokter, het is toch niets ernstigs? [Doctor, I hope it's nothing serious?]* – trials of widely-available products are not commonplace (Ackerson *et al*, 1998; Buwalda and Bouman, 2009). Instead, researchers undertake trials of materials that they themselves have written. Scogin *et al* (2003) urge caution in the use of self-help books that have not been subject to empirical trials.

Richardson *et al* (2008:544) state that 'results from trials of one self-help product can only be generalised if all self-help manuals and materials are regarded as a single class of product.' However, all self-help books are not of the same quality or usefulness. Thus, 'the results of trials generated by one book… cannot be generalised to others' (Richardson *et al*, 2008: 551). This is known as the 'class argument' and stems from NICE's judgement that establishing the effectiveness of one cCBT resource was not the same as establishing the effectiveness of all cCBT

resources (Richardson *et al*, 2008). As RCTs usually trial materials that are not commercially available, the majority of the books on BoP booklists have not been trialled in RCTs (Floyd, 2003; Scott Richards *et al*, 2006; Dysart-Gale, 2008). Therefore, the 'class argument' applies to discussions of BoP titles, as it is inappropriate to assume that one self-help book is of equal value to another (Richardson *et al*, 2008:551). This undermines arguments applied to the implementation of some current bibliotherapy schemes, as will be discussed in chapter four.

Richardson *et al* (2010) investigated the potential impact of the therapeutic relationship on the use of a non-guided self-help model. The therapeutic relationship is an integral part of face-to-face psychotherapy, and includes establishing, developing, and maintaining a therapeutic alliance. While Richardson *et al* (2010) found that there was evidence of the establishment of a therapeutic alliance between the self-help book and the reader, they found that the book did not provide adequate feedback or flexibility, particularly problematic if difficulties with the therapy occurred. These findings are supported by Redding *et al*'s (2008) work, which judged a sample of popular self-help books on similar criteria. However the quality of face-to-face therapy can be affected by the quality of the training received by the therapist (McKendree Smith *et al,* 2003). Bibliotherapy can be more closely standardised, so a well-designed self-help book might present more effective, equivalent treatment than some therapists (McKendree Smith *et al,* 2003).

Having established the effectiveness of self-help bibliotherapy according to EBP criteria, it is necessary to make some critiques of the EBP approach. As Mol (2002: 237) states 'a treatment is always done under specific – these, not those – conditions.' RCTs are designed with highly defined parameters which limits the focus of investigations. In practice, mental health treatment is applied on an individual, case-by-case basis. Without definition of these variables, as Middleton and Shaw (2007: 297) highlight, RCTs are meaningless. Comparison between the number of RCTs conducted and the number selected to contribute to meta-analyses and systematic reviews provides evidence of low research quality. For example, Cuijpers (1997) uses just six studies, while Bower (2001) identifies eight that meet inclusion criteria, and Cuijpers *et al* (2011) include seven studies. Fanner and Urquhart (2008) and Chamberlain, Heaps *et al* (2008) conducted systematic reviews from an LIS perspective. Fanner and Urquhart (2008) reviewed trials of bibliotherapy for different conditions, including depression, substance abuse, and sexual dysfunction,

incorporating papers published to 2005. They found 130 articles were relevant and of appropriate quality for inclusion. Chamberlain, Heaps *et al* (2008) concentrated on depression and anxiety and identified 57 relevant papers published before 2006. Strict inclusion criteria are common for systematic reviews and meta-analyses, yet the limited number of studies meeting these standards may be indicative of a wider quality issue in bibliotherapy research.

Questions about RCT quality often concern their statistical analytical power, sometimes affected by small sample sizes or the attrition rate. Small sample sizes mean that statistically significant conclusions cannot be drawn about the effectiveness of interventions according to EBP criteria. For example White's (1995) trial of the Stresspac intervention – a self-help anxiety management package – while well-designed (and with a low attrition rate), was conducted with only sixty-two participants and can be considered underpowered. Several trials of bibliotherapy have high attrition rates – usually of the control group, but sometimes of treatment groups (Bilich *et al*, 2008; Buwalda and Bouman, 2009). In Reeves and Stace's (2005) study, over half of participants did not complete the course of therapy. The high attrition of participants means that statistically significant conclusions cannot be reached. High attrition rates may also be a comment on the effectiveness of bibliotherapy as an intervention; it may be undermined by poor participant motivation. As chapter five shows, symptoms of mental health problems impact on engagement with bibliotherapy texts.

Trials of self-help bibliotherapy resources are also affected by the prevalence of comorbidity in mental health (Bentall, 2009; Holdsworth *et al*, 1994). High-quality self-help resources typically address specific conditions, yet in psychopathology comorbidity is common, e.g. people have symptoms of depression and anxiety (Redding, 2008). Seekles *et al* (2010) trialled guided self-help with 53% of their sample having a comorbid condition. However, their study was underpowered because of issues with recruitment and no significant results can be drawn about the impact of guided self-help on comorbid conditions (Seekles *et al*, 2010). Strengthening the evidence base requires RCTs addressing the suitability of self-help materials for comorbid conditions; but RCTS often exclude 'those with inconvenient comorbidities who would spoil the trial design' (Wilson, 2005: 93). The impact of comorbidity in relation to BoP was discussed in Grundy's (2005) research finding that doctors and service users found a disparity between prescribed titles and comorbid conditions when prescribing texts.

Severity of mental health problems is also not addressed in trials for bibliotherapy. For example, people who express suicidal ideation are excluded from RCTs, as are people whose scores on clinically defined measurement scales are too high or not high enough. In practice, self-help bibliotherapy is not used within these parameters (Bowman *et al*, 1995). Strict exclusion criteria mean that there have been no RCTs examining the use of bibliotherapy for more enduring, severe mental health conditions such as schizophrenia or bipolar disorder. A recent study by Lucock *et al* (2008) examining bibliotherapy for anxiety did not exclude participants based on severity or comorbidity, though it did provide a telephone support service throughout the trial to deal with potential issues as they arose. The study did not find any statistically significant differences in outcome for the intervention and control groups (Lucock *et al*, 2008). While there are ethical implications of trialling mental health treatments, the need for risk management can mean that artificial conditions are created in RCTs. Mental health can deteriorate rapidly; and the implication is that there is a responsibility to monitor treatment in RCTs such as the telephone support offered by Lucock *et al* (2008). In practice, this may not be possible or feasible.

A recent meta-analysis concluded that the effectiveness of psychological treatment was not affected by the severity of depression; indeed it was found that psychological treatment was more effective for people with more severe depression (Driessen *et al,* 2010). The analysis included bibliotherapy within its definition of psychological treatment, though it did not quantify the effect size of adopting bibliotherapy as a method of delivering psychological treatment.

Common estimates observe that 90% of all those with mental health problems receive treatment in primary care (NICE, 2011). However, the majority of bibliotherapy research is conducted in a secondary care setting, reducing its impact for primary care professionals (Fitzgerald *et al*, 2003; White, 1995). Relating this to issues of availability of materials, Holdsworth *et al* (1996: 196) found that there is little attempt to make the self-help materials assessed in these secondary care trials available to general practitioners (GPs). White (1995), for example, found that the Stresspac intervention had statistically significant positive effects on those who undertook the intervention, yet Stresspac is not widely available and has not been

commercially published.[2] Naylor *et al*'s (2010) study attempted to rectify these issues of setting and availability, locating a trial in primary care and using a commercially available text. It found that book prescription was at least as effective as TAU. However, this RCT had some limitations, particularly in relation to current practice in the UK: the sample size was small (with thirty-eight participants randomised to two groups); weekly contact was increased throughout treatment, meaning that the conditions of primary care were not reproduced precisely; the relationship between the authors of the paper and the author of the text trialled in this RCT is not clarified, leading to questions of potential bias; and the location of the research in the USA means that the findings have not been related to bibliotherapy schemes in the UK.

As discussed, the locus of treatment in bibliotherapy is not clear, as is demonstrated by questions of whether self-help needs to be guided (conducted with professional support) or unguided (Apodaca and Miller, 2003; Bilich *et al*, 2008). The locus of treatment appears to depend on the client group in the trial. For example, a trial using bibliotherapy for alcoholism found that a telephone advice line was not used by participants; whereas a trial for panic attacks found that those with more contact improved more than those with less (Apodaca and Miller, 2003; Febbraro, 2005; Febbraro *et al*, 1999). Nevertheless, a recent trial examining bibliotherapy for panic disorder refutes Febbraro *et al*'s (1999) conclusions about the necessity of supportive guidance, suggesting that other aspects – such as establishing a deadline for completing the treatment – impact on the effectiveness of treatment (Nordin *et al*, 2010). The effective components of treatment are therefore not clearly established. One reason for this lack of clarity is that there is little information on patient interaction with the self-help materials (Bower *et al*, 2001: 844). Studies typically report symptom reduction, and discussion of the self-help materials is reduced to information about the number of pages and reading age of the text. The lack of detail is problematic; no analysis is made in terms of linguistic style, therapeutic approach, or the balance of instruction and reflection that facilitates effective treatment. Thus, common factors for the effectiveness of bibliotherapy are still debated (Richardson *et al*, 2010).

Bibliotherapy is more successful when conducted with volunteers who are motivated to use the intervention (Cuijpers, 1997; Fanner and Urquhart, 2008). Differences in the effectiveness of treatment when conducted with volunteers or a general clinical

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[2] White's recent work as team leader for the Glasgow Steps self-help programme is, however, freely available online: http://glasgowsteps.com/home.php, showing that the impact of open access online resources may help to solve this issue.

population have been found (Fanner and Urquhart, 2008; Favazza, 1966). Compliance has implications for bibliotherapy, and conclusions of various trials emphasise that treatment needs to be acceptable to patients (Bergsma, 2008; Favazza, 1966; Mead *et al*, 2005). Symptoms of mental health problems including reduced concentration and decreased activity impact on treatment success. Studies reinforce the role of motivation, finding that contact with mental health professionals can encourage patients to read, meaning that patients are more likely to finish their treatment (Febbraro *et al*, 1999; Kupshik and Fisher, 1999; Naylor *et al*, 2007). Current BoP models are unguided and contact with service users is not explicit within the process of self-help bibliotherapy. Some GPs may arrange a monitoring programme with their patient though there are currently no guidelines suggesting that monitoring may be appropriate.

Returning to issues of participant motivation, while it seems obvious that bibliotherapy will only help people to tackle their problems if they actually read the books recommended to them, it is still a point worth noting. Many studies do not specify whether the research design asked participants what proportion of the book they read (Bowman *et al*, 1995). However, compliance questionnaires testing knowledge have been used in some studies (Febbraro *et al*, 1999; Naylor *et al*, 2007; Scogin *et al*, 1998). Green and Malouff's (2007) investigation into reading self-help books to treat psychological problems found that there was a correlation between a close reading of the text and an improvement in the experience of symptoms.

Having established the effectiveness of a self-help bibliotherapy intervention, reported in Mead *et al* (2005), Macdonald *et al*'s (2007) research focused on the acceptability of this treatment. It concluded that the insights sought by patients were different to those provided by the self-help intervention, which concentrated on symptom reduction (Macdonald *et al*, 2007). The implications of this study are important for my research, as it found that there are 'conflicting definitions of a "successful outcome" between patients and practitioners' (Macdonald *et al*, 2007: 33). Thus, the aims of those designing bibliotherapy interventions may be different from the aims of those using them, as will be explored in chapter six.

Recent research has moved away from the artificial formulation of bibliotherapy in the RCT, instead looking at bibliotherapy in practice. It is important to emphasise that such a shift could not have occurred without previous RCTs establishing appropriate

constructions of effectiveness. Building on Gellatly *et al*'s (2007) review of delivering self-help CBT for depression, Williams and Martinez (2008) conclude that book-based guided self-help is an appropriate method of delivering CBT. Most CBT-based BoP schemes in the UK do not operate a guided self-help model, instead using an unguided intervention. In Devon, a guided self-help BoP scheme was developed, using graduate mental health workers to administer Self-Help Clinics (Farrand, 2005). However, a cohort study investigating the effectiveness of these clinics encountered problems, including a high drop-out rate (Farrand *et al*, 2008). Literacy, symptomology, cognitive skills, and motivation can be identified as potential barriers to accessing such schemes (Robertson *et al*, 2008: 225). Porter *et al*'s (2008) examination of BoP in Wales (to be examined in more detail in chapter four) focused on the equity of implementing bibliotherapy schemes, observing that the use of self-help books was often affected by socio-economic background and the perceptions of the prescriber, leading to a high level of variation in the application of the scheme on a national basis.

Service user experiences of use of a BoP scheme in Ireland included unfamiliarity with the concept of book prescription; ease of access to relevant and useful materials; satisfaction with the low cost; flexibility of use; frustration with the unavailability of face-to-face resources; and feelings of stigmatization when collecting the book from the library (McKenna *et al*, 2010). Interaction between the service user and the medical professional, and the interaction with the library staff, needed to be positive to facilitate use of the scheme. Service users in McKenna *et al*'s (2010) research felt that having to take the paper prescription into the library to access the book was a stigmatizing and potentially negative factor. Research into a BoP scheme in Scotland reached different conclusions, as the paper prescription was viewed positively by professionals (Robertson *et al*, 2008). Medical staff felt that they were able to give patients something to take away (as in a traditional consultation), and thought that the paper prescription would increase confidence when going to the library (Robertson *et al,* 2008). The example of paper prescriptions demonstrates that service users and service providers may have different views on the same aspects of a bibliotherapy scheme. Again, this finding has direct implications for my study, as it emphasises that service providers' views do not reflect service users,' and there may be gaps in understanding.

To summarise, there are a number of advantages to using book-based self-help therapies, including the removal of barriers to treatment; destigmatization; increased

treatment choice and availability; and patient acceptability when compared with psychotherapy, medication, and cCBT. However, section 2.2.2 has identified a number of factors problematising previous research: namely the quality of studies, sample size and attrition rates; concerns about severity and comorbidity; and compliance with treatment programmes. Recent studies examining bibliotherapy in current practice have started to address some of these issues and formulate a more patient-centred approach to research into bibliotherapy that may have implications for current models. As an earlier article concluded, 'the real question is not whether bibliotherapy is effective… but rather how and when it should be used as part of a treatment programme' (Riordan and Wilson, 1989: 507). Having considered self help, this chapter now examines bibliotherapy with imaginative literature.

2.2.3 Effectiveness of bibliotherapy: interacting with literature

At the time of writing, no RCTs have been conducted examining the use of creative bibliotherapy. Dysart-Gale (2008) comments that the concentration on anecdote and unsubstantiated case study in creative bibliotherapy research has negated its importance to the medical community. While she criticises the positivistic slant to RCTs, she sees methodological flaws in qualitative research as an important barrier to acceptance of creative bibliotherapy as treatment (Dysart-Gale, 2008). A lack of scientific rigour has been applied to the currently published evidence. Many studies provide compelling yet anecdotal evidence for the benefits of bibliotherapy (Allen Heath *et al*, 2005; Heller, 1987; Ilhanus, 2005). However, for EBP, anecdotal evidence is not enough to recommend creative bibliotherapy as a practice. Individual patient case studies further problematise creative bibliotherapy research; as Davidson (2005: 32) comments, the psychotherapist is often portrayed as 'the hero of case studies… who guides the patient towards recovery by providing therapeutic interventions.' Despite these criticisms, there are some academic studies on creative bibliotherapy; and research on related subjects such as reader response theory. Literary studies investigating the potential emotional impact of literature are important. Oatley (1995; 2011), Miall (1995) and Cupchik (1995) are amongst scholars who consider the emotional responses to literature, with Oatley (1995) commenting that basic emotions are key to many literary genres.

Cohen (1992b) took a phenomenological approach to her examination of individual therapeutic reading, investigating the experiences of eight participants in America. Her work does not focus on depression or other mental health problems, instead examining therapeutic reading in the context of difficult life situations. While several

participants in her research specified that they had found benefit in reading following a bereavement or depressive episode, others referred to more general information seeking, on topics such as parenting and health. Cohen (1992b: 31) acknowledged that the limitations of her study included the diversity of participants. A requirement of her sample was that participants had 'sufficient skill with language to describe complex feelings and ideas' leading to a sample of participants who were well-educated and read avidly (Cohen, 1994b: 44). In her earlier work, Cohen (1989) theorised that bibliotherapy might be applied using the principles of group therapy, and though she was not able to explore these ideas in practice, her ideas link with current models. Cohen (1992b) concluded that there were several outcomes of therapeutic reading including self-recognition; validation; comfort; hope; inspiration; catharsis; understanding and information gathering. She discussed characteristics of reading, including purposive information seeking, re-reading, immersion, and escape (Cohen, 1992b). Similar findings were replicated in Usherwood and Toyne's (2002) study of the value of imaginative literature. Escapism; relaxation; reading for instruction and to learn about the world; self or personal development; and insight were all cited by participants as motivations for reading (Usherwood and Toyne, 2002).

Readers in Cohen (1992b), Sheldrick Ross (1998; 1999) and Toyne and Usherwood's (2001) projects reported finding new knowledge about the world via reading, which encouraged them to change their perspectives. Conversely, readers also found confirmation of thoughts and beliefs, reassurance, comfort and acceptance of their views in literature (Cohen, 1992b; Toyne and Usherwood, 2001). Readers felt a connection between their experiences, and those of characters in the book, creating a sense of connection which validated their emotions (Toyne and Usherwood, 2001). Jones' (2010) work, taking a psychological approach to self-construction through narratives in literature, concludes that the value of a work lies in its verisimilitude, representing emotions and feelings, not its believability as a story that is true to life. Thus, 'reading imaginative literature is regarded as a special activity which serves to satisfy a wide variety of needs' (Usherwood and Toyne, 2002: 40). Ideas of reading serving a need summarise the perceived effects of creative bibliotherapy. Participants in Toyne and Usherwood's (2001) study felt that reading improved their mental and physical well-being by enabling them to relax. One participant even stated that she found reading 'better than anti-depressants', emphasising the effect that literature can have on welfare (Toyne and Usherwood, 2001:30). Enabling people to find pleasure in literature can be considered an

outcome – as well as a process – of recovery. The symptoms of depression often include a reduced capacity for enjoyment and interest.

Many pejorative judgements have been made about reading and literature; the concept of escapism, with its connections to fantasy and avoiding responsibility, has particularly been seen in a negative light (Nell, 1988). Nell (1988) connects escapism to other qualities ascribed to literature, including absorption or entrancement in a story – the idea of being 'wrapped up' in what you are reading – which are viewed more positively. Usherwood and Toyne (2002: 34) move forward from the negative connotations of escapism, emphasising that it is 'more than merely a denial or retreat.' They view reading as emancipation, making a contribution to knowledge and coping techniques. Rosenblatt (1970) also regards identification and escape as two key features of the reading experience.

Nell (1988) observed the reading speed and comprehension of thirty-three volunteers using a number of literary extracts. The aim was to examine the experience of reading for pleasure. Nell (1988) concluded that the pace of reading was vital to the reading experience, with the reader choosing to read extracts that they enjoyed at a slower speed than ones that they did not. Nell (1988: 114) differentiates between the construction of 'a good book' and a reader's construction of 'a good read.' Similarly, Gold's work (1990: 6) found that readers often do not talk about the reading they enjoy, because it is in conflict with notions of classical or great literature. Both authors engage with a construction of trash fiction, as opposed to the reading of the literary canon,[3] finding that readers find emotional support and personal identification in many kinds of literature.

Gold's (1990) work engages with psychotherapeutic notions, such as catharsis, to explain emotional engagement with literature. Catharsis, an Aristotelian concept, contains notions of emotional expression, suspense, and thrill seeking, which combine to produce an emotional reaction in the audience of a text (Scheff, 1979). Oatley (1995) regards catharsis as a form of clarification of emotions. Scheff (1979: 13) discusses catharsis in terms of resolving earlier painful experiences, finding that the vicarious experience (e.g. reading) may not be as overwhelming. Reading literature or watching a play can bring a distance to remembered experience that will

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[3] While notions of the literary canon are open to debate, the term will be used here to refer to texts by authors such as Charles Dickens and William Shakespeare. There is no definitive list of works that belong to the literary canon, but for this thesis Bloom's (1994) treatise on the literary canon will be used to shape thought on the subject.

then enable the audience to process their feelings. Cupchik *et al*'s (1998) work on the stories of James Joyce found that reading could either generate fresh emotions (such as anger on behalf of a character) or enable readers to revisit emotional memories (seeing their emotions reflected in those of the characters) connecting emotional memories to catharsis.

Returning to Nell's (1988: 245) observational study of reading for pleasure, two types of experienced emotions are contrasted; strong emotions with a cathartic purpose and unmanageable ones which readers may choose to avoid. To clarify, he differentiates between 'the catharsis of a good cry' and being 'scared to death', determining that only the former may be positive emotional engagement (Nell, 1988: 244-5). Building on this, Nell (1988: 254) distinguishes between two types of readers; type A, who read 'voraciously and anxiously to hold consciousness at bay' and type B, who read to 'heighten consciousness.' While it can be argued that these types of readers are not as clear-cut as Nell (1988) describes, the idea of two types of reading behaviour is a key concept for my study. Nell (1988) regards his types of readers to be reflective of personality, whereas reading types are seen in this research as reacting or responding to a situation rather than as reflecting fundamental traits.

Significant work has been conducted on reader response theory, with implications for therapeutic interaction with literature. Several key concepts are identified, including the positioning of the reader as the creator of meaning in the text, rather than the author (Rosenblatt, 1970).[4] Rosenblatt (1970: 196) emphasises that the reader is not a 'blank photographic plate' on which the author can impose their own images. Reading is seen as a process of exploration; literature increases comprehension and understanding (Rosenblatt, 1970). The perspective of the reader is paramount, as they interpret texts in the context of their personal experience. From Rosenblatt's perspective, interaction with the text is always a 'transaction' in which the reader approaches the text from their own personal standpoint (Rosenblatt, 1970: 35). Reading is seen as an active – not passive – phenomenon, and literature is the 'process, not [the] product' (Atkinson and Coffey, 1997: 60; Leitch, 1995: 36). The exchange between the text and the reader relies on the biography of the reader as much as the content of the text (Atkinson and Coffey, 1997). For these reasons, Rosenblatt (1970: 35) also comments that reading the same text at different times in

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[4] Rosenblatt's study was originally published in 1938 in the USA, but was not published in the UK until 1968. The edition used here is the 1970 UK reprint.

life may encourage a re-interpretation of the content. Nevertheless, there is some commonality in responses to literature, explained in part by Fish's (1976) notion of the 'interpretive community' in which a basic customary response to a work of literature is adopted by the reader; the creative aim of the writer is also included within an interpretive community. Criticisms of Fish's (1976) interpretive communities include lack of attention to wider socio-cultural factors and the loss of self and identity in the constructed community (Leitch, 1995). Situating the reader and their response to a text in their socio-cultural environment and personal history was seen as key throughout later critical engagement with reader response theory (Iser, 1995; Leitch, 1995). Miall and Kuiken's (2002) research with thirty readers responding to the same short story found both the individuality and 'orderliness-within-diversity' in responses, suggesting some commonality of interpretation. Oatley's (1999) discussion of dialogue and reading communities encompasses the idea that reading and interpreting a text – particularly in a group situation – was 'the full act,' with the writing of a narrative as just 'half an act.' He argues that interpretation is creative, with the text as a 'shared cultural object' (Oatley, 1999: 452). Concepts of shared reading are important for this thesis, and will form the focus of analysis in section 5.3.3.

Evaluation of creative bibliotherapy schemes – to be explored in more detail in chapter four – has focused on observations in the group environment (Billington *et al*, 2010; Hodge *et al*, 2007). Hodge *et al*'s (2007) exploratory study focused on the 'non-specified' benefits of reading literature in a social setting, commenting that the interaction between literature and group members mirrored the theoretical interpretation presented by Oatley (1999). Hodge *et al*'s (2007) work concluded that further research was required to ascertain the effect of interacting with literature; a later study aimed to provide more detailed qualitative and quantitative evidence, though this was statistically inconclusive and regarded by the authors as preliminary work for further research (Billington *et al*, 2010). The findings of this study built on the work of theorists like Fish (1976), applying ideas of interpretative communities to conclude that the mix of literature, group facilitator and group environment were essential to a successful therapeutic interaction, which focused on the 'telling [of] a new story about oneself' (Billington *et al*, 2010: 6-8; 18). Criticisms of Hodge *et al*'s (2007) work, like those of Billington *et al*'s (2010), include the lack of critical distance from the groups studied and will be discussed in further detail in section 4.4.

Gold (1990: 346-354) summarises ten characteristics as the outcomes of using literature in psychotherapy:

- Language growth, or increasing understanding by improving the vocabulary.
- Life information – learning and information-gathering via the reading of fiction.
- Identification, which can be split into two areas: the cathartic response to recognising negative emotions, also experienced as abreaction (recognising the need to avoid some emotions/ distance from these emotions) and positive identification in which readers share a character's success.
- Modelling – participating (if indirectly) in characters' lives to test different behaviour, which can help readers to break negative patterns of behaviour.
- Cognitive shift – reframing ideas and understanding different perspectives.
- Problem solving, which can result from cognitive shift and modelling.
- Immunisation – the safe experience of negative emotions that can then be used to cope with these emotions in life.
- Feelings, or the articulation of positive and negative emotions. Gold (1990) suggests that avoidance of negative emotions is not possible and instead readers use literature to learn to survive these emotions. This view differs from Nell's (1988) construction of escapism and literature.
- Normalisation – similar to identification, normalisation enables readers to recognise their emotions and feel that characters undergo similar experiences to themselves.
- Sharing – reading not only connects our experiences to those of characters in a text, but to other people who have undergone similar experiences, thus increasing empathy and understanding.

Gold (1990; 2002) considers the emotional (or affective) and cognitive engagement with a text, viewing the process of reading as one that can facilitate transference of emotions and transformation of thought and behaviour. The effectiveness of the reading experience (and thus of bibliotherapy) is its ability to 'call forth feeling along with thought in the reader' (Gold, 1990:19). Earlier work conducted in the field of librarianship reached similar conclusions, suggesting that for these reasons the librarian should ensure they understood the reading process (McClellan, 1977).

Information seeking in works of fiction has been explored by Sheldrick Ross (1999). Notions of information encountering emphasise the potential positive experience in finding information in unexpected places, such as literature (Erdelez, 1999). Sheldrick Ross (1998: 343) states that one of the reported outcomes of avid reading is serendipitously finding information that can be used to improve a life situation. Her

qualitative research project, with 194 adults who regularly read books, examined their use of reading in a number of contexts (Sheldrick Ross, 1998). These conclusions are supported by Toyne and Usherwood's (2001) work, which found that fiction books could be used for problem solving and information gathering.

In summary, research from LIS, literary theory and psychology locates the impact and effectiveness of creative bibliotherapy in the interaction between the text and the reader, placing emphasis on the role of the reader in meaning creation and problem-solving. While research on the topic does not meet EBP standards, several qualitative studies have been conducted and there is cross-disciplinary replication of results. The literature review will now move away from questions of effectiveness, turning to considerations of bibliotherapy in contemporary UK society, firstly in terms of public library involvement, then in relation to current health care initiatives.

2.2.4 The role of public libraries in supporting bibliotherapy

Bibliotherapy was originally delivered within a hospital environment, mirroring mental health treatment at the time (Peterson-Delaney, 1938). As community care has become the norm, and treatment for mild to moderate depression has become widespread within the UK, the delivery of bibliotherapy services has also altered (Frude, 2004b). As will be discussed in detail in chapter four, current models of bibliotherapy are delivered in public library or community settings. Recent studies have taken steps to examine bibliotherapy in practice, though there has been limited consideration of the impact of location on service delivery (Grundy, 2005; McKenna *et al*, 2010; Robertson *et al*, 2008). The exception here is Billington *et al*'s (2010) work, which concluded that the environment of a bibliotherapy group was one of the four key factors to its success, albeit the least important of these factors. While there is evidence that health care and psychological services can be off-putting to people who have previously had bad experiences with these services, there has been no research into whether the library is an appropriate alternate location in which to base services (Adame and Knudson, 2007). Section 2.2.4 will thus synthesise the potential benefits and drawbacks of locating bibliotherapy services in public libraries.

There is an estimated disparity between the number of people with mental health problems and the number who access treatment. Singleton *et al* (2000) estimate that only 75% of people with depression attend their GP's' surgery for their condition. Of these patients, only half are diagnosed as having depression (Kisely and Goldberg 1996). The consequences of these difficulties mean that only around 37.5% of those

experiencing depression begin treatment for their condition (NICE, 2004c: 9). One solution to enable people with depression to access treatment could be locating access outside of a health care environment. Re-location would also enable people who did not regard their problems as medical to access support (Priest *et al*, 1996). The nationwide provision of public libraries in the UK provides a network of accessible, community-based locations in which to provide treatment. Anton (2010), reporting on the location of Macmillan cancer care services in UK public libraries, identified two key benefits to establishing information and support services in public libraries – normalisation of the condition via a community setting, and matching the information to the local community via the library's outreach expertise. These benefits may also apply when locating mental health services in the public library.

Public libraries aim to increase social inclusion, and to work with excluded groups (Social Exclusion Task Force, 2006). People with mental health problems are recognised as an excluded group, so locating bibliotherapy services in the public library contributes to these aims (Huxley and Thornicroft, 2003). The perceived neutrality of the library increases its potential to be inclusive (Hicks *et al*, 2010). Inclusivity was discussed by librarians in Brewster's (2007) research; other factors indicating that libraries may be socially inclusive settings for bibliotherapy schemes are their physical location in the community, accessible to all; the knowledgeable, well-trained staff who are used to dealing with sensitive queries; the anonymity of borrowing; and the lack of cost to access the service. Middleton (2005: 13) states that self-help bibliotherapy schemes 'allow patients and doctors greater choice in terms of treatment interventions. [They are]… an example of social inclusion in action.'

Bibliotherapy schemes provide an opportunity for libraries to formulate partnerships with external agencies. Previous research revealed that libraries had tried to go into partnership with their local Primary Care Trust (PCT), but that partnerships had not always been successful (Brewster, 2007). Librarians felt that there were advantages to working in partnership (Brewster, 2007). Benefits included the kudos of medical authority, and the confidence staff felt they could have in recommending self-help books endorsed by professionals. There were some issues in sourcing materials, reflecting the health service professionals' unfamiliarity with supply and stock management, and with engaging reluctant health professionals in the partnership (Brewster, 2007).

Black's (2011) work and Rooney-Browne and McMenemy's (2010) analysis of the public library as an impartial space address some reasons that the public library may be seen as a suitable space for locating bibliotherapy schemes. Black's (2011) conclusion that the public library can be seen as a place of 'reflection, self-realisation, and sanctuary' emphasises that the space is both safe and social. The intrinsic qualities of the public library as a service are widely recognised, yet difficult to define (Elkin *et al*, 2003). As MP Lynda Waltho (2007) commented in a debate about the closure of libraries, the library is more than the sum of its parts. While these inherent factors are seen as an intangible and indefinable benefit of library use, such inexpressible qualities may be intimidating to people who do not regularly use the library (Toyne and Usherwood, 2001).

Radford (2001) discusses the notion that institutional practices in the library may act as a barrier to service access. Drawing on Foucauldian concepts of power, he states that the librarian can be seen as a 'formidable gatekeeper' (2001: 299). His study of the portrayal of the librarian and the library in literature reflects the perceived power relationship between the library-as-institution and the library user. The rules of the library contribute to a fear on the part of the library user that they may not understand the rituals of the institution. This evocation of the discursive construction of fear suggests that the library might not be the most appropriate site for bibliotherapy. Contextualising the library in a discourse of fear creates a cultural code of expectations that need to be overcome before non-users of the library will be at ease within the institution (Radford, 2001).

Chamberlain *et al*'s (2008) work addresses these abstract concepts in a more concrete manner, examining the issue of fines, charges and user registration in a survey of 20 BoP service providers in the UK. Research into lapsed library users confirmed that some had decided not to return to the library after issues with library staff or library fines (Garland and Willett, 2009). Clayton and Chapman's (2009) exploration of fines and other charges concluded that concessions were not made on grounds of low income, reaching similar conclusions; namely that fines may have discouraged some users from accessing the library. Other practical considerations are also important; unfamiliarity with the routines of the library can have a negative impact on interaction. For example, Grundy (2005) cites an example of a non-user of the public library system accessing services via a BoP scheme, who tried to collect their book prescription during hours when the library was closed. Some library services now accept a GP's prescription for a BoP book as proof of identity in order

to join the library, as well as removing the need to pay fines on books in the scheme (Hicks *et al*, 2010). These changes, along with free reservations, aim to encourage people to use the library for bibliotherapy. However, social inclusion is not simply about removing barriers to service access; it is also about providing a welcoming and open service, as discussed in Matarasso (1998b) and Durrani's (2001) work. Training on mental health issues may help to create a more open and accessible service (Smeaton and Leonard, 2009).

Access to the recommended books is an area of debate within the provision of BoP services, with some public libraries choosing to prioritise the needs of those prescribed the books, and so holding their BoP books as a separate collection, only accessible with a doctor's prescription; and other library services recognising that some people may feel uncomfortable accessing the books via prescription; or may not even have consulted medical professionals about their difficulties and so instead hold the books on the library shelves, open to all. The open access approach also recognises the benefits that the prescribed books could bring to others in the community who do not necessarily choose to access health care services for mental health issues. These self-prescribing patrons are an important, if unexpected, outcome of the implementation of self-help bibliotherapy schemes in libraries (Brewster, 2007). In some areas, there has been less of an inclination for the health and library sectors to go into partnership, and so the model is by necessity a self-prescribing one. The public acclaim for BoP schemes has encouraged various library services to recognise the contribution that the BoP collection can make to their issue figures; the demand for these titles within the community; and the perceived benefits of accessing these texts. Thus, they are choosing to add the BoP titles to their holdings without a partnership with the medical profession, and so titles are only accessed by self-prescribing patrons.

Two major surveys of bibliotherapy and health and well-being activities in public libraries in England have been conducted (Hicks, 2006; Hicks *et al*, 2010). Fanner and Urquhart (2008) also addressed the use of bibliotherapy in the library in their systematic review. Hick's (2006) mapping exercise of the provision of bibliotherapy schemes concluded that there were already around 80 BoP schemes operating in England, with a small amount of creative bibliotherapy activity conducted on the basis of local initiatives (Hicks, 2006: 2-6). Frude's (2008) estimate updates this to around 100 currently in operation. In 2006, most schemes were in their infancy, and little evaluation had been conducted. This survey concluded that the majority of

people using bibliotherapy schemes were female, white and middle aged (Hicks, 2006: 26-7). Hicks *et al*'s (2010) work focused on interviews with ten 'key opinion leaders'; a survey of current provision; and three case studies. The report found diverse provision of health and well-being services, including self-help and creative bibliotherapy, leading to concerns about a 'postcode lottery' of access to services (Hicks *et al*, 2010: 55). Resourcing issues; staff enthusiasm; unavailability of funding; differing stakeholder priorities; and unsuccessful partnership working were all seen as contributing factors to this diversity (Hicks *et al*, 2010). Hicks *et al*'s (2010) recommendation of a national offer of health and well-being services can be seen as a positive development towards ensuring minimum service delivery (Hicks *et al*, 2010).

A broad range of health and well-being activity is conducted in English public libraries (Hicks *et al*, 2010). Examples include the extensive spread of BoP projects, often with some alteration to the booklist (Frude, 2008; Tameside Metropolitan Borough Council and NHS Tameside and Glossop, 2011). The creative bibliotherapy model designed by TRO, branded in Merseyside as GIR, is also used in other areas of the UK, including groups running in Sandwell and London (Neale and Musgrave, 2011; TRO, 2011). Some library authorities, such as Stockport, use both a creative and self-help approach to providing services (Nother, 2011). Other library public library authorities have also explored the idea of connecting creative reading and health, with pilot well-being projects in Derbyshire, Northamptonshire, and Nottinghamshire (Hodgkins, 2009).

In summary, the public library has a role in supporting the provision of bibliotherapy. Accessible, neutral community locations separated from health care services can provide a cost-free gateway to materials. Partnerships with health care services can provide training for public librarians and increase treatment choice for patients who do choose to access mental health treatment via primary care services. There are a number of potential barriers to services for those who are not comfortable with the institutional atmosphere of the public library and its routines, but as public libraries aim to be socially inclusive, steps are being taken to remove these barriers and facilitate access to services. Partnership working with the NHS may be an antecedent to social inclusion and the impact of NHS policies on the provision of bibliotherapy services is the focus of the following section.

2.2.5 Bibliotherapy and NHS policy

Section 2.2.5 locates current models of bibliotherapy in the context of NHS policy. Various relevant documents impacting on the provision of bibliotherapy were published between 1999 and 2011 by the Department of Health (DH), NHS and NICE, forming the basis of health and mental health care policy. Creative bibliotherapy schemes began in the UK in 2000, with self-help schemes following in 2003. These schemes were preceded by the *National Service Framework for Mental Health* (NSFMH) (DH, 1999), a ten-year plan addressing mental health care in the UK. Recently published policy takes a well-being-centred construction of mental health treatment in which creative bibliotherapy has an obvious role; and there is also a focus on self-care that includes self-help bibliotherapy, thus confirming that bibliotherapy is still relevant (DH, 2009b; DH, 2011).

Following the publication of the NSFMH, the focus on health shifted to place an emphasis on the provision of information; patient choice and expertise; and service user involvement in health care (DH, 2001; DH, 2004; DH, 2006). Reports on self-help and equity and quality of care were also influential in guiding policy (Darzi, 2008; Lewis *et al*, 2005). Underlying these new agendas were themes of partnership or multi-agency working, and providing value for money. Public health promotion conceptualised personal responsibility as a form of preventative medicine to encourage healthier behaviour (DH, 2001). Policy direction throughout this era created the space for bibliotherapy schemes in libraries to emerge as successful networks, contributing to a number of governmental agendas. Robertson *et al*'s (2008: 227) work discussed the impact that wider health policy initiatives, such as a target to prevent an increase in antidepressant prescription, can have on the provision of schemes like BoP.

The NSFMH (DH, 1999: 14) estimated that mental health problems cost £32 billion in England each year. Costs include lost employment, health care and the 'human costs of reduced quality of life (and loss of life) among those experiencing a mental health problem' (DH, 2009b). Recent estimates place the total at £105 billion (DH, 2011). An acknowledgement of the wider social costs of poor mental health has meant that there has been a move towards initiatives like bibliotherapy that promote good mental health in a community setting. NICE (2004c) guidelines also emphasise the financial pressures of mental health problems. Their costing exercise states that the introduction of interventions such as watchful waiting, exercise and guided self-help for mild depression would cost the NHS in England £7 million but would save £5

million in medication costs (NICE, 2004c). As previously established, psychosocial interventions like talking therapies are more popular with patients than medication, and so there are benefits other than cost when considering the introduction of alternative interventions to medication (Priest *et al*, 1996). Using self-help techniques like bibliotherapy can reduce the amount of medication and psychotherapy required, and so it is seen as a cost-effective option (Bower *et al*, 2001).

NICE (2004a; 2004b; 2004c; 2004d; 2011) produces guidance for conditions like depression, anxiety, eating disorders and post-traumatic stress disorder (PTSD), influencing NHS policy, and contributing to a cost-benefit analysis. Section 2.2.2 summarised the evidence base on self-help bibliotherapy; this evidence forms the basis of guidance on applying bibliotherapy via a Stepped Care model. Stepped Care models are based on three assumptions – equivalence, efficiency and acceptability (Bower and Gilbody, 2005: 13).These assumptions state that minimal, often non-medical, interventions like bibliotherapy will be at least as effective as other psychotherapeutic interventions for some patients; that Stepped Care is an efficient way to utilise available resources; and that minimal interventions are more acceptable to medical staff and patients (Bower and Gilbody, 2005: 13). The aim of Stepped Care is to 'deriv[e] the greatest benefit from available therapeutic resources' thus creating non-intrusive, cost-effective care (Bower and Gilbody, 2005: 11).

Since 2007, the NHS has funded the Improving Access to Psychological Therapies (IAPT) programme, which focuses on increasing the number of psychiatric staff employed in the NHS (Hewitt, 2007). This demonstrates a shift in health care to acknowledge the value of psychological therapies, and contributes to NHS agendas enabling patients to choose treatment (DH, 2007). Prior to the commencement of the IAPT programme, there was a recognised shortfall in the availability of psychological treatment (Hewitt, 2007). The model adopted for the IAPT programme uses a short course, CBT-based therapy to enable more people to access a brief form of psychological therapy, as part of a Stepped Care approach. The programme is based on NICE clinical guidelines, and is in part funded by the perceived cost savings in other areas of mental health treatment costs including medication (NICE, 2004c; NICE, 2004d). Access to self-help resources is often part of IAPT initiatives (Clark *et al*, 2009). Recent reports on NHS restructuring have maintained similar priorities and made a commitment to the IAPT programme, with patient choice, personalised care, EBP, and cost-effective high-quality care considered important. Thus, the provision of self-help bibliotherapy services is still considered appropriate

care (DH, 2010a; 2010b; 2011). Recent NICE (2011) guidelines focus on the identification and treatment of common mental health disorders, and recommend the use of individual guided or non-guided self-help for depression, anxiety, and panic.

In summary, examining NHS priorities for mental health treatment contributes to an overall picture of the emergence of bibliotherapy. The relationship between current models of bibliotherapy and NHS policy will be further analysed in chapter four. Key themes explored here include the provision of cost-effective psychosocial treatment for mental health problems in line with the principles of minimal intervention and Stepped Care; patient choice; and a focus on information.

2.3 Contextualising bibliotherapy – constructing mental health

Section 2.3 of the literature review provides a context for the emergence of bibliotherapy. It examines how wider socio-cultural factors including constructions of mental health; gender; culture; the medicalisation of society; and stigma interact with the experience of mental health problems. Symptoms of mental health problems will also be discussed, contextualising the experiences of participants in the research presented in chapter five.

2.3.1 Constructing mental health problems

Busfield's (2000) review summarises many important arguments about the construction of mental health. She posits the appropriateness of the holistic approach to mental health problems, emphasising that genetic, environmental, and social processes all construct mental health. Her work cites a number of examples demonstrating that considerations of pathological behaviour, diagnoses and treatment all change over time. Busfield's work is supported by wider concerns about psychiatric diagnoses, with questions about the assumption that they can be applied across time and cultures (Pilgrim and Bentall, 1999: 268). Personal accounts of emotion are 'translated' in a diagnosis, leading to questions about the nature of shared understanding (Pilgrim and Bentall, 1999: 269). Concerns have developed regarding a lack of clear differentiation between unhappiness and diagnosable mental health problems (Horwitz and Wakefield, 2007). Champion (2000) remarks on the poorly-defined nature of this continuum, in which the differences between 'distress' and 'disorder' are not clearly defined. It is not clear if symptoms such as 'low spirits' or 'difficulty getting to sleep' should be considered pathological (Horwitz, 2007). Ideas presented by Busfield (2000), Pilgrim and Bentall (1999) and Horwitz and Wakefield (2007) will be taken as the starting point for this section.

Several explanations of the causes of mental health problems are commonly defined. The main views are referred to as the biomedical, social, psychological, and holistic models (Kangas, 2001). The holistic model is also referred to as the biopsychosocial model as it includes elements from the biomedical, social, and psychological models (Pilgrim, 2002). These models are positioned as externally imposed perspectives which are different to the perceptions that people with a diagnosis of depression or similar have about their own conditions (Lucock *et al*, 2007a; Rose *et al*, 2008). NICE (2011) guidance states that health professionals should use the 'different explanatory models of common mental health disorders' to ensure that mental health problems are successfully identified and treated, emphasising the importance of understanding these different models.

The biomedical perspective sees mental health problems as disease, caused by neurochemical imbalances. Neurotransmitters including serotonin, dopamine, and norepinephrine are cited as causes of mental health problems (NHS Choices, 2010a). From a biomedical perspective, mental health problems require treatment, usually in the form of pharmaceutical intervention. Commonly, Selective Serotonin Reuptake Inhibitors (SSRIs) are used as a first-stage treatment, to increase the amount of serotonin in the brain and counteract the symptoms of mental health problems (NHS Choices, 2010a). While other perspectives on mental health acknowledge the definable neurochemical differences between those with mental health problems and those without, they posit that a serotonin imbalance could be a symptom, not a cause of these problems (Greenberg, 2010; Healy, 1997). Thus, SSRIs can help to correct a lack of serotonin, but do not tackle the underlying emotional or social causes of the episode of poor mental health. It has been suggested that the causes of mental health problems are genetic, though this is disputed within the scientific community (Caspi *et al*, 2003; Risch *et al*, 2009). Recent research has revealed some replication of findings into the impact of a specific chromosome (different to that investigated in previous research) on the probability of a predisposition to depression, though the authors of these studies urge caution in the application of these findings (Breen *et al*, 2011; Pergadia *et al*, 2011).

Social perspectives assert that mental health problems are a response to poor social conditions and inequality (Champion and Power, 2000). An antithesis to biomedical theories, social perspectives dispute conceptualisations of mental health problems

as disease and see them as legitimate responses to life events. Brown and Harris's (1978) study of women with psychiatric disorders established the social perspective using terms such as 'provoking agents' and 'vulnerability factors' to contextualise symptoms, rather than using the symptoms as a starting point for analysis. Social perspectives can be highly political, locating problems in the environment rather than the individual, and objecting to conceptions of mental health that medicalise feelings as symptoms (Middleton and Shaw, 2007; Pilgrim and Bentall, 1999). Social theorists see mental health as culturally relative, taken in a context of normative behaviour (Kleinman and Good, 1985; Lutz, 1985). According to social theories, as the causes of mental health problems are located in society, the appropriate treatment is therefore to reform society, improving conditions and reducing inequalities. Shaw and Taplin (2007: 366) feel that the medicalisation of mental health problems 'creates a dichotomy between the individual's experience of distress and the wider social context that underpins it.'

A third perspective contends that mental health problems are a personal state, caused by emotional problems exceeding available coping mechanisms (NHS Choices, 2010b). Psychological models often concur more closely with personal explanations (Champion and Power, 2000). Mental health problems can therefore be improved by psychological therapies, in which the person is taught coping mechanisms. In this construction, poor mental health is caused by a reaction to traumatic events such as bereavement, divorce, or pressures at work. Rather than mental health problems being seen as disease, they are seen as an emotional state.

Finally, the holistic or biopsychosocial model combines biomedical, social, and psychological perspectives, views poor mental health as a combination of factors leading to diagnosis and treatment (Kangas, 2001). A holistic approach is often accepted as an explanation by people who have been diagnosed with mental health problems as it mirrors their personal understanding (Kangas, 2001). Acceptance of a biopsychosocial model can occur even where it causes internal contradictions within the person's illness narrative (Karp, 1994). As is suggested by its overarching construction, treatments including medication, lifestyle changes, psychotherapy, and social support are all considered to be appropriate. Treatment does not simply concentrate on alleviating symptoms but instead on improving overall well-being. Pilgrim (2002) states that the biopsychosocial model is unpopular with clinicians because of the re-legitimisation of biological explanations, which focuses on diagnosis rather than the 'longitudinal context' of symptoms. As Pilgrim and Bentall

(1999: 272) comment, there is also a need for flexibility in choices of therapy, allowing for 'a more holistic understanding [to] attend to the social determinants of misery and… explore the patient's individually attributed meanings.' Personal narratives of depression acknowledge an accumulation of long-term factors, such as a difficult relationship with family members or a genetic predisposition to mental health problems, combined with a specific event, as the causal factors. Explanatory narratives are sense-making exercises, and Bentall (2009) theorises that their purpose is more closely linked to a need for meaningful explanations than they are to factual accuracy. Broom's (2009) analysis complements an understanding of the holistic approach, finding that his interview participants engaged pragmatically with various medical and non-medical discourses. He observes that there is 'a process of bricolage,' constructing explanations as a process of sense-making to understand their own health and well-being (Broom, 2009: 1053).

Kangas (2001) and Karp (1992; 1994; 1996) have examined the meanings that people give to their diagnosis of depression. Kangas (2001) concludes that there are three main stories that people tell about themselves to explain why they suffer from mental health problems. These narrative accounts are based on psychological models, and discuss issues that the person encountered in childhood such as bullying or loneliness; 'burn-out' caused by excessive pressures in the work environment; and problems in adult life with relationships and other misfortunes. Kangas sees these narratives as indicative of the decline of acceptance of purely biomedical constructions. Karp's (1992; 1994) work reinforces a holistic construction of depression. Research also shows that service users recognise that there is a need to accept biomedical constructs and diagnosis regardless of personal explanations in order to access treatment (Beresford *et al*, 2010).

Shaw and Taplin (2007) posit the need for a multi-causal approach to constructing mental health problems, with wider socio-cultural factors influencing treatment success. While symptoms and severity need to be taken into account, they cite factors such as medical professionals being less likely to refer poorer patients to psychotherapy (Shaw and Taplin, 2007). The therapist–patient relationship may be affected by economic disadvantage, with a lack of financial income contributing to a lack of confidence on the part of the patient, leading to them being less likely to attend the full course of therapy (Shaw and Taplin, 2007: 366). These considerations also support Galasinki's (2008) hypothesis that service users need to 'speak the language' of therapy in order to benefit from the system. Neville (2010) and Philip

(2009) address similar concerns, related to self-help books and schemes. Philip (2009) critiques one title common to many BoP lists – David D. Burns's *Feeling Good: The New Mood Therapy* – concluding that its emphasis on personal liberal virtues ignores the socio-political context of conditions like depression. Similarly, Neville's (2010: 224) work refutes the accessibility of self-help book prescription schemes, because of the class inequalities and related low levels of literacy in Ireland: 'well-being becomes a function of being well-read.' Both articles relate these issues of socio-political context to the doctor-patient power dynamic discussed by Galasinki (2008) and throughout health-related research (Broom, 2005; Henwood *et al*, 2003).

Socio-cultural considerations of mental health problems necessitate a brief examination of the history of diagnosis, beginning in 1952 with the first Diagnostic and Statistical Manual for Mental Disorders (DSM). It contained sixty diagnoses, and included homosexuality within its auspices. By the time the second edition, DSM-II, was published in 1968, its list of conditions had more than doubled in length. Criticisms of psychiatry in the 1970s from Scheff (1975), Szasz (1974), and Rosenhan (1973) amongst others led to drastic revisions by the 1980 edition, DSM-III. A vote of the American Psychiatric Association in 1979 redefined homosexuality, excluding it from DSM diagnoses and illustrating that what is considered a mental health problem can be a reflection of societal attitudes (Spector, 1977). The revisions to the DSM-IV in 1994 raised the number of conditions listed to over 300, and it could be argued that again, these revisions are a reflection of societal and medical attitudes, conceptualised in the idea of 'an ill for every pill' (Busfield, 2010). As Karp (2006: 212) states, 'surely a 480% increase in the number of psychiatric abnormalities over fifty years cannot result solely from dispassionate scientific discovery.' Similar arguments recurred with the release of the first draft of the DSM-V (Frances, 2010). Thus, social attitudes impact on diagnosis and treatment.

Building on this critical analysis of the construction of mental health problems, the research in this thesis can be positioned in the biopsychosocial tradition, acknowledging that there are multiple causes for mental health problems. The nature of the research presented here, as will be discussed in chapter three, emphasises that the key aspect of this construction is the personal understanding of the person who is experiencing symptoms of poor mental health. Thus, throughout the data collection process, a holistic view of mental health problems was taken, and the construction of problems offered by the participant was seen as key to

understanding. Section 2.3.2 moves on from these theoretical constructs of mental health, examining the diagnosis and symptomology of mental health problems.

2.3.2 Symptoms of mental health problems

The umbrella term of mental health problems includes numerous conditions, and thus numerous symptoms. There are no definitive tests for mental health problems; diagnosis is in the hands of experts. As discussed in the previous section, diagnoses have changed over time. Different scales are used to measure the symptoms of mental health problems, including the Beck Depression Inventory (BDI) and Hospital Anxiety and Depression Scale (HADS). These scales seek to standardise symptoms to assess treatment needs, and improvement or deterioration in conditions. They are considered a reliable measure of mental health by medical professionals, and used to diagnose and monitor conditions including depression and anxiety. Building on work by Horwitz and Wakefield (2007), Philip (2009: 157) comments that the use of a scale cannot differentiate between 'healthy sadness' and 'clinical depression.' Most scales delineate a 'clinical cut-off point' defining the difference between mental illness and mental health. Scales are used as comparative, longitudinal measures, and the aim of treatment is to reduce the score on the assessment scale. Mol (2002: 218) contextualises measurement as common practice in health care; conditions 'are better or worse: than they were, than their alternatives, than an agreed threshold, than might be expected.'

Mol's (2002) work explores the need to quantify and measure in health care, which – as will be seen in chapter four – is essential to understanding current models of self-help bibliotherapy. Her conclusions can be applied to considerations of the mental health diagnostic interview and use of quantified scales, which are criticised for discounting contextual factors affecting mental health (Pilgrim, 2002). Mol's (2002) comments contrast the requirement to record symptoms with a need to be aware of the context, stating that:

> 'once numbers are scribbled in the patient's file, they come to have an independent existence as 'indicators,' and possible errors of translation are no longer retrievable. Nor is the tone of voice (confident, hesitant, pleading). Thus some complexities are left out; but something is also gained as numbers are easy to handle' (Mol, 2002: 221).

While standardised scales enable doctors to diagnose and treat, they do not take into account life circumstances. Scheurich (2004) comments that 'depth and nuance' are lost in the use of medicalised scales. Galasinki's (2008) work with the BDI emphasises that people often do not find their experiences represented within

treatment scales, but have to engage with them to access treatment. While these standardised psychological screening measures can increase efficiency and help to identify the severity of mental health problems, the use of standardised forms can hide subjective experience.

The International Classification of Disease (ICD-10) and DSM-IV-TR provide a guide to symptoms of mental health conditions (American Psychiatric Association, 2000; World Health Organisation, 2007). Middleton and Shaw (2007: 293) view the DSM-IV-TR and ICD-10 as 'exercises in pattern recognition' and do not consider that they fully represent experiences. However, from my perspective as a librarian and non-specialist in mental health, there is a difficulty in defining experiences without reference to diagnostic guidelines. Many service users shared a commonality of symptoms which affected their experiences of bibliotherapy, as will be explored in chapter five and appendix two.

A symptomology of some commonly accepted symptoms of depression is presented here as an example of the conditions under discussion (American Psychiatric Association, 2000). Depression can be seen as being on a continuum of mental health and well-being, with mild, moderate, and severe episodes. It can be a recurrent condition, and the definition of a depressive episode is to have had three or more symptoms listed below for a period of two or more weeks The more symptoms identified, the more severe the episode is considered to be.

- Low mood
- Reduction of energy and increased tiredness
- Decreased activity
- Reduced capacity for enjoyment and interest
- Reduced concentration

- Disturbed sleep
- Diminished appetite
- Reduced self-esteem and self-confidence
- Difficulty carrying out ordinary activities
- Suicidal thoughts/ act

Many of these symptoms were mentioned by service user participants in the research, as were excessive anxiety and worry, obsessive compulsive behaviours, panic attacks and somatic symptoms, including severe tension headaches and fatigue. As referring to a diagnosis is considered a highly political act by some service users, the terminology of each service user was adopted in the interview scenario, and will be used later in the thesis to describe individual conditions. For example, some service users referred to a 'breakdown' or 'nerves' as their primary

reason for seeking help. Rather than trying to impose a diagnosis on these conditions, individual terminology is adopted and used to help situate experiences. To provide further context, the next two sections will look at the relationships between culture, gender, and mental health, examining the impact of these aspects on individual understanding.

2.3.3 Mental health problems, culture and ethnicity

The cultural specificity or commonality of experience is widely debated (Kleinman and Good, 1997; Lutz, 1985). For example, the higher rate of diagnosis of schizophrenia amongst members of Black and Minority Ethnic (BME) communities in the UK is seen as evidence of differing conceptualisations of mental health, with a 'Westernised' psychiatric framework applied to thoughts and behaviours (Johnstone, 2008). Watters (2010) posits a cultural argument of the 'Americanisation' of mental health, influenced by the use of the DSM on an international scale. He provides several examples of mental health problems which were previously defined as culturally-specific syndromes, but are now interpreted as DSM-defined conditions (Watters, 2010). Watters' (2010) work is influenced by Kleinman and Good's (1997; 1985) anthropological research, which finds that while symptoms of mental health problems are recognisable throughout the world, culture defines whether these symptoms are regarded as pathological. The inadequacy of international standardised systems to represent the totality of different experiences was also found in Mallinson and Popay's (2007) work and Pilgrim and Bentall's (2002; 1999) critiques of the Anglo-American model of psychiatric symptoms and treatment.

Jadhav's (1996) study of emotional vocabulary compared linguistic nuances, hypothesising that they can be lost in translation. He observes that translation can mean that experiences discussed by those with mental health problems can be 'glossed over or pruned to fit into conventional psychiatric nosological systems' (Jadhav, 1996: 270). Mallison and Popay (2007) found that these issues of language meant that there was an underrepresentation of mental health problems in certain ethnic groups. Kokanovic *et al* (2009: 709) reinforce Mallison and Popay's (2007) findings, stating that 'despite claims of depression being a global epidemic... in some cultures there is no emotional description of depression.' They conclude that in some cultures, the symptoms of depression are considered a legitimate response to difficult life events (Kokanovic *et al*, 2009). Some evidence suggests that the same somatic metaphors are applied to cross-cultural experiences of depression, but

reactions to these metaphors diverge widely in accordance with cultural, including ethnic and religious, considerations (Mallinson and Popay, 2007).

The absence of a universal emotional vocabulary with stable meanings has implications for diagnosis and treatment. Firstly, there are difficulties with translating standardised diagnostic forms like the BDI into other languages. Secondly, there are implications for the treatment of mental health problems utilising translated materials. For example, it may not be effective to translate CBT-based books into BME languages as the translation will only represent one (possibly irrelevant) cultural experience. There is a tendency that available literature will reflect Western attitudes, and thus such texts would not be useful. Brewster's (2007) research revealed that there were few translated books on mental health conditions in languages including Arabic and Urdu because of the lack of cultural acknowledgement of such conditions. Thus, Jadhav (1996) concludes that the subjective nature of mental health problems means that there is no universality of mental health diagnosis. Similarly, Kokanovic *et al* (2009) emphasise the importance of being aware that reflexivity and cultural factors and ethnicity shape experience.

2.3.4 Mental health problems and gender

Another socio-cultural factor that impacts on the experience of mental health problems is gender. Women are more likely to be diagnosed with mental health problems than men, with prevalence rates in the UK at 19.7% for women and 12.5% for men (McManus *et al*, 2009). A recent large-scale survey found that diagnoses including anxiety and depression and eating disorders are more common in women, though men are more likely to have panic disorder and OCD (McManus *et al*, 2009). However, these gender imbalances are not reflected in research on mental health problems (Johansson *et al*, 2009). Very few studies refer to gender as a variable that can affect the outcome of treatment.

Johansson *et al*'s (2009) work reveals that there are several different gendered narratives of depression, demonstrating that gender affects the understanding of mental health problems. Women described a gradual insidious onset of depressive symptoms, but men tended to refer to a sudden 'breaking point' (Johansson *et al*, 2009: 636). Men referred more to physical symptoms and viewed their mental health problems as caused by external sources, such as overwork. Women tended to blame themselves for their problems rather than external causes. The gendered lay

discourse was thus in direct opposition to the medical discourse which viewed 'diagnostic criteria as neutral, genderless and concise' (Johansson *et al*, 2009: 641).

This gendered perception of mental health de-legitimises biological models as female behaviour is pathologised, running counter to feminist arguments. Feminist discussions of mental health centre on the diversity of treatment needed, with concerns that women are not pathologised in terms of symptoms and treatment (Lupton, 2003). Middleton and Shaw (2007: 300) comment on the high proportion of female mental health service users, questioning the idea that there are 'inheritable vulnerabilities… [which] are systematically sex linked.' Instead, it is more likely that 'social roles and cultural expectations increase women's vulnerability to a number of emotional disorders' (Karp, 2006: 23). Gendered constructions of mental health problems also need to consider the increased likelihood of women seeking help. Help-seeking behaviour, and the narrative of men being 'struck by the lightning' with conditions like depression, can also be seen to be reflected in the proportionally high male to female suicide rate (Canetto *et al*, 1998). The implication here is that women do not necessarily have a disproportionately higher rate of mental health problems than men, but that the way that the genders react to symptoms is different. Thus, gender impacts on the appropriateness of treatment. While – as sections 2.3.3 and 2.3.4 show – gender and culture influence experiences of mental health at a personal level, wider socio-cultural factors including stigma and the medicalisation of society, also impact on the understandings. These factors will be explored in the following section.

2.3.5 Medicalisation and stigmatization

Two socio-cultural concepts impact on the understanding of mental health problems. Firstly the medicalisation of society, with its implications for the acceptance of biomedical models of mental health problems and the dominance of DSM criteria, in diagnosis is examined. The feminist, Foucauldian and Marxist critiques of medicalisation are explored and mental health problems are specifically related to the Parsonian sick role (Annandale, 1998; Foucault, 1973; Lupton, 2003; Nettleton, 2006; Williams, 2005). The stigmatization of mental health problems and its impact on treatment seeking is then discussed (Scheff, 1975). These concepts have implications for the identity, treatment, and acceptance of diagnosis for the person with mental health problems.

Building on the discussion of the biomedical construction of mental health in section 2.3.1, the model is also relevant to perceptions of the medicalisation of society. Annandale (1998) summarises applicable aspects of the model as its reductivist approach, locating illness in the body rather than an interaction between the person and their environment; a specific aetiology or cause of an illness (rather than a recognition that a number of factors can contribute); and a claim to be rational and neutral, based in science rather than constructed in interactions. The biomedical model has great implications for the treatment of mental health. From a Marxist perspective, this acceptance of the biomedical model as the sole provider of medical treatment reinforces its dominance, and thus profitability (Annandale, 1998:11-13). Marxist critiques of the welfare state, prioritising its role in ensuring the health of the workforce, are also important (Higgs, 2003: 189). The mental health service user is positioned as a consumer, implying choice, which can be a false distinction to make when considering crisis care and sectioning. Zola (1972) critiques medicalisation as an 'institution of social control,' with its focus on curing disease for the affluent rather than the impoverished. This has direct implications for mental health, which is seen as both a cause and an outcome of poverty. As discussed in section 2.3.1, health inequalities influence epidemiology and outcomes (Ostler *et al*, 2001).

Feminist critiques of the biomedical model engage with the problems of the lack of distinction made in biomedicine regarding gender. While feminist approaches are diverse, the main critique of the medicalisation of society provided is that of women's invisibility. As was discussed in the previous section, this can also lead to a pathologising of female behaviour. Historical considerations of conditions like hysteria, in which mental health problems were seen as emanating from the womb, are relevant to feminist concerns (Nettleton, 2006). Critiques of power relations are also important (Lupton, 2003). Similarly, Foucauldian concepts of relationships of power, with the scrutiny of the 'clinical gaze' providing a panoptical view of health and illness in which surveillance is key, also impact on ideas of medicalisation (Foucault, 1973; Higgs, 2003). This surveillance is not, however, simply imposed in a 'top-down' fashion, and instead is seen as an internalised process related to wider societal norms (Lupton, 1997).

The Parsonian sick role reflects aspects of medicalisation. Conditions of the Parsonian sick role are twofold, and can be summarised as the exemption of the patient from normal roles and duties in return for acceptance of the diagnosis, and the obligation to seek help and return to health as soon as possible (Williams, 2005).

The construction of illness as something to be cured is complicated by mental health problems, which often have complex causes and only achieve a management of symptoms rather than a full recovery (Davidson, 2005). Numerous benefits are attributed to those fulfilling the Parsonian sick role, including sympathy and – in America – health insurance coverage (Greenberg, 2010: 41). Criticisms of Parsonian perspectives include the implication of illness-as-deviance within his definitions; a lack of awareness of contextual factors such as age, class, ethnicity, and gender; and the relationship of the Parsonian sick role to long-term conditions (Williams, 2005). Karp (1992) observes that such an explanatory model positions the person as a victim, taking little personal responsibility for their own symptoms.

There is a blurred boundary between sadness and clinical diagnosis, as considered in sections 2.3.1 and 2.3.2, which impacts on the medicalisation discourse (Horwitz, 2007). Critics of medicalisation comment on the rising diagnosis rate of some conditions – for example Attention Deficit Hyperactivity Disorder (ADHD) – in response to their recent classification in medical literature (Fox and Ward, 2008; Frances, 2010). Healy's (1997) work examines blurred boundaries, connecting rising diagnoses to the prevalence of pharmaceutical treatments. For example, there was a higher rate of diagnoses of panic anxiety disorder following the patenting of Xanax, a drug specifically to treat the disorder, in the 1980s (Healy, 1997). Similarly, Fox and Ward (2008) view social phobia and social anxiety disorder as a redefinition of the concept of shyness, which was not previously regarded as a health problem requiring treatment.

There has been a progression from seeing issues as social, personal or emotional, to seeing them as medical and thus treatable. Rubin (2004: 375) comments that social problems are thus re-located in the individual; 'reinterpreted as personal failures and then re-contextualized as illness.' The rise of medicalisation can be interpreted as a reaction to the decline in social contacts, with the consultation with a medical practitioner replacing previously strong familial and religious connections (Mechanic, 1966). Szasz (1970) regards medicalisation as a phenomenon that legitimises the role of medical professionals, positioning them as experts to whom patients must defer. Again, this links with Marxist interpretations. Williams (2005) re-examines notions of the Parsonian sick role in light of recent trends in health care towards patient choice and the creation of expert patients, concluding that the changed expectations of patients do not challenge the authority of the medical professional. Patients are still cast within a sick role allowing them to have embodied

knowledge, but not the technical expertise of the professional. Taking influence from Szasz's (1970) work on the contested nature of mental illnesses, Greenslit (2005) identifies two potential concerns for people with mental health problems. Firstly, there is a need to ensure that their symptoms are recognised as illness so that they are able to access treatment and – in the USA – health insurance providers will cover costs. To access services, there is a need to medicalise symptoms. One example is Vietnam war veterans' struggle to persuade medical practitioners that PTSD should be recognised as a disease (Greenslit, 2005). On the other hand, the introduction of gender identity disorder to the DSM-IV in 1994 caused controversy amongst transgender people who felt that their personal identity had been medicalised and classed as disorder (Cole and Meyer, 1998; Lev, 2005). Thus there is a need to normalise and not medicalise. Again, transgender identity is complicated by arguments about the provision of gender reassignment surgery, for which a medical diagnosis is required, linking to Beresford *et al*'s (2010) finding that people are forced to accept diagnoses that run counter to personal narratives to access treatments.

Nevertheless, Nettleton (2006) disputes the idea that medicalisation is the only influence on clinical decision making, with lay knowledge and complementary medicine in resistance to medical authority. The recent trend towards narrative-based medicine also suggests that doctors rely on personal and experiential knowledge as much as EBP criteria to make clinical judgements (Greenhalgh, 1999; Greenhalgh and Hurwitz, 1999). Similarly, Bolton (2010) challenges models of medicalisation stating that concepts of health and illness are 'embedded in culture' rather than decided by professionals. A resistance to medicalisation can also be seen within service-user movements in mental health, which dispute the legitimacy of psychiatric treatments and diagnoses. The mental health system survivor movement presents a shift away from the Parsonian sick role and patient-as-victim discourse (Adame and Knudson, 2007). Recent work on low-intensity CBT found that language and labelling affects the accessibility of treatment, moving towards a de-medicalisation of resources to improve access (Chellingsworth *et al*, 2010; White, 2010). These shifts in the medicalisation discourse impact on patients and service users in three ways:
   (i)   There is no longer one authoritative account of the body and illness; instead there are many truths.

(ii) There is a move away from a teleological approach to medicine and scientific progress. Again, such a move allows for the acknowledgement of many legitimate truths.

(iii) The expertise of doctors is called into question, and 'all accounts, and types of knowledge, whether based on experiential knowledge or rational science, have validity' (Nettleton, 2006:31; Johansson *et al*, 2009:634).

Stigma also affects the experience of mental health problems. As a term relating to mental and other health issues, stigma is defined as the 'situation of the individual who is disqualified from full social acceptance' (Goffman, quoted in Fitzpatrick, 2008: 249). Ben-Zeev *et al* (2010) refine this into concepts of public stigma, consisting of widely-held stereotypes which can lead to social exclusion; self-stigma, in which stereotypes are internalised, affecting self-esteem; and label avoidance, or the reluctance to accept diagnoses, in order to avoid further stigma. When questioned about the prevalence of stigma, 87% of respondents to the *Attitudes to Mental Illness* survey felt that those with mental health problems experience stigma and discrimination (Prior, 2010).

Mental health problems are often constructed as 'just like physical illnesses', and it is suggested that this construction reduces the stigma attached to mental health issues (DH, 2009a: 5). However, the purpose of constructing mental health as physical health is problematised, because physical health problems can also be stigmatized (Fullagar, 2009; Kinderman *et al*, 2008). A distinction can be drawn between concepts of sickness and illness. Dysart-Gale (2008) – drawing on Kleinman's (1997) work – refers to sickness as symptoms; and to illness as the social meaning of sickness. Such a distinction is important as it separates the experience of symptoms of mental health problems from others' reactions to these symptoms, stigmatization by the self or others, and the socio-medical reaction to mental health problems.

Moves have been made to try and de-stigmatize mental health problems, end discrimination, and correct prejudicial myths about mental health problems (BBC, 2009). Attitudinal surveys reveal measurably increased understanding of mental health problems (Prior, 2010). White (1995) theorises that stigma makes it difficult for people to find coping solutions because they do not feel able to talk publicly about their mental health problems and their self-imposed silence contributes to feelings of isolation and a lack of shared experience. Karp (1994) reaches similar conclusions

regarding the potential stigmatization as encouraging isolation. Adame and Knudson (2007) conclude that the stigma of diagnosis can have a negative impact on people with mental health problems, with stigma regarded as something to 'survive' as well as symptoms.

Ben-Zeev *et al*'s (2010) concepts of stigma are influenced by Labelling Theory, which critiqued previous constructions of mental health issues. Labelling Theory states that mental health problems 'qua concept [are] not neutral, value free or scientifically precise' (Scheff, 1967: 7). Rosenhan's (1973) work on labelling, examining the status of people with mental health problems in a hospital environment via covert observation, concluded that the situation in which a person was placed played a significant role in others' perceptions of them. His work found that once a diagnosis, such as schizophrenia, was given to a person, it was irreversible; 'he was not sane, nor, in the institution's view, had he ever been sane' (Rosenhan, 1973: 252). Similarly, as Allan (2010) discussed more recently, once a person has been sectioned they permanently lose a number of rights, including the right to stand for office in the House of Commons in the UK, reinforcing an idea of irreversibility (see also: All-Party Parliamentary Group on Mental Health, 2008).

To summarise this section, the medicalisation of society has a significant effect on perceptions of people with mental health problems, in terms of their own identity and the assessment of their behaviour by other people. Medicalisation impacts on the way that people with mental health problems are treated in society, including stigmatization and the resulting prejudices that can accompany stereotyping. Socio-cultural factors impact on acceptance and experience of diagnoses.

2.4 Concluding remarks on the literature

Part one of the literature review showed that there is a significant body of research underpinning current models of bibliotherapy. While questions need to be asked about the appropriateness and quality of this research, bibliotherapy can be shown to have a demonstrably positive impact on mental health and well-being. Other disciplines, such as reader response theory, situate bibliotherapy in a wider body of qualitative and theoretical research. There are distinct advantages of bibliotherapy over other mental health treatments. Bibliotherapy has had a long and varied history, often mirroring trends in the treatment of mental health problems. Current models use the resources of the public library, and section 2.2.4 examined the barriers and

antecedents to public library use. Bibliotherapy's recent popularity has been affected by shifts in NHS policy.

Part two of the literature review focused on the wider context of mental health. Differing explanations of the causes of mental health problems were discussed, delineating the biomedical, psychological, and social theories presented to explain symptoms, and drawing these theories together to present a holistic model. The conflict between personal, or lay, understandings of mental health problems and professional understandings was considered. A brief history of diagnosis was presented, showing the changing conceptualisation of mental health, followed by a discussion of the symptoms of mental health problems. Section 2.3 explored diagnoses, focusing on psychiatric measuring scales. Socio-cultural factors, including gender, culture and the perceptions of a medicalised society, were explored to further contextualise the experiences of using bibliotherapy.

The aim of the literature review – which also addresses objective one of the research – was to locate the current study in a wider historical and socio-cultural context, drawing on previous research about bibliotherapy and the treatment of mental health problems. It identified the key factors that led to the emergence of current models, which will be further explored in chapter four, and has begun the task of situating the findings from the interview and observation studies (presented in chapter five) in the literature on experiences of mental health problems.

Chapter Three: Methodology and research design

3.1 Introduction

In chapter one of my thesis, the aims, objectives, and research questions were contextualised by the research rationale. Chapter two further situated the project by examining the literature on bibliotherapy. Chapter three is split into three main sections following this introduction; the first introduces the theoretical frameworks and methodological constructs for the study. The research was conducted from an interpretative perspective, meaning that there were no preconceived expectations of the outcome of the research. The instability of the data collected is also acknowledged in this section. Section 3.3 outlines the research design and considers data collection and analysis. Three qualitative sources of data – interviews, participant observation, and documents, supplemented by descriptive statistical data – imbricated to form the research design. Section 3.3 also explores how the sampling, recruitment, and research design evolved in collaboration with the experiences of research participants. A brief outline of the pilot study for the project is presented in section 3.4, as a foundation for the analytical chapters which follow.

3.2 Methodological constructs

Part one encompasses the philosophical approach to the research, examining constructionism and reflexivity as an epistemological basis; ethnographic theories and methods, with a focus on Denzin's (2001) Interpretive Interactionism; and an outline of ANT, which was used as a framework for policy data analysis (Latour, 2005). While the use of more than one methodological framework is unusual, section 3.2.5 examines the justification for combining these approaches and comments on the validity and verification of the study's methodology. The use of Interpretive Interactionism and ANT was driven by the research questions, which established the need for a two-part research design.

3.2.1 Research philosophies: constructionism and reflexivity

Section 3.2.1 outlines the epistemological and ontological position of my thesis, addressing questions of what can be known and accessed in a research study; and how reality is shaped and constructed. My research uses a reflexive framework, based on constructionist perspectives, to recognise that understandings of the world are locally situated and constructed as 'part of the world they describe' (Silverman, 2006: 129). While there is some debate about the use of terms such as constructionism, it is used here to differentiate this work from a positivist perspective

in which 'truth' can be accessed (Talja *et al*, 2005). Constructionism is an approach which enables researchers to study how knowledge is created in relation to society (Talja *et al*, 2005). This is particularly pertinent for the research study, which aims to qualitatively investigate how current models of bibliotherapy came to exist in their current format, before comparing these institutional constructions to more personal experiences of the research participants. As will be discussed in section 3.2.3, this reflexive stance is also the basis for modern ethnographic thought, including Interpretive Interactionism.

From a constructionist perspective, all data is jointly created by the researcher and participants, with the researcher's role to interpret and produce an account of an experience. Reflexivity is an important element of the approach, and posits the notion that there is not one truth, but a series of reflexive truths. Such constructs imply the use of qualitative methods with each in-depth interview representing one participant's construction of their experiences, which is then interpreted by the researcher. Thus, the researchers' own experiences shape the data, which is co-constructed with the research participants (Kvale and Brinkmann, 2009). Interpretive Interactionism, discussed below, subscribes to this reflexive, constructivist approach, with Denzin (2001: 46) commenting that 'every human situation is novel, emergent, and filled with multiple, often conflicting, meanings and interpretations.' Thus, reflecting on the context is key to constructionism and Interpretive Interactionism. ANT, discussed below, also subscribes to a reflexive perspective, acknowledging that 'there is no view from nowhere' (Callon and Law, 2005: 720).

Elliot (2005: 153) defines reflexivity as 'a heightened awareness of the self, acting in the social world.' His definition acknowledges that the position of the researcher is an active one, requiring analysis throughout the study. Ethnographers such as Denzin (2001) and Karp (1996) acknowledge that the personal experiences of the researcher can help to formulate trust and rapport with interview participants, and can benefit the research project. Clarke (2005) stresses that the researcher is not a *tabula rasa* and requires self-awareness while conducting research, but views this acknowledgement of self-location as a positive step within the research process. As Bryman and Bell (2006: 529) comment, reflexivity locates the researcher within the creation of knowledge, criticising the positivist, realist model of knowledge transmission. Work on self-location, however, needs to remain analytical, to ensure that the focus of the work remains the subject under investigation, and not the researcher (Elliott, 2005: 155).

The aim of the research is not to be generalisable, but instead to examine individual experiences with awareness that each of these experiences may be different (Denzin, 2001: 41). Similarly, concepts of 'situated knowledges' recognise that all theory production needs to be considered within its context (Mauthner and Doucet, 1998). A constructionist approach justifies the methods of data collection used, aiming to access the many truths of health and illness via interviews, observations and reflective analysis. Concepts of relativism are discussed in Nettleton's (2006: 28) work, leading her to challenge critiques of a relativist approach; 'the argument that all knowledge is socially contingent is not the same as the statement that all knowledge is worthless; rather it attempts to gain an alternative understanding as to how knowledge is created.' Again, this shows that an awareness of the context of the study is vital.

A commitment was made to ensure that the voice of the author was not privileged over the voice of research participants. Such a decision is a controversial one, from a positivist, realist perspective. Positivists take the view that the researcher should be an objective scholar, focused on extracting data from its source in a scientific manner. However, this approach does not fit with my epistemological and ontological concerns and my aim to provide a polyvocal account of experiences.

3.2.2 Ethnographic approaches

Ethnographic techniques, shaped by Denzin's (1989; 2001) construction of Interpretive Interactionism, were used for data collection and analysis. An ethnographic approach is appropriate in light of the research philosophies explored in the previous section and the research questions presented in section 1.2. Contemporary ethnographic research rests on techniques that complement the reflexivity on which the thesis is grounded (Seale, 1999). The constructionist perspective typically asks how events occur, rather than what happens (Elliot, 2005: 19). A similar formation of research questions is also used in Interpretive Interactionism (Denzin, 2001: 72). Reflexivity is a prerequisite of ethnographic research for scholars like Banks and Banks (1998: 68) who comment that this helps to avoid 'assumptions of objectivity.' As Karp (2006: 9-10) states, the researcher is not the expert, regardless of their knowledge of the literature – the participants are the experts on their own situation. The perception of the researcher as neophyte, not expert, was the starting point for the analysis conducted in later chapters.

Characteristics of ethnography include:

- The exploratory nature of investigation, as opposed to an aim to test a hypothesis
- Analysing data with no preconceptions of codes or categories
- Small sample or population size
- Qualitative interpretation, not a focus on quantitative methods

(Atkinson and Hammersley, 1994)

These characteristics are important for my study, which aimed to explore the emergence of current models and service user experiences. Data analysis was conducted using codes emerging from the data itself rather than using previously established concepts and the majority of data collected was qualitative. The sample of service users interviewed was twenty-seven, reflecting the small-scale nature of the project.

Ethnographic work typically includes some observation of participants in their environment – in this case, the bibliotherapy group. While there are many variations in ethnographic observational techniques, for this research I adopted an overt stance with participants, talking with them about my research and answering any questions they had. In bibliotherapy groups, I participated in discussion as appropriate and observed participants. I tried to avoid shaping the direction of discussion or dominating the conversation with talk of my research project. My role could thus be best described as 'observer-as-participant' (Adler and Adler, 1994: 379).

Ethnographic research is often based on what Silverman (2007) refers to as 'naturally occurring' observational data, rather than 'manufactured' data such as interview transcripts. However, while it was possible to observe bibliotherapy groups, in BoP schemes and the individual therapeutic reading discussed by participants, the focus is on reading alone for personal benefit. There is no method to capture this experience that does not involve the researcher intervening in some respect, and thus interviewing participants was considered more appropriate. Denzin's (2001: 66) Interpretive Interactionist stance encourages open interviewing (discussed in section 3.3.1.1), as it 'fits naturally with participant observation.' Gobo (2008: 16-17) describes ethnography as a polysemous methodology, often using a number of different means of data collection. This concept of methodological pluralism reinforces the validity of using both observational and interview techniques to collect data.

Ethnography and Grounded Theory share some approaches to working with data (Glaser and Strauss, 1967; Starks and Brown Trinidad, 2007). Familiarity with a Grounded Theory approach, which I used in a previous study, means that the influences of this methodology will be seen in the thesis (Brewster, 2007). However, as Starks and Brown Trinidad (2007) explore in their comparison of three methods including Grounded Theory, there are distinct differences in outcome when using different methods of analysis. Comparison between techniques used in Grounded Theory and the more ethnographic, interpretive ones used here highlighted some important aspects of this research. For this project, it was felt that techniques of coding produced in Grounded Theory 'glossed' the world of the research participant (as will be discussed in more detail in section 3.2.3) but some ideas and influences were still felt to be of value.

For example, techniques of constant comparison, examining each set of interview data to help improve future interviews by picking up on relevant topics as they emerge from the data, were highly influential (Glaser and Strauss, 1967). Constant comparison helped to ensure that the issues that were most relevant to the participants themselves were discussed, rather than focusing on the perspective of the researcher (Glaser, 1998). Reflecting on the data collection and analysis can help to identify relationships within the data, which can be useful in a broad, interpretive framework (Charmaz, 2006). Charmaz (2006) uses an ethnographic memo-based approach to reflect on the data; an approach taken throughout the data collection process to supplement the observation and interview data, creating rich, evocative descriptions of events and facilitating analytical reflection. Charmaz (2006: 10) recognises the influence of reflexivity on Grounded Theory, stating that 'any theoretical rendering offers an interpretative portrayal of the studied world, not an exact picture of it.'

Nevertheless, it needs to be remembered that proponents of Grounded Theory aim to provide a coherent account, based on techniques involving collecting data until saturation is reached (Glaser and Strauss, 1967). The requirement for saturation differs from an Interpretive Interactionist approach which recognises that the experiences of research participants may not always cohere, but are still valid and valuable. If the researcher is attempting, as here, to produce a 'reflexive, messy text' then a Grounded Theory approach, which aims to formulate hypotheses or generate theory is not appropriate (Marcus, 1998). As some proponents of Grounded Theory advocate conducting the research from a perspective in which preconceptions are

minimised, this implies that the position of the researcher cannot be acknowledged. In Glaser's (1998) construction of Grounded Theory, there is encouragement not to conduct a literature review before commencing the research project. For this study, the research questions were identified based on a gap in the literature initially found in previous research (Brewster, 2007). Again, this is in conflict with Glaser's Grounded Theory approach, though there is disagreement within the Grounded Theory community about this aspect of Glaser's work (Strauss and Corbin, 1997). Concepts of the theory 'emerging' from the data are also criticised; mainly by Selden (2005: 127), who concludes that it is wrong to say that analysis emerges from the data; 'data do not generate theory. The researcher generates theory.'

As discussed above, ethnographic approaches to data collection and analysis are compatible with the reflexive approach taken in the thesis, and provide a suitable methodology to answer the research questions. Denzin's (1989; 1994; 2001) approach to ethnographic work will be considered in more detail in the next section.

3.2.3 Interpretive Interactionism

Interpretive Interactionism is an ethnographic approach, which concentrates on understanding individual or private experiences and contextualises them in the 'public reactions' to these individual experiences (Denzin, 1989; 2001). For this thesis, the identification of the need to critically analyse bibliotherapy schemes (the public reaction) and to explore service user perspectives (the private experience) meant that Interpretive Interactionism presented a useful framework for answering the research questions. Interpretive Interactionism is thus ideally suited to examining gaps between service provision and experience (Denzin, 2001). Interpretive Interactionism can be used as an 'evaluative' research method, examining whether 'policies and interventions actually benefit the people the schemes target' (Mohr, 1997: 273). As the research project progressed, Denzin's (2001: 3) statement that: 'the programmes don't work because they are based on a failure to take into account the perspectives and attitudes of the persons served' helped to shape thought on the reasons for the gaps found between service user understandings of bibliotherapy and design of the services. While the Interpretive Interactionist approach is not widely used within LIS research, it is more common in sociological and medical research (Mohr, 1997; Sundin and Fahy, 2008). Interpretive Interactionism concentrates on an analysis composed of the individual voices of the participants in in-depth interviews, making it fit consistently with the constructive, reflexive philosophy at the heart of the research.

The strengths of Interpretive Interactionism include its recognition of the complexities of the participants' lives and research. Denzin (1994: 507) comments critically on the politics of representation; to present research is always to represent the researcher's view of participants. The need to create a multi-vocal text, connecting the researcher with the people under investigation, is thus established (Denzin, 2001). Building on these concerns with polyvocality, Denzin (1989: 136) observes that there is a 'conflictual, contradictory nature of lived experience' and recognises that any analysis of the data is just one interpretation. His work emphasises the importance of using the language of lived experience – the terminology that the participants themselves use – in framing the research. The narratives that are constructed may contain contradictions and Schwandt (1998) comments that Interpretive Interactionism borrows from cultural studies in its self-conscious concentration on understanding the representation of experiences.

Interpretive Interactionism owes a debt to Geertz's (1973) ethnographic work on Thick Description. Thick Description is a response to the 'top down' imposition of the understanding of cultures. Geertz (1973) was concerned that the typical 'thin' description 'glossed' the meaning of events, removing the language of people being researched, and did not situate their experiences within a context. While this study did not produce traditional Thick Descriptions, it also takes influence from Geertz's work, looking to use the language of those being studied, and ensuring that a strong awareness of the context was maintained. Geertz's guidance on ensuring that the research does not 'gloss over' the experiences of participants was particularly important for the coding or bracketing (see below) stage of the data analysis process. Similarly, in the view of Majima and Moore (2009: 209), ANT, which will be discussed in section 3.2.4, is 'a logical extension of Geertz's argument for Thick Description.' Latour's (2006) attention to description, as explored in his work on Paris, presents an example of how Interpretive Interactionism and ANT – which are quite different approaches – cohere in their aim to present a detailed picture of a particular situation, as will be discussed further in section 3.2.5.

Several stages of Interpretive Interactionism form the process of data collection and analysis:

- *Framing the research question*
  Locating and defining the object of study, then formulating the research questions as a single statement. In this case, the statement was: 'there has

been little critical analysis of current models of bibliotherapy, particularly from the perspective of those who use the services.'

- *Deconstruction and critical analysis of prior conceptions*
  In this thesis, deconstruction takes the form of a critical review of the literature and an analysis of current practice in the UK. Denzin (2001) states that the researcher often needs to work 'backwards', from the public to the private, to enable examination of the broader structure and the gaps within it. Throughout the project, I moved from analysis of the public bibliotherapy scheme to the private/ lived portrayal of depression, with the aim of contrasting these public and personal experiences.

- *Capture*
  Capturing consists of locating sources of data and obtaining multiple examples of the object of study. In this instance, capture consisted of a series of in-depth interviews with individuals who had taken part in bibliotherapy schemes or used independent therapeutic reading, and participant observation of bibliotherapy groups. Mohr (1997: 276) states that the purpose of capturing the phenomenon is to allow 'informants [to] remain free to respond within their own frame of reference.'

- *Bracketing*
  Bracketing involves reducing the object of study to its 'essential elements', or 'key factors' and decontextualising it so that structures and features can be uncovered (Denzin, 2001:75). Bracketing can be seen as 'self-reflective', attempting to examine data without relation to previous knowledge (Starks and Brown Trinidad, 2007:1376). A variety of coding methods were used as a form of bracketing, discussed in section 3.3.4. However, bracketing needs to take influence from Geertz and not Grounded Theory to ensure that it does not 'gloss' the experiences of the participants. Bracketing aims to see that the stories in question are 'both like, *and not like*, any other story told by any other person' (Denzin, 1989: 128, italics added). Bracketing clarifies the meaning of phrases used by participants in their personal context, rather than the context of preconceived meanings.

- *Construction*
  Construction can be defined as rearranging the object of study in terms of its

essential parts, pieces and structures, and involves translating the lived experiences of those interviewed into a polyvocal account of the practices of bibliotherapy. Broom's (2009: 1053) interpretive work with cancer patients also took a similar approach; 'within this process, the focus was on retaining the complexity of the respondents' experiences, and documenting atypical cases, conflicts, and contradictions within the data.' Unlike more positivist methodologies, it is not an attempt to produce a streamlined account of the similarities of experience.

- *Contextualisation*

  The contextualisation stage usually involves relocating the phenomenon back in the natural social world. For the purposes of the thesis, it involved connecting the deconstructed phenomenon identified in the literature and ANT analysis, with that captured during the interviews and observations. The approach ensures that these experiences are presented within the context of their emotional landscape and language. Contextualisation has to be meaningful to those who participated in the research (Adapted from Denzin, 1989; 2001).

In summary, this exploration of Interpretive Interactionism has helped to clarify why it is a particularly suitable ethnographic approach to use within this research. Its focus on both the individual and the institutional response to that individual will help to explore the role of bibliotherapy schemes in society and the personal experience of the participants in this research. The key characteristics of the Interpretive Interactionist approach are:

- A recognition that traditional ethnographic participant observations are important, but should be supplemented by interview data in cases (such as this project) where the aim is to address private experiences as well as public reactions to these experiences.
- An awareness that lived experience can be complex and data may be contradictory; however, it is important to acknowledge these contradictions and not gloss over them.
- Similarly, an appreciation that understanding the context of the experience is important.
- A commitment to reflexivity, locating the researcher within the data collection and analysis, which differs from positivist criteria of research quality.

- Its use as an evaluative methodology, asking whether or not services benefit those they intend to help.

Denzin's (2001) formulation of Interpretive Interactionism focuses on gathering data about the public reaction to a service through interviews with frontline staff. As discussed in Brewster (2007), faults were identified with data gathered via this approach, and it was decided that the use of documents to access policy, or the public response, was necessary for this study. Thus, the ethnographic, interactionist approach was not appropriate for every aspect of this study, and an ANT framework was used to understand the emergence of current models of bibliotherapy. This will be discussed in the next section.

3.2.4 Actor-network theory (ANT)

Hodder's (1994) work engages with Interpretive Interactionism and other ethnographic methods, and provides theoretical insight justifying my decision to use multiple methodologies for this study. Having established the importance of critically analysing current models of bibliotherapy, I identified documentation about these models as the most appropriate source of data. Previous research based on interviews with library staff concluded that interview data may present a picture of bibliotherapy based on the responses of enthusiastic individuals, rather than the institutional overview (Brewster, 2007). As the aim of this thesis was to examine the emergence of these models in response to wider socio-cultural agendas, it was also recognised that individual interviews would not necessarily provide these insights. Thus, Interpretive Interactionism and other forms of ethnography which focused on analysing 'interaction with speaking subjects' were, in the words of Hodder (1994: 398), ill-equipped to 'deal with material traces' such as documents and statistics. For these reasons, ANT was used to analyse documentary evidence.

ANT provides a framework for analysis of situations, relationships and systems (Cho *et al*, 2008). It focuses on network formation, and aims to facilitate a greater understanding that is not centred only on the agency of individual human subjects; it awards agency to organisations and objects, examining the active role that they can play in the construction of networks. As Cho *et al* (2008: 616) assert, there is 'no unified body of knowledge' concerned with ANT, and only the key concepts relevant for this thesis will be defined here. The concept of the actant, or actor, is key; actors are defined by their role within the network, and any object or person that participates in a network can be considered to be an actor (Jablonski, 2001: 131). These actors

are also not defined by size – an organisation such as the NHS can be considered an actor, as can a single book, and both can interact with one human individual as another actor of equal importance to form a network linking micro and macro levels of action (Sarker *et al*, 2006). Tracing the actions of the actors helps to examine the formulation of the network. Typically, a research study will follow the 'focal actor' or main actant in a network, to provide clarity when exploring the deconstruction of the network; this focal actor can be anything from a door closer to an information system (Cho *et al*, 2008; Latour, 1988). The conceptualisation of 'following the actors' can be seen as a potential weakness within the approach. Law (1991: 11) observes that researchers may find it difficult to 'sustain any kind of critical distance' as they follow one actor. Law's comments on critical distance need to be taken within the context of earlier discussions of reflexivity – see section 3.2.1 – and in light of the ethnographic focus of other strands of the research.

ANT was seen as an appropriate framework for investigation in this instance as it provided the opportunity to explore what have been referred to as 'relational understandings of power' and to examine the role of non-human actors within a network (Juntti *et al*, 2009; Latour, 1988). As the research aimed to investigate the formation of three current models of bibliotherapy, ANT was also seen as a particularly prescient method of analysis. ANT is regarded as a methodological approach that involves both deconstruction and reconstruction (Latour, 2005). Latour (2006) states that this reconstruction can never capture the whole at a glance. While methodologies often try to capture a phenomenon in a snapshot, there are numerous complexities that prevent reconstruction occurring. Latour (2006) uses the city of Paris as an example to illustrate the different meanings of the same city for different people, and their different understandings of it. He refers to plans, maps of telephone and electrical networks, photos of landmarks and street signs to demonstrate that all these things both are, and are not, Paris.

The explanation of Paris as a city that is visible, yet at the same time inaccessible and invisible emphasises the philosophical underpinnings of ANT. What we see and capture in research is always a representation; 'the map is not the territory' (Latour, 2006: 26). Latour (2006: 17) argues that even the 'selves' that we take for granted are actually formulated socially; 'we receive our identity via another alignment of circulating documents.' ANT does not take social explanations or society for granted, with Latour (2005: 5) instead stating that what we refer to as social explanations are actually simply another form of connector within a network. This refuting of society as

an explanation for the formation of relationships also impacts on one of the main controversies surrounding ANT; that non-humans form, and contribute to networks equally with humans (Cho *et al*, 2008: 616). Whittle and Spicer (2008) criticise ANT, stating that its perceived relativism is undermined by this lack of separation, missing the 'meaning' inherent in action.

ANT examines the emergence of networks, looking at how they achieve coherence and maintain stability. ANT will be used in this thesis to analyse the formation of current models of bibliotherapy, considering how networks were created and maintained, and how the main actants enlisted others in the projects. In ANT, these concepts are referred to as 'moments of translation' and are central to the analysis (Callon, 1986). These moments of translation are defined as:

- Problematisation, or the definition of the object of concern for the proposed network by the focal actor. This includes the identification of the Obligatory Passage Point (OPP) through which all actors must pass.
- Interessement, or ensuring that all actors in the proposed network agree to take the roles formulated by the focal actor as a solution to the problem.
- Enrolment, which can be defined as strengthening the network via relating defined roles and connecting the agendas of different actors.
- Mobilisation, in which the actors who speak for the network are established.
- Irreversibility, or the extent to which it is possible to go back to a situation similar to that before the network was formed.

In the final stages, the main actants also become responsible for speaking for others and 'a constraining network of relationships has been built' (Callon, 1986: 218). Callon (1986) emphasises that a network is not irreversibly constructed; translation is an ongoing process that requires constant reinforcement. Cho *et al* (2008: 616) link these abstract concepts to a more process-oriented understanding, defining the aims of ANT as to understand 'how people and objects are brought together in stable, heterogeneous networks of aligned interests… through processes of translation.' Analysis of health care policy from a 'policy-as-discourse' perspective also contributed to the theoretical background (Shaw, 2010). Instead of viewing policy as 'a formal, rational process that can be planned in advance', policy-making decisions are located as 'an emergent stream of social action' (Shaw, 2010: 196). Juntti *et al*'s (2009) criticisms of evidence-based policy – the constructed nature of evidence itself; the politics of policy-making; and the operation of power – were also influential.

A tension can be seen between the ANT approach and some of the ethnographic influences on the research. Moments of translation are a framework into which experiences must fit; a theory is applied to the data, rather than allowing data to lead analysis (Callon, 1986). Care is needed to ensure that the framework does not overwhelm the data and still reflects diversity. Latour (2005) asserts that description and analysis of relationships are key to ANT, rather than application of a specific framework, and his approach shaped the decision to apply Callon's (1986) translation framework only as appropriate.

Whittle and Spicer (2008) also critique the staged model of ANT, suggesting that translation may be a longer and more 'disorderly' process. The analysis presented in chapter four acknowledges and embraces this aspect of their critique, emphasising that the process of analysis via concepts of translation is a messy, reflexive procedure presenting one interpretation rather than the only interpretation. Adams and Berg (2004: 151) discuss the 'familiar Latourian argument' that it is not desirable to analyse the 'final state' of things but the points before that, taking an almost historical analysis of how things have come to being. I would argue that this is pertinent to the analysis of current models of bibliotherapy; there is not yet a final state of things, and there is still a state of flux within the schemes themselves reflected in analysis.

In summary, this section has outlined the main features of an ANT approach to data analysis. Together with reflexive, ethnographic and interactionist methodologies explored in the previous sections, this section completes the review of methodological approaches used for this study. Moving on, the next section will combine to examine how these approaches combine to produce piece of research that can be considered to be trustworthy by thinking about validity and verification.

3.2.5 Bricolage, validity and verification

The justification for using several interlinked methodological approaches – ANT, Interpretive Interactionism and ethnography – rests on Denzin and Lincoln's (2000: 5) hypothesis that this will 'add rigour, breadth, complexity, richness and depth' to an enquiry. The approach can also be conceptualised as the 'qualitative researcher as bricoleur or quilt maker' (Denzin and Lincoln, 2000: 4). Notions of bricolage are well-known in qualitative research (Broom, 2009; Denzin and Lincoln, 2000; Kincheloe, 2001; Kvale and Brinkmann, 2009). Kvale and Brinkmann (2009: 323) define bricolage as 'mixed technical and conceptual discourses where the interpreter

moves freely between different analytical techniques and theories.' Thus, the research project was approached from a practical perspective, drawing on different frameworks to answer different research questions as appropriate.

Morse's (2011: 1019) comments on challenges for conducting qualitative health research include reflection on formulated designs versus a more open approach, stating that 'sometimes deviations are essential because the research context does not allow one strategy… for data collection.' For this thesis – guided by the research questions – the use of observations, interviews, and document analysis were all regarded as essential to data collection and answering these research questions. While ethnographic methods – focused around the subset of an Interpretive Interactionist framework with its concentration on the public-private dichotomy – shaped the study as a whole, these methods were less appropriate to the documentary and statistical data gathered to examine public or institutional perspectives. Thus, a dual research design was adopted. ANT, with its key aim to understand relationships, was seen as an appropriate method to use, as discussed in section 3.2.4 above. Mauthner and Doucet (1998: 126) assert that methodologies can be adapted to fit to the constraints of the research project, and need to be considered reflexively. A view of the research as a quilt, collage, or montage also links with ideas that the aim of the project is not to achieve a consistent representation; it is to represent different views and experiences which may not always agree (Denzin and Lincoln, 2000).

When considering validity and verification, Denzin and Lincoln's (2000: 12) feel that, for qualitative researchers, such criteria have limited value, instead 'reproduc[ing]… a certain kind of science, a science that silences too many voices.' It is my concern here that this research should not reflect this silence, and should instead fill previously defined gaps in the evidence base regarding service user perspectives. Thus, this section engages with these debates on research quality in light of the 'crisis of representation' (Seale, 1999).

Commonly, Lincoln and Guba's (1985) four criteria by which qualitative research can be judged – credibility, transferability, dependability, and confirmability – are used, but as will be explored, not all of these criteria were considered to be appropriate to the nature of the project. For example, when considering complicated, in-depth interview work the rapport between the interviewer and the participant is crucial. As personal issues are being discussed, it is unlikely that the same participant would

give exactly the same answers on different days to different interviewers. The aim is not to produce data that can be re-tested to prove validity, as per experimentation. Instead, issues such as 'verisimilitude, emotionality, personal responsibility, an ethic of caring, political praxis, multi-voiced texts and dialogues with subjects' are considered to be evidence of the quality of research (Denzin and Lincoln, 2000: 12). Holt (2003: 23) advocated the use of criteria including whether the work makes a substantive contribution; has impact; and expresses a reality – all of which are applicable here. Thus, there is a tension between the positivist criteria for valid and reliable research, and what Seale (1999) defines as the 'new language' of qualitative research.

Elliot (2005) investigates how researchers in the post-positivist tradition use concepts including internal and external validity. To resolve the issue of internal validity or credibility, Elliott (2005: 23) recommends using an open interviewing technique, allowing the participant to set the agenda of the research and present their own narratives. The participant is empowered to dictate the direction of the interview, and thus their concerns are addressed, rather than those of the researcher. While it has long been recognised that terms such as 'generalisability' cannot simply be applied to qualitative research, researchers still aim to provide some form of useful, transferable knowledge with their research. Hammersley's concepts of relevance are useful here (discussed in Seale, 1999). As previously discussed, the research will contribute to filling a gap in the evidence base that has been defined by numerous other studies and practitioners, confirming the relevance of the research. While the work is not generalisable, it will provide useful recommendations for practice and future research.

Daly *et al* (2007) present a hierarchy of four types of qualitative studies, concluding that the presence of theoretical and conceptual analysis means that studies are more likely to provide evidence-for-practice. According to the criteria of their hierarchy, the thesis sits somewhere between the top level – level I (generalisable) and a level II (conceptual) study, as it is based on conceptual analysis that 'recognises diversity in participants' views,' and clearly defines its analytic procedures (Daly *et al*, 2007: 46). The application of quality criteria to qualitative research, such as those suggested by Daly *et al* (2007), is integral to ensuring that the work is of a high standard.

Seale (1999: 184) views the clarity of the research as vital to its validity – the work must be understandable, both to the audience for which it is intended, and to those who take part in the research. This is also key to Interpretive Interactionism (Denzin, 2001). Trustworthiness is also crucial to validity; for example, the audio recording of the interviews means that I am making a commitment to representing statements made by the research participants honestly (Seale, 1999). As a researcher, I also need to remain aware of what Elliot (2005: 163) refers to as 'interpretive omnipotence' and reflect on Denzin's (2001) criteria for good research, ensuring that research participants felt that they were fairly represented. A strength of this research, in contrast to most previous studies of bibliotherapy, is my independence from the groups and texts being observed. As discussed in sections 2.2.2 and 2.2.3, the self-help bibliotherapy materials tested are usually written by the authors of the RCT; and in creative bibliotherapy there are concerns about the 'hero narrative' of psychotherapist-as-saviour (Davidson, 2005). Recent research reports have typically been written by those implementing the intervention, counter to Markless and Streatfield's (2006) guidance on impartial evaluation. However, my aim to produce an exploratory study of various projects, engaging with service users and analysing service provision distinguishes this work from criticisms of previous research.

Kitto *et al* (2008) provide a guideline to establishing quality in qualitative research using various techniques appropriate for this research. They refer to:

- Credibility – the clarity with which the findings are presented, and the extent to which they can be considered meaningful.
- Evaluative and procedural rigour – a 'transparent description' of how the research was conducted, based on ethical and political aspects. This process was begun in section 1.3, and will be considered throughout sections 3.3.2, 3.3.3, 3.3.5, 5.2 and 5.3.
- Transferability or relevance – as mentioned above, while the project is not generalisable, it still aims to provide relevant, useful findings that can be used in practice, including considering the implications for various stakeholders in chapter seven.
- Triangulation – the use of multiple theories and methods to provide a comprehensive approach to research. The use of ANT, ethnographic, and Interpretive Interactionist methodologies, combined with the use of interviews, participant observations, descriptive statistical analysis and textual analysis aimed to produce the comprehensive account required by this criterion.

Whittemore *et al*'s (2001) summary of validity criteria was also used to think about ensuring validity, including acknowledging the researcher's perspective, giving voice to research participants, reflexive writing, and bracketing. These techniques for improving the quality of qualitative research will be further explored throughout this chapter.

Summary

Section 3.2 has aimed to provide what Seale (1999:163) terms 'reflexive methodological accounting.' A value has been placed on both the clarity and rigorousness of the explanation of theoretical assumptions that will support the use of the methods described in subsequent sections of the chapter, and will be mirrored in a rigorous explanation of the procedures of data collection. The important concepts to emerge from the use of an ethnographic approach to data collection and analysis are:

- An acknowledgment of the social construction of the data, recognising that it is formed via a process of co-production between the author and the research participant.
- A realisation that statistical analyses cannot be used to represent or investigate the experiences of service users.
- An awareness of the need to be systematic and apply methodological rigour to qualitative research.
- Recognition that the use of methodological bricolage, shaped by the research design, is appropriate in this instance.

3.3 Research design

Section 3.3 examines the practicalities of conducting the research. Methods of data collection and analysis are discussed, and the recruitment and sampling frameworks are outlined. The research process as conducted is then summarised, including a discussion of ethics, in preparation for section 3.4 which presents the pilot study.

3.3.1 Research methods

The research methods for the project – in-depth interviews, participant observations, descriptive statistics, and analysis of texts – are outlined in this section. The relationship between these methods and the research questions they aim to answer are also explored.

3.3.1.1 Interviews

Kvale and Brinkman (2009) contend that there are seven statements that can be made about the knowledge gained via interviews. These seven concepts form the ethos that underpins my interviewing technique and the data gathered using this method. Interview knowledge is considered to be:

- Produced, or co-authored by the interviewer and interviewee
- Relational – 'neither objective nor subjective, but intersubjective'
- Conversational and linked to the meaning of the lived world
- Contextual, not generalisable
- Linguistic and interactional
- Narrative, using stories as a means of sense making
- Pragmatic, or legitimised by its usefulness to our understanding of the world.

(Kvale and Brinkmann, 2009: 53-56)

The use of interviews rather than questionnaires was chosen in light of a previous evaluation of GIR (Hodge *et al*, 2007). In this study, service users commented that they would prefer to talk about their experiences, and would be more open if asked in person than they would be in questionnaires. Despite the sensitivity of the subject, which might encourage the consideration of anonymous questionnaires, the experience of those involved in the GIR evaluation shows otherwise. As Hodge *et al* (2007: 101) state, 'the administration of formal questionnaires such as standardised quality-of-life or depression scales would have been inappropriate, given the informal, first-name-only nature of the projects and the particular client groups involved.' The decision not to use standardised depression scales for my project also relates to Galasinki's (2008) work concluding that these scales did not fully capture experiences. Although I was aware that it might be more difficult to gain access to service users and establish a rapport with them in an interview, interview data would provide a greater depth of understanding and richness to enable me to answer the research questions.

Keats' (2000) guide to interviewing explores the importance of establishing a rapport between the participant and the researcher, and it was felt that this could be achieved by explaining the reasons for undertaking the research, and the research aims and objectives to the participant. The broad aim of the research – to capture representations of experience – meant that these explanations would not unduly influence the direction of the participants' responses to further questions. Fontana and Frey (1994: 369) question the ethical implications of interviewing. Despite the

intentions of the researcher to be ethical and fair, there is still a balance of power in the interview relationship, in which the interviewer is expected to ask questions; and decides within the answers what is important. However, this is also balanced by the participants' power to refuse to answer, or mislead the researcher. The semi-structured nature of the interview focused on asking open questions, and eliciting narratives about life, experiences and ascribing personal meanings. Within the telling of stories and explanation of personal meaning in interviews, the interviewee constructs their own version of life history, and so narrative is shaped in ways that can be considered to be flawed (Riessman, 2004). The reflexive, constructionist nature of the research means that it is vital to acknowledge these potential flaws in the data; and such awareness of the limitations of language and representations can be seen as a strength of the project.

Empathy and assurances of confidentiality in interviews are always important to ensure that the participant is at ease, but it was felt that they were especially crucial because of the sensitive topic. While I produced an interview schedule – see appendix three – this was a guide or *aide memoire* and participants were allowed to define the direction of the interview. I was conscious that 'the overly-directive researcher can cut off the most interesting leads and rich data' and wanted to avoid this if possible (Charmaz, 1990: 1167). Lofland and Lofland (1995) refer to interviews as 'directed conversation' and this ethos was used throughout the interviews. There needs to be a degree of flexibility within an interview schedule to ensure that new angles introduced by participants can be accommodated (Bates, 2004: 18). As Fontana and Frey (1994: 364) conclude 'there is no single interview style that fits every occasion or all respondents' and this was recognised throughout the interview process.

3.3.1.2 Participant observation

As creative bibliotherapy projects often involve group work, it was decided that it was appropriate to observe these groups, as well as to interview group members, to answer the research questions formulated around experiences of bibliotherapy schemes. Gobo (2008: 5) states that participant observation allows the researcher to:

- Establish a direct relationship between the researcher and participants
- Examine the natural environment of actors
- Observe and describe behaviour
- Interact in everyday ceremonies

- Learn the code that enables the understanding of meaning.

The use of ethnographic fieldwork, observing bibliotherapy groups, aimed to provide an understanding of the experience of bibliotherapy that could not be achieved through other methods. Silverman (2006:68) highlights that the aim of observational research includes an 'attention to mundane details.' The use of observations meant that I was able to participate in group discussions, and think about the connection between the participants and literature *in situ*. Observation highlighted the centrality of social connections within the groups (Hodge *et al*, 2007:101). The length of time spent with two of the groups meant that I was able to establish a rapport with the group members, observing their interaction over a number of months. When interviewing group members, their narratives could be seen to be retrospectively constructed to highlight key points, in contrast with their observed behaviour. My own position in the groups as a person who interacted with the fiction and poetry being read meant that I experienced similar emotional engagement with the texts to the participants. In the case of the two groups with whom I interacted repeatedly, relationships with the group members were also established, providing further insights into group interaction and behaviour. In order to understand the service user experience and answer the research questions, the participant observations focused on:

- Interaction between group members
- Use of literature to reflect on events in life
- Interaction between individuals and literature.

Questions of validity in observation can be resolved by the use of multiple observers; nevertheless, the constraints of the PhD project in which the researcher must work alone meant that this was not an option (Adler and Adler, 1994: 381). I did, however, discuss all the groups with their facilitators on an informal basis. This enabled me to confirm or refute my initial impressions, gather another perspective on the group dynamic and its membership, and ascertain the group facilitators' view on the impact of my presence in the group. Gobo (2008: 124) refers to this as the 'indeterminacy principle' or the idea that the researcher impacts on their object of research in observational research. Discussion with the group facilitator enabled comparison between groups in which I was present to those where I was not; and there was a recognition that the group sessions progressed as usual when I was in attendance, particularly when I attended the group on a longer-term basis and group members became used to my presence. Despite these issues, as Adler and Adler (1994: 382)

comment, observation 'produces especially great rigour when combined with other methods' and as participant observations were also supplemented by interview data, it was felt that it was an appropriate method of data collection.

3.3.1.3 Descriptive statistical analysis

Descriptive statistical analysis is, in many ways, a method that does not fit with the qualitative, ethnographic nature of the thesis. However, inclusion of these statistics contributes to the analysis of BoP schemes, discussed in chapter four. While an examination of issue figures for BoP books cannot be taken as a representative measure of whether or not books are useful as a treatment, they are used by public libraries and health services to 'prove' the success of the schemes. Rasmussen and Jochumsen (2007: 54) view the tendency to use issue figures to legitimise the existence of the public library as indicative of the modernist shift from viewing the public library as providing enlightenment to a 'performative rationality' that legitimises through statistical measurement. Law (2009: 248) echoes these notions of the performativity of statistics. Thus, it was considered appropriate to examine a sample of statistics relating to libraries in Wales to illustrate perceptions of self-help bibliotherapy schemes.

A data archive, the Public Lending Right (PLR) statistical database (also known as LEWIS) was used to collate annual issue figures for books on the BoP list for a representative sample of libraries in Wales between 2000 and 2010. The PLR employs statistical sampling methods to ascertain the number of issues each specific book in a library has over the period of a book. Typically, around 1000 branches nationwide per year provide data for the scheme. The PLR figures do not provide a complete picture of self-help book borrowing, but they are designed to provide a representative sample from a population of library services (Parker, 2009). The analysis was primarily a descriptive one, as it was not an attempt to infer characteristics of that population; 'sometimes we are simply interested in describing the numerical characteristics of the set of cases' (Garner, 2005: 46). The aim was to represent the longitudinal effect of introducing BoP and explain how book issue figures have a legitimising role.

3.3.1.4 Texts

The final method of data collection used was textual analysis. An approach building on the ANT and ethnographic approaches to the research was taken, drawing on influences from the work of Silverman (2006), Coffey and Atkinson (1996), Law and

Mol (2002) and Hodder (1994). As the aim was to critique current models, the documents analysed were predominantly produced by local government and organisations responsible for bibliotherapy schemes or were statements of national government policy. Questions were asked of the texts including their intended audience; authorship; purpose of production and use of language (Coffey and Atkinson, 1996). A close reading of key sections was then undertaken, with the aim of analysing the effect of these particular representations on the construction of bibliotherapy schemes.

3.3.1.5 Relating methods to the research questions

Having outlined the main methods used for data collection in the research, it is appropriate to link these methods directly to the research questions outlined in chapter one. Table 3.1 clarifies these links.

Table 3.1: Research questions and methods of data collection

Research questions	Methods of data collection
How do people with mental health problems use reading as therapy, both in formal bibliotherapy schemes and independent of these schemes?	Interviews with bibliotherapy group members and non-users of bibliotherapy schemes; participant observations.
How did the three main models of bibliotherapy in the UK emerge?	Analysis of documents; descriptive statistical analysis; interviews with identified key informants.
What is the relationship between bibliotherapy schemes and the use of reading as therapy by people with mental health problems?	Comparison of findings from interview, observation, and document analysis studies.

The following sections will outline the practicalities of conducting the research, engaging with questions of sampling, recruitment, and data collection.

3.3.2 Sampling and recruitment

Initial constructions of the research design focused on observations and interviews with users of formal bibliotherapy schemes. Suitable locations were identified for recruitment and data collection, aiming to gather experiences of different models of bibliotherapy. As few areas offer creative bibliotherapy in the UK, this limited the number of potential sites for analysis. In all areas, the primary aim was to gather the experiences of users of bibliotherapy services, and to supplement the understanding of current models of bibliotherapy via interviews with appropriate institutional representatives. However, this was not always possible, as will be explored here. A number of other bibliotherapy schemes and groups operating emergent models were

also identified as appropriate for analysis, and I contacted several schemes to try and facilitate access to groups. However, for reasons including lack of response, lack of appropriate groups running within the data collection period, and concerns about the vulnerability of those taking part in the bibliotherapy groups (some of whom were under 18), these schemes were not included in data collection. The sites included in analysis will now be outlined; to preserve the anonymity of participants in the research, these locations are referred to by pseudonyms.

Smithville: An urban location, in which a BoP-type self-help scheme, typical of many in the UK operates. Participants were recruited in co-operation with the public library service, who advertised the research project using posters and leaflets located in library branches. A key contact facilitated access to library mailing systems and promoted my research throughout the city.[5] An advertisement was also placed in a local mental health service user magazine, distributed throughout the Smithville area. Support groups dealing with mental health issues, identified via a Community Information Service database were asked to distribute information about the project to their members.

While the focus of the advertisements was schemes like BoP, the posters attracted the attention of other public library users who felt a connection with the themes of the project – literature and mental health. These participants were a sample group not initially considered as part of the research design, yet their experiences of using therapeutic reading independently of bibliotherapy schemes have obvious implications for current models of bibliotherapy. Thus, the decision was taken to interview these volunteers about their use of public libraries, therapeutic reading and mental health.

Twelve participants volunteered to be interviewed. Three further participants who initially contacted me about taking part in the research were unable to take part in an interview. I chose not to interview a representative from the library service about the BoP-type scheme after initial conversations with a number of members of library staff, who identified the recent neglect of the BoP-type scheme as a reason for lack of use of the scheme. Participants interviewed had almost universally not used the scheme, so it was not thought that a discussion of the scheme with staff would provide additional insight.

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[5] The ethnographic concept of 'key contacts' is used throughout to preserve anonymity. I met all my key contacts at conferences and via professional networks.

Smithville North: Discussion with my key contact in the Smithville public library service also enabled me to negotiate access to a therapeutic reading group run by the library service. This group, the only one of its kind in Smithville, was based on a typical library reading group model, but was primarily aimed at people who had previously undergone NHS counselling and was facilitated by a counsellor. This group represented an emergent form of bibliotherapy not previously examined in exploration of current models, and so I felt it appropriate to work with this group to understand their experiences in the context of other models of bibliotherapy. I conducted interviews with four group members and the group facilitator; and observed four group meetings.

Williamstown: Previous interaction with bibliotherapists in Williamstown facilitated access to the group. I observed seven group meetings, enabling me to establish considerable rapport with the group, and interviewed two group members. I also interviewed the group facilitator, and two members of library staff with responsibility for managing bibliotherapy groups in Williamstown.

Jonesfield: Again, using a key contact enabled me to negotiate access to bibliotherapy groups in the Jonesfield area, which operated on a different model to the Williamstown group. I observed four different group meetings in this area, and also had informal discussions with group facilitators, which I recorded in my field notes. While the participants in Jonesfield groups were happy to be observed, none volunteered to be interviewed. This is potentially because of the location of Jonesfield in relation to my research base, which meant I could not repeatedly attend group meetings as I had in other areas, and so there was less opportunity to develop a rapport. As no service users were interviewed, I decided not to request formal interviews with staff.

Taylorbridge: The facilitator of the Taylorbridge group was a key contact in facilitating access to participants; the group operated on a similar model to those in Jonesfield, and so as I had been unable to secure any interviews in Jonesfield, I decided to observe a meeting in Taylorbridge to try and recruit further interview participants. The enthusiasm of the group facilitator, who was conscious of the need for evaluation of bibliotherapy groups, meant that I was able to conduct a group interview and a further three telephone interviews. I also had an informal discussion

with the group facilitator about the role she felt the group played in the maintenance of mental health.

Wales: As Wales has the only nationalised bibliotherapy scheme in the UK, I decided not to use a pseudonym to refer to it, as it was easily identifiable by definition. Key contacts with national responsibility for the direction of bibliotherapy schemes were again established at conferences, and two were interviewed. However, contacts in local public libraries, who could have facilitated access to service users, did not wish to participate in the research for reasons of time constraints. As my research base is a significant distance from Wales, it was not possible to advertise the research project without the assistance of local library services and thus I did not recruit service user participants to the research in this project.

The sample was a purposive one, gathering experiences of therapeutic reading and bibliotherapy (Silverman, 1997). Research participants were asked to pass on details of the project to other potential participants as snowball sampling is best suited to working with more vulnerable groups of people (Gobo, 2008: 104). Mental health is a sensitive topic, and as was discussed in chapter two, people with mental health problems may feel stigmatized by their condition. Therefore, I had concerns about recruiting enough volunteers to conduct an appropriately detailed qualitative analysis within the time constraints of the thesis. For this reason – and because of the aims of the project to produce a locally-situated, ethnographic piece of research – the only criteria established for screening participants were that people:

- Were over 18 years of age
- Had used a formal bibliotherapy scheme in the UK *or*
- Self-identified as using reading to manage or improve their mental health problems.

Initially, the aim was to talk to those who had used a formal scheme, but as stated in the section discussing recruitment in Smithville, this evolved as the project progressed and the third criterion mentioned above was included. A convenience sampling method was used, talking to all participants who volunteered to be interviewed and met these criteria (Denscome, 2003). All participants were therefore self-selecting; self selection meant that participants were comfortable talking about mental health and their experiences, thus minimising potential distress. As has been discussed, the aim of the research was not to produce a generalisable piece of

research, so there was no need for the sample to be representative (Denzin, 2001; Denzin and Lincoln, 2000).

Recruitment in Smithville and Williamstown raised a number of potential issues. For practical reasons, the advertisements for the research contained a postal address and an email address – to maintain confidentiality, I could not provide a telephone number by which to contact me. As participants came forward, I became aware that not all participants had a positive relationship with modern technology. Computer literacy was low amongst many participants, and even those who engaged with some aspects did not feel comfortable with email. While I was able to recruit several individuals who later discussed their dislike of computers – and three service users who bypassed the issue using the postal service or word of mouth – this may have had an impact on those who chose to be involved with the research as potential participants who preferred phone contact may not have contacted me. As discussed in section 2.2.2, some preliminary conclusions have been reached about the role of technology in treatment for mental health problems and a reluctance to engage with cCBT in particular has been observed. Conversations with members of bibliotherapy groups also revealed a similar disinclination to engage with technology. The recruitment via bibliotherapy groups may have gone some way to providing access to a more diverse group, including those who would not have been recruited via email, helping to limit the potential for bias inherent within the interview recruitment process. Engagement with technology and its relationship to bibliotherapy will be further be discussed in section 5.3.1.1.3.

3.3.3 Conducting the research

Section 3.3.3 is purposefully descriptive of the research process, aiming to address Kitto *et al*'s (2008) criteria of procedural rigour and to provide what is often referred to as an 'audit trail' within the research (Seale, 1999: 160-1). Data collection began in March 2009 with the location of appropriate documents, which form the basis of chapter four. I submitted a Freedom of Information Act request to the Welsh Assembly Government (WAG) to access further appropriate documentation, and initial collection and analysis of the PLR book issue statistics began. Interviews with identified representatives from Wales were conducted after receiving ethical approval for the research. Following this, I started to work with the Williamstown group, while producing and distributing my publicity materials for recruitment in Smithville. This led to two interviews in Williamstown. I published a short recruitment advert in a Smithville mental health service user magazine, which led to two

interviews in Smithville. There was then a short lull in service user recruitment, during which I was able to conclude work with Williamstown service users and complete my interviews with managers and the group facilitator before resuming recruitment in Smithville. Around this time, based on my experiences and written reflections on the research, I restructured my interview schedule. While the main content of the questions did not change, I organised it into sections, creating a more versatile schedule that formalised the introduction and conclusion of the interview more clearly.

As I asked all participants where they found out about the research project, I found that advertisements in libraries had recruited more volunteers than my mail out to local mental health service user groups. Without information as to what the mental health support groups did with the materials, it is difficult to speculate why this might be. The success of recruitment via libraries meant that I decided to distribute another set of advertising posters with revised wording based on my improved understanding of the use of bibliotherapy in Smithville. I also published a longer article in the same mental health service user magazine, reflecting more broadly on bibliotherapy as a therapy, and again asking people to come forward. Often, participants stated that they had seen both the poster in the library and the article in the magazine, a combination of which encouraged them to come forward. Twelve further participants volunteered to be interviewed, though this only resulted in ten interviews.

Concurrently, I started to work with the Smithville North reading group, observing group sessions, and conducting interviews with four participants. I also interviewed the group facilitator. I spent three days in Jonesfield observing their rolling programmes of reading groups, with the hope of recruiting further participants for my research. However, as detailed above, this did not occur at this juncture. Following this lack of success, I approached the Taylorbridge bibliotherapy scheme and was able to observe and interview this group.

All interviews were audio-recorded and after interviews I explained the next steps of the research process to the participants. The procedure was that I would transcribe the interview; send a copy of the transcription to the participant to read; then they could correct, clarify, or remove comments as appropriate. This member checking is not a technique that can be used to ensure validity, or evaluate the quality of the transcript (Taylor 2001: 322). It was to allow the participants to review the representation of their views, and to engage in a short dialogue if they wished to

expand on, or withdraw, any comments. As mental health is a sensitive issue, I felt that this member checking via distribution of transcripts would help to ensure the project maintained its commitment to ethical research, and allow participants to withdraw personal information if they wished. Sixteen out of the total of thirty-three participants (including service providers and managers) responded to their transcript. All participants were happy with their transcripts, with only three choosing to clarify comments.

All participants were assigned a pseudonym, cross referenced with a transcript number; care was taken not to assign any participant's real name as a pseudonym. To differentiate between service user participants and participants who contributed in their professional capacity, the latter are referred to by their transcript number, prefaced by the letter S for service provider (e.g. S-1). Most interviews were conducted as individual, face-to-face interviews. Five interviews (three with service users; two with representatives from Wales) were conducted over the telephone, for practical reasons related to the location of the participants. However, I had previously met three of these participants, meaning that it was easier to establish a rapport. One group interview, with members of the Taylorbridge group, was conducted. Fontana and Frey (1994: 365) state that there are three key elements to a successful group interview – the interviewer must ensure they stop any one person dominating; encourage all group members to participate; and try to obtain responses from all to ensure the fullest coverage. Reflecting on this interview, I feel that I achieved two of these key elements, but failed to stop one participant from dominating the interview.

Interviews took place in University meeting rooms or public library buildings. Concerns from the Information School Ethics Review Board meant I was discouraged from attending participants' homes, and security procedures were put into place to ensure my personal safety (see appendix four). One interview was conducted in a participant's home, and these security procedures were followed throughout. Reflection on this interview showed that interviewing a participant in their own home was a rich source of data. While participants often referred to books that were of importance to their experience, they could not always remember the titles or authors. Thus, some details were lost, or I had to guess at the title from the description given.[6] Interviewing a participant in her own home meant that she was

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[6] See appendix seven.

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able to go and get titles to which she wanted to refer from her bookshelf as appropriate. It also provided context in terms of observations of the books she also read, but chose not to discuss. Future work should consider this as an important source of contextual data.

As people with mental health problems are considered to be vulnerable, I decided not to use a written questionnaire to collect demographic data. I was aware – and early interview experiences showed – that participants might find official-looking forms to be off-putting. As it was vital that the participant read the information sheet and gave informed consent, I made the conscious decision to focus attention on these forms, and to collect demographic information by observation and questions throughout the interview instead. I was aware that asking for detailed information about diagnoses might confer the impression of an overly biomedical perspective and constrain the conversation. Participants and I talked round the subject until they felt comfortable discussing their diagnosis or symptoms.

Reflecting on observational data collection, I felt the observations of the groups I was able to meet on a more frequent basis provided data that was more rich and detailed. The establishment of a rapport and familiarity with group members, coupled with the opportunity for multiple observations, meant that I was able to understand the mechanics of these groups and focused my attention on the more mundane interactions, as advocated by Silverman (2006) and discussed in section 3.3.1.2. While attending the groups in Jonesfield and Taylorbridge provided a breadth of experiences that could not have otherwise been gathered, I felt that observing a smaller number of groups on a repeated basis may have been more appropriate for this project. However, having conducted observations in Jonesfield and detailing my perceptions of the shortcomings of my interactions, both the observational data and interviews conducted in Taylorbridge were richer, more detailed, and strived to establish more in-depth level of rapport. As I was aware of the short amount of time I would spend with the group, I contributed more to the discussion than I had done in Jonesfield, helping to build a reciprocal level of trust with the group. Combined with the enthusiasm of the group facilitator for the project, which also encouraged group members to be interviewed, this led to a more successful interaction with the group.

Participant observations were recorded in two ways following the interaction with the groups. Firstly, field notes based around the three themes detailed in section 3.3.1.2 were written. While it is generally thought ideal that the notes are written *in situ*, I felt

that note-taking may have disrupted the flow of the group discussion, and made participants feel self conscious. Similarly, it was decided not to video or audio record the sessions for the same practical reasons. The decision to maintain a low observational profile was reinforced in one group when an unfamiliar member of staff came to a group meeting and took notes, causing comment from the group participants. Obviously, as there were no *in situ* notes or recordings, this then potentially presented an issue of validity, but it was felt that a partial record was preferable to disrupting the group and potentially restricting the behaviour of the group members. Following these observational field notes recording interactions, I also wrote reflective field notes, recording my personal response to the observations and thinking about my own role in the process of data collection and analysis.

In the observational field notes, I tried not to be too analytical, noting as much detail as I could about each group meeting, with a defined focus on the interaction between group participants, and between the literature and participants. The aim here was to have a clear record of the meetings. Field notes were then transferred into a computer file, allowing further time for reflection. All transcripts, observations, and reflective field notes were uploaded into NVivo 8, a software package for organising qualitative data. Preliminary analysis was conducted throughout the data-gathering process, with the reflective field notes highlighting initial commonalities of experiences, repeated concepts, and significant differences in experiences.

Charmaz's (1999) work on memo writing was a useful guide to thinking critically about the experience of collecting data. The process of interviewing and participant observation required great sensitivity, and interviews and observations were not always straightforward to arrange, conduct, or analyse. Rather than gloss over my experiences, I reflected on these experiences to enrich my understanding of the research process (Taylor, 2001: 41). However, I took care not to descend into 'methodological angst' (Seale, 1999). Reflective field notes were written after each interview and participant observation session, and also when I felt that there was a particular need to note an experience or reflect on a change, challenge, or insight; sixty-four pieces of writing were created. I separated these memos into four categories – observational, theoretical (or concerned with evolving impressions of the data), methodological (or about how to remedy issues in the fieldwork) and emotional (or self-analytical) (Gobo, 2008: 208). The purpose of the writing was to think critically about choices made, from the direction of individual interviews to the final representation of research participants in the thesis. I reflected on strengths and

weaknesses of the process and thought about how it could have been improved. Many of the reflections from this process form a significant proportion of this section.

To explore the justification for the use of observational fieldwork, I will present a brief reflection on my involvement with one of the groups – Williamstown – to explore the insights that being a member of this and other groups gave me. Before I begin this section, I am conscious of two insights from Hannabuss's (2000) work on ethnography in LIS; firstly, his statement that 'the researcher is also there *qua* human being' resonates with my approach to the research (Hannabuss, 2000: 100). Throughout the observations, I was conscious of my own role, personality and experiences and their impact on shaping the notes I made. Hannabuss (2000: 101) also comments on the nature of ethnographic reflection, which can 'lur[e] the researcher into reminiscence rather than record-keeping'. This section uses a bullet-pointed structure rather than a narrative one to encourage focused reflection rather than tangential reminiscences.

My interaction with the Williamstown group provided a number of key insights that could have not been gained using other data collection methods:

- The opportunity to read group members' poetry and understand the context of the poems being written. Despite access to a publication containing poetry by some group members, I found the explanations and discussion surrounding the poems to be as important to my understanding as the poems themselves.
- Similarly, reading the same poetry as the group enabled me to ascertain which poems resonated with them; which influenced their writing; and to note which poems they asked to be photocopied for them to keep. When I asked group participants in interviews to name poems that they enjoyed or felt were important, often they could not remember titles or authors, and this information would otherwise have been inaccessible.
- Reading the poems at the group, which could be obscure and require some decoding, meant that I was able listen to participants' understanding of the poems, to share my insights and to understand the relationship between the language used in the poetry and the experiences that were shared as a result. The inter-relationships that developed were complex; to take a descriptive example, Ethel[7] wrote several poems about her family history, which inspired the telling of an anecdote about her mother. This anecdote led

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[7] See participant profile in appendix two.

the group facilitator to read two very family-centric poems by Don Paterson to the group, which in turn led to the suggestion that the group write a poem with the same title as one of these poems for the next session. The direction of the group was continually shaped by what had come before, and the literature that had personal impact on group members.

- Taking part in the group enabled me to understand the skills of the facilitator, who adapted her plans according to the group members present, their mood, and the direction of the discussion. She presented these ideas to me during our interview, but observation captured these methods and abilities in action, presenting a richer picture, and allowed me to appreciate the organic nature of the group interaction.

- While the aim of developing a rapport with research participants is to gain trust and elicit information, working with the groups led me to develop genuine concern and admiration for group members, some of whom had overcome numerous difficulties. My personal experience of mental health problems, though different, led me to empathise with group members.

- This genuine feeling of engagement with the group culminated in my delight, in week four of my observations, in my participation in what I referred to in my field notes as the 'tea ritual.' Every meeting trusted member of the group (limited to a small number of group members) poured hot drinks for other group members. This was an important framing moment within the group, signalling a change from general chat to discussion in the group 'proper.' Partaking in this responsibility made me feel accepted by the group members as 'part of the furniture.'

- My participation in the group was also shaped by my personal love of reading poetry and experience of writing it. Having ascertained the structure of the group in the first meeting, I decided to participate in a 'homework' exercise – to write a poem containing five lies about yourself – giving me further insight into the group experience:
    - I struggled to write on the theme, experiencing the challenge of a lack of ideas and the time constraints of writing a poem on a defined theme in two weeks.
    - My feelings were further complicated by the need to disclose five 'lies,' which implied that there would be five accompanying 'truths' to tell. I felt uncomfortable disclosing these lies to people I barely knew, and my awareness of their proficiency in poetry writing made me feel self-conscious. I felt that this must be the experience of many group

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members who wished to join a bibliotherapy group. Indeed, later discussions with the Smithville North group members confirmed this (see section 5.3.3.3).

- Arriving at the group with my five lies homework, I was very aware of the competing demands for attention from the group facilitator; the time available for the group, and the genuine enjoyment experienced by the group members. The group was an important part of their week, and was too short for the amount of discussion. I decided not to share my work, giving time instead to listening and sharing in their work. Several group members also took this approach during my time with the group, though I did not discuss their motivations for doing so with them. Despite not sharing my own work, I still felt able to participate in discussion of others' work, and appreciated both their desire to share work, and their openness.

- Taking part in informal discussions before and after the group enabled me to learn more about the personalities, likes, and dislikes of group members. This enabled me to understand some of the 'running jokes' of the group, which I could easily have misinterpreted without an awareness of the context.

- As considered in section 3.3.2, participating in the group made me understand my own lack of awareness of the interaction between people with mental health problems and computer technology. It was not until I explained to Ethel that the information sheets I produced presumed that the participant had email access that I recognised this as a problem and altered both my recruitment procedures and information sheets. Without this feedback, I would not have realised this potential issue for a longer period of time. Appreciating my own shortcomings as a researcher made me more able to react to the needs of those taking part in my research, which also helped me to develop a rapport with interview participants later in the project.

- Defining the end of the observations with the group allowed me to reflect on my relationship with the group. Having first consulted with the group facilitator, I managed my exit from the group after seven meetings. My observations of the group noted the importance of biscuits to the group interaction, and so I provided some as a thank you to the group members for the intrusion (with some crumpets for the member of the group who did not eat sweet things; this also related to a poem he wrote for an earlier meeting). These gifts enabled me to define the end of my presence in the group, and to understand my impact on it. The group appreciated the gift, and I understood

that my presence had not been seen as an intrusion. After the group had ended, I sent a letter and enclosed my work address, to ensure that people could contact me if they wished. I felt that this management of an ending worked well, leaving channels of communication potentially open without placing expectations on either myself or the participants to maintain contact.

Gobo's (2008) work on ethnography highlighted that this process of observation and reflection enabled me to 'learn the code' of the group and to understand the significance of some actions within the group. Further reflection on my involvement with the groups led me to conclude that the long periods of time I spent with group members may have positively affected the analysis of the data. I was conscious of the need to present participants sensitively, aware that they were human beings with lives outside of the research project and not just 'data' to be analysed. Similarly, the highly personal stories told to me by interview participants enhanced this desire to be sensitive to participants as people. Conducting observations for a relatively small-scale thesis project was problematic because of the sheer volume of data accessed. The rich, thickly descriptive memos that I wrote were difficult to bracket, despite Denzin's (2001) Interpretive Interactionist guidance. While I feel I was able to analyse the key points in depth – using the methods outlined in section 3.3.4 – much of the context was then lost in the need for concise academic writing in the thesis.

The theoretical and methodological constructions on which the research is based were not compatible with the concept of reaching 'saturation' in data collection. Instead, the research was constrained by the practical time constraints of the thesis project; data collection was reviewed throughout the process, with the aim of ending recruitment in October 2010, providing that an appropriate amount of rich, detailed data had been gathered. By October 2010, sixteen group meeting observations and a total of thirty-three participants had been interviewed. Comparison with other similarly-sized research projects showed that this was a comparable amount of data and thus data collection ceased. As Denzin (2001: 83) states, 'all interpretations are unfinished, provisional, and incomplete' and time constraints meant that this was the case in this project. Having finished data collection, focus shifted to data analysis which will be outlined in the next section.

3.3.4 Data Analysis

Preliminary data analysis was conducted throughout the data collection process; the act of writing and reviewing field notes, and of transcribing interviews requires a

process of analytical thought (Jovchelovitch and Bauer, 2000:69). Indeed, Rapley (2004) posits that analysis begins during the interview itself. His review of the interview-process-as-method concluded that the act of asking for clarification of a response or asking a 'follow-up question' shapes the interview and thus constitutes a form of analysis (Rapley, 2004).

Interview analysis was conducted according to Denzin's (2001) Interpretive Interactionist criteria – ensuring that rich, descriptive data was gathered; both contextualised within my prior knowledge and deconstructed and bracketed separately as narratives in their own right; 'assum[ing] that multiple meanings will always be present in any situation' (Denzin, 2001: 117). As the interview schedule was a flexible document, I was also able to react to emergent concepts from previous interviews and allow participants to shape the direction of interviews. I took two main approaches to the analysis of interview and observational data; one holistic, and one thematic. Both approaches took influence from Merrill and West's (2009: 131 - 135) guidance on how to read interview transcripts and identify the key themes within them. Firstly, I looked at transcripts individually and wrote short participant profiles of all interview participants, thinking about their diagnosis, symptoms, personal understanding of mental health, and how their methods of maintaining mental health might impact on their use of bibliotherapy. These profiles are presented in appendix two.

I then took four transcripts from participants I considered to be very different, based on their profiles – Alfie, Ethel, Julia, and Winston – and adopted a process of descriptive coding (Saldaña, 2009). Transcripts were closely read, and I wrote words or phrases from the transcripts that I felt encapsulated experiences. Coffey and Atkinson (1996: 29) describe this process as 'noting relevant phenomena; collecting examples of those phenomena; and analysing those phenomena in order to find commonalities [and] differences.' A list of forty-five initial codes was produced; from this list, and aided by one of my research supervisors, I then drew up an initial model, trying to focus on key themes. I then set this descriptive bracketing or coding work aside, and chose another transcript which I felt contained elements of many different reading experiences, that of Vivienne. Again using pen and paper, I read through and descriptively coded this transcript, producing a list of forty-two coding terms, some repeated from the initial list. From these initial two frameworks, I drafted a coding structure which was then transferred into NVivo 8. The approach was similar to pattern, or focused, coding which aims to define and organise codes to

refine the structure (Saldaña, 2009). From an Interpretive Interactionist perspective, this stage involved moving from bracketing to construction (Denzin, 2001). In Grounded Theory, this form of analysis is referred to as moving from open coding to axial coding (Charmaz, 2006). A decision was taking to code transcripts in this manner because of the need to look at intertextual relationships; for example, to identify participants talking about the same book titles.

This structure, available in appendix five, was then used to code all transcripts, including the five previously coded using the preliminary structure. A process of simultaneous coding was adopted, to address the complexity within the transcripts, and codes were allowed to overlap to express multiple meanings and conceptualisations (Saldaña, 2009). For example, participants talked about titles that they needed to own (coded as 'reading habits – book ownership') that they might also want to re-read (coded as 'reading habits – re-reading'). Further simultaneous coding might occur if the title of the book was also mentioned, leading to a need to code a section of the same data as 'interaction with the text – book title.' Similarly, the process of coding was also holistic; the complexity of interview transcripts meant that codes were applied to sizeable sections of the data to ensure that the context was maintained (Saldaña, 2009). A brief definition of each coding category was written, so that the same categories were applied consistently across all transcripts.

To further ensure consistency, I compared the initial paper-and-pen codes noted on one transcript against the version coded with the final structure, to examine if the same key themes had been identified and the coding was broadly similar. Throughout the coding process, as I came across potential codes not previously identified, I recorded these in a spreadsheet, and reviewed the list after coding all transcripts according to the initial framework. The coding framework was altered where applicable, to capture other significant experiences not previously considered, and all transcripts were re-coded with in line with this further revised structure. The coding framework and conclusions from the data were regularly discussed with the research supervisors, to provide additional insight and consider other perspectives on the data.

After coding thematically and thinking about the key categories for the analysis, I wrote narrative accounts of the use of literature by five participants – Julia, Winston, Nathan, Vivienne, and Milly. This helped me to think about the role that literature played in the context of life and focus on the use of specific titles. I also examined

the participant narratives in relation to the emerging concepts I had identified, reflecting on the categories in relation to participants' experiences. This process enabled me to connect my initial holistic approach to data analysis with the themes delineated at the coding stage, comparing my impressions of participants' individual experiences with the themes in the analysis. One criticism of coding methods is that they can decontextualise personal responses; the application of a holistic approach to coding – preserving background information in the codes – combined with the initial participant profiles previously discussed and narratives considered here tried to ensure that this was not the case (Geertz, 1973). Finally, having established the four models of bibliotherapy presented in section 5.3.5, I again examined Nathan's transcript in relation to these models – see section 6.3 for this example of holistic coding, moving between personal and theoretical to ensure clarity and coherence. As stated the finished product must be both coherent, and understandable to research participants, representing their experiences in a way that they understand (Denzin, 2001: 84). Recognition of experience and a focus on honest, empathetic portrayals were regarded as important concepts for data analysis. The ethical considerations of this project are further considered in section 3.3.5.

3.3.5 Ethics

The University of Sheffield's ethical research policy was followed throughout the research, complying with guidelines for participant safety and anonymity. Ethical approval for the pilot study was given in April and July 2009 for the main research respectively. After lengthy debate about NHS partnerships with libraries, the head of the University Research Ethics Committee concluded that because of the recruitment methods for the project, it was not necessary to apply for NHS ethics approval. Copies of emails detailing ethical approval are contained in appendix six.

As the project evolved, so did the information sheet, which was resubmitted for review and re-approved in May 2010. Participation in the project was voluntary, and participants were asked to read an information sheet and sign a consent form, confirming that they understood the purpose of the research. Consent to attend group meetings was obtained in advance via the group facilitator, who explained to members that I would be attending the group. I often had discussions with the group members about the purpose and context of my research, and was happy to answer any questions they had in as much detail as possible. Volunteers were also informed that they could withdraw their data from the research at any time. Data was anonymised and kept securely on a password-protected computer. Transcripts were

only accessible to the researcher and the individual participants who gave the interview. Following this discussion of the ethics of the research project, the pilot study for this project is the subject of the next section of this chapter.

3.4 Preliminary research: the pilot study

The preliminary work for this study was conducted as an MA Librarianship dissertation project talking to front-line library staff (Brewster, 2007). Three concepts of bibliotherapy relevant to the modern public library were established in this research. The need to talk to service users about their experiences was confirmed in this previous project, highlighting the need for further evaluation. The project examined the implementation of current models in practice, by front-line staff who administered the bibliotherapy scheme in libraries.

Further preliminary work for the current study was conducted with library, social work, and health care staff. Again, the focus was on staff involved in implementation of current models, but the work was used to confirm relevance of previously established concepts of bibliotherapy. The research was conducted at a conference where I led a workshop. The focus of the conference was creative bibliotherapy, but staff involved in self-help bibliotherapy schemes also contributed.

Workshop participants were asked to discuss questions about the scope, audience, and location of bibliotherapy. The purpose of the second pilot was to clarify terminology, and update research conducted in 2007. Around thirty participants in eight groups contributed to the data, with twenty-one participants also submitting demographic information. The majority of participants were female, and there was an equal mix of representatives from the library and health sectors. There was also an equal spread of ages represented, but the sample was not ethnically diverse.

A basic thematic analysis of the data was conducted; concluding that concepts of bibliotherapy in practice informing this research were still relevant (Coffey and Atkinson, 1996).

The preliminary study found that:
- Staff felt that bibliotherapy should be for everyone, but might be more appropriate for people with mild to moderate problems.
  - 'Bibliotherapy is for people who are 'self-helpers' rather than with acute psychological disorders' (group two).

- 'It's for people with mild to moderate anxiety or depression' (group three).
- 'Everyone benefits' (group four).

- Bibliotherapy schemes should be provided in accessible and non-threatening environments. Libraries were mentioned as an example, but it was felt that other safe environments were also appropriate locations.
    - 'Bibliotherapy schemes should be provided in safe environments where people feel comfortable and relaxed' (group one).
    - 'They should be provided in places which feel comfortable for people' (group three).
    - 'Libraries [are the] perfect partners but can it happen anywhere where people can access – prisons, schools, health centres, care homes, hospitals, homes, where ever it is needed' (group six).
    - 'Somewhere accessible and non-threatening/ neutral. Community spaces/ libraries/ hospitals/ residential homes/ own homes' (group eight).

- The mix of expertise between library staff and health care workers established successful partnerships.
    - 'Joint working between libraries and health services [is] essential – a mix of expertise' (group four).
    - 'Bibliotherapy should be provided by libraries and health sector working in partnership. Two areas of expertise coming together' (group one).

- Evaluation of bibliotherapy schemes is often difficult, but is highly necessary to ensure the quality of the scheme. The benefits of bibliotherapy can be difficult to quantify.
    - 'There is a need for evaluation models and a system all partners can use – case studies etc' (participant eleven).
    - 'There is a difficulty of measuring outcome – perhaps a need to link to other projects' (participant three).

Overall, the pilot studies confirmed the necessity and appropriateness of the main research project, showing the gaps in the evidence base I previously identified were the same as those found in practice. The findings from the pilot study were used to

confirm the relevance of terms which were then used on recruitment advertisements; and to shape the focus of the interview schedules used with service user participants.

3.5 Methodology and research design summary

The research project connects a number of different epistemologies, data collection methods, and modes of analysis. The paradigm on which this research is based 'assumes a relativist ontology (there are multiple realities), a subjectivist epistemology (knower and respondent co-create understandings), and a naturalistic (in the natural world) set of methodological procedures' (Denzin and Lincoln, 2000: 24). The research avoids the 'illusion of critical distance,' recognising that every researcher operates from a subjective standpoint (Pool, 1991: 318). It recognises the diversity of the world, and tries to represent its polyvocality, rather than concentrating on streamlining experience into categories.

As Watson *et al* (1995) state, using a methodology always in itself requires interpretation. Recognising the need for reflective practice acknowledges that 'in real world practice, problems do not present themselves to practitioners as givens' (Schön quoted in Watson *et al*, 1995: 448). Throughout the project, I was careful to maintain an awareness of my own position in the research, and examine how self-location could be related to the formulation of research questions and the interpretation of participant responses.

Section 3.2 explored a number of methodologies and theories not typically found in LIS, including Interpretive Interactionism and ANT. The qualitative methodologies to be used for data collection and analysis have been summarised, and I have demonstrated how these multiple methods fit together to formulate the thesis as a whole. It is hoped that the use of documents, interviews, participant observations, and descriptive statistics will provide an insightful picture of current use of bibliotherapy that can be translated into recommendations for practice. As Seale (1999: 8) states 'rather than opting for the criteria promoted by one variety, 'paradigm', 'moment' or school within qualitative research, practising researchers can learn valuable lessons from each one.' The concept of the researcher as bricoleur links with a number of assertions that analysis and research are 'craft skills' rather than models to be applied to the research (Denzin and Lincoln, 2000).

Section 3.3 outlined the primary methods of data collection and analysis. It has demonstrated the suitability of using a mixture of methods. These methods form a coherent research design, connected to the research questions in table 3.1. Finally, the findings from the pilot study were outlined, preparing the ground for the following two chapters which critically analyse the construction of current models of bibliotherapy, and present the findings from the interview and observational studies.

Chapter Four: The emergence of current models of self-help bibliotherapy

4.1 Introduction

As explored in chapter one, there are three main models of bibliotherapy – BoP, RAYS and GIR – in use in the UK. Chapter four aims to analyse these models, and presents the first findings from the research study, critically reviewing current practices of bibliotherapy in the UK. An ANT framework – discussed in 3.2.4 – was used to analyse documents, interview transcripts, and descriptive statistics and these sources of data are used supportively throughout the chapter, to illuminate specific points. Building on the approaches of Van House (2004), Callon (2002) and Cho *et al* (2008), ANT is used here as a model to trace the evolution of a network, focused on events and processes. Law's (2002) work, examining the translation between the world of design and the world of lived experience is also of particular relevance for this chapter.

Following on from the examination of the emergence of current models of self-help bibliotherapy in section 4.2, sections 4.3 and 4.4 will perform a similar analysis of the two main models of creative bibliotherapy in the UK. The chapter will thus engage with recently emerging models of holistic health care and their inscription in policy documents, and will locate models of creative bibliotherapy in the context of their aims to provide relaxation and access to literature; the construction of the proposed connection between reading literature and health will also be discussed. Finally, section 4.5 draws together an analysis of these three models and the key characteristics of the three models discussed – RAYS, GIR and BoP – will be compared to ascertain the main features of the networks and the implications for service users, before the interview and observation studies are presented in chapter five.

4.2 Books on Prescription

This section examines the translation of reading self-help books to improve mental health from an informal practice into a national primary-care scheme. Although many models of bibliotherapy exist, one has become particularly influential – the BoP model (Frude, 2004a). Originally piloted in 2003, recent estimates suggest that there are now around one hundred BoP schemes, making it the most widely used model of bibliotherapy in the UK (Hicks *et al*, 2010). The BoP model was also implemented across Wales as a flagship initiative known as Book Prescription Wales (BPW) in

2005 (Frude, 2008a). This section addresses the question of how this scheme has come to be so widely adopted.

The importance of evidence-based interventions has been a key element of health care policy and practice over the past decade. EBP is highly influential in LIS and other sectors and has been defined as placing a 'premium on the retrieval of rigorous and reliable evidence to inform clinical decision making' (Booth and Brice, 2003: 2). The prominence of the EBP discourse implies that the dominance of the BoP model of bibliotherapy is strictly based on evidence. However, the findings of this section show that the application of BoP is more complex and encompasses various different discourses.

While BoP is often presented as an evidence-based solution to the problem of providing accessible mental health treatment, the evidence base is not conclusive as discussed in section 2.2.2, and is applied to the model selectively. Thus there is high-quality evidence for providing guided self-help bibliotherapy for specific mental health conditions, but in the case of BoP the evidence is extrapolated to presume that a non-guided model of self-help can be applied to a diverse range of mental health conditions. It is clear that BoP has therefore come to prominence for reasons other than the evidence base about its clinical effectiveness.

The scheme has achieved wide acceptance, though this cannot be seen as simply an outcome of EBP. As is discussed elsewhere, the evidence-based ideology presented by health care services does not fully explain how certain treatments come to be accepted and others do not (Fitzgerald *et al*, 2003; Juntti *et al*, 2009; Morgan, 2010). Similarly, in studies of political policy, a discourse of EBP is used by policy makers to justify decisions which they feel are an appropriate response (Juntti *et al*, 2009). The analysis of self-help bibliotherapy presented here reveals some of the methods used to encourage acceptance of its use as a treatment, specifically examining the current need of health service providers to offer an accessible, low-cost treatment for mild to moderate mental health problems. However, the use of evidence-based arguments legitimises a disregard for other relevant paradigms; in particular, patient perspectives are excluded.

There has been a shift towards providing patient-centred, personalised care which has created tensions in policy making between EBP and patient choice. There is an awareness that professional expertise and patient perspectives are required to

ensure that treatment is successful, and that while EBP is a useful tool for assessing effectiveness, it is not the only tool that should be used. Thus a complex debate is emerging about the precise relationship between the evidence base and health care policy (Shaw, 2010). This section contributes to that debate by examining the process by which BoP is justified and investigates the reasons for its acceptance without a conclusive evidence base.

Section 4.2 addresses the question of how far BoP can be seen as evidence based and how weaknesses in the evidence are overcome, to ensure that it emerges as a dominant model in mental health care. An analysis of the process of policy creation is presented, exploring the reasons that the Books on Prescription model has been adopted in preference to alternative constructions of bibliotherapy. The section focuses on the arguments presented by those implementing the initial BoP scheme, emphasising the way that the evidence itself is applied 'strategically or symbolically' to support the introduction of BoP and its legitimisation within health care policy (Juntti *et al*, 2009).

For this section, the main mental health strategy for Wales, *Raising the Standard: The Revised Adult Mental Health National Service Framework and an Action Plan for Wales* (WAG, 2005e), and overall Welsh health strategy *Designed for Life: Creating World Class Health and Social Care for Wales in the 21st Century* (WAG, 2005d) were used to examine the role that BoP/BPW plays in health care policy. Patient information leaflets, entitled *Books Can Help* and *BPW Patient Leaflet*, were examined to gain further understanding of the perspective presented to patients about what they should expect from the scheme (WAG, 2005a; WAG, 2005c). Press releases, NICE guidelines, and published articles promoting the scheme were also used to gain further understanding. As was discussed in section 3.3.2, two semi-structured interviews were conducted with representatives identified as being key actors in the scheme. These interviews were used to clarify key points and gain further insight into the translations forming the network, in accordance with an ANT perspective. Section 4.2 introduces the current context of self-help bibliotherapy schemes more generally throughout the UK, observing some potential issues with the current model identified after its inception, before this model is deconstructed in detail in the remainder of the section.

4.2.1 Self-help bibliotherapy: the BoP model

Self-help bibliotherapy in the UK is typically delivered using the BoP model which focuses on a list of books collated by a number of mental health professionals (Frude, 2004b). It is designed to capture aspects of the expertise of secondary care and deliver advice in a primary care GP setting. The list comprises a number of CBT-based self-help books on specific conditions, including depression and anxiety (WAG, 2005f). As stated, over 100 BoP schemes have been set up in UK public libraries (Frude, 2008). These schemes aim to allow people with mild to moderate mental health problems to access high-quality self-help books via a list of recommended materials. The scheme is usually run in partnership between the public library and the health service, with the public library holding the collection of recommended books, and GPs prescribing a specific book to a patient they feel could benefit from the techniques and information in the book (Frude, 2004b). The patient takes the prescription to the public library, in the same way that a prescription for medication is taken to the pharmacy.

Despite the limitations of the evidence base for the use of self-help bibliotherapy for some mental health problems – discussed in section 2.2.2 – Richardson *et al* (2010: 68) conclude that there are several reasons why the BoP model has found popularity in the UK:
- the need to treat common psychological issues in primary care
- a lack of access to psychological therapies, despite increased funding
- a shift in government policy towards self-care, particularly for long-term conditions.

As participant S-2 highlighted in her interview, *'the aims are to make it as accessible as possible and it's linked in to improving access to psychological therapies for people in Wales.'* Added to this list should be an awareness that the BoP model is highly cost-effective, and easy to administer. McKenna *et al* (2010) observe that the 'structured, transparent and clear' nature of CBT means it is highly suited to self-help bibliotherapy, and the recent focus on CBT-based treatments for mental health in the NHS helps to explain the popularity of these schemes (Holmes, 2002; Layard, 2006). Like self-help bibliotherapy, CBT has also come into conflict with notions of EBP (Holmes, 2002; Stiles *et al*, 2006).

As discussed in section 2.2.2, recent studies have detailed some concerns about current practice in self-help bibliotherapy, concerned with barriers to accessing the schemes, which will be further examined in section 4.2.6. The high level of literacy required to read CBT-based self-help books was found to be of concern in several studies examining readability (Martinez *et al*, 2008; Richardson *et al*, 2010). Participants in McKenna *et al*'s (2010) work also thought that the use of other formats, such as audio-visual material, may make the scheme more accessible. Notwithstanding these potential limitations, self-help bibliotherapy and the BoP model is still used in a number of cases. In Richards' (2004: 117) view, this is because of a conflict between the expectations of health care services, and the financial limitations faced by these organisations; 'without an emphasis on self-treatment, northern hemisphere state health services would never be able to deliver the health improvement goals they have set themselves.' The following sections examine this focus on self-treatment using the specific experience of BPW.

4.2.2 Problematisation

Studying the translation of an informal practice into a national health care policy requires an engagement with discourses of health care policy. All actors in the proposed network had to accept the focal actor's formulation of the problem; the solution proposed; and their role in the proposed network to enact the solution. In this case, the translation process was a two-stage one; first, the need for access to psychological therapies had to be translated into a local BoP scheme; then this model had to be re-conceptualised as a national initiative – BPW.[8] For clarity, this process is presented in figure 4.1.

The first stage of network formation is considered to be problematisation, in which the focal actors define the object of concern and identify other actors who could be recruited to the network (Callon, 1986). In this case, the focal actor was an individual, working as a secondary-care psychiatrist in Wales. He identified that the more people needed to be able to access expert psychological therapy. This needed to be achieved without increasing demand on secondary care services. The recommendation of a book prescribed in primary care fulfilled the need to access treatment options other than medication; and satisfied the expectations of both patient and health care professional.

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[8] The BPW is one specific example of the BoP scheme, and the analysis of the BPW scheme, as it emerged from the Cardiff BoP scheme, can be applied to other BoP schemes.
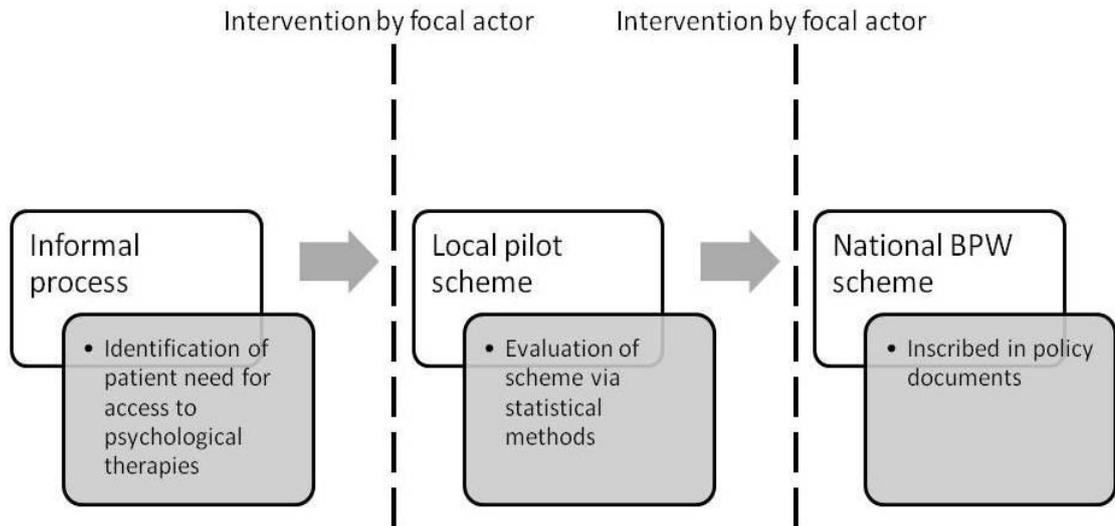
Figure 4.1: BPW - from informal process to national scheme

The focal actor identified a gap between patient needs, and the availability of psychotherapy services in his local area; 'there was a waiting list of up to two years to see a psychologist and that was very frustrating. I thought there's got to be something we can do to deliver these highly effective treatments to more people' (Participant S-1).

The focal actor identified the issues that formed the basis of the problematisation process as:

- a lack of expertise in treating mental health conditions in primary care
- a need for access to treatments other than medication for patients with mild to moderate mental health conditions
- barriers, including waiting lists and limited resources, for patients wishing to access secondary care psychotherapy.

Moreover, the focal actor identified 'a problem about which something can and ought to be done' (Baachi, quoted in Shaw, 2010: 200). As Shaw (2010: 201) states, such problems are 'never innocent, but are framed within policy proposals with power playing an integral role in the policy creation process.' The focal actor thus formulated a solution: that the psychological expertise contained in self-help texts might provide adequate treatment for mild to moderate mental health conditions. Patients did not need to be referred to secondary care to enable them to access these texts – but primary-care physicians would need to be aware of the high-quality resources recommended by secondary-care psychotherapists; there needed to be a 'cascading of expertise' from secondary care to primary care (WAG, 2005b: 4).

However this implies that such expertise can be successfully transposed from secondary care professionals to those in primary care. It also conflicts with notions of an evidence-based scheme, instead creating 'localised understandings based on practical experience' (Juntti *et al*, 2009:210).

Nevertheless, the solution of a list of books recommended for different mental health conditions was proposed. There was a need to address access to these texts, which could be expensive to purchase for individuals; while there were measures in place to enable people with low incomes to receive prescriptions for medication without cost, this needed to be translated into access to books. The purchase of books to give to patients in GPs' surgeries would have required a significant increase in financial support; hence, a system of lending the books to patients was formulated. The 'existing service infrastructure' of the public library was used as a node in the network, which operated to provide free access to books (WAG, 2005c).

The passage from initial problematisation to interessement, or the beginning of the acceptance of the focal actor's solution to the problematisation occurs via the OPP. The OPP was thus defined in a question and answer format:
'How could the enormous need [for psychological treatment] be met within reasonable resource limits?
Answer: Through a scheme that facilitates the use of high-quality self-help materials' (Frude, 2003). Various actors needed to accept that the focal actor's translation of the problem would result in a feasible solution that would benefit those in the proposed network. This process is represented in figure 4.2. These actors were:

- Psychiatrists, who needed to agree that self-help books would be useful to patients. Their acceptance of problematisation rested on their recognition of the importance of quality resources which would ease the demand on secondary care services and enable them to meet waiting list targets, without removing their role as experts in the field.
- GPs, who were essential for administering the prescriptions and enrolling patients into the scheme. They needed to acknowledge the potential issues with referral to secondary care, and that self-help books might be an appropriate alternative.
- Patients needed to accept that self-help via books was a potential solution to their problems. They needed to view psychotherapy, rather than medication, as a possible treatment but to accept that it was not suitable for them because of long waiting times.

- Librarians, who were responsible for administering the book stock, needed to accept the expertise of psychotherapists over their own expertise in selecting resources. They also needed to accept the benefits of joining a network predominantly focused on meeting NHS aims. The benefits of the network were promoted to the library service as: an increase in book issue and visitor figures; access to a socially-excluded audience; and a prestige, funded partnership scheme.

- Funding sources, who needed to accept that the scheme met their requirements to provide accessible, cost-effective treatment, and would thus provide financial support for the introduction of the scheme.

- Books, which needed to be available to buy for the library. The books needed to be low cost and accessible to patients, both in terms of physical availability and readability. Of the focal actors listed above, books are excluded from figure 4.2 as they did not have an obstacle-problem to be overcome within the network; instead they were part of the solution, or the OPP within the diagram.
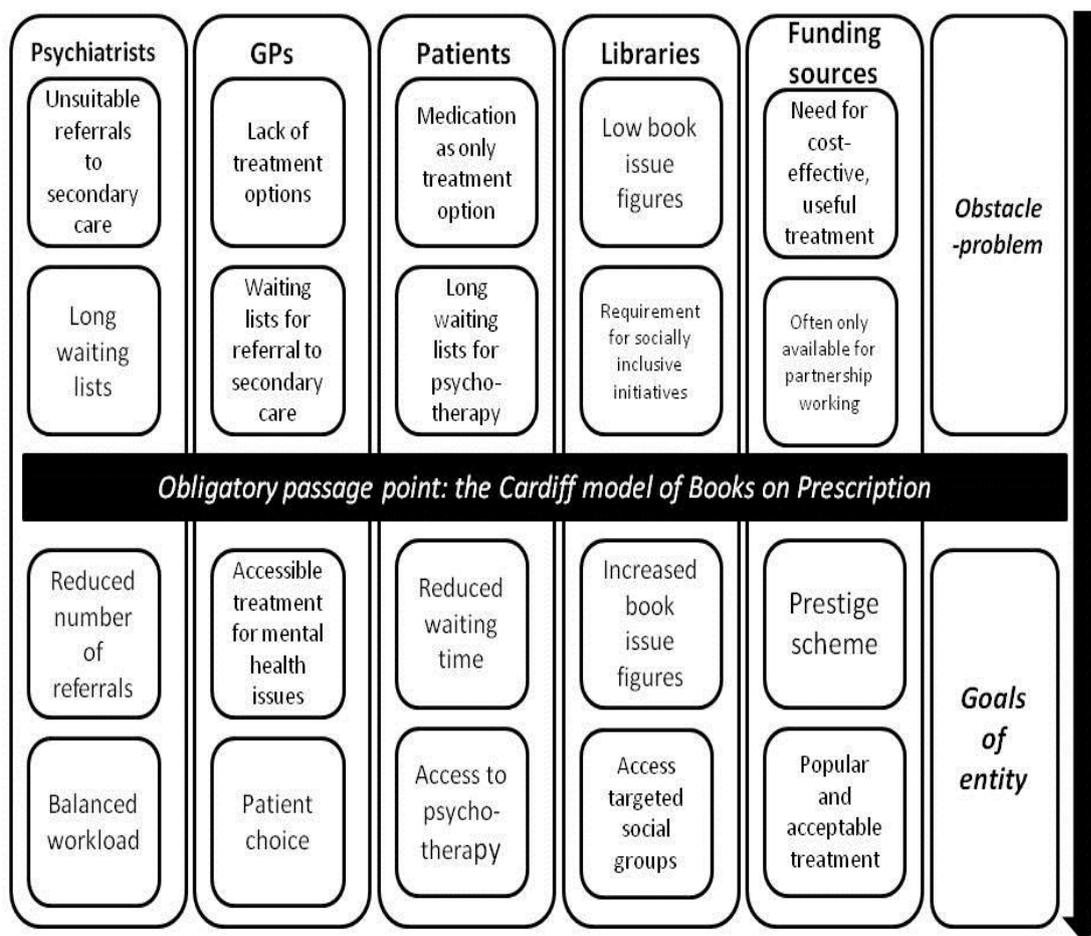
Figure 4.2: From obstacle-problem to solution, via the OPP of BoP

(adapted with permission from: Callon, 1986)

The focal actor's argument was that if the treatment need was to be met in a cost-effective manner, bibliotherapy delivered by GPs and libraries must be used and would benefit all actors in the network (Frude, 2008). The simplicity of the system of BoP was also one of the main selling points of the scheme. Moreover, the essentials required for the scheme were already in existence; instead it was a question of 'joining the dots' together to create BPW; *'if somebody went to their GP and they got a prescription for a book which they would perhaps pick up from the library – but obviously the library would need to make sure it stocked the appropriate books, and the GPs would need to know about the list of books. So it needed really no new elements; there were the libraries, there were the GPs, there were the books. It just needed them to be threaded together into a system'* (S-1). Consequently, the acceptance of the problematisation that would be solved by the BPW model was achieved, and self-help bibliotherapy delivered via the public library was seen as the

most feasible solution to the multiple problems defined in access to psychological treatment.

4.2.3 Interessement

Network creation needed to overcome several challenges before the next stage, interessement, was complete. Interessement is defined here as an acceptance of network roles by all actors (Callon, 1986). Once the problem has been defined, the focal actor must define both their own role in the network, and that of all the other actors. The focal actor must be viewed by the other actors as an indispensible node in the network for it to succeed. Constructing indispensability can be complicated, as Latour (1991: 104, italics in original) comments, because 'the *force* with which a speaker makes a statement is never enough, *in the beginning*, to predict the path that the statement will follow. This path depends on what successive listeners do with the statement.' In other words, it is not enough for the focal actor just to tell the other actors of their role; network formation has to be based on convincing arguments that ensure that the actors are aware that alternative solutions to their problem are undesirable. Thus the actors in the network maintain their autonomy at the interessement stage in the process.

The focal actor used health care agendas to reinforce his argument that the treatment scheme was viable. Analysis of statements of these agendas provides an important contribution to understanding this stage of the process of translation. The agendas mobilised in this instance included the Expert Patient agenda (DH, 2001), which argues that patients need to take responsibility for their own treatment, with the role of the health service as the provider of information. The WAG, supporters of the scheme, subsequently observed that; 'the scheme provides an excellent example of how patients can be encouraged and empowered to manage their own health care' (WAG, 2005b). The Patient Choice agenda (DH, 2007) was also appropriated to reinforce treatment choice in the network; 'this is an alternative treatment option that can be used to support existing psychotherapeutic services giving greater patient choice and empowerment' (WAG, 2005e: 39). Statements including 'as patients become more vocal in their demand for psychological treatment', also imply that doctors should be expecting the situation of waiting lists and demand-exceeding-supply to get worse as patients become more aware of the potential options open to them (WAG, 2005b).

A shift to the use of self-help bibliotherapy places responsibility for the success of the treatment with the agency of the patient as actor. When utilising medication, for example, it is the responsibility of the health care provider to monitor symptoms and side effects, and to change doses or even choice of medication to try to alleviate symptoms. Within the sphere of self-care, much more responsibility for the alleviation of symptoms lies with the patient. While the doctor will 'prescribe' the book, the onus is then on the patient to engage with the text, and patient responsibility is emphasised within patient information leaflets.

During the interessement process, the focal actor translated his conceptualisation of the role of several actors in the network. This stabilised their identity and legitimised their relations with other actors in the network. These translations included constructions of:

- Self-help books as accessible to all
- Libraries performing the role of pharmacies
- Prescription models as familiar to patients
- Mental health problems requiring treatment other than medication
- Geographical variation in care as unacceptable
- Cost-effective care as ideal
- Patients as responsible for their own self-management
- EBP as a legitimisation for treatment.

(Frude, 2004a; 2004b; WAG, 2005b; 2005d; 2005e)

At this stage in the translation process, the focal actor's definition of the accessibility of self-help books was linked to a construction of the ideal patient, who would view the CBT-based self-help text as '*a gardening manual or a recipe book or whatever*' (S-1) thus positioning themselves as *'somebody who is used to the notion of a manual to actually follow, to do car repairs or something*' (S-1). Statements in the patient information leaflets including 'it will need some effort on your part' and 'effectiveness does depend on how much effort the reader puts into following the guidance given by the book' illustrate the shift in personal responsibility implied (WAG, 2005a; 2005c). However, patients' views of this construction of their needs and abilities as an ideal patient was not taken into consideration; *'I've no idea. I mean, it's not one of the things that we are privy to, we don't get that sort of feedback [from patients]'* (S-2).

Further translations allowed the focal actor to legitimise two actors – the public library and the books – within the network. The negotiation of the identity of the library was a key re-definition in the interessement process; patients are repeatedly told to 'think of the library staff as you would think of your local pharmacist,' and libraries are referred to as 'dispensing' prescriptions (WAG, 2005a; 2005b: 4, 9). An emphasis on medicalising the public library ensures that the identity of the library as an institution fits in with the BoP/BPW model – as an administrator for, and indirect source of, expert medical advice. Familiarity for all actors with the system of prescription and distribution of medication was also cited by Frude (2005a) as evidence of the potential effectiveness of the model. Frude (quoted in Donaghy, 2005: 4) reinforced the importance of using public libraries to access books within the scheme by referring to the tradition of working-class library use in Wales. References to these helped to negotiate the identity of the library within the network.

Another translation in the interessement process concerned the books which form the basis of the scheme. Direct comparison between the books and medication was made, and this contrast showed a number of favourable advantages to the use of books. The simplicity of the CBT-based book was presented as key to the success of the scheme. Moreover, the scheme was constructed by the focal actor so that the question of whether or not the books were an effective treatment was not addressed; *'we know that bibliotherapy is very, very powerful but I think it's then a sort-of act of faith to say if it works in America it's going to work in Wales'* (S-1).

Acceptance of the scheme rests on the belief in a strong, defined evidence base of systematic reviews, meta-analyses and RCTs for self-help bibliotherapy and this evidence base is portrayed in the patient and prescriber information leaflets and health care policy documents. While it can be argued that an evidence base advocating bibliotherapy exists – see section 2.2.2 – it does not necessarily reflect the conditions defined as suitable for treatment by the scheme. As discussed by Richardson *et al* (2010), the evidence base for bibliotherapy does not include evidence indicating that all the books specified on the BPW list are effective. Indeed, the majority of commercially-available texts have not been subject to RCTs examining their effectiveness – see section 2.2.2. The 'act of faith' argument posited above is vital for acceptance of the scheme, with an interpretation of the evidence base as 'strong' being more important than the evidence base itself. Thus, 'evidence is often used strategically or symbolically' (Juntti *et al*, 2009). This faith in the inter-changeable nature of self-help books was undermined after the scheme began, as

discussed in section 2.2.2, by the 'class argument' which concludes that 'the results of trials generated by one book… cannot be generalised to others' (Richardson *et al*, 2008: 551). This 'class argument' confirms that all self-help books should not be considered to be equally effective. As many of the books in the BPW list have not been tested in RCTs, this challenges the assertion that a simple 'leap of faith' provides evidence of effectiveness. The evidence-base/'act of faith' argument is supplemented with an emphasis on self-help as the 'sensible' option, including statements professing that 'empirical evidence, supplemented with plain common sense, points to a number of advantages of bibliotherapy compared with medication' (Frude, 2005b: 29).

The creation of the BoP/ BPW booklist raises questions regarding the focus on the evidence base. The booklist was formulated, according to participant S-1, as follows:

> *'I did a survey of 50 clinical psychologists in Cardiff to ask them what books they would recommend. We collected a large list. We wanted a list that would be no more than about 30 or 35 books – which would cover the main common problems of a mental health nature that GPs are faced with. So it's anxiety, depression, low self-esteem, eating disturbances and so on.'*

This quotation demonstrates that while the rationale behind the scheme is presented as an evidence-based one, the experiences of local practitioners and a response to a perceived need were the driving force. With the rise of EBP, there has been a move away from a reliance on the rhetoric of clinical experience (Greenhalgh, 1999). Participant S-1's quote shows that clinical experience is still necessary as there is no pre-existing evidence-based list of suitable self-help books for mental health problems. As Richards and Farrand (2010: 202) observe, booklists themselves are problematic as the recommendation of a text is 'self-reinforcing' and the existing popularity of a text influences whether or not it will be further recommended.

As Brown (2009: 23) states, running a bibliotherapy scheme 'demands ambitious and creative partnerships between government, libraries, the health service.' There needed to be agreement from all partners that the BPW scheme would be acceptable and fulfil their aims and needs. To achieve this, a recognition of benefits of BPW over other possible solutions was key. Only then could the translation from a local pilot to a national mental health care solution occur. Translation was predominantly achieved using two methods to ensure the advantages were recognised: linking the aims of the scheme to national policy agendas, and the use of statistics. It is to these methods of enrolment that this section now turns.

4.2.4 Enrolment: policy documents

Raising the Standard (WAG, 2005e) lays out some of the Welsh political agendas creating conditions in which BPW could flourish at a national level. It presents eight standards for improving mental health care in Wales. Those relevant to the introduction of the BPW scheme include 'social inclusion, health promotion and tackling stigma' and 'delivering effective, comprehensive and responsive services.' The implementation of BPW therefore fits with a conceptualisation in which NHS Wales provides cost-effective, accessible, and evidence-based treatment for mental health conditions.

Raising the Standard (WAG, 2005e) also sets out targets and standards for Wales, and BPW is a vital component in services provided to meet these targets. For example, Robinson (2008c) observes that there is a target that 'all patients… who are assessed to require access to evidence-based psychological therapies will commence therapy within three months of assessment.' As BPW is available in every library in Wales, it helps to meet this target; and it negates the potential for waiting lists for secondary care treatment to undermine set targets, as it will reduce the number of patients initially referred to secondary care. Locating mental health treatment in primary care and ensuring its recognition as EBP enables a three-month waiting time target to be achieved.

Designed for Life (WAG, 2005d: 28) reinforces a focus on the changing nature of services, stating that 'Mental Health Services will be remodelled over the three years to strengthen primary care.' Situating BPW as a joint primary care/public library project supports this shift away from secondary care. However, in an ANT framework, 'policy is seen as a process of incremental decision making, or 'muddling through'… that involves negotiation across multiple perspectives' (Shaw, 2010: 200).

Raising the Standard (WAG, 2005e) stresses the intention in Welsh mental health care to 'improve the collaboration between existing services. These system developments require little or no additional financial investment.' Indeed, Key Action One in the document focuses on 'strengthen[ing] inter-authority/ agency arrangements… [in order to] foster the development of life-skills' (WAG, 2005e: 10). BPW therefore fulfils several distinct aims in service provision that are not fulfilled by the prescription of medication or referral to secondary care.

BPW is also positioned to relate to a holistic construction of mental health, as previously defined by governmental representatives. As *Raising the Standard* (WAG, 2005e: 36) asserts:

> 'our strategy and NSF [National Service Framework] have taken us from a purely illness, disease and treatment approach to one that makes the links between good mental health, poor mental health and the quality of life of individuals and communities. Improving the quality of people's lives is at the heart of this strategy.'

As CBT concentrates on changing patterns of thought and behaviour, it contributes to this 'improved quality of life' argument.

Thus, as *Raising the Standard* (WAG, 2005e: 6, italics added) states: 'services need to ensure timely delivery of evidence-based interventions that focus on outcomes and service user recovery. Such a cultural shift will require a change in both service user and staff expectations of *where*, when and *how* services are delivered'. Taken in the context of Shaw's (2010) work, this statement can be seen as evidence of emergent strategy, and associates BPW with outcomes not previously defined.

Accordingly, BPW enrols actors in its network in several ways: it is presented as an evidence-based intervention; it is instantly accessible; it focuses on changing behaviour that will be reflected in a treatment outcome (a key priority for health care providers hoping to reduce demand on secondary care); and it provides an innovative solution to service location and delivery. The inscription of changed location as an objective for services also supports the placement of schemes in public libraries.

Returning to arguments surrounding clinical evidence, while health care in Wales is a devolved subject, there is still an obligation to subscribe to the NICE clinical guidance that forms the basis of NHS policy in England. NICE (2004a; 2004b; 2004d) recommend the use of guided self-help treatments like BPW for depression, anxiety and bulimia nervosa. Evidence from NICE was used by those championing book prescription to support the appropriateness of the scheme (Frude, 2005b).

The importance of the clinical evidence was mentioned in interviews: *'the National Institute for [Health and] Clinical Excellence published guidelines on treatment for anxiety and depression and eating disorders, and in all of these they suggested that bibliotherapy was something to be considered… that GPs should consider books before considering medication'* (S-1). The prescriber information booklet (WAG, 2005b) also highlights the importance of the NICE evidence base, mentioning it on

no fewer than three occasions throughout the booklet, with comments like 'NICE recommends bibliotherapy as an appropriate first active treatment strategy.'

However, problems were identified with implementing this appropriately in practice; *'the problem was of course that while NICE said the high-quality books are really the ones to go for, they didn't actually point out any books. So the GP who wanted to follow NICE guidelines couldn't actually do it. With drugs they're told 'this drug's good, that drug's bad', but with books they weren't told'* (S-1). Consequently, health professionals were enrolled in the network; but as is considered here, while self-help bibliotherapy is recommended, specific titles are not, creating a conflict between a reliance on clinical expertise and the evidence.

In addition to enrolling clinicians, there is a need to enrol patients in the network and this is demonstrated in the design of the patient information leaflets (WAG, 2005a; 2005c). Firstly, the *Books Can Help* leaflet (WAG, 2005c) emphasises that 'emotional problems are very common.' This statement works to de-stigmatize mental health problems and tries to prevent misunderstandings about diagnosis. It draws on a discourse that locates mental health problems as an individual psychological responsibility, creating a context in which the patient possesses the resources to solve their own problems with limited medical intervention (Shaw and Taplin, 2007). Such clarification is important in light of surveys of the general public about depression, which emphasise that patients and medical professionals do not always see the same causes, or the same solutions to mental health issues (Jorm *et al*, 1997; Prior 2010; Weich *et al*, 2007). The definition of mental health problems as based on emotion, rather than genetic or biomedical causes work to alters the perception of the patient, and thus their expectations of treatment; *'depression is sometimes called the common cold of psychopathology'* (S-1).

The second statement in the leaflet affirms that 'GPs can offer help for emotional problems' (WAG, 2005c). The pronouncement that GPs can provide guidance for these issues moves the focus of the network away from secondary care mental health treatment and positions mental health problems as a 'general' condition which primary care health providers can treat. While the leaflet refers to the possibility of being referred to secondary care, which may have been the expectation of the patient, it places a barrier to accessing secondary care services, stating that their availability is limited. The statement locates the self-help books as a stage between

primary care and secondary care; one that needs to be explained to patients to ensure enrolment in the scheme.

The third statement made by the leaflet is that 'books can help' (WAG, 2005c). This unequivocal statement provides only minimal explanation to support its claims, and referring back to the emotional nature of mental health problems, the provision of help in primary care, and the introduction of BPW. The language used within the leaflet to impress on the patient the importance of the scheme to their lives is highly emotive. The leaflet stresses the 'award-winning' nature of the scheme, stating that only 'highly-recommended' self-help books are proposed. It differentiates between ordinary self-help books and the 'best' ones, which are 'highly effective.' These books have been 'specially selected by health professionals' and the inference is that this selection makes them the 'best' books previously mentioned. The leaflet (WAG, 2005c) also concentrates on the equity of access and lack of cost to the patient. The emphasis on self-help – but not all self-help – contributes to the idea that the scheme is still the solution to the problem as defined by the focal actor; only the high-quality self-help of BPW will function in an effective manner.

To ensure that both secondary care providers and patients are enrolled in the scheme, the leaflet states that 'many of the most effective books present self-help versions of the kind of therapy that would be given by a professional' (WAG, 2005c). All actors in the network are thus made aware that while the contribution of secondary care professionals is valued and useful, it is not always accessible, and so these books often provide an adequate substitute, or first step, in many cases.

4.2.5 Enrolment via statistics

Enrolment in the BPW network was also negotiated using statistics recording and representing book issues. Library services typically consider book issue figures to be an appropriate measure of the success of an initiative, and the number of books issued was also seen as a representation of a lowering of demand for secondary-care psychiatric services, leading to reduced waiting lists and clarifying the perceived benefit for health care professionals. BPW statistics are thus taken to illustrate the legitimisation of BPW as demonstrably achieving its aims of reduced demands on secondary care and enabling access to expert psychological therapies.

It can be argued that these book issue figures do not represent the usefulness or effectiveness of the books as treatment – or even whether or not the books were

read by those who borrowed them – but these statistics do perform a function within the network of BPW. This quantification can be said to perform as a 'calculative lingua franca' in a scheme in which there is partnership working between groups with different agendas, requiring different outcomes (Callon and Law, 2005: 724). Bloomfield's (1991) work on calculation in the NHS takes this further, referring to the 'tyranny of numbers' in defining outcomes. The necessity of an awareness of the performativity of statistics was reinforced in interview and documentation analysis. One interview participant stated that *'our statistics are mainly based on what books are being borrowed… in terms of people's opinions of whether they think it's a good thing or a bad thing – we've never had a feedback form'* (S-2). The value placed on the scheme directly relates to figures showing how many people had used the scheme.

As previously discussed in chapter three, the PLR database was used to examine the impact of the introduction of BPW on book issue figures in public libraries. Table 4.1 shows the number of books on the BoP list issued in Cardiff libraries before and after the introduction of the scheme. It demonstrates the dramatic rise in issue figures that was used as evidence when considering the funding for the BPW scheme. While the increase in issue figures reflects a rise in the number of copies of the books available, it is also used to claim that usage has increased and the scheme meets a real, previously unmet need.

Table 4.1: BoP booklist titles issued in Cardiff 2000-2004

Year	Total number of BoP booklist issue figures in Cardiff
2000-1	84
2001-2	98
2002-3 [BoP introduced, 2003]	1113
2003-4	3704

Table two presents the data illustrating categories of books borrowed as part of the scheme in Wales as a whole in 2004-2010. As the figures show, BPW was introduced on a national level in 2005, dramatically increasing the number of books on each subject issued. Figures in bold represent the most borrowed categories in each year; books about anxiety, depression, panic and self-esteem make up the bulk of titles borrowed.

Table 4.2: Categories of BPW booklist titles issued in Wales 2004-10

Category of title, according to the BPW list	2004-5[9]	2005-6	2006-7	2007-8	2008-9	2009-10	*Total issues for each category*
Anger	**23**	278	329	249	203	93	*1175*
Anorexia	7	67	66	90	61	16	*307*
Anxiety	2	**351**	**458**	**472**	**292**	**176**	*1751*
Assertiveness	11	150	131	103	112	50	*557*
Bereavement	0	107	132	131	70	25	*465*
Bulimia/ binge eating	3	184	129	120	120	52	*608*
Depression	**37**	**1012**	**1204**	**890**	**635**	431	*4209*
Head injury	5	31	26	20	19	1	*102*
Health anxiety	0	9	32	10	5	26	*82*
Manic depression	7	130	115	88	103	24	*467*
Obsessions	3	**361**	304	**309**	**285**	**143**	*1405*
Panic	**37**	**350**	**435**	**380**	316	**135**	*1653*
PTSD	3	136	142	104	117	31	*533*
Self-esteem	**27**	**500**	**574**	**544**	**418**	**245**	*2308*
Sexual abuse	15	164	132	100	97	16	*524*
Social anxiety	**19**	177	158	127	124	6	*611*
Stress	0	347	**443**	296	**277**	73	*1436*
Worry	9	185	183	144	123	128	*772*
Total book issue figures for the year/ overall total	**208**	**4539**	**4993**	**4177**	**3377**	**1671**	***18965***

While this usage reflects the epidemiology of mental health issues, the categorisation can also be said to reflect the needs of service providers, rather than the evidence base, with books for self-esteem, panic, obsessions, and stress – i.e. those which are not evidence based, as discussed in section 2.2.2 – forming a significant proportion of those issued. The evaluation of the BPW scheme by Porter *et al* (2006) revealed that BPW was being used to fill in gaps in treatment programmes where it may not have been appropriate to do so. In the case of anger management, it was felt that there were a large number of referrals to BPW for books about anger because of a lack of other treatment options (Porter *et al*, 2006: 40). Similarly, Rowland *et al* (2000) found that while self-help therapy is often presented as the first stage in a Stepped Care model, it can actually represent an inequity of access to other treatments. However, it is important to note that some categories on the BPW list address specific symptoms of conditions like depression and anxiety. Low self-

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[9] BPW was introduced in 2005.

esteem, for example, can be a symptom of depression, and panic attacks are often a symptom of underlying problems with anxiety.

These book issue statistics are used to represent all patients with mild to moderate mental health difficulties. From Mol's (2008) perspective, this reduction of a person's presumed successful treatment to a number indicates an agreed translation from a point at which a person is deemed 'ill' to one where they are considered 'well'. In this case, once a book on the subject of depression has been borrowed from the library, the person with depression is regarded as 'well' or 'treated.' In this way, patients are provided with a role in the network that does not enable them to speak about their experiences. They are silenced by other actors in the network, as the capturing of the patients' perspective is replaced by the book issue statistics given here. The patients' perspective is translated into a set of numbers which can be used to mobilise and maintain the network. Through the use of these statistics, 'the enrolment is transformed into active support' (Callon, 1986: 218). The use of issue statistics enables the focal actor to speak for the librarians, patients and books – all have achieved their aims as defined by and within the network, and can be easily represented in the format of graphs and diagrams demonstrating impact.

4.2.6 Irreversibility

BPW is legitimised by drawing on key institutional agendas including cost-effectiveness and reduced waiting times for treatment. These key agendas bypass the need for further evidence – for example, experiences of patients utilising the scheme. In this way, 'a constraining network of relationships has been built. But this consensus and the alliances which it implies can be contested at any moment' (Callon, 1986: 218-9).

Callon's (1986: 196) final stage in the translation process is that of 'irreversibility'. This can be defined as 'the degree to which is subsequently impossible to go back to a point where alternative possibilities exist' (Cho *et al*, 2008: 617). From the analysis presented here, it appears that this point has not been reached in the case of BPW. As Callon (1986: 196) observes, 'translation is a process, never a completed accomplishment, and it may… fail.' In the case of BPW, the network is under constant pressure from realigned governmental agendas such as those accompanying a change of elected parliament and the re-structuring of health services. For example, when participant S-2 was discussing funding for the scheme she commented that *'we're reviewing that obviously, like every other department*

within the UK, we are going to have budget cuts with the financial crisis that we are in.' Alternative programmes providing mental health treatment may also impact on the irreversibility of the network. For example, the widespread adoption of the IAPT programme provides wider access to face-to-face CBT therapy via a program of training for CBT therapists, rather than encouraging access to a collection of book-based resources.

Various barriers may impact on use of the scheme, as discussed in section 4.2, and identified as readability, the class argument, and accessibility, all of which may cause the network to break up. Readability of the texts may undermine the strength of the network, as the books themselves have had their accessibility redefined by subsequent studies (Martinez *et al*, 2008). Research conducted in Ireland theorises that rather than bibliotherapy making treatment more accessible, it actually decreases accessibility and increases inequalities as it places an emphasis for the success of treatment on literacy (Neville, 2010). Issues of patient motivation also need to be taken into account when considering the stability of the network. The symptoms of mental health problems can include: reduced energy; decreased activity; and reduced concentration (World Health Organisation, 2007). Thus, activities such as reading and concentrating on a text can be problematised for people with mental health conditions. Patients, therefore, may be able to destabilise the network by being unable to utilise the resources that have been designed to provide treatment for them.

Another factor that may impact on use of the scheme is the static nature of the booklist. Although four new titles were added to the booklist in 2010, these titles were related to dementia and the list of titles itself was not altered (WAG, 2010). As shown in table 4.2, use of the BPW books has declined, particularly over the 2009-10 period. This is not necessarily reflective of a decline in the use of self-help books; other titles published more recently may have been selected by readers. Examination of the PRL data available on subjects such as anxiety and depression shows a proliferation of titles that may reflect a stability in the number of books issued, but a greater diversity in recent self-prescription of titles. However, the fast-moving nature of publishing with new titles being published and others going out of print shows that the very nature of the recommendation of a list of books themselves may contribute to a destabilisation of the network.

BPW is portrayed by service providers as an evidence-based, cost-effective scheme, providing patient choice and reducing inappropriate demand on secondary care. However, as this section has demonstrated, the construction of the network is not a simple application of scientific evidence about effective treatments. EBP is presented as a justification for the introduction of the scheme, yet evidence is applied strategically, and carefully selected to ensure it is accepted by all actors. EBP is appropriated as the most persuasive discourse to bond the disparate members of the network to accept the solution negotiated by the focal actor. There is a need to use available discourses to frame the construction of the network and ensure its stability. Documentation and statistical evidence are used to inscribe the network and to strengthen it. In a similar fashion, discourses of partnership working, meeting targets, and providing cost-effective care are also used to legitimise and strengthen the network.

4.2.7 Conclusion: legitimising self-help bibliotherapy

Section 4.2 has analysed mental health policy formation in Wales, reflecting on the socio-political processes and drivers involved. This has implications for concepts of policy making as a rational and coherent endeavour. It has also explored some criticisms of the application of the notion of EBP, demonstrating that the evidence can be translated to meet socio-economic agendas. While BPW is presented by policy makers as a response to the needs of the general populace with mental health problems, this ANT analysis demonstrates that the needs of service users are interpreted to ensure that the requirements of policy makers are also fulfilled.

While EBP is still presented as a legitimising discourse for many health care treatments, including bibliotherapy, there are growing criticisms of its underlying structures, including the perceived lack of an evidence base in support of an evidence-based approach (Cohen *et al*, 2004). Policy formation, as Juntti *et al* (2009) observe, is a complicated political process, and this section has added to the growing body of research examining the way in which EBPs are used to legitimise decision making and policy. In the case of self-help bibliotherapy, the application of an evidence-based rhetoric has created a 'black box' which medical professionals can utilise with patients to produce a defined outcome – that of successful mental health treatment. While it might not be the case that a 'black box' does always produce the defined outcome, acceptance of this aspect of the model has been very important in terms of its recognition as a success by the actors within the network, and has legitimised the introduction of bibliotherapy.

Nevertheless, the aim of section 4.2 is not to criticise EBP as a rationale for decision-making; or to disregard the evidence base concerned with the effectiveness of self-help bibliotherapy under specific conditions. Instead, the intention has been to show that the way evidence-based arguments are deployed selectively, influenced by the requirements of policy-making. Currently, there is a shift in policy thinking towards inclusion of the service user or patient voice, and this has implications for BPW, as well as EBPs more generally. To date, the use of the argument that EBP legitimises bibliotherapy has enabled the actors in the network to justify overlooking more patient-focused narrative of the experiences of treatment.

Section 4.2 has examined the introduction of the Cardiff model of BoP from an ANT perspective, concentrating on the network forming the bibliotherapy scheme. It identified a number of relevant agendas utilised by the focal actors in the scheme, and commented on whether the evidence base surrounding bibliotherapy supported the application of these agendas in practice. The acceptance of the Cardiff model, translated into the BPW scheme, was demonstrated via an examination of documentation about the scheme, white papers written by the WAG, statistical and interview data. The exploration has focused on the reasons behind this acceptance, and has used ANT as a critical lens to analyse policy driving the scheme. A similar analysis will now be applied to models of creative bibliotherapy, starting with RAYs.

4.3 Creative bibliotherapy: the RAYS model

The RAYS model of creative bibliotherapy operates in two ways, seeing people on an individual basis and running groups. Initially operating in Kirklees, it began in October 2000. For four and a half years, it also operated in the neighbouring local authority of Calderdale. RAYS began in the library sector, and this was of critical importance in the construction of the model. This section explores the emergence of the model in response to local needs, which then aligned with national agendas. RAYS can be seen as the most flexible of the three models, using a variety of imaginative texts and adapting the aims of the project to meet the needs of those using it. These aims can be defined as: to provide relaxation and an inclusive, open environment in which people interact to discuss literature, focused on encouraging people with mental health problems to enjoy reading.

The aims of RAYS are presented as improving access to literature and well-being; and helping to provide a socially-inclusive library service (Kirklees Council, n.d).

Section 4.3 presents the key aspects of this model, examining the emergence of a person-centred creative reading therapy, guided by professional staff in response to client needs. The emergence of the RAYS model from the library sector facilitated its implementation as a more flexible approach to bibliotherapy, based around ideas of access to all literature for excluded groups, targeted at improving their well-being. Problems in the initial construction of the model led to changes that ensured its sustainability and created a model of bibliotherapy that was in part shaped by those using the service.

In RAYS, as in the BoP model, the role of an enthusiastic individual was paramount, with one person designing the initial model, enrolling others in the network and championing the scheme outside the network. In this case, the principal librarian Catherine Morris can be seen as the 'focal actor.' Her role built on local experiential knowledge to design and instigate the scheme, bid for funding and locate suitable staff to undertake and manage the project. As participant S-5 stated; *'it was her brainchild really.'* Unlike BoP, the RAYS project was formulated in the public library, involving health professionals later in the process. The public library focus had implications for both the actors enrolled in the network, and the means used to enlist actors. As the project evolved, different members of the network took on the role of the focal actor until relationships were built and the network became self-sustainable and mainstreamed within public library funding.

The RAYS model originally built on the basic idea that reading literature was beneficial to library users and was a form of relaxation that could be used to reduce stress. The aim of the project was thus to harness and formalise these benefits by highlighting the relationship between reading and well-being. The focus here will be on the emergence of this project, examining its origins as a pilot scheme initiated by the experiential knowledge of librarians in Kirklees and its translation into a prestige scheme, mainstreamed within council funding, and receiving national and international interest. The perceived success of the project in Kirklees, compared with neighbouring Calderdale, will be investigated. The analysis of RAYS will also encompass its initial difficulties in engaging health professionals, shifts away from the medical model of mental health, changing aims, and the role of wider health policy agendas.

A number of key texts were identified to analyse the emergence of the network of RAYS. These included an overview of the funding application process (DCMS,

2000); *Reading our future: evaluation of the DCMS/ Wolfson Public Libraries Challenge Fund 2000-1* (Wallis *et al*, 2002); published articles by Catherine Morris (2002) and Bernard Murphy (2002), principal librarians in Kirklees and Calderdale respectively; articles in national newspapers (Cunningham, 2002; Wyke, 2003); the Bibliotherapy Toolkit published by the Kirklees bibliotherapists (Duffy *et al*, 2009); leaflets and web pages aimed at service users (Calderdale Council, c2005; Kirklees Council, 2001; Kirklees Council, n.d); the job specification for bibliotherapists (Kirklees Council, 2009b) and short council 'storyboard' evaluation documents (Kirklees Council, 2008; Kirklees Council, 2009a; Kirklees Council, 2009c). A project evaluation report provided valuable information about the trajectory of the scheme in Calderdale (Murphy, 2006). These documents were supplemented with interviews with three relevant members of the management and facilitation team for the bibliotherapy scheme in Kirklees, referred to here as S-3, S-4 and S-5. Again, it is not appropriate to provide further details of these participants, to preserve their anonymity.

4.3.1 Problematisation

Problematisation in RAYS occurred in response to two stimuli. In the words of the focal actor, the public library service in Kirklees had been 'heavily committed to promoting fiction' for a number of years (Morris, 2002). This had been in the form of an annual literature festival, but according to S-3, a participant in the research, new ideas were being sought to replace this endeavour; *'we decided that perhaps we need to take a different direction.'* The second stimulus was the Department of Culture, Media and Sport (DCMS) Wolfson Public Libraries Challenge Fund (referred to hereafter as the DCMS Wolfson Fund), a competitive source of funding which aimed to 'enhance public libraries' traditional strength in promoting reading as a skill and pleasure' (Wallis *et al*, 2002). The chance to bid for this project funding provided an opportunity for innovative thinking centred around the potential of literature. The focal actor connected experiential knowledge about the relationship between reading and health with a source of funding for a project exploring this on a more formal basis. Further research by the focal actor, looking at articles in the professional and academic journals, found a small body of research literature on the role of using poetry as an adjunct to therapy, predominantly with children or institutionalised adults. Building on the professional experiences of the focal actor, this research then was translated into working with fiction and poetry, and aimed at adults with short-term mild to moderate mental health conditions, who were seen as those feeling 'stressed, anxious or depressed' (Morris, 2002).

Social prescribing (e.g. exercise therapy) for physical health problems had already been accepted as a solution by local PCTs and GPs, with the Practice Activity and Leisure Scheme (PALS) (Kirklees Council, 2009c). Initially, concepts of bibliotherapy in Kirklees were framed along similar lines, with doctors 'prescribing' a visit to the bibliotherapist (Morris, 2002: 7). However, as will be discussed in section 4.3.2, this construction of the role of both the bibliotherapists and medical professionals was not accepted by all members of the network, causing network boundaries to shift. Various actors in the proposed network needed to accept the construction of this model, including:

- Public library staff, who needed to agree that the scheme would promote literature and library use in order to bid for funding, recruit bibliotherapists and promote the scheme.

- Library funding bodies, (firstly the DCMS Wolfson Fund; later followed by various others), who provided the majority of the initial financial backing for the scheme, and needed to perceive the scheme as having the potential to achieve the aim of improving access to literature in an innovative fashion for excluded groups.

- Health-related funding bodies, including local PCTs and Surestart, who needed to view the scheme as potentially beneficial to mental health and well-being.

- GPs, who needed to accept the perceived mental health benefits of bibliotherapy and refer patients to the scheme.

- Mental health professionals, including Occupational Therapists (OTs) and Community Psychiatric Nurses (CPNs) who needed to accept the benefits of bibliotherapy in a similar fashion to GPs. The nature of their work meant that they would be more diverse in their understanding of mental health, but also deal with people who had more severe and enduring mental health problems. The differences in clientele between mental health professionals and GPs meant that less focus was initially placed on enrolling these professionals in the scheme.

- Bibliotherapists, who needed to be recruited to the network. As actors, their role was initially defined by the public library staff who formulated the aims of the project and the bibliotherapists' job descriptions. This role evolved throughout the interessement and enrolment processes.

- Library users, who were the potential audience of the scheme, needed to accept that it could be of benefit to them to take part in the scheme. Their

experiential testimonials later proved to be key to the sustainability of the scheme.

These actors and their acceptance of the scheme as an OPP are also represented in figure 4.3.
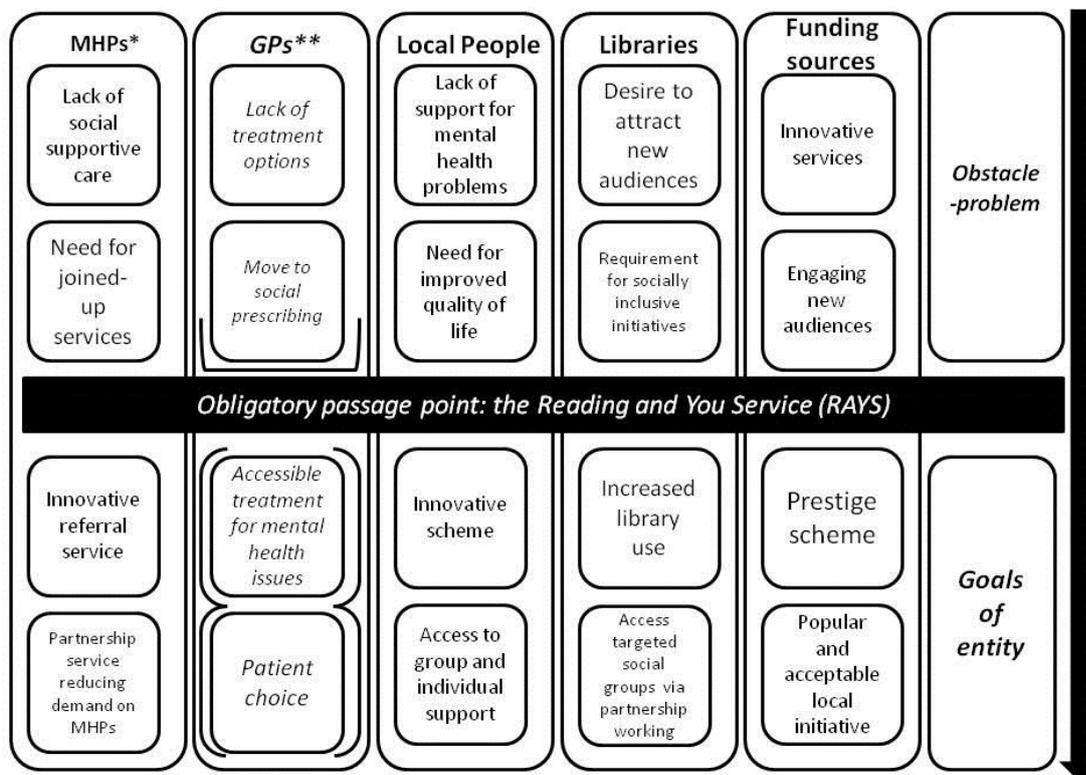
Figure 4.3: From obstacle-problem to solution, via the OPP of RAYS

(adapted with permission from Callon, 1986)
* MHPs – Mental Health Professionals
** GPs – As will be explored, GPs did not accept their role within the RAYS network, despite its acceptance by PCTs and other mental health professionals. Thus, their proposed path through the OPP is italicised and barriers added to emphasise this unwillingness to participate in the network.

4.3.2 Interessement

Acquiring funding for the scheme was a key translation in the formation of the network. This rested on ensuring that as a service, the project was strongly defined and differentiated from other services. The initial aims of the RAYS project defined it as a library-centred service encouraging relaxation and stress relief. Its *'unique selling point'* (S-3) was its connection between health and literature, though from a library perspective, this was supplemented by aims to increase library use particularly for those who did not currently use the library regularly.

The DCMS Wolfson Fund provided financial support for the pilot project (running from 2000-01), which was formulated to promote reading to excluded groups and

new audiences. Local PCTs also provided funding. Increasing library membership and use of book stocks were key aspects of the DCMS Wolfson funding aims (Wallis *et al*, 2002). While the aims of PCTs and DCMS Wolfson funding were different, with one aiming to promoting reading and the other to provide social prescribing alternatives to medication for long-term conditions, the format of RAYS encouraged a focus on both reading and alternatives to traditional mental health care. Other aims of the DCMS Wolfson Fund included encouraging partnership working – achieved by the location of services in primary health care facilities – and 'achieving best value' (Wallis *et al*, 2002). A key factor here was the encouragement to develop 'imaginative partnerships involving bodies not usually associated with libraries or reading' – such as those between the public library service and the PCT (DCMS, 2000: 5).

As some areas of Kirklees suffer from high socio-economic deprivation and a proportion of the population are viewed to be socially excluded, these areas were targeted as areas in which the scheme should operate. Despite external funding, the project was a small-scale outreach service, aiming to 'promot[e] well-being, relaxation and friendship through books and reading' (Kirklees Council, 2001). Following the acquisition of funding, three part-time bibliotherapists were employed by the public library service. These bibliotherapists emerged as focal actors in the network, taking on some of the role of the original focal actor – as will be shown in later sections. The enthusiasm of individuals was a key factor in establishing success. The promotion of the scheme on a national and international level ensured the stability of the network. While the focal actor originally conducted the majority of press interviews and promoted the scheme widely, this task was later undertaken by the bibliotherapists themselves, and their passion for the scheme encouraged wide-spread interest in the idea of bibliotherapy.

The individual bibliotherapists had an impact on the direction of the scheme, eventually demarcating the key concepts of the model. Interview participant S-3 defined the initial focus of the scheme; *'originally, it was to work with people with mild depression, and actually be a doctor referral scheme. The original bibliotherapists were based around particular health centres.'* The focus on health centres indicates that partnership working was initially very important. Partnerships were instigated at a management level, and managers chose the locations in which the bibliotherapists would be based without consultation with staff in those health centres. However, the use of health centres as a project base was unsuccessful. Despite the support from

managers in the PCTs, the bibliotherapists struggled to engage with GPs in the health centres, leading participant S-3 to stress that *'originally, the concept was to work with health professionals – the doctors – but it's found its own way.'* The lack of success in engaging with GPs demonstrates that the top-down imposition of a partnership agreement can be destabilised by actors who need to enact the partnership on a day-to-day basis. These set-backs in partnership working were initially seen as negative, but provided greater scope for the bibliotherapists to alter the direction of the schemes based on their experience.

To fully understand the evolution of the RAYS project, it is first necessary to define the original model and identify its failings. While the service was designed as a partnership project between the library and health services, the onus was on the library service to deliver the scheme. The financial support from the DCMS Wolfson Fund was conditional; it relied on achieving matched funding from another source. In this case, the PCTs covering the Kirklees area provided this funding. While the higher-level partnership between PCTs and the library service was successful, establishing partnerships between bibliotherapists and individual GPs proved problematic. In the words of the focal actor 'getting to see a doctor in person was a bit like gaining access to the inner sanctum of MI5' (Morris, 2002:8). The narrative of 'family doctors as sceptics' was an influence on the changing nature of the scheme (Cunningham, 2002). While the scheme was marketed as a time-saving intervention for GPs, this was ignored by the GPs involved (Brewster, 2007).

Initial definitions of the potential users of the scheme came from the PCTs; *'the idea was we would work with the health trust and people with lower-level stress, anxiety, depression, and that definition came from the health trust. That was their kind of input as to people who would be most likely to benefit'* (S-5). Initial constructs focused on this mild to moderate criterion, with leaflets aimed at service users stating that 'RAYS is for anyone who doesn't read very much or doesn't use their local library and who may be suffering from stress, mild depression or is feeling isolated and lonely' (Kirklees Council, 2001). However, moving away from these initial ideas, the project evolved in two ways:

   i.   a translation from locating services in primary care practices and the doctor referral model.

   ii.   a translation to use of the scheme for people with more severe and enduring mental health problems.

While these two evolutions may seem inherently contradictory, as will be seen in the following sections they are both underpinned by a repositioning in relation to medical models of mental health, towards a socio-cultural understanding of mental health encompassing creative therapies. Open acceptance of people with mental health problems in the community and the potential problems with accessing services via diagnosis and medical referral were also key. As participant S-5 commented about the groups; *'anybody could join them, you didn't have to bring your credentials in terms of whatever diagnosis you had, in terms of mental health. We discovered that lots of people [are] not necessarily seeing somebody, a medical practitioner – but there will be underlying, or just not identified [problems].'*

Morris (2002: 8) cites these initial difficulties with the medical profession as related to the nature of EBP; 'doctors seem to require evidence before they will take on board anything new.' In her view, the project was designed to provide evidence that had not previously been available. It is, however, significant that the evidence provided by the scheme – focused on qualitative evaluations – was still not of the correct calibre within an EBP framework to fulfil the needs of medical professionals. The previously untested nature of creative bibliotherapy as an intervention meant that there was a reluctance to place clinical terms such as 'treatment' on the work being conducted. Instead, the construction of a scheme that *'believes… reading helps us relax, and that improves our health and well-being'* was used to promote the benefits of RAYS (Kirklees Council, n.d). Well-being-related constructs of the project may have de-medicalised the scheme and meant that GPs were reluctant to engage with it, but as RAYS evolved, this was seen as a positive trend by the focal actor.

At this point in network formation, the actor taking the role of the focal actor also shifted. The three bibliotherapists appointed to deliver services (as one actor) became significant, with Catherine Morris taking a less central role. As S-5 states, *'when it was set up, Catherine was quite farsighted. She had certain ideas, but she was happy for them to be adapted, and to trust us. She saw it more as a creative project than… all about mental health, and these are the results that we want. It was very much use your skills.'* The move from a centrally-controlled project to one managed more by the people directly responsible for service delivery helped to refine the aims of the scheme, strengthen the network, and enrol patients and library users in the network.

From this section, it is clear that GPs did not pass through the OPP of the RAYS scheme. While there is evidence of individual successes in GP – bibliotherapist partnerships, there was a definite progression from a referral-based delivery of services (Brewster, 2007). By 2002, there was a distinct separation from a medical construct of services, as observed evaluation had found that the GP-referral model contributed to anxiety for service users, and also contributed to false expectations about what the project would contain; 'some of the media spread the idea that it would be recommending a different book for every condition, as an alternative to medication or psychiatry. That was wide of the mark'[10] (Cunningham, 2002). While the scheme still focused on referrals from health professionals, encouraging referrals from secondary care professionals – including CPNs, OTs and health visitors, who generally accompanied their clients to meetings with the bibliotherapist – moved the focus of the scheme from constructions of 'patients' to constructions of 'clients.' As was discussed in section 2.1.1, linguistic changes often indicate broader changes in scope. The positive relationship between secondary care staff such as OTs and the bibliotherapists was responsible for the second shift in the boundaries of the network. People who had more severe and enduring mental health problems began to access the bibliotherapy scheme. Connections with local mental health service user support groups were also established. The changing focus of the network was not seen as a negative development by the managers of the scheme: *'so it actually turned out to be about those people developing their own links that weren't necessarily with the doctors but were with other practitioners. To spread the word that reading was not a passive thing. You could use as a stimulation, as an escape or whatever. Also that it could be a social thing'* (S-3).

As discussed above, evaluation of the scheme can be considered problematic, and contributed to the changed membership of the network as GPs did not take the role in the network originally envisaged for them. Evaluation focused on two elements; firstly, a basic quantitative analysis of the number of clients seen by the RAYS bibliotherapists, either in groups or individually. Secondly, bibliotherapists wrote individual client stories, observing the role of the scheme in improving the lives of those who took part. The sensitive nature of this evaluation means that the RAYS staff keep all information relating to this evaluation confidential. Nevertheless, from the perspective of the DCMS Wolfson Fund, the aim of the project was to increase public library use and membership; this quantitative use of statistics satisfied their terms. Sustainability – measured in terms of the retention of important members of

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[10] RAYS began before BoP had been formulated.

staff and the increased number of bibliotherapy sessions – was also taken as an indicator of success (Resource, 2003).

The shift away from primary care referral and towards more enduring mental health problems also changed the content of the model itself. Participant S-5 thought that there were two reasons for this; one concerned with the personalities of the staff who undertook the role of bibliotherapist, and the other related to the people who took part in the scheme. In her view, *'the idea was… getting [people] interested in reading. It moved on from there, it widened out – just by the people who were appointed to be the bibliotherapists themselves.'* However, the initial model of setting up traditional reading groups did not work with the revised clientele of the scheme; *'fairly early on we realised that actually setting up actual reading groups was not really practical – it didn't work, it had to be much more flexible than that… some of the people we see can't commit themselves to picking up a novel and thinking 'I'll be able to read this.''* Thus, the RAYS model shifted from one where people were met individually, introduced to the public library and joined a traditional reading group to one which was much more *'catholic'* (in the words of participant S-4) and responded to the needs of those who took part in specially set-up groups. The scheme was eventually translated into a number of different groups, often in outreach settings, in which the needs of the individual clients in the group dictated the content of the group. While the severity of mental health problems that many of the clients of RAYS had increased, the social experience of reading remained the focus of the scheme. While many clients had been 'round the [health care] system' repeatedly, RAYS was positioned as a different intervention and was not there to cover the same ground (Cunningham, 2002). Before long, the mantra of the scheme became that the bibliotherapists were offering 'not therapy, but normality' (Duffy *et al*, 2009).

However, as this crystallisation of purpose was being achieved, questions of funding also needed to be addressed. Following the first successful DCMS Wolfson Fund application, a second was submitted in 2001-2. Changes in the funding application criteria emphasised the importance of establishing new partnerships, and interest from the neighbouring borough of Calderdale meant that this was a joint bid, with the RAYS scheme spreading to Calderdale and three new bibliotherapists being appointed to work alongside the Kirklees team. At this point, tensions developed in the expanded network, which now included two library services and two teams of bibliotherapists with differing aims. Despite the shift in Kirklees away from the medical model of mental health to a social model of the benefits of reading, the focus

of the Calderdale model was a more medical one. In Kirklees, the backgrounds of the bibliotherapists were predominantly creative, with some personal or professional experience of dealing with mental health problems. The bibliotherapists appointed in Calderdale were appointed for their skills in counselling or group work, rather than their interest in literature; *'the people they recruited and appointed to the posts in Calderdale were all people who had been working in mental health, so they were a very different team, and it worked differently'* (S-5). The differences between the Kirklees approach of *'not therapy but normality'* and the Calderdale focus on *'a creative activity based upon interaction between a therapist and a client using printed text to achieve a therapeutic outcome'* demonstrate the contrast in approaches clearly (Duffy *et al*, 2009; Peter Good, Calderdale bibliotherapist quoted in Stevens, 2005).

While there is little information documented about this partnership, anecdotal evidence suggests that the differing aims of the schemes meant that this partnership was not entirely successful (Brewster, 2007:36). Following the DCMS Wolfson Fund-based partnership, both local authorities had to seek further funding. This was achieved separately, with Calderdale obtaining a Yorkshire Forward grant and Kirklees acquiring funding from the local Neighbourhood Renewal Fund and the Healthy Living Initiative, then from the Arts Council. At this point (circa 2005), the partnership between Calderdale and Kirklees appears to dissipate further; the success of the Kirklees scheme meant that it was 'mainstreamed' within the library service's core offer in 2006, at the end of the Arts Council funding, while Calderdale's scheme did not continue in the same form, ending work with individual clients and bookchat-type groups in March 2006 (Murphy, 2006). As participant S-5 commented: *'I would be loath to say that we were more successful [in Kirklees], but in balance we had some advantages.'* Instead, retaining the same publicity materials, the Calderdale scheme shifted to a BoP type model, using the Cardiff booklist, and initially positioning the recommendation of self-help books as a 'supplement' to the services of the bibliotherapists. These changes to the scheme are in direct contrast with comments made earlier by the Calderdale bibliotherapists. In their view, the focus of the RAYS Calderdale model was very clear that 'there is no prescriptive list of books that cure' (Wyke, 2003). Bibliotherapists were also careful to state that 'I'd be suspicious about prescribing a book for a condition; you have to match it to a person… it might not even be a diagnosable mental health problem, but just loneliness or bereavement' (Sheila Graham, Calderdale bibliotherapist, quoted in Wyke, 2003). In a press release providing information about the changed focus of

this scheme, a local councillor stated that 'through reading novels and poetry people have been able to reduce stress... but we are now offering a range of self-help books, which enable people to address their difficulties in a more practical way' (Calderdale Council, 2005). The change to a BoP model, the main tenets of which are seen as its cost-effectiveness and its evidence-based credentials, places the scheme on a health-focused platform of value. The decision not to 'mainstream' the RAYS services in a literature-focused manner in Calderdale, in contrast with Kirklees, demonstrates the way that the formation of a network is not inevitable or irreversible, and is reliant on the actors within it to sustain the initiative (Callon, 1986).

4.3.3 Enrolment

Turning back to Kirklees and the well-being-centred, literature-focused construction of the RAYS scheme, several characteristics of the model need to be explored to explain the current strength of the network. Constructions of inclusivity were vital for enrolling clients into the network and reinforced the translation from a medical perception of mental health to a social one. In conjunction with this focus on inclusivity, the clients themselves were responsible for strengthening the network, helping to promote and stabilise the network within Kirklees. The introduction to the network of actors including OTs, whose raison d'être is defined as 'to promote people's health and well-being through their everyday activities' also impacted on the focus of the network (NHS Choices, 2010c). Shifts in national mental health policy towards a well-being-centred construction were also important to enrol local council funding and were essential for mainstreaming the scheme within the core library offer. The network of RAYS altered throughout this time, with different funding bodies, the Calderdale partnership, and changes in the referral structure, from primary care to secondary care professionals. However, despite these shifts in network boundaries, the core of the network remained solid.

When examining the information leaflet aimed at service users of RAYS (Kirklees Council, n.d), the language used is also inclusive, and constructs the idea that the scheme is open to all and can benefit people with a variety of problems. The repeated use of the word 'us' places the bibliotherapists and service users on the same level, implying that while the bibliotherapists are providing a service, they are also benefitting from interacting with literature; RAYS is framed as 'a scheme that believes: reading is good for us; talking about books is fun, and libraries are important places for us all' (Kirklees Council, n.d). This socially inclusive language is

used in conjunction with concepts of ''not therapy, but normality' (Duffy *et al*, 2009). Previously explored in detail in Brewster's (2007: 41- 43) work, 'not therapy, but normality' fits within notions of the social model of disability, in which it is a problem of society not making reasonable adjustments rather than locating the problem in the individual with mental health problems (Abberley, 1987). The concepts of stigma and normalisation, related to 'not therapy, but normality' were also explored in section 2.3.5 (Duffy *et al*, 2009).

One of the key elements of the model is enabling people to make choices and choose the books that they enjoy; *'that's the strength of those bookchat sessions, that people feel it's normal activity, it's not a group of people with mental health problems. And that was the idea – we'd get that mix'* (S-5). Social inclusivity is emphasised in the current bibliotherapists' job description, which states that the essential criteria for the job include the abilities to 'widen access, increase involvement and make it easier for people to get involved' and to 'support and empower individuals to improve confidence, self-esteem and inter-personal skills by reading' (Kirklees Council, 2009b). The emphasis placed on the perception in RAYS that 'there are no right or wrong books to read' and 'every response to the novel is unique to the individual' also increases the impression of a socially inclusive scheme by focusing on the variety of literature used in RAYS (Duffy *et al*, 2009). Again, these perceptions of variety were reinforced by comments from interview participants, who stated that:

> S-4: '*they differ from the standard book group format in that they're more fluid, they don't all read the same book, and it's more relaxed and informal. And sometimes they do little writing exercises, and…*'
> S-3: '*sometimes [the bibliotherapist] just reads to them.*'

Concepts of RAYS as both 'person-centred' and 'library-centred' have led to two key factors in its success. The location of the scheme in the library means that the 'robust' evidence required by medical professionals has not been required. Instead, the bibliotherapists concentrate on the individual reactions and feedback from clients to ascertain measures of success. The use of client testimonials both on leaflets and in person to promote services also reinforces the person-centred nature of the scheme. Participant S-4 saw the use of RAYS as: '*a sort of social contract. That's the way that they can put something back into the whole scheme. They benefit from the service but there are so many of them who are actually willing to put something back in, and come and talk about things which are obviously quite hard to talk about.'* This concept of the 'contract' in RAYS was essential for its promotion throughout the

region. While scheme users were under no obligation to promote the scheme, their willingness to do so created an impression of the scheme as well-used, well-liked and beneficial. Feedback from clients was seen as integral to the sustainability of the scheme (Brewster, 2007).

The acceptance of anecdotal evidence of the impact of the scheme performed two functions within the network, including some network members and excluding others. As discussed, GPs were excluded from the network because of their reluctance to engage with the constructed evidence base. The differences in the observed behaviour of clients of the scheme (including their own testimonials) engaged OTs, whose work with those with mental health problems often focused on creative therapies including art, music and writing in the network. It could be theorised that OTs viewed the use of reading under the same umbrella of creative therapies. While many trials of creative therapies are inconclusive, other creative therapies have received significantly more attention than bibliotherapy, and have established a greater acceptance of their role in mental health treatment (Warren, 1993). An extrapolation of the recognised benefits of these therapies – for example, connecting writing-as-therapy to reading-as-therapy – combined with the observed improvements in quality of life for clients of RAYS may have occurred to increase acceptance of the scheme. Similarly, the popularity of the scheme with service user groups, and anecdotal testimonials of clients using the scheme, were seen as ensuring its acceptance.

Despite the rejection of the medical model of mental health, changes in national mental health policy were still influential on the increasing stability of the RAYS network. Participant S-4 ascribed the continuing success of RAYS to the inscription of the well-being agenda in various health care policy documents. The influential Darzi (2008) report, for example, states that 'PCTs will commission comprehensive well-being and prevention services, in partnership with local authorities... Our efforts must be focused on six key goals…[including] improving mental health.' This inscription of the ideas on which RAYS is based – with a need for partnership services and a service that offers mental health care at various stages of treatment – led participant S-4 to state that;

> 'it's now come more on-stream with higher-up corporate national agendas. It just fitted perfectly with the whole rise of the well-being and health agenda... the will from central government that health care and well-being will be addressed in ways external to the NHS, that there are other ways – social systems – that can be put in place that can increase people's well-being. And it just fits. It dovetails with

> *that beautifully. And that's been a real opportunity for us because that's what basically enabled us to secure funding for things.'*

While participant S-3 placed more emphasis on the success of building relationships at a local level, participant S-4 felt very strongly that the influence of national governmental health agendas had ensured the success of RAYS.

4.3.4 Conclusion: national, local, personal well-being

Building on the analysis presented in preceding sections, several factors appear to affect the emergence of RAYS as a mainstreamed library service focused on social constructions of mental health treatment. These factors can be defined as shifting national agendas, an acceptance of anecdotal evidence of the impact of the scheme, and the role of project-oriented cultures within library services, all of which formalised key aspects of the scheme. These three factors will now be addressed in turn. Firstly, the construction of a national well-being-based agenda recognised the need to change behaviour, rather than just provide medication. While this was predominantly concerned with mild to moderate mental health conditions, a similar conclusion was also reached for those with more severe and enduring mental health conditions. OTs and CPNs recognised the role of social engagement focused around reading as an important resource. The necessity of the management of symptoms and awareness that the underlying causes of enduring mental health problems could not always be addressed meant that RAYS was seen as a useful source of social support. The focus on relaxation, enjoyment and social engagement links with a need to alleviate boredom and enrich life on a long-term basis.

A recognition of the need for 'softer' de-medicalised services dealing with long-term conditions was also important for this acceptance; since the inception of bibliotherapy, its role in providing entertainment and distraction for those with long-term conditions has been acknowledged (Peterson-Delaney, 1938). Constructions of long-term conditions, by nature, tend to demedicalise the patient. As there is no expectation of a cure, the focus is on promoting health in a wider sense (Warren, 1993). Instead, what Rosen (1968:312) refers to as 'psychiatric social work' is conducted. As many mental health conditions are enduring, requiring maintenance rather than acute treatment, it is not possible to maintain the construction of a medical model of illness on a day-to-day basis and symptoms are located in behaviours (Scheff, 1967). Creative therapies and social support are thus used as a form of normalisation, management and to mediate behaviour, mitigating the need to

'recover' in relation to the Parsonian sick role (as explored in section 2.3.5; Armstrong, 1983; Williams, 2005).

The acceptance of anecdotal evidence of impact also performed the role of excluding GPs from the network. As was considered in section 4.2, there is a perceived need to refer people with mental health problems to evidence-based psychotherapy services. BoP was accepted because it was portrayed as an EBP resource. In the RAYS scheme the focal actor assumed that the scheme could be seen as evidence-gathering, rather than evidence-based. Throughout the evolution of the scheme, the scepticism of medical professionals was observed, and this led to a disengagement with them. The main difference appears to be between softer therapeutic services dealing with more endemic long-term problems and GPs who deal with milder problems but construct them in a medical model of illness-and-cure.

Finally in this consideration of factors affecting the emergence of RAYS as a mainstreamed library service, the role of a project-oriented culture needs to be examined. While there has been a shift away from project-oriented work, for reasons of a lack of financial support and concerns with sustainability, in the early 2000s, it was seen as a useful model for piloting new ideas without a commitment from mainstream service funding (Hicks *et al*, 2010; Matarasso, 1998a). The prestige of receiving project funding was recognised at a local and national level as a positive reflection on the library service. The impact of this project funding on RAYS cannot be underestimated; the investment required in employing three additional part-time staff, providing a designated book fund, publicising the service and covering incidental costs could not have been achieved without external support. Costs are often cited as a reason that other library services have not implemented this model. The innovative nature of the RAYS scheme ensured its eligibility for project funding, and means that other library authorities have not adopted it because of the lack of investment available. The construction of RAYS as a network can thus be seen as reliant on a number of forces shaping expectations of the service.

Turning to a consideration of the ANT concept of irreversibility, this section has examined how RAYS was translated from an initial pilot project to a mainstream library service. Although Callon (1986) views translation and network construction as a process that is never completed, RAYS' status in Kirklees places it on a level with other library services such as local history and information provision. This entrenchment in service provision means that it can be seen as a strong network that

will require active contestation to destabilise. The main threat to the stability of the network can be seen as a threat to the library service as a whole – reductions in budgets may lead to fewer staff and resources to support RAYS. The sustainability of the scheme also depends on the appointment of appropriate staff to act as bibliotherapists, a continued alignment with the aim to provide de-medicalised services, and continued support from the principal librarian and those using the scheme.

Section 4.3 has introduced the key concepts of the RAYS model of bibliotherapy, and has explored its instigation in both Kirklees and Calderdale, examining the reasons for its continued existence in Kirklees and changed format in Calderdale. It has engaged with holistic concepts of mental health, and charted the negotiations inherent in network formation. While the boundaries of the RAYS network may have shifted, the focal actors in the network ensured that this happened without threatening the stability of the network. Actors such as GPs may have played a less central role, but the changed direction of the network, leading to a socio-cultural focus on more severe and enduring mental health conditions, meant that the network remained solid and satisfied the requirements of the majority of its members – including, for example, funding bodies, who could have destroyed the network by withdrawing support. This chapter will now turn to the second model of creative bibliotherapy in the UK – GIR.

4.4 GIR and TRO

GIR, a scheme run by TRO in Merseyside, concentrates on reading fiction and poetry aloud in a group environment. Unlike RAYS and BoP, TRO operates independently of the public library and the health service, though it still maintains connections with both sectors. If RAYS can be said to be people-centred or library-centred, and BoP is focused on health and treatment, the main concern of GIR can be said to be literature, with the 'text as expert' (Farrington and Fearnley, 2010). It concentrates on the benefits of reading classic literature and the uses of literacy, creating a tightly defined model of creative bibliotherapy that contrasts with the more flexible RAYS model. This section traces its emergence as an applied model of bibliotherapy in practice, assessing the challenges to the organisation and the benefits of the intervention.

4.4.1 Creative bibliotherapy: the GIR model

TRO is a charitable organisation, previously operated as an outreach unit of the University of Liverpool and is still closely involved with the University. TRO began in 1997 as a 'magazine-based' project, looking to expand the audience for literature outside of the university environment (TRO, 2010: 53). TRO now manages several schemes to promote reading, with GIR as the main arm of its 'social outreach' programme. The focus here will be on GIR's work with adults, rather than the use of GIR for children or TRO's wider work. In 2001, funding was allocated by the University of Liverpool to establish two reading groups, with the joint aims of adult education and increasing access to literature. In common with other bibliotherapy schemes discussed in detail in this thesis, GIR was instigated by one enthusiastic individual, who worked hard to convince others of the value of the scheme. Jane Davis, an academic from the University of Liverpool, can be regarded as the lynchpin or focal actor. Following a process of personal realisation of the social impact of the reading groups, Davis sought and gained funding for wider-scale projects; the organisation expanded; and the GIR model and brand were developed.

The format of GIR groups is precisely defined, beginning with informal chat, often over refreshments, before the group facilitator begins reading the chosen text aloud. After an appropriate point, reading stops and the content is discussed, before reading resumes. Typically, other members of the group read aloud, and the pattern of reading, pausing and discussing continues. To end the meeting one or two poems are read – first by the group facilitator then by group members – and discussed. Group length ranges from one to two hours, and the model can be adapted in line with the needs of those in the group. For example, transient groups or those with lower concentration will read short stories rather than a novel that requires commitment over a number of weeks.

As with analysis of RAYS and BoP, a number of key documents were identified as relevant; Jane Davis has published widely on the subject of GIR, including project evaluation reports and articles in the Lancet and Public Library Journal (Davis, 2006; Davis, 2008; Davis, 2009a; Davis *et al*, 2008). Further evaluation reports provided information on the development of the model, while recent developments are described in the charitable company's annual reports (Curran, 2007; Robinson, 2008a; Robinson, 2008b; Scott-Graham, 2008; TRO, 2009; TRO, 2010). Evaluation reports were often written by those closely involved in GIR and so do not necessarily provide independent analysis; as Markless and Streatfield (2006: 12) comment

'service evaluation is… a political process, especially if the intention is to use the evidence to secure funds.' Published academic articles and research commissioned from the Liverpool Health Inequalities Research Institute (LHIRI) demonstrated GIR's endeavours in the field of research, which aim to improve the evidence base about shared reading (Billington *et al*, 2010; Hodge *et al*, 2007; Thierry *et al*, 2008). A number of newspaper articles were examined to ascertain public interest and perceptions of the scheme (McCrum, 2010; Morrison, 2008; The Express, 2009; Viner, 2010; Winterson, 2010). Discussion of the scheme in the House of Lords helped to define the balance between health and culture (The Lord Bishop of Liverpool, 2010). TRO also publish extensively on its website; via *The Reader* magazine; and produce self-promotional documents (TRO, 2011c; n.d-a; n.d-b). Finally, guidance provided by funding bodies supporting TRO was consulted to examine the impact of its status as a charitable organisation on service provision (Esmee Fairbairn Foundation, 2011; Paul Hamlyn Foundation, 2007; 2009; 2011c; The Rayne Foundation, 2011).

Analysis here will concentrate on a number of aspects of the GIR model – social inclusion, the literary canon and reading aloud – and will focus on several key points in the emergence of GIR as a network, including Jane Davis's personal experiences; funding; commissioning; and promotion of the model. From initial constructions of the groups as a small-scale project emerging from the sphere of adult education, GIR is now internationally recognised as a model of reading aloud for health and well-being. The translation from literature-as-education-and-literacy to literature-promoting-well-being occurred in several stages, and developed from Davis's belief in the wider appeal of classic literature. Definitions of classic literature are very important to GIR as a model, and will be explored in the next section.

4.4.2 The literary canon and self-improvement

Promotional material for TRO states that GIR is 'carrying out in modern terms the Victorian mission of reading for life's sake' (TRO, n.d-a: 7). This connection between the Victorian aim of self-improvement and GIR emphasises the narrative of self-improvement that can be said to underpin GIR, via its roots in continuing education. GIR use texts from the literary canon, read aloud to facilitate discussion and understanding (TRO, 2008). The literary – or Western – canon is a complicated concept, and there is disagreement on the titles that form the canon. It is used here as a shorthand for titles considered in TRO to be 'great literature.' Bloom's (1994) opus on the canon separates works into four canonical eras, and many of the titles

used in GIR groups are taken from the lists given by Bloom (1994), with a concentration on novels written in the nineteenth century by writers like Charles Dickens, Leo Tolstoy and George Eliot. Contemporary fiction and poetry is also read in GIR groups, though the emphasis is on these texts as a 'stepping stone' to more complex texts. TRO's base in the School of English in a redbrick university and its origins in adult education affect the construction of the literary canon used. The use of the literary canon implies the placing of a value judgement on literature, suggesting that some titles are better for the reader than others. As Gold (1990:24) states; 'what is regarded as great literature is what the authorities have decided will last' critiquing notions of the literary canon in relation to narratives of power. Similar debates abound throughout the academic literature discussing the provision of materials in public libraries, with some authors concluding that the aim of libraries is to provide literature for the betterment of the general populace, with others arguing that libraries should provide the materials that readers want to read rather than those they "should" read (Black, 2006; Stewart, 2006; Usherwood, 2007).

The rationale behind the use of texts from the literary canon is to inspire confidence in people who have never read such texts alone, and may not think of doing so. TRO hypothesise that these great works of literature contribute more to the reader's experience than works outside the literary canon (Hodge *et al*, 2007; TRO, 2008). Building on ideas referenced in the library literature, the aim of GIR can be referred to as the 'reading as a ladder' metaphor, as readers are expected to progress to more difficult texts (Sheldrick Ross, 1987). Service evaluation with those who attend GIR groups has reinforced the idea that group members feel they are making progress with their reading (Davis, 2008). Group members can gain confidence; an improved ability to concentrate; and enjoy literature that they may not have read alone (TRO, 2008). Following this background on the ideas of the literary canon, this chapter now turns to how GIR uses the materials in the literary canon in practice, tracing the project's emergence, and examining its popularity.

4.4.3 Problematisation

Three key points can be identified in the problematisation process; Jane Davis's personal realisation of the potential of the GIR programme and her investment in this process; the need to gain funding to support the groups; and the translation of the problem from one of literacy and education to one of well-being, enrolling a wider network of actors. Davis's experience in starting GIR has been widely documented, both by herself and by others involved with the schemes (Davis, 2008; TRO, 2011c;

TRO, n.d-b). The story highlights key moments in Davis's life, leading to her work with reading, social inclusion and mental health. Her interest in the relationship between reading and well-being can be said to be highly personal; having had a difficult early life, she left school with few qualifications (Davis, 2008:76). Her view of reading as an education and a solace led her to study English while in her early 20s, gaining a PhD in English Literature and working as a lecturer in the Department of Continuing Education at the University of Liverpool. Her personal recognition of the "uses" of literature in her own life, and enthusiasm for sharing reading and learning led to a dissatisfaction with teaching literature, as those who took her courses were those who already appreciated the texts. Davis's desire to provide access to literature to 'the girl I'd been at 20: uneducated, needy, poor and rough round the edges' led to the start of two groups encouraging a wider audience to read the classics for pleasure (Davis, 2008:77).

Building on this concept, the first groups aimed at bringing literature and reading for pleasure to a wider audience were started in a deprived area of Merseyside. The beginnings of the group are again widely reported (Davis, 2008; Hourihane, 2011; Viner, 2010). While TRO emphasises that the GIR model was discovered 'accidentally' within an adult educational context, there is also a narrative presented of the need to 'get books out of the University and into the hands of people who could really benefit from them' (Paul Hamlyn Foundation, 2011b; TRO, 2010:41). Davis's (2008) account of the group rests on two key moments of realisation, both facilitated by group members. Firstly, a group member requested 'the good stuff,' enforcing the idea that there was a class divide in perceptions of access to literature, with the 'poshknobs having all the best stuff' (Davis, 2008:78). His comments shifted the focus of the project from one just focused on reading for pleasure, to one that aimed to change perceptions about literature and provide access to texts that readers may not have read otherwise. When beginning the groups, Davis did not have any information about the literacy levels of group members and so chose to read aloud herself in the group, to ensure that those who were in the group could participate. This led to the development of reading aloud as a facet of the GIR model.

The second moment of realisation occurred in response to a poem read aloud, Tennyson's *Crossing the Bar*, in which the author muses on his own death (Davis, 2008:78). In both groups, this poem made group members cry; rather than this ending the group or changing the subject as individuals struggled with their

emotions, Davis was encouraged by those emotionally affected to continue reading and the group provided a supportive environment in which people were able to discuss their experiences in relation to the poem. Davis's narrative of the emergence of GIR as a model identifies these two moments as those in which she realised that 'getting literature out of the university… was going to have real social consequences' (Davis, 2008:79).

The translation from literature as a support for literacy to a recognition of its benefits for health and well-being had thus begun in the GIR project. Recent promotional material from TRO, examining the reasons for using these texts rather than others states that 'our reading groups focus on the experiences and the felt meanings raised by these 'classics'… our greatest writers become the greatest reads because they address the human condition' (TRO, 2011b). Thus, the key aspects of the model – classic literature read aloud in a group environment for emotional health and well-being – became established.

Following these initial groups, which were funded as a five-week project from the University of Liverpool's Widening Participation Fund, Davis decided to seek funding for further groups under the GIR brand (Davis *et al*, 2005). A bid to the Paul Hamlyn Foundation, in partnership with Birkenhead and Wallasey PCT (now NHS Wirral) and Wirral Libraries secured funding for a one-year pilot project to run thirteen groups (Davis *et al*, 2005). An additional bid for funding continued this project for two years, further expanding the scheme (Hicks, 2006:61). This was run under the brand of 'Merseyside Reading Communities' (MRC) and aimed to promote library use and improve evidence around reader development initiatives as well as running reading groups (Davis, 2006). This project focused quite heavily on specific excluded and deprived groups, working with established populations such as those in drug rehabilitation facilities and neurological units (Davis, 2006:10). One of the initial aims of this project was to train and place volunteers, a strand of the project that changed as the GIR brand became more defined, as will be discussed below.

The funding bodies that support GIR have similar main aims to GIR, which also helped to shape the direction of the scheme. For example, Curran's (2007:6) report observes that the groups are 'intentionally based in areas of deprivation' and this may be in part to meet funding criteria as well as to encourage reading amongst those who would not usually read. Current guidance from the Paul Hamlyn Foundation emphasises that they concentrate on supporting disadvantaged

communities, improving quality of life via innovative work (Paul Hamlyn Foundation, 2011a). Providing a scheme that meets funding criteria has helped to shape the direction of the service, when taken into the context of Jane Davis's own beliefs in the benefits of literature for all, rather than literature for the few.

At this point, it is appropriate to consider the actors who can be said to form the network and their obstacle-problems and goals, with the aim of establishing the network as it initially existed. This process is also represented in figure 4.4. The actors in the network can be said to be:

- The University of Liverpool, who wished to work with the local community to maintain a good relationship between the local population and the university as an institution. The provision of outreach programmes fulfilled their aim of widening participation and increasing access to education. GIR can also be seen as a prestige scheme, supported by influential philanthropic organisations which would contribute to the perceived benefits for the University.

- Birkenhead and Wallasey PCT, who were looking for low-cost, innovative solutions to problems of poor mental health and well-being, and were looking to reduce health inequalities in the area. GIR provided targeted interventions with specific deprived groups, and while – as this section will discuss – the provision of evidence and impact measurement was problematic, those commissioning services for the PCT came to believe in the effectiveness of the model, which ensured continuing support for GIR.

- Wirral public libraries, who wished to attract members to the library, encourage reading and gain funding to conduct an innovative project. TRO also provided training in its model to library staff, and the interim report to the Paul Hamlyn Foundation states the aims of the project as to 'remove barriers to library use' and 'extend literacy,' both of which support the key aims of the library service (Davis, 2006:4).

- Jane Davis and the staff of TRO, who were responsible for establishing and expanding the model. Unlike other models of bibliotherapy operating in the UK, TRO did not use an existing infrastructure. Although a small staff had previously worked on The Reader magazine, project workers had to be employed and trained and new skills had to be acquired, including writing funding bids and project reports, managing a large number of staff and volunteers, and promoting GIR to health professionals, librarians and funding

bodies. Jane Davis and TRO are not included in figure 4.4, because their role is seen as part of the OPP/ solution as well as part of the network.

- Funding bodies, who needed to see the benefits of the GIR model, including its contributions to social justice, well-being, health inequalities and literacy. Their enrolled support was key to the success of the scheme, ensuring its continued existence.

- Clients, or beneficiaries as they are referred to by TRO, needed to accept that a literature-based intervention would have a positive impact on their mental health and well-being.
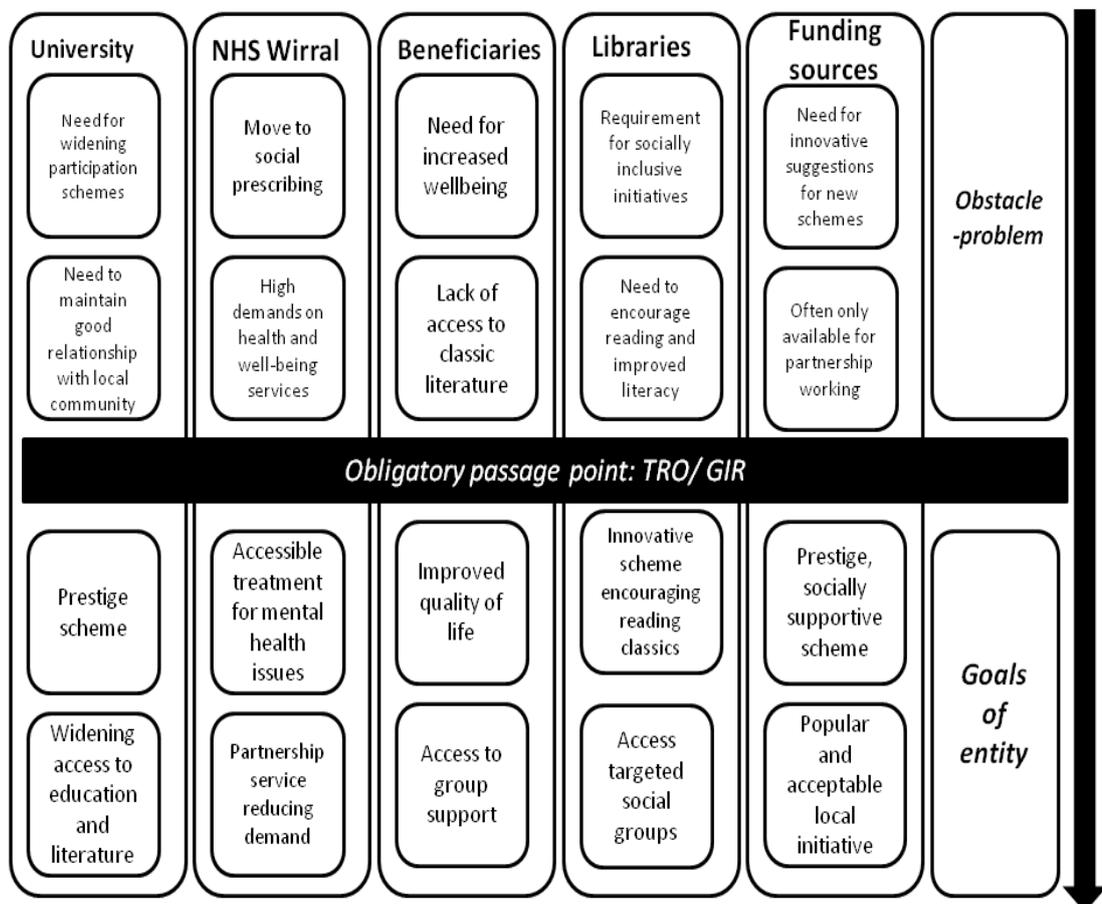
Figure 4.4: From obstacle-problem to solution, via the OPP of TRO/GIR
(adapted with permission from Callon, 1986)

Thus, the 'problem' for which GIR can be seen to provide a 'solution' can be seen as the low number of people, particularly from poor or deprived backgrounds, reading works from the literary canon. The personal belief and experiences of the focal actor translated this lack of interaction with literature into a need to do so in order to thrive emotionally, socially and in order to understand the 'human condition.' Having

established the initial basis of the model, this section will now analyse the growth of the project – including the need to convince others of the benefits of reading the literary canon – based around a number of significant points in the history of TRO that strengthened and concentrated the network.

4.4.4 Interessement

Having secured funding from the Paul Hamlyn Foundation, who continue to support GIR and TRO, further funding bids were submitted and financial support was gained from the Esmee Fairbairn Foundation from 2006 onward, and The Rayne Foundation from 2009. Securing funding for GIR and TRO's connected activities was vitally important, particularly from 2008 when a series of key events occurred, both strengthening and condensing the network of GIR. These key events can be defined as attaining national interest, developing a commercial training model, and applying for status as a registered charity and a Company Limited by Guarantee.

TRO regard an article published in the Guardian newspaper in January 2008 as a key turning point in its history, presenting the GIR model to an international audience and dramatically increasing its profile as an organisation (Morrison, 2008). Following this turning point, the language used to describe the organisation and its aims altered; as the article stated: 'these reading groups aren't just about helping people feel less isolated or building their self-esteem… they're an experiment in healing… an attempt to see whether reading can alleviate pain or mental distress' (Morrison, 2008). Blake Morrison, the author who wrote the article, has long been a supporter of TRO, and the emotive way in which he presented the groups defined the presentation of GIR to the public, emphasising the health benefits over those of literacy. Another, more recent newspaper article, aping the style of Morrison's original article, comments that 'along the way, the goalposts shifted. Davis has effectively turned William Shakespeare and Charles Dickens… into therapists' (Viner, 2010). This use of persuasive language telling the stories of people in the reading groups and how GIR has improved their lives provides powerful publicity. The international interest in the model that followed the publication of Morrison's (2008) article led to a wide expansion in its use, and was accompanied on the part of TRO by a desire to secure some form of quality control of application of the model.

Although TRO had run training for its GIR facilitators since its inception, this national interest in the project meant that its 'Read to Lead' programme expanded. As well as running brief introductions to the GIR programme, TRO offer a week-long residential

training programme, initially accrediting those who had undergone training to run GIR groups. One of the reasons for this shift to a paid-for training model rather than training volunteers may have emerged from the MRC project, in which there were problems establishing strategic relationships with organisations, and with training and placing volunteers (Davis, 2006). The cost of Read to Lead training meant that TRO were able to control the number of people accredited to facilitate its groups.[11] The provision of training also provided a source of income for TRO that would not have been accessible if training volunteers. From this early accreditation, independent, non-affiliated groups which use the GIR model operate in a number of areas, e.g. Sandwell, Lancashire, Durham.

Throughout the interessement process, two further shifts in TRO policy occurred; while the training course still operates in the same fashion, those undertaking it are no longer 'accredited' at the end. Instead, TRO aim to encourage organisations such as PCTs or library services who might want to run GIR groups to commission a 'reader in residence' from TRO, or to go into partnership with them. Readers in residence – or TRO project workers – are trained and employed by the organisation, enabling a more consistent application and promotion of the model and closer control of the literature used. As the TRO website states, this will help to ensure that the application of the model of shared reading will be 'sustainable, cost efficient and quality-assured' (TRO, 2011a). While there are strengths to running GIR groups from a central base, ensuring that the resources needed are shared and providing a support system for the project worker, this can also be seen as indicative of the desire to ensure quality control of GIR and to establish TRO at the centre of an international network.

TRO's concentration on strengthening its own organisation can be seen as reflecting developments in the network of GIR; in 2008, TRO 'spun out' from the University of Liverpool, establishing itself independently as a registered charity and a Company Limited by Guarantee. While still supported by the University, this status as an independent organisation meant that there was a need to ensure self-sustainability. Training others to run GIR groups puts the organisation in competition for funding with those it has trained. Those completing the training are also able to adapt and develop the model, potentially diluting its message or usage. Little research has been conducted examining the outcomes of use of the model in areas other than

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[11] TRO offer one highly discounted place per Read to Lead training course to ensure that the training is accessible to a wider audience.

Merseyside. Promotional materials produced for TRO emphasise the ambition of TRO to maintain its role at the centre of current practice: 'our aim is to be the UK's leading practitioner of shared reading' (TRO, n.d-b). Having examined the manner in which the network was strengthened and condensed throughout this interim period, this section will now examine three developments that reinforced the centrality of GIR on Merseyside, and analyse the methods TRO are using to ensure the irreversibility of the GIR network.

4.4.5 Enrolment

During the enrolment stage of network formation, two developments ensured the prominence of TRO. Firstly, as with RAYS and BoP, the rising importance of well-being in government policy meant that GIR was aligned with national agendas. Concerns about cost-effective care, also relevant to TRO, were also highlighted in policy. Secondly, the wide expansion of the GIR model meant that further partners were enrolled in the network.

Returning to the considerations of the earlier MRC project report, Davis (2006:22) stated that 'as reading and health or bibliotherapy rises up the national agenda, so GIR is increasingly coming to prominence.' The rising awareness of the status of GIR was key in the enrolment process. As discussed earlier in this chapter, NHS policy currently supports social interventions for health and well-being, and on Merseyside there were specific targets to set to improve social well-being inequalities as well as health inequalities, a role which GIR was seen to fulfil (Doran *et al*, 2010). Indeed, GIR itself was presented as an example of 'best practice' in social health care in the New Horizons mental health services consultation report (DH, 2009a). TRO became a partner in Liverpool's 2010 Year of Health and Well-being, a year-long event to promote better health in Merseyside (Liverpool Primary Care Trust, 2010). A key narrative at this stage in the evolution of the network was that of cost-effectiveness. Kathy Doran, Chief Executive for NHS Wirral, referred to GIR as a 'smart investment' while David Fearnley, a clinical psychiatrist at a secure hospital and supporter of TRO, commented that it was 'very cheap and easy to do' (Hourihane, 2011; TRO, 2011c). GIR was also the subject of brief attention in the House of Lords, with the Lord Bishop of Liverpool (2010) stressing that 'groups cost about £6 per person per session; by comparison, an in-patient stay costs £9000 on average.' Awareness of this cost-effectiveness was a contributing factor in the long term sustainability of the GIR network.

By the end of April 2010, there were 190 weekly reading groups running as part of GIR in the North West, South West and London (TRO, 2010: 9). Much of this work has been conducted with commissioned groups in locations where the group environment is already established – for example, day centres, residential care homes, prisons and schools. This has benefitted the model, as it has meant that group members already have social bonds aiding group formation. Recent research conducted on behalf of TRO observed the benefits of working with pre-formed groups (Billington *et al*, 2010). TRO's expansion as a charitable company means it must publish its annual reports, which present TRO as a highly successful organisation with a turnover of over half a million pounds a year (TRO, 2009). It has also achieved a high level of public recognition, with nominations for numerous awards (TRO, 2011c). Its aims to integrate the GIR model into services throughout Merseyside has led to work with the criminal justice and dementia care sectors. Despite this widespread support, the evidence base for the project does not meet the requirements from organisations like NICE, with the intervention yet to be subject to an RCT, and TRO's recognition of the need to enrol medical professionals in the network has led them to acknowledge the need to improve this evidence base. As will be discussed in the next section, TRO uses both research and the opinions of medical professionals to stabilise and promote the network and ensure its continued stability.

4.4.6 Mobilisation and irreversibility

Following on from this process of enrolment, key opinion leaders developed their role, mobilising the network by speaking for it and disseminating perceptions of its work. TRO's research work also aims to mobilise the network, providing the evidence base currently missing from studies of creative bibliotherapy. Key opinion leaders were enrolled in the network and their opinions were used as evidence of the outcomes and impact of the GIR intervention. Dr David Fearnley and Professor Louis Appleby (the former director of NHS Mental Health) are both considered to be champions for the GIR programme, citing its connections with well-being and community building as important (Davis, 2009b; TRO, 2011c). Despite GIR's status as a non-evidence-based intervention, Fearnley supports its use in a secure psychiatric hospital, with the aim of improving a sense of community on the ward, and because it 'isn't a typical hospital experience… it hasn't been sanitised or processed' (Davis, 2009b: 36). Again, this can be compared with the RAYS model which is seen as a source of long-term social support rather than a treatment per se.

TRO staff are also involved with research aiming to provide a scientific basis to the idea that works from the literary canon have more value than those less revered, recognising that while some psychotherapeutic professionals will accept the outcomes presented by seeing the GIR programme in action, others will not. Raymond Tallis, an author and retired medical professional, commented that the wider body of published findings on the use of literature for health were 'equivocal findings in fourth-rank journals,' despite personally respecting the work conducted by TRO (Morrison, 2008). Recent research connected with GIR includes a neurological study examining the impact of functional shift – or the conversion of word types, e.g. using nouns as verbs – on neural pathways in the brain (Thierry *et al*, 2008). This study focused on Shakespeare's writing, positing the theory that it was his use of functional shift that made his prose more engaging than modern genre fiction. Socio-linguistic research has also looked into the content and 'formal dynamics' of the group interaction (Billington *et al*, 2010). This study used the PHQ-9 (Patient Health Questionnaire with nine questions) to try to measure improvement in perceptions of health in members of the group. However, while a statistically significant improvement was found for those who were not considered to be depressed, those who completed the questionnaire with higher scores representing depression did not show a statistically significant improvement (Billington *et al*, 2010: 24). Small sample size was also a problem for this study, with only eight participants providing baseline and follow-up data. However, Billington *et al*'s (2010) study – in combination with various evaluation reports published by TRO – aims to improve the evidence base surrounding its model, and form the basis of planned RCT work.

From the data gathered from documents and presented this section, it is clear that GIR has worked hard to become established as a secure network, and continues to do so, in line with the other projects of TRO and the ongoing quest to establish a solid basis in empirical research for GIR. However, there are some threats to the network of GIR, which may destabilise it. For example, as a charitable company reliant on grant funding, there is the danger that funding bodies may withdraw support. Similarly, proposed changes in the structure of the NHS may alter the commissioning structure and support for GIR may decrease. The difficulties of measuring the 'soft outcomes' of GIR, such as increased confidence, social interaction and well-being may also destabilise the network (Curran, 2007: 17). As discussed in Curran (2007: 20), there are also perceptions of 'a conflict of interests between the library service and GIR' which may affect the support of public libraries for the GIR model. Concerns from library staff about the value judgements placed on

literature by TRO contribute to this potential disruption to the relationship (McLaine, 2010). Nevertheless, TRO's awareness of both the strengths of the GIR model and its weaknesses has led to a number of translations that have ensured it currently remains dominant and is prepared to adapt to remain so, enrolling further actors into the network in support of its aims as needed.

4.4.7 Conclusion: Victorian values

As introduced in section 4.4.2, TRO's belief in the value of nineteenth-century classic literature extends to the application of Victorian social values. A recent article in the Irish Times concludes that 'with its optimism and practical philanthropy, GIR and TRO are reminiscent of the best of the improving Victorian social crusaders' (Hourihane, 2011). This can be directly contrasted with perceptions of the alternate model of creative bibliotherapy in the UK, RAYS, about which an article in the Guardian stressed that the literary discussion was 'not, however, an update of Victorian self-improvement' (Cunningham, 2002). TRO's repeated references to the historical narrative surrounding the power of reading and the role of reading aloud – e.g. the criminalisation of reading the bible aloud in 1543 – try to locate it within a defined history and thus strengthen belief in the power of the written word spoken aloud (TRO, 2009).

The teleological structure of self-improvement applied to the GIR narrative emerges from the programme's origins in adult education and literacy. Improvements in literacy can be seen as a measurable and tangible development, unlike improvements in mental health and well-being, which can be difficult to capture and subject to deterioration. The shift from a model promoting literature to one promoting health and well-being has complicated the teleological narrative of GIR, leading to its presentation as 'an alternative or complement to existing diagnostic discourses' (TRO, 2010:38). Thus, claims of improvements in mental health are tempered with references to the social benefits of the groups.

Section 4.4 has introduced the actors forming the network of GIR, highlighting the role of the focal actor, Jane Davis, analysing its reliance on the literary canon and tracing its rise as a service promoting the connection between books and health and well-being. The shift from GIR as a project to improve literacy and access to literature in deprived areas to one promoting well-being has been explored. The section has examined key points in the history of the intervention, locating it in wider discourses and investigating the strengthening of the network through the use of key

opinion leaders as advocates. Although GIR works to remove elitist notions of literature, stressing that the works in the literary canon are for all, its reliance on the canon itself may be regarded as another form of elitism, which may reduce the effectiveness of the intervention for some.

4.5 A comparison of the three models of bibliotherapy

Building on the ANT analysis of the three main models – RAYS, BoP and GIR – of bibliotherapy in the UK, this section aims to present a brief comparison of the key facets of each model. Comparative evaluation of the three models foreshadows the analysis presented in chapter five, in which the experiences of those using bibliotherapy – either independently or in a formal scheme – are presented.

A fragmented picture emerges, in which different models of bibliotherapy have come to prominence in response to local pressures and requirements, and have been sustained by current national agendas in health and social care. This will be discussed in more detail in chapter six, in which comparison will be made between the needs of service users and current models of bibliotherapy.

To summarise, the key facets of each model will be presented here. Firstly, the aim of BoP is to provide self-supported psychological treatment. Its emergence as a scheme was motivated by increasing demands on psychological care that could not be met by current resources. Patient dissatisfaction caused by increased waiting times was also a factor considered by those implementing the scheme, who identified a need for cost-effective, accessible, evidence-based care for mild to moderate mental health conditions. Thus, the model was designed using the existing infrastructure of primary care and the public library to widely distribute evidence-based CBT resources using a prescription method. The innovative nature of the model, transferring findings on the effectiveness of self-help bibliotherapy and guidance from NICE into practice – combined with the enthusiasm of the focal actor – ensured publicity, promotion and funding to expand the scheme. The focus of the scheme around a specific booklist of mainly CBT-based self-help texts means that it is the least flexible model of bibliotherapy currently operating, and there have been criticisms about its accessibility for those with lower literacy levels.

In contrast, RAYS can be regarded as the most flexible model of bibliotherapy currently operating; it uses any imaginative literature including contemporary and classic novels, short stories including Quick Read titles and poetry to achieve its

aims of increased public library use, enjoyment of literature and awareness of the well-being benefits of reading. Its aims emerged inductively from a bid for project funding which aimed to promote literature and reading to a wider audience, in partnership with another organisation. The project developed over time to include work with people with more enduring mental health problems and adapted to meet their needs. As an innovative scheme, the first to formalise the use of creative bibliotherapy and employ people as specialists in this role, it attracted a significant amount of publicity and funding. RAYS was eventually mainstreamed within local authority funding and regarded as a core aspect of the library offer. Its work also aims to be socially inclusive, engaging with groups who may not usually use the library and offering outreach work in a variety of locations as well as working with groups in the public library. Thus, the scheme raised the profile of the public library service in the area and encouraged people to engage with reading and appreciate its health-related benefits.

The final model of creative bibliotherapy currently in operation, GIR, emerged from the School of English at a redbrick university. The aims of this project included providing increased access to the literary canon, and self-improvement. There was a shift from the recognition of the educational benefits of reading to the health and well-being benefits. GIR is regarded as a social outreach project, aiming to tackle the problem of the low number of people – particularly from deprived backgrounds – reading literary canon. Its focus on high-quality literature makes it less flexible than other models of creative bibliotherapy, though it responds to the needs of those participating in its reading groups by reading aloud and focusing on short stories rather than novels with some groups. The lack of evaluation and high-quality evidence about creative bibliotherapy is of concern to GIR and its parent organisation, TRO. This evidence is required to provide proof of the benefits of the GIR programme, and as TRO is a charitable company, it needs to ensure that sources of funding and NHS commissioning of GIR groups continues.

As observed, despite some basic similarities between the models, the origins of the schemes were very different. While RAYS began in the library sector, and was formulated as a reader development programme, BoP was designed by a clinical psychologist and utilised the expertise of health care to shape development of the model. In further contrast, GIR started as a project in the sphere of adult education and the School of English in a redbrick university. The sector from which the bibliotherapy models emerged is of great importance to their aims, objectives,

priorities, responsiveness to service user needs, and ongoing stability. The three different schemes do not have the same understanding of bibliotherapy as a concept, and this has a direct impact on the schemes as a whole. All three models of bibliotherapy were initially designed by service providers without consultation with those who would be using the services. Table 4.3 compares the initial characteristics of the three models of bibliotherapy directly, illustrating the key differences and similarities between the models.

Table 4.3: Summary of initial characteristics of three main models of bibliotherapy

	BoP	RAYS	GIR
Year of origin	Pilot project began 2003; adopted as national scheme in Wales in 2005	Pilot project began in 2000; mainstreamed in 2006	Pilot project began in 2001; became charitable company in 2008
Sector in which project originated	Clinical psychology/ NHS	Public library/ local government	School of English/ Higher Education
Initial partners	Local public library, GPs surgeries	Local PCT, neighbouring local authority public library service	University, local PCT, local public library service
Texts used	CBT-based self-help books	Various wide ranging literature	The literary canon and some contemporary literature
Role of the text	Text as expert	Text as intermediary	Text as expert
Key aspects of intervention	Providing self-managed treatment for mental health problems to support mental health care services and enable people to manage long-term conditions independently.	Working to improve health and well-being via reading, relaxation and social contact. Reading for pleasure. Improving access to the public library.	Working to improve well-being and self-understanding via reading classic literature.
Aims	Improving mild to moderate mental health problems; reducing waiting times for face-to-face therapy.	Bringing people into the public library. Improving well-being via reading.	Engaging an audience with classic literature, promoting classic literature. Improving well-being via reading.
Intended audience	Individuals with mild to moderate mental health problems	Groups and individuals, focused on the socially excluded and those with mental health problems.	Groups, mainly those in deprived areas, sometimes with mental health problems.
Source of funding	WAG, NHS Wales, Welsh public library service.	Mainstream library funded service	University of Liverpool, Paul Hamlyn Foundation, Esmee Fairbairn Foundation, Rayne Foundation, local PCTs commissioning services
Means of measurement of success of schemes	Statistical measurement of book issue figures; anecdotal evidence of success, national promotion of the model by the focal actor, acceptance of model throughout the UK and Ireland.	Statistical measurement of number of clients; qualitative 'comment capture' of impact on clients; statistical measurement of increase in library membership; significant use of testimonials of those using the scheme; promotion of the model by the focal actors.	Statistical measurement of number of clients; qualitative 'comment capture' of impact on clients; significant use of testimonials of those using the scheme; statistical record of partnerships achieved; international promotion of the model by the focal actor and her team.

As table 4.3 shows, the key aspects of the three current models of bibliotherapy; their aims; and their sources of funding have all shaped the direction of the interventions. While all bibliotherapy schemes engage with people with mental health problems, aspiring to improve mental health and well-being, the ways that they interact with their audience, the texts that they use and the measured outcomes of the schemes are very different. Schemes aimed to meet national agendas on health information provision; non-medical interventions; well-being and self-directed treatment; and meeting these agendas was highly important to perceptions of the success of the schemes. It is clear that the timing of the emergence of these models in the UK is highly significant in terms of their relationship with wider health care agendas. Table 4.4 builds on the data presented in table 4.3, comparing the ongoing progression of the schemes, their spread throughout the UK and their sustainability.

Table 4.4: Summary comparison of the sustainability of the three main models of bibliotherapy

	BoP	RAYS	GIR
Adoption/ development of the schemes elsewhere in the UK	Widespread – over 100 schemes in operation. Some development of certain aspects of the scheme, including booklist and adherence to prescription model.	While influential in terms of encouraging a focus on health and well-being, no other library authorities run a scheme with employed bibliotherapists.	Previous training programme means that some there is some adoption of the modified model e.g. Sandwell, East Lancashire. GIR groups run in the North West, London and the South West.
Published research evaluating the scheme	Evaluation of BPW scheme with accompanying peer-reviewed article (Porter *et al*, 2008; Porter *et al*, 2006). D.Clin.Psy thesis on Cardiff BoP (Grundy, 2005).	No in-depth analysis conducted at peer-reviewed level. Some analytical comments in (Brewster, 2007; Duffy *et al*, 2009; Morris, 2002; Murphy, 2002).	Evaluation reports conducted by leaders of the scheme (Davis, 2005; Davis, 2006; Davis, 2008; Davis *et al*, 2005). Peer-reviewed article evaluating scheme (Hodge *et al*, 2007). Interdisciplinary research project, again conducted by closely connected members of the project team (Billington *et al*, 2010).
Sustainability of source of funding	Little investment required so sustained funding less critical to success of the project. Funding bodies appear committed to the service.	Currently secure as mainstream service but could be threatened by reduced public library service budgets.	Need to bid for funding to ensure continued sustainability.
Relationship to evidence base	Evidence base for effectiveness of prescription model more limited than previously acknowledged.	Issue of a lack of evidence may threaten scheme.	Research base and attempts to solidify evidence base for the model as a key strength.
Threats to resilience/ irreversibility of the scheme	Threat from alternative projects, e.g. IAPT. Concerns about accessibility and motivation.	Wider library service funding may impact on service provision. Difficulties of measuring 'soft' outcomes.	Need to bid for funding to ensure continued sustainability. Difficulties of measuring 'soft' outcomes.
Strengths/ resilience of the scheme	Shift to non-medical interventions as key. Cost-effectiveness important in current economic climate.	Rise of social prescribing/ non-medical interventions important. Flexible nature of the model as a key strength.	Currently in line with national health care agendas for non-medical interventions. Focal actor established resilient charitable company with national champions.

An argument can be presented about the differing value of the evidence base for current models of bibliotherapy. BoP assumes an evidence base, using the existing evidence on the effectiveness of self-help bibliotherapy to ensure the continued existence of the scheme, while the basis of RAYS in the library sector means that the evidence it gathers, uses and regards as conclusive is different and can be said to be less scientific in tone. TRO, although a creative bibliotherapy scheme focused on literature, can be said to recognise the importance of creating an evidence base surrounding its model to promote it to medical professionals. Despite these attempts by TRO to strengthen the evidence base examining creative bibliotherapy, there are still recognised weaknesses in this evidence base similar to those in the evidence base for self-help bibliotherapy. For example, there is little analysis of the views of service users of the schemes. TRO's evaluation reports resolve this issue to some extent, as interaction with mental health service users is recorded in their evaluation reports. However, TRO's research and evaluation reports are mainly conducted by people involved with the scheme, and aim to present a positive picture in line with the need of TRO to capture funding and maintain their income.

This chapter has analysed current models of bibliotherapy and has engaged with one model of self-help bibliotherapy and two creative models of bibliotherapy to ascertain their aims, objectives and current usage. Section 4.5 presented a comparison of the three current models, ascertaining their initial characteristics and ongoing sustainability. Building on this analysis, and in line with identified shortcomings in previous research – including a lack of independent evaluations and little qualitative analysis of those using bibliotherapy services – the following chapter will present analysis from the interview and observation sections of the research project.

Chapter Five: Experiences of therapeutic reading and group bibliotherapy

5.1 Introduction

Section 5.2 outlines participant and bibliotherapy group demographics, while section 5.3 presents the findings from the interview and observation studies. Section 5.3 addresses key issues of interaction with texts – their use for cathartic purposes, empathy and escapism — and role of personal choice in reading. The act of reading itself is explored, both in a social and individual context. Changes in reading habits caused by symptoms of mental health problems are analysed. The role of self-help and other non-fiction titles to provide information and treatment is also considered. Participants' interaction with bibliotherapy groups is explored, with a focus on interaction between group members; the role of the group facilitator; and the function of literature within the group. Bibliotherapy schemes are then discussed in relation to the role of the library. Finally, the chapter draws together participants' understanding of the concept of bibliotherapy. In chapter six, these conceptualisations are contrasted with existing models of bibliotherapy discussed in the previous chapter.

5.2 Demographics of interview and observation participants

The ethos of this research is to maintain an awareness of the diversity of experience; it is not the aim to provide generalisable conclusions applicable to all people with mental health problems. Participants should be regarded as individuals, rather than solely within the context of the bibliotherapy scheme – research participants do not have lives that begin and end at the interview or observation situation. The demographic characteristics of participants, and more detailed profiles available in appendix two, should be read in the context of section 3.3.2 on sampling and recruitment. Outlining these characteristics aided thinking about the impact of other factors, such as symptoms and life events on experiences of bibliotherapy services. As Clandinin and Connelly (2000) observe, this contextualisation is important in ethnographic or narrative-focused modes of analysis.

Lipson (1997) discusses issues of confidentiality, providing guidance on the balance between protecting participant anonymity and creating a rich, descriptive picture. There is no easy answer to this issue, but Lipson (1997) emphasises that it is vital to make the reader aware that details have been changed. In this thesis, personal, geographical, and organisational names have been replaced by pseudonyms; approximate ages are given; and significant details that could identify participants

have been excluded. Quotes have been edited for clarity, but care has been taken to contextualise comments and maintain an accurate sense of the conversation as recorded.

5.2.1 Research participant demographics: interviews

Twenty-seven participants were interviewed and demographic information about participants was gathered from observation and clarified in the interview itself. Fifteen service users volunteered for interview following my attendance at a bibliotherapy group. Other participants were recruited using methods described in section 3.3.2.

Table 5.1: Demographic data of service user participants interviewed

Pseudonym	Approximate age	Gender	Ethnicity	Location
Ajeet*	late 30s	male	Asian	Taylorbridge
Alfie	late 40s	male	white	Smithville
Amelia	mid-30s	female	white	Smithville
April*	mid-50s	female	white	Taylorbridge
Beatrice*	early 60s	female	unknown**	Taylorbridge
Connor	early 40s	male	white	Smithville
Courtney*	early 20s	female	white	Taylorbridge
Douglas*	late 40s	male	white	Taylorbridge
Ethel*	mid-70s	female	white	Williamstown
Grace*	late 60s	female	white	Smithville North
Henry*	early 70s	male	white	Smithville North
Isaac*	early 40s	male	white	Smithville North
Julia	mid-50s	female	Asian	Smithville
Louis	mid-30s	male	white	Smithville
Lucas*	late 50s	male	white	Williamstown
Milly	early 50s	female	white	Smithville
Mya*	mid-30s	female	Asian	Taylorbridge
Nathan	mid-50s	male	white	Smithville
Olivia	early 30s	female	white	Smithville
Ralph	mid-40s	male	white	Smithville
Rodney*	early 40s	male	white	Taylorbridge
Serena	mid-20s	female	African-Caribbean	Smithville
Silas	late-30s	male	white	Smithville
Virginia*	late 50s	female	white	Taylorbridge
Vivienne*	mid-40s	female	white	Smithville North
Walter*	early 50s	male	white	Taylorbridge
Winston	late 40s	male	white	Smithville

* indicates member of a bibliotherapy group
** This participant was only contacted by phone and email, and ethnic origin was not discussed

The youngest participant interviewed was in her early 20s, with the oldest in her mid-70s. The majority of participants were in their 40s and 50s. Most interview participants came from a white British background. My research, while not an in-depth study into mental health and socio-economic status, did engage with issues about the accessibility of bibliotherapy. Some participants had enduring mental health issues that meant they were unable to work, and had a low income. Several of those interviewed or observed attended day centres for vulnerable and socially excluded members of society. Several participants had taken time out of employment because of their mental health issues, though most had returned to paid employment in careers including mechanics, education, and administration. Six participants had retired from work, some of whom had taken early retirement on (mainly physical) health grounds.

5.2.2 Research participant demographics: observations

I attended seven different bibliotherapy groups (over a total of sixteen different meetings), observing sixty-seven group members; for clarity, I now present a short profile of each group. Information about the areas in which the groups were located in was taken from the NOMIS website, based on 2001 census data (National Office of Statistics, 2010).

5.2.2.1 Williamstown

The group met fortnightly in Williamstown central library, using sofas in the main reading room to conduct their meeting. I attended seven group meetings over four months. The group was one of many in the Williamstown area, facilitated by a small team, and had been running for around six years. While it was open to any member of the community, the group was originally set up to be a resource for people who attended a local referral-only mental health service, referred to here as MH1. Williamstown is a town in Northern England which has higher than average ethnic diversity, with a large Asian population. It has slightly higher than average unemployment, and residents are more likely to have fewer educational qualifications than national averages.

Table 5.2: Demographic characteristics – Williamstown group

Pseudonym	Approximate age	Gender	Ethnicity
Andrew	50s	male	white
Anna	late 40s	female	white
Donald	40s	male	white
Ethel*	mid-70s	female	white
Eva	early 20s	female	white
Frank	mid-40s	male	white
Fred	early 50s	male	white
Hayley	50s	female	white
Janine	early 20s	female	white
Jess**	50s	female	white
Larry	late 40s	male	white
Lucas*	late 50s	male	white
Marvin	50s	male	white
Sally	early 20s	female	white
Sheri	60s	female	white
Wayne	early 20s	male	white
Wendy	late 40s	female	white

* Group members interviewed.
** Group facilitator, also interviewed.

The group read poetry because some members had difficulty concentrating on longer texts, and group members also wrote poetry. On average, between five and ten members attended meetings; meetings lasted two hours, with refreshments. Throughout the time I attended, the group looked at poetry by Simon Armitage; Les Murray; Jacob Polley; Mike Longley; Michael Donaghy; Ian McMillan and Don Paterson.

5.2.2.2 Smithville North Library

The Smithville North Library group met once a month in the meeting room of a small branch library. The group resembled a traditional reading group, in which the members took away a novel to read independently then met up to discuss the book over refreshments. Meetings lasted around one and a half hours, and membership of the group was fairly constant, with ten members in regular attendance. The group had been running for around two years and I observed four group meetings.

The main difference between a traditional reading group – typically facilitated by a librarian or operating as a self-facilitated group – and this group was that the group was facilitated by Leah, who also worked as a counsellor. Many of the members of the Smithville North Library group had been invited to join the group by Leah. Therapy was not, however, the focus of the group, and there was a tacit

understanding that members were not required to disclose their previous contact with Leah. The group was also open to new members, and the dividing line between members who had been referred by Leah and those who had found the group independently was not clear.

Table 5.3: Demographic characteristics - Smithville North Library group

Pseudonym	Approximate age	Gender	Ethnicity
Alexa	mid-40s	female	white
Allison	late-30s	female	white
Esme	late-50s	female	white
Evelyn	late-60s	female	white
Grace*	early-70s	female	white
Heather	mid-40s	female	white
Henry*	mid-70s	male	white
Ian	late-50s	male	white
Isaac*	mid-40s	male	white
Leah**	mid-40s	female	white
Nora	late-50s	female	white
Rosemary	late-30s	female	white
Violet	late-60s	female	white
Vivienne*	mid-40s	female	white

* Group members interviewed
** Group facilitator, also interviewed.

The Smithville North Library group was funded by local public health inequalities funding. While Smithville itself is a very mixed urban area in terms of affluence, diversity, and education, the neighbourhood in which the Smithville North Library group operates was of average affluence, and people there were more likely than average to suffer from long-term health problems. Unemployment was higher than the national average for the UK. The catchment area for this group, according to the funding body, was a less affluent neighbourhood nearby. This neighbourhood did not have a public library, hence the decision to locate the group in Smithville North.

Novels read at the groups attended were: *Notes on a Scandal* by Zoe Heller; *Mapp & Lucia* by E.F. Benson; *Blood River* by Tim Butcher; *Mrs Palfrey at the Claremont* by Elizabeth Taylor and *The Return* by Victoria Hislop. Books were chosen at random, with none of the group members wishing to take responsibility for choosing titles.

5.2.2.3 Jonesfield 1

The Jonesfield 1 group met at a community centre, and I attended one group session. It was part of a community reading group schemes, following a model of reading a novel aloud over a number of weeks. The Jonesfield 1 group was run in an

area of high socio-economic deprivation. Jonesfield as a whole had higher than average unemployment, average ethnic diversity, and residents were more likely than the national average to be employed in lower-paid manual jobs.

Table 5.4: Demographic characteristics of group members at Jonesfield 1

Pseudonym	Approximate age	Gender	Ethnicity
Albert	late 50s	male	white
Alejandra	mid-60s	female	white
Bethany	mid-60s	female	white
Carlene	mid-60s	female	white
Justin	mid-40s	male	white
Rae	mid-50s	female	white
Roslyn*	mid-50s	female	white

* Group facilitator

Weekly meetings lasted two hours, and refreshments featured. Membership of the group appeared constant, with group members commenting on others who were not in attendance; the nature of the group, in which one novel was read over a number of weeks, suggested that members would need to attend regularly. The group were reading *Tom's Midnight Garden* by Philippa Pearce. The format of the group allowed for the reading and discussion of one or two poems to close the meeting. In this case, the poem was an untitled one by John Bernard Scollen.

5.2.2.4 Jonesfield 2

The ethos behind all the Jonesfield groups was the same, but individual groups often differed in scope. This was usually due to the needs of those taking part. Jonesfield 2 had weekly, hour-long meetings in the activities room of a residential home for people with nursing care needs. Again, I attended one group meeting. Many of the residents were elderly, so the emphasis – according to Noemi, the facilitator – was the enjoyment of the social occasion and the sharing of memories. In the group I attended, a Theodore Roethke poem *My Papa's Waltz* was read by different members of the group, followed by Noemi reading some extracts from *The House At South Road*, a memoir by Joyce Storey.

Table 5.5: Demographic characteristics of group members at Jonesfield 2

Pseudonym	Approximate age	Gender	Ethnicity
Ashlee	late 80s	female	white
Chandra	mid-90s	female	white
Cody	late 60s	male	white
Edwina	late 80s	female	white
Ericka	mid-80s	female	white
Margery	early 90s	female	white
Marylou	late 80s	female	white
Max	early 80s	male	white
Noemi*	mid-50s	female	white
Paulina**	early 50s	female	white

* Group facilitator
** Paulina was a member of nursing home staff, who contributed to the group.

5.2.2.5 Jonesfield 3

The Jonesfield 3 group was run on an hour-long, weekly basis in a day-centre for vulnerable people, referred to here as MH2. The group read short stories aloud rather than novels; reading short stories reflected the needs of the group, some of whom had enduring mental health problems leading to problems with concentration. MH2 operated in a highly deprived area, recognised as an area with many socio-economic problems. The group had been running for around six months.

Table 5.6: Demographic characteristics of group members at Jonesfield 3

Pseudonym	Approximate age	Gender	Ethnicity
Carmella*	mid-50s	female	white
Clayton**	mid-40s	male	white
Daryl	mid-50s	male	white
Hugh	early 60s	male	white
Karrie †	mid-20s	female	white
Kurt	late 50s	male	white
Lance	late 50s	male	white
Laura	late 40s	female	white
Ted	mid-40s	male	white
Thomasina	early 50s	female	white
Xavier	late 50s	male	white

* Carmella was employed by the MH2 centre, and attended the group to help the facilitator.
** Clayton was a local drama project worker, attending the group for the first time with the aim of meeting participants and working with them in the future.
† Group facilitator.

I observed one group meeting, where the group read a short story by Tim Gatereux, *Waiting for the Evening News*. Eight members attended, which represented the majority of those in the centre at this time.

5.2.2.6 Jonesfield 4

The final group located in Jonesfield was run in a public library as an open group. Four members regularly attended, but only two were present on the occasion I observed. The group met on a weekly basis for two hours at a time, with refreshments. When I attended, the group were reading *A Short History of Tractors in Ukrainian* by Marina Lewycka, and also read two poems – *Love Songs in Age* by Philip Larkin and *Let Me Die a Youngman's Death* by Roger McGough.

Table 5.7: Demographic characteristics of group members at Jonesfield 4

Pseudonym	Approximate age	Gender	Ethnicity
Guy*	early 40s	male	white
Melissa	early 40s	female	white
Zoe	early 40s	female	white

* Group facilitator

5.2.2.7 Taylorbridge

The Taylorbridge group was one of two in the area. Both these groups were facilitated by Arlene, a local counsellor who had received training from those running groups in Jonesfield. As one of the groups was still in its infancy, I visited the more established one, which had existed for around six months. The group met on a weekly basis in a community room in the central library, for two hours. As in Jonesfield, the model was to read a short story and then one or two poems aloud, with a break for refreshments. In the session I attended, the group read *Through the Tunnel*, a short story by Doris Lessing, and two poems – *Rising Five* by Norman Nicholson and *Giving Up Smoking* by Wendy Cope.

Table 5.8: Demographic characteristics of group members at Taylorbridge

Pseudonym	Approximate age	Gender	Ethnicity
Ajeet*	late 30s	male	Asian
April*	mid-50s	female	white
Arlene**	late 40s	female	white
Beatrice*	early 60s	female	unknown
Courtney*	early 20s	female	white
Douglas*	late 40s	male	white
Martha	late 30s	female	Asian
Mya*	mid-30s	female	Asian
Rodney*	early 40s	male	white
Stella	mid-50s	female	white
Virginia*	late 50s	female	white
Walter*	mid-50s	male	white

* Group members interviewed
** Group facilitator

The group was open to the community, though some participants mentioned that they had found out about the group via the mental health charity Mind. Taylorbridge had an unemployment rate that was almost double the national average, again meaning that it suffered from socio-economic deprivation. The population was highly ethnically diverse, with around 40% of the population in BME communities.

Summary

This section introduced the participants and groups who contributed to the findings presented in this chapter. It has shown that a diverse group of people use bibliotherapy for mental health. Participants were both male and female; with a range of ages, and from a variety of socio-economic backgrounds. Health often affected their ability to undertake paid employment, either on a long-term basis, or for a brief period of time. Little ethnic diversity was found in this sample of participants; this is further discussed in section 6.2.4. Having introduced the participants in the study, this chapter will now turn to the data presented in interviews and observations.

5.3 Interview and observation data analysis

Section 5.3 presents the findings from the interview and observation studies. It is organised thematically, examining the physical process of reading and the impact of symptoms of mental health problems on this process; interaction with the content of the text, either to provide an emotional connection, escapism or for information. These findings highlight one of the main themes of the thesis – that people use bibliotherapy for a various reasons, with various outcomes – a theme clarified in section 5.3.5 and discussed in detail in chapter six. The remainder of chapter five looks at the interaction between people in bibliotherapy groups and literature, assessing the benefits of belonging to a formal bibliotherapy scheme as opposed to experiencing bibliotherapy independently. It will conclude that there are similar benefits, focused on the socio-cultural impact of reading literature. Interaction with the public library is then discussed, relating library use to the lives of people with mental health problems.

5.3.1 Interaction with texts

Section 5.3.1 explores participants' interaction with the texts they read. It will look at the process of reading, examining the value that people can place on reading itself, and the episodic changes that can occur in reading habits for people with mental health problems. It will explore reasons why people read, grouped around a number of key themes – reading for emotion, escapism and information.

5.3.1.1 The act of reading

For some participants, it was the act of reading itself that helped them to cope with their mental health problems, rather than a specific title. Alfie identified several reasons that he felt that the process of reading was beneficial to his mental health. He used reading to distract himself from his problems; *'I used to drink a lot. I find if you concentrate the mind... you get a sense of well-being, both physical and mental. And it's not just something to do. It concentrates the mind – oh, you feel you're a different person.'* Alfie returned to the theme of concentration throughout the interview, comparing the effect of reading to that of playing sport and commenting that; *'you feel happiness, a sense of glow and happiness inside you. Reading gives me a sense of purpose.'* He used reading to alleviate his symptoms on a frequent basis; *'last Saturday, because I was feeling depressed, and felt like a drink, I read the whole of the Pickwick Papers in one day.'*

Olivia also used reading as a distraction when she was feeling particularly depressed;

> *'I had a particularly low point… and I was on the verge of tears the whole time. The only way that I could keep going and not just collapse into a heap on the floor was by reading, quite fiercely and determinedly. Just making myself read, and making myself focus on what was on the book, instead of what was in my head.'*

Speaking broadly, the subject of this reading did not seem to be of great importance for participants like Alfie and Connor, though as discussed in section 5.3.1.4, Olivia preferred escapist literature.

For Connor, it was the act of reading that was important rather than a particular title: *'I can't think of suddenly picking up The Alchemist, and thinking oh, my life is wonderful or whatever.'* Unlike other participants in this research, who had a list of titles that they felt were important to them, Connor felt that it was the reading itself that was key to his well-being; *'I don't think there's any book and I've read it and thought has had a massive impact. I think it's more to do with the process of reading, rather than particular books.'* Connor identified several personal benefits to reading; *'there's a whole range – there's the concentration, there's the socialisation, there's the learning. They're the primary reasons that I've identified for how reading's helped manage my condition.'* The contrast between the physical process of reading for therapeutic purposes and the cathartic and empathetic engagement with the content of literature is discussed throughout this chapter.

5.3.1.1.1 Depression and the act of reading

Participants' narratives featured an awareness of the impact of their symptoms of mental health problems on their ability to read. Reading was sometimes a preferred leisure activity as well as a coping mechanism, and one of the problems encountered when participants were feeling particularly low was their inability to read at all. For most of the participants who discussed the phenomenon of not being able to read, this was only temporary; but for those with more enduring mental health problems, it was a long-term concern. Ethel and Lucas both mentioned that prior to their mental health problems they had enjoyed reading, but as Ethel stated, this was no longer possible; *'I can't read books, because I can't concentrate. I can read for about 30 pages and then – that's it. I've got a pile of books that I've never finished.'* The inability to read was more commonly related to episodic, symptom-related changes in reading habits and was predominantly associated with a reduced ability to concentrate. There was a continuum of experience; at one end was Olivia, who stated that *'I never have a time when I don't read, although what I read might change.'* At the other end of this spectrum were Connor, Serena, Nathan, Julia, and Ralph, who all mentioned a complete inability to read when depressed.

Connor related this change in his reading habits to his problems with concentration when depressed; *'I struggle to concentrate. Throughout my adult life, I've had a number of episodes of being depressed, and one of the things that I've struggled with is concentration. Generally when I'm depressed, I don't read. Whereas when I'm not experiencing a bout of depression, I tend to read more.'* Serena and Nathan commented that they could not concentrate on books when they felt particularly bad, and even found it difficult to focus on other forms of media. As Nathan told me; *'when I was very depressed, I could basically do nothing, except just listen to the radio. And I even found radio programmes difficult to follow, because I was just drifting off.'* Both Serena and Nathan felt that as their mood slowly improved, they were able to read more again. Serena talked about her recent period of depression, observing that; *'towards the end I was able to read again. While I'm still depressed, I still didn't want to do very much, I could read.'* While Nathan was more able to read as his concentration improved, his symptoms still affected his choice of texts. He tried to read books about depression to understand his condition, but this was still beyond him; *'I couldn't engage with it at all. I think because I was still too depressed to settle. I'm still too anxious and depressed to do that effectively.'* Nathan's

experience has implications for current models of bibliotherapy, as will be discussed in chapter six.

Ralph and Nathan both praised Matthew Johnson's *I had a Black Dog*, a pictorial exploration of depression, with Ralph telling me that;

> '*it's the one thing I would recommend to anyone with depression. Because you don't want to be reading CBT or some grandiose theories about hormones or brain circuitry. It can be incredibly hard, where you're spending maybe fifteen, sixteen hours a day in bed, you don't want something that's hard to read.'*

The ease of reading *I had a Black Dog* was mentioned by Nathan; *'I felt a bit ashamed that actually I needed a comic but it's very compassionate and gentle and I found that very useful.'* The value placed on the simple, easy-to-read, comic-book style text is reflected in another kind of literature repeatedly mentioned throughout interviews as beneficial reading for people with depression; children's literature (discussed in section 5.3.1.4.1).

Julia recognised that reading was a problem for her when she felt depressed, and took steps to combat this; *'if I'm really bad I can't read at all. I can't read books, I can't concentrate, which is why I tend to go for shorter things.'* The texts she felt were personally important were all short – poems, vignettes, short stories and a short memoir.[12] Ralph's description of his reading while he was feeling low was related to his symptoms; *'my mind's very flighty with OCD, I'm often ruminating on other things.'* However, as Ralph regarded his symptoms as chronic, he did attempt to read even when he was feeling particularly bad, finding some fulfilment in the achievement of reading; *'it is a battle in itself to read, but I do get satisfaction out of finishing anything.'* Ralph's feeling of achievement echoes that experienced in bibliotherapy groups, explored in section 5.3.3.2. Again, Ralph chose the books he read carefully; *'I avoid anything that's long. Anything that's overly descriptive. I tend to go for something with short chapters because with my attention span, I really struggle.'* The comments presented here show that reading habits can change when people are depressed. Building on these ideas of changing reading habits, the desire to re-read the same texts will now be discussed.

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[12] See appendix seven, table nine.

5.3.1.1.2 Re-reading texts

Participants often returned to 'old favourites' in times of need. Winston and Julia discussed their need to keep familiar titles close at hand; Winston mentioned that *'I have a little flock of books at home.'* Julia regarded the books she brought to the interview as faithful companions; *'I just have these four books, they're always sort of close together and close to me, usually. And it's quite comforting, really.'* The need to re-read familiar texts was particularly pronounced in times of distress, as Nathan found when reading *Dry* by Augusten Burroughs; *'I found most helpful his book on being alcoholic. I read it I think two or three times.'* Similarly, Milly read *Unless* by Carole Shields in a different manner to her usual reading habits; she found that despite her tendency to *'rush from one book to the next'* she re-read this title on several occasions; *'I read this book about three times. I just started it again as soon as I'd finished it.'* She re-read the title because she had a deeply emotional relationship with the text, discussed in section 5.3.1.1.2.

Participants had various reasons for re-reading. Ralph, for example, associated texts with different times in his life; *'I do re-read things from the past. To maybe bring up how I was feeling – if that was positive at a certain point ages ago.'* Winston's approach, which differed from Ralph's, was motivated by literary content rather than remembered emotions. Texts could be reassuringly familiar, or in the case of Umberto Eco's *The Name of the Rose; 'it's more of an intellectual gymnasium than a book, and I think every time I read it, I get something more out of it.'* Winston talked about relating differently to the same literature at different times in life; he discussed not understanding Thomas Hardy's poems while at school, but finding them a great comfort after a bereavement later in life. For Winston, there is thus a timely quality to reading that is significant to the experience. His tendency to read different books depending on his mood had been previously observed by his wife; *'we've got thousands of books in the house and my missus always says she gets a bit of insight into what state of mind I'm in by what I'm reading.'*

Winston also re-read texts to find inspiration; to identify with the characters; and because he felt that sometimes he needed; *'not quite cheering up, but a bit of a reminder that it's maybe not all as bad as it could be.'* Reading a familiar narrative was also used by Julia to help her manage her mental health; when discussing John Tittensor's *Year One: A Record* she commented that; *'I've just read it over and over and over and over again, and you know, it does help me.'* These comments clarify

the use of the re-reading preferred texts as a coping mechanism to deal with situations of distress.

5.3.1.1.3 Reading a book: the role of the medium

As mentioned in chapter three's discussion of recruitment, some participants were uncomfortable with technology like email. Even amongst the more IT-literate participants, there was still a resistance to the idea that a computer or e-reader could ever replace the physical object of a book. Winston, who needed to remain up to date with IT for work purposes, felt that there was no role for technology in his personal life;

> '*I can't be doing with all these things [gestures to his Smartphone]. E-book readers are OK for technical manuals, but you know – if I drop Mr. Book in the bath, I get a wet book. If I drop an e-reader in the bath, I either get electrocuted, or a very, very dead e-reader.*'

Vivienne also felt that e-readers would not meet her needs. She was interviewed at the time of the launch of the first Apple iPad, and she connected use of reading as a time for herself to the suggestion she'd seen on the news that this new technology would have the capability to replace books. She felt that this would not be the case for her; *'I like a book in my hand. There's just something tactile, there's something nice.'* Olivia agreed that she preferred the more *'traditional, natural'* physical book for personal reading, though like Winston, she did feel that e-readers may be useful in her professional life. Winston was adamant that *'with regard to books, there's a whole raft of things associated with them that you will never get from electronic media'* showing that he valued the book as an object as well as a container for content.

This reluctance to engage with technology has obvious implications for the recent rise of cCBT as a form of therapy, though as Winston commented, his reluctance to use technology may not reflect wider trends, and people who interact regularly with computers may feel more comfortable using this medium *'[it'll] probably be reflective of what works for them. In what medium they interact with on a general basis.'* Based on these comments, the impact of changing technology on the reading experience requires further exploration.

5.3.1.2 Reading as a personal choice

Analysis of interview transcripts showed that reading was a highly personal experience. Indeed, some participants questioned the potential for bibliotherapy to be effective without prior knowledge of the person to whom they were recommending titles; '*I might recommend certain books to certain people; there are others I will not even suggest they go and read that book, because it's not them*' [Winston].

Winston had strong views on the possibility of recommending texts, returning repeatedly to the idea that *'different people get different things from the same book.'* Conversely Vivienne felt that in some situations, she had successfully recommended books to friends;

> *'I've had books that I've passed on to friends that have been divorced, etc, and been like 'read that. Just go away and read that.' And it does work. A friend that I am thinking of in particular came back and said 'it's my new best friend, this book.' So as I said, there are things that are just universal, through experiences – emotions.'*

Vivienne's comments reflect her engagement and empathy with some texts, discussed in section 5.3.1.3. The premise of some current bibliotherapy schemes centres on providing a list of recommended titles, but the personal nature of reading discussed here problematises that. The findings presented here suggest that this might not be a preferred form of bibliotherapy for participants. In line with reader response theory, one of the reasons for this may be the impact of participants' previous experiences on their interaction with the text (Rosenblatt, 1070). As Vivienne observed; *'every book's got something to give you, and it's also about what you bring to the book as well.'* Vivienne, also a member of the Smithville North group, described some titles she had read as *'powerful'* and commented that she was always looking for titles that *'resonated'* with her. While she was happy to recommend to close friends, she had never recommended any of these titles to be read in the reading group because; '*they're personal to me. It's like giving them a bit of your soul and saying 'what do you think to that?'*'

Participants sometimes discussed the same titles but this did not mean that they agreed about the text. *To Kill a Mockingbird* by Harper Lee is one example of this, with Winston and Ralph discussing the text in very different terms. Winston felt there was an expectation on him to enjoy this title because it was a classic,[13] as per the GIR model. However, Winston was also very clear that in his experience, people

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[13] See discussion of the literary canon in chapter two.

reacted differently to the same titles. Again considering the value of texts, it was their timeless appeal and ability to *'say something to each generation that comes along, whilst maintaining the same underlying story'* that was key for Winston. Winston's view of the timeless appeal of a text contrasted with his belief that the relationship between a book and a reader was also very personal and difficult to predict.

He discussed *To Kill a Mockingbird* along with *The Catcher in the Rye* and *Catch 22* as examples of classic novels that he did not enjoy at all. On *To Kill a Mockingbird*, he remarked that;

> *'some people say 'it's a great book of hope… but the guy still gets hung. And that was a bit of a downer to me. And I understand how people look at it, but to me, they don't work. They don't work because I was thinking well; actually, the poor bugger's still got hung.'*

Ralph, on the other hand, found *To Kill a Mockingbird* inspiring. His view, which contrasted with Winston's, was that; *'To Kill a Mockingbird is a very wonderful book. Got a lot of magic in it. Very much from a child's perspective. So yeah, I like that.'* His reflections on the enjoyment he felt at reading *To Kill a Mockingbird* differed with Winston's opinion of the title, demonstrating Winston's point that different people get can have a very different opinion of the same title.

5.3.1.3 Reading and emotion

Emotional engagement with literature was valuable to many participants. There were three strands to this engagement: the use of literature for catharsis; empathy with characters' experiences, and emotional validation. Literature was used as a coping mechanism to deal with difficult situations.

5.3.1.3.1 Catharsis

As explored in section 2.2.3, catharsis is the use of literature to provide relief through reading about difficult subjects. Catharsis conflicts some experiences presented later in the findings, as some participants could not read about painful, emotional situations. Olivia and Nathan, for example, discussed their need for escapism rather than catharsis. Milly, Julia and Vivienne sometimes felt able to read cathartic material, but at other times they did not find it of benefit to them. Despite Olivia's use of literature for escapism, she was aware that others read for cathartic reasons; *'a friend told me that after her mum died, she read an awful lot of literature which revolved around death, as a way of processing it.'* 'Processing' emotions using literary depictions is at the heart of the concept of catharsis. Julia's repeated return to *Year One: A Record* – a title exploring the grief felt following the death of a child –

is an example of using literature for cathartic purposes.[14] Julia often read this book when she was feeling low; she commented that *'as you can see it's well-thumbed.'* She felt that reading about someone who had gone through a similar traumatic experience helped to put her own loss into perspective.

Vivienne had been widowed suddenly, and subsequently raised two children on her own.[15] Following her bereavement, she found catharsis in reading fiction about experiences similar to her own. Vivienne related the inherent grief in Audrey Niffenegger's *The Time Traveler's Wife* to her own life; *'for me, having lost somebody – you become very focused on the past that you've had. Just that whole concept of the potential and how emotionally you'd feel, seeing that person again.'* While *The Time Traveler's Wife* explored themes directly related to her experiences, Vivienne found other texts to be cathartic for different reasons. She had a lot of praise for Alice Sebold's two novels and memoir; *The Lovely Bones, The Almost Moon* and *Lucky* respectively. While *The Lovely Bones* also deals with themes of death and grief, *Lucky* focuses on the aftermath of a rape, which Vivienne also found cathartic;

> *'I feel having gone through not just the grief; I think the whole thing was so life changing. You go down to real, raw, basic emotions, and they're so universal. They map and overlap so many other experiences. I felt there were loads of ways I could associate with [Alice Sebold].'*

Empathy with characters was not always something that Vivienne sought. Her desire to read cathartic texts waned as she moved forward in her grief; *'it was eight years ago now, since I was widowed, and I had started to feel like I need to read something else [laughs]. It's like: please let me get to something where nobody dies.'* Vivienne felt that not every book she read needed to be cathartic and powerfully emotional; *'my personal feeling is that it's impossible to expect every book to grab you. It would be exhausting if every book did that to you.'* She recognised that not everyone desired catharsis from their reading, and found that people did not always understand her need to read about bereavement; *'the trouble is, if you've read loads of books about dealing with death, people think that it's miserable and it's awful.'*

Nathan, despite his tendency to read escapist literature when depressed, also sought cathartic texts. These texts were often autobiographical in nature. For example his reading of the works of Augusten Burroughs – particularly his memoir

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[14] See appendix two for detail of Julia's life and experiences.
[15] See appendix two for further detail.

Dry (2005) – can be considered cathartic. These memoirs, which present Burroughs' childhood and struggle with alcoholism, are often light-hearted about serious subjects, and Nathan used them to provide perspective about his own situation; '*I read personal narratives about feeling miserable so that I could feel snugly and warm. You know – it might be bad, but at least there aren't thirty gin bottles littering the floor.*' While Burroughs' work deals with dark subject matter, it is also wryly humorous, and this helps to explain why Nathan engaged with these texts. Nathan was aware of the similarities of his and Burroughs' experiences, as considered in the discussion of his sense of *'detachment'* (see section 5.3.1.4.3). He found the memoirs to be particularly poignant to his personal situation. Many research participants found similar familiarity and comfort in literature, acquiring a level of self-understanding through self-recognition.

5.3.1.3.2 Empathy and identification

The experience of mental health problems can be isolating and lonely; similarly, many participants reported that life-changing events such as bereavement or retirement had made them feel alone. One of the reported benefits of reading literature was recognising familiar events and emotions. Experiencing empathy in relation to characters' narratives and identifying their own emotions in the texts made participants feel less isolated, and legitimised their own reactions to experiences. While most participants found their experiences represented in fiction, some also spoke of self-help literature providing this validation; for example, Louis stated that: '*I'm not unique in feeling this way, because for there to be a book written about it, it's got to be fairly commonplace. So it's reassuring. It validates the way that I'm feeling.*'

Milly discussed *Unless* by Carole Shields as a work that had been particularly helpful to her in understanding her experiences during her depressive episodes. Milly identified with the experiences of the lead character in the novel; *'it's about a woman whose daughter has gone off the rails – she's completely dropped out, and their communication has broken down. At the same time my daughter was having a really bad bout of mental illness, and reading it while I was coping with that was incredibly helpful.'* Milly found it difficult to explain why this book was so important to her; *'I can't put my finger on exactly why, except that sometimes I think to find your own experience reflected and expressed in a way that you can't express yourself is really helpful.'* Validation was a positive effect of reading for Milly. She commented that reading about incidents which reflected her life; *'makes you feel less alone in a way, that you feel that that's your experience there on the page.'*

Milly and Vivienne used similar language to talk about the effects of literature. Vivienne felt that the power of literature to articulate inexpressible emotions was of immense value and helped her to understand her own feelings. She discussed her recognition of feelings of grief and loss in indirectly-related literature. When talking of Alice Sebold, she commented that; *'you feel almost validated. The emotions and feelings you had… that wasn't just me. It's there and it's real.'* She recognised the importance of reading about other's situations, and reflecting on them in light of her own circumstances; *'having gone through such a traumatic experience, for me, they have been a lifeline, and having read other people's experiences and stories, they've been a validation.'*

Winston also identified with texts he read, seeing his reading as *'a valuable reflection on myself.'* The story of Johnny Cash, the American singer-songwriter, was of particular help to him. Cash's suicide attempt in the 1960s led to a reaffirmation of his Christian faith, and was a turning point in Cash's life that Winston found inspiring; *'he actually did manage to find his way out and turned his life around. But it's that whole thing – you can be totally and utterly messed up, but there's still hope.'* Like Vivienne and Milly, Winston reflected on the normalising effect of literature; *'the book provides a validation. You're not the only one who's done this; you're not the only one who's been here. You're not the only one who's asked these questions. You're not weird. You're normal.'* Concepts such as normalisation and self-recognition have impact on wider concepts such as the reduction of stigma, discussed in later sections of this chapter.

5.3.1.4 Reading and escapism
Escapism is often referred to in reader development (Elkin *et al*, 2003). In this section, emphasis rests on the perceived therapeutic nature of the escape, which progresses beyond relaxation and relates to some participants' inability to engage with emotionally-challenging texts when depressed. Participants discussed escapist literature as a safe world, talking of the importance of having a strong narrative. Olivia admitted that when she was feeling low, *'I find that escapism is much preferable.'* Examples of authors regarded as escapist included Jules Verne, Terry Pratchett, P.G Wodehouse and Stephen Fry. The accessibility of these works was their light-hearted, humorous nature. For Olivia, these texts engaged her attention without challenging her emotional state of mind.

Serena felt that reading literature helped to quieten her negative internal monologue, and allowed her relief and relaxation; *'I always have this tape playing in my mind, a running commentary. But if I'm wrapped up in a fictional life, then it's not completely silent, but very quiet.'* Connor found therapeutic benefit in literature that was similarly escapist; *'there's a sense of being able to enter into a world that's different to the real world.'* The otherworldliness of books was also important to Julia, who professed to liking short stories set in foreign locations and looking at maps and atlases when she was feeling low; *'that's part of the reading thing for me, to go on a little journey somewhere else… it's all to do with escaping.'*

Nathan's reading choices reflected his need to escape from his symptoms, and he talked of reading compulsively to alleviate the way he was feeling; *'I don't normally read so obsessively; reading everything by Augusten Burroughs, and everything by Sloane Crosley and everything by David Sedaris. There was something in me that was fed by that and I'm sure it was a sense of safety and security.'* Ralph felt that escaping into his imagination was important to his reading of books about popular culture and music. He talked of enjoying *'bleak'* books, but when he was low he enjoyed books that *'took his mind off things'*. He called these books *'more throwaway stuff,'* though he was very much against the *'Disney-fied, saccharine'* portrayals of life found in some books. During our discussion, he found my reframing of his thoughts to be a helpful reflection of his use of literature; '*what you said about escapism was quite pertinent.'*

Winston discussed the elements of literature he found escapist – and similarly to Olivia and Nathan – regarded them as part of a *'very safe world.'* He mentioned Evelyn Waugh's *Brideshead Revisited* and P.G. Wodehouse's *Jeeves and Wooster* stories, both of which are set in the 1930s as having a value in their distance from the modern world. Reading texts set in bygone eras was mentioned as escapist by several participants, and this may be because these texts exemplify the disconnection from daily life and the perceived safety of other worlds. The next subsections discuss some types of literature that participants found escapist, with a view to examining further common factors in the texts.

5.3.1.4.1 Children's literature

A recurrent theme within participants' escapist reading was that of a need to read strong narratives. Children's books, either generally as a corpus or in terms of specific titles, were mentioned by several participants who read them in times of

distress. Olivia, for example, read children's books when depressed or anxious because of her desire to avoid difficult emotional content; *'I really can't cope with big themes, like love and death and people having intense emotional traumas. Which unfortunately does actually rule out a lot of what you might call literature.'* Children's books, while still sometimes covering these themes, did so in a gentle, accessible manner. Olivia particularly read sci-fi and fantasy titles, such as the work of Ursula Le Guin, providing a further disassociation from real-life contexts.

Amelia also found similar respite in children's fiction; *'when I have been in a very severe depressive state, I read children's books. Sometimes I just go [to the library] and look at the pictures.'* Nathan read a number of 'crossover fiction' fantasy titles – the *Twilight* series; Christopher Pasodini; and Ursula Le Guin. As he commented, *'the story there is really very safe.'* The desire to read fantasy genre and crossover fiction related to Nathan's symptoms of depression, and represented a defined change in his reading habits. Before his illness, his interests involved politics and contemporary art, but *'I found that they required too much reflection to engage with.'* Instead, his move toward books that required little emotional engagement safeguarded him at an emotionally vulnerable time. This was an important mechanism of defence or self-protection and participants recognised that this was not necessarily a conscious decision. Their awareness of their inclination to read *'safe'* literature often only realised in hindsight. Avoiding texts when feeling sensitive or low also indicates perceptions of literature as powerful and emotionally engaging.

5.3.1.4.2 Crime

Crime fiction performed an important role for some participants, providing escapism through its predictable outcome in which crimes will always be solved. For example, Milly read crime novels;

> *'if my mood is low, I probably want something that's got quite a strong narrative. If I'm really stressed, nothing is better than crime fiction. There's a very strong narrative, obviously, with the cliff hangers [that] make you want to keep going. And also I think the predictability of it. Even though you don't know who did it, you know that you're going to go through a process and find out at the end who did, so it's quite comforting.'*

The familiarity of the outcome in reading genre fiction, such as crime, has previously been considered as a positive reason for reading such texts (Sheldrick Ross, 1995; Sheldrick Ross, 2009). The narrative conventions of crime, with its familiar journey from discovery of crime to its solution, provide reassurance.

Nathan sought solace in inter-war detective fiction, such as Agatha Christie, Ngaio Marsh and Margery Allingham. The reasons for reading these books were obvious to Nathan; *'I read detective stories of the rather old-fashioned, very safe type. I think I wanted reassurance that there were boundaries. Despite the fact that somebody's been hideously murdered in the study, there is a safe boundary all around it and someone's going to come along and solve it.'* Nathan found the familiar tropes in genre fiction to be comforting without being too emotionally engaging. Briefly relating this to the academic literature, Gold (1990: 48) concludes that crime may be a popular choice of genre because it encourages problem solving and allows the reader to feel they are in control of the reading experience.

Silas read several Patricia Cornwell forensic crime novels and referred to them as *'distraction therapy.'* He considered reading these texts to be a form of treatment, helping him to avoid ruminating on the causes of his depression;

> *'I think what helps me with reading and being depressed is that you get absorbed in something and it takes your mind off other things. So certainly reading Cornwell, you can get so absorbed in that. So that's been a real benefit, that's enabled me to focus on that and then you tend not to think so much about why you're depressed.'*

One of the reasons Silas found these novels so compelling was because of their *'clear, strong story.'* Although he had not been interested in reading before his recent depressive episode, he was now enthralled by these books; *'the last one I finished, I didn't want to finish it, because it was so good and so gripping. There's nothing worse than when you read a really good book and come to the end.'* His comments again reflected the theme of the need to escape from the world and the idea of losing yourself in a good book.

5.3.1.4.3 Narrative non-fiction

Narrative non-fiction was also read by numerous participants during an episode of low mood. Examples varied, but can be loosely grouped into genres including history, popular science, and autobiography. Olivia felt that this was because narrative non-fiction was further removed from distressing emotions, but still had a strong narrative; *'I recently read one called Bluestockings, which was about the first women to fight for an education. And so it had intellectual appeal, without going too close to the bone.'*

Nathan also considered these changes in his reading habits, detailing that he read; *'some non-fiction. But things like the history of the Byzantine Empire that was really*

fairly distanced.' His desire to keep a distance from reality, as with his need for boundaried, *'safe'* stories, was a sign of his symptoms of depression. For example, Nathan recognised his engagement with the work of Augusten Burroughs as related to his rumination on Burroughs's descriptions of '*the sense of detachment from an outside world that's going on, while you're ill, and the challenge of actually returning to that world.'* However, for Nathan reading narrative non-fiction was not necessarily positive; *'it felt like I'm feeling miserable and I'm wasting my time here, reading about the Babylonian invention of zero. I'm really avoiding it.'* While these titles had an appeal because they were disconnected from Nathan's life, he began to feel that there was a need to focus on the issues he was facing in order to facilitate his recovery.

Conversely, Connor connected his reading of narrative non-fiction with more positive emotions, feeling that reading was an educational experience; *'I think learning is beneficial too. And often, through reading, there's an element of learning within that.'* The differences in their views may be down to a number of factors, possibly including the timing of the interview; while Connor was discussing mental health problems that occurred a number of years ago, Nathan was still recovering from a depressive episode. Like Connor, Amelia had started to recover from depression, and she used narrative non-fiction to educate herself, borrowing titles on empowering subjects like feminism and self-defence; *'I'm feeling as though I am discovering something about the world, and not just digging myself deeper and deeper into mental health.'* Nevertheless, the suggestion that learning may also be a part of therapeutic reading links to the next sections in this chapter; reading for purposes of gathering information and challenging long-held beliefs and views.

5.3.1.5 Reading for information
One of the aims of self-help bibliotherapy is to provide information about techniques to maintain mental health. Several participants in my research also regarded information seeking and self-education as the primary functions of bibliotherapy. Serena summed up the aim of her therapeutic reading as; '*the more educated I can be on topics like this, the better equipped I am to make my own choices for my own condition.'* A variety of texts were mentioned, from the CBT-based texts on BoP lists to those in the anti-psychiatry movement which rejecting psychological principles entirely. For Vivienne, the reasons for reading for information linked closely with life events; '*it's obviously been to do with dealing with grief. I read a multitude of books in the beginning. I didn't realise it at the time but it was obviously part of how I was*

coping – informing myself.'

Serena's use of texts for information and education was focused on texts concerned with Mindfulness (a therapeutic technique) and the anti-psychiatry movement. She felt these texts contributed to her ongoing recovery, and reading these texts had helped her to view her mental health problems in a different light;

> *'that's the major shift in thinking that I've had. And it has been down to the books that I've been reading. I'm definitely reading a lot about meditation. I've read about some books that were fairly critical of psychiatry, which were pretty mind-blowing because I'd never even thought to question it.'*

Questioning conventional therapeutic techniques was beneficial to Serena, allowing her to reframe her attitude to depression.

Serena was highly information literate and aware of the need to be very selective about the texts that she used to inform herself about her condition and treatment; *'there are a lot of crap self help books out there [laughs]. I don't read those.'* Instead, Serena used the advice of experts and her own expertise in information seeking to find helpful texts; *'I have a counsellor, and she recommended some really good books on depression for me. I looked into those and that kind of led me to other good books that were recommended. It's been really helpful because the books I've been reading changed my entire view of depression.'*

Serena had had some negative experiences with CBT as a form of treatment, exclaiming *'oh god, people in this country are obsessed with CBT'* when I discussed BoP with her. In her view; *'CBT is good but... the biggest problem with CBT is – you have these negative thoughts. You have to change them to more balanced, healthy thoughts. But then it's like there's no feeling or conviction behind believing those thoughts.'* Serena's shift from a CBT-model to a Mindfulness model was mainly precipitated by the reading she had done on the subject.

Amelia and Ralph also found advantages to looking beyond the traditional catalogue of CBT-based self-help texts to provide information about alternative forms of treatment. Amelia had had bad experiences with psychiatric treatment, and considered herself to be a *'psychiatric system survivor.'* Reading helped to inform her about the arguments against the biomedical model of mental health. Amelia's use of these texts made her realise that others had similar experiences to her, and encouraged her to find alternate sources of support. Ralph read about Mindfulness,

and despite offering a personal critique of the subject, concluded that; *'I do hyperventilate and I think I need to focus on deep breathing. Then I think it could have some positive effects. So maybe I'm being a bit dismissive.'*

However, Silas, who had recently been diagnosed with depression (unlike Amelia, Ralph and Serena, who all spoke of recurrent life-long episodes) found reading about CBT to be helpful to him. He found that – rather than reading about depression and symptom management – he benefitted from borrowing *CBT for Dummies* from the library, a basic training manual on the technique; *'it's given me some insight into trying to get over my depression... the more insight I can get into how I can help myself, the better.'*

Milly felt that Louis Wolpert's *Malignant Sadness* had helped her to comprehend her own condition; *'that's how he describes depression. I think it's really good, it's like sadness that just keeps growing and doesn't go away.'* As was discussed in section 5.3.1.3.2, Milly had great respect for authors who verbalise her emotions and feelings when she felt unable to do so. Milly found that books by people who had themselves suffered from mental health problems themselves were also helpful to facilitate understanding; during the member checking stage of the research, Milly emailed me to provide further information on an author she could not remember the name of during our interview, stating; *'the author I couldn't remember was Sue Atkinson. Atkinson has a bipolar disorder and it's clear from her writing that she knows exactly what she's talking about.'* This reference to authors writing about their own experiences was important to some participants in the research, who felt that this was an authoritative and useful source of information on how to cope with mental health problems.

The use of non-fiction titles to provide information about mental health and treatment can be seen as a form of self-help bibliotherapy. Indeed, with Serena, Silas and Ralph's use of books, the boundary between information-seeking and treatment is blurred. As Serena stated; *'reading has been of enormous help to me, and has actually enabled me to think of my issues in an entirely different way and believe that recovery is truly possible.'* Serena's self-education can be seen to have therapeutic benefit as well as providing information. Some participants had strong opinions on the use of self-help books as a form of treatment, and their experiences will now be explored.

5.3.1.5.1 Using self-help texts as a form of therapy

Large numbers of self-help books are available in the UK,[16] with around 30 CBT-based titles recommended on BoP booklists. Not all participants felt there was value in using books for therapeutic purposes. Connor was familiar with CBT-based therapy, finding its techniques useful in coping with depression. Nevertheless, he did not see the benefit of reading about CBT, preferring to access therapy through a face-to-face model; *'I think I've got a reasonably good understanding of [CBT]. I use it a lot. But I don't think I've learned it from a book.'*

Vivienne felt that while there were texts that she found helpful, these were not necessarily to be found within the corpus of self-help literature; *'there's loads and loads of self-help books out there, but they're not necessarily the ones that will inspire you.'* Alfie recognised that people required high motivation and concentration to use self-help books successfully, which may have been problematic for people with symptoms of low motivation and concentration; *'self-help books are very good but the point is a lot of the time you've got to stick at them, ain't you?'* Vivienne, Connor and Alfie's comments emphasise that for some people, self-help therapy may not be an option.

However, for others, like Louis, there was value in engaging with therapeutic titles. At the time of our interview, Louis was reading *Feel the Fear and Do It Anyway* [*FtF*], and felt that the book provided him with coping techniques; *'I've done a couple of chapters a week, made notes, done the exercises and yeah, I think it's been beneficial.'* Louis was also having counselling, but was convinced that some aspects of his improved mental health were prompted by the books he had been reading, rather than the counselling; *'my internal monologue's got a lot more positive as a result. I've got posters up all over my house, in my bedroom, in my bathroom, on the back of the front door. So everywhere I go I've got reinforcement of the ideas that I'm getting from this book.'* While the effects of counselling and reading are hard to separate, Louis felt there were definite benefits to both.

While Louis had a positive experience with *FtF*, he had also borrowed *Overcoming Shyness and Social Anxiety* [*OSSA*] from his local library. Louis was interviewed

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[16] A search on the online book retailer www.Amazon.co.uk conducted on 2nd November 2010 found that 124,848 titles were located with the search term 'self-help'; 3383 results returned for 'self-help depression' and 1825 results for titles concerned with 'self-help anxiety.'

twice,[17] and in our initial interview, he felt that *OSSA* would be most helpful for him; but by the time of our second interview, he commented that this text did not have the right focus; *'I felt like I had bigger fish to fry. Rather than targeting one aspect of the things that I wanted to improve, I wanted a more all-round approach.'* When considering both texts together, Louis discussed the reasons he thought he had found *FtF* more appropriate for him at that time. He felt that *OSSA;*

> *'was a bit drier, and it took a while to get to anywhere. There was a lot more about the introduction of the problem and why it happens and the Feel the Fear one, it more or less says: look, it can happen for all kinds of reasons, it's probably not worth analysing it, just start from now. So I thought, well, that's better, so I'll do that.'*

The directness of *FtF* appealed to Louis' need to find practical solutions to enable him to cope with his situation.

In our first interview, Louis had read the introduction to *OSSA*. He recognised the CBT techniques in the book from previous therapy he had undertaken. Despite his shift to reading *FtF*, Louis felt that reading *OSSA* enabled him start to understand his problems;

> *'I've got my first counselling session tomorrow and I feel like I'm going into it with more of an agenda, rather than just flouncing in there and saying 'oh, I don't feel up to much – help me.' And some of the stuff in this book is pretty similar to the exercises they were giving me on the NHS.'*

Louis's comments suggest that there is a therapeutic value to reading texts, but also that there needs to be flexibility within the approach, to allow readers to change the title they are reading.

Quality of self-help titles was a cause of concern for several participants. Serena was adamant that while some self-help books were helpful, others were not;

> *'now that I've read quite a few, I think a lot of it is separating the really bad and useless ones from the really good ones. And unfortunately there are a lot of bad, useless self-help books out there. I think that might confuse a lot of people who might not be able to discriminate.'*

Serena and I then discussed the BoP approach to recommending titles, which she felt might be helpful for some people to signpost the useful texts and to help them to avoid the poor-quality titles. Amelia related questions of quality to a query about the definition of self-help books as a genre; *'when you say self-help books, I tend to think*

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[17] See participant profiles in appendix two

of rubbish pop psychology. Which I don't tend to read.'

Questions regarding the quality of self-help resources were also present in Olivia's interview. She had read several self-help books at various times when undergoing symptoms of depression and anxiety, and felt that the ones she found most helpful were the ones that *'showed their working a bit, and treated me as if I'm an intelligent person.'* Olivia was aware that this was not for everyone. When discussing *The Worry Cure* she commented that; *'this probably isn't the most accessible book.'* All the texts read by Olivia were suggested by her doctor, though not necessarily through a formal prescribing scheme. The recommendation of texts was not always successful; Olivia felt that her doctor's suggestion of *Overcoming Low Self-Esteem* had been *'a bit of a misdiagnosis, so I didn't find that book that helpful.'*

Olivia had also read *Mind Over Mood*, regarded as a classic CBT text, and had worked through the text during a course of CBT several years ago. As with Louis' experiences, discussed earlier in this section, she felt that *'I find it quite difficult to unpick what was the effect of the book, and what the effect of the therapy, and what was the effect of just other changes in my life that were coincidental.'* Nevertheless, her recent return to face-to-face therapy led her to conclude that she felt her previous reading had not really *'got to the root of anything.'* Thus, self-help texts cannot be seen as a panacea for all conditions (Frude, 2004a).

5.3.1.5.2 Self-help texts as accessible therapy
Self-help texts are also regarded as potentially valuable because they provide access to otherwise unavailable therapy. The availability of therapy could be affected in four different ways:
- Location – therapy is sometimes not available in a particular geographic location. This may be because of long waiting lists effectively prohibiting access, rather than its absolute unavailability.
- Timing – face-to-face therapy is only available in office hours, again limiting its availability.
- Cost – undertaking a course of psychotherapy can be expensive.
- A preference for self-reliance – some participants spoke of a desire for a 'do-it-yourself' option, rather than undertaking therapy that may encourage reliance on a mental health professional.

Serena's use of self-help was affected by questions of location and timing. When she

was discussing *The Mindful Way through Depression*, she observed that the course on which the book is based is *'not widely available in the UK at the minute, so they wrote this book to help people and gain a wider audience for it.'* Serena felt that the value of self-help books was to teach her techniques to use to manage her symptoms at times when she was not in contact with her counsellor or support team; *'[it] has this thing called Three Minute Breathing Space. Basically, it's bringing the whole formal Mindfulness meditation in, when you have a situation when you feel stressed out. So, it's something you can do when you're on your own and you don't have access to the professional therapists.'* Louis mentioned similar location-based factors in his rationale for choosing to engage with self-help literature; *'I thought I'll give it a go... I'll get one of these books out – because I was waiting for counselling at the time – and just see how it goes.'* As face-to-face therapy was currently not accessible to him, he decided that there was no harm in thinking about the issue independently while on a waiting list.

Louis felt strongly that the library's provision of self-help books was important for equity of access. He commented that; *'especially in this climate, with the finances the way that they are, going into your library is a hell of a lot cheaper than fifty quid a time to go and see a therapist.'* Equitable access to these therapies was particularly significant for Louis, who lived in a socio-economically deprived area of Smithville, and observed that he was struggling financially since his relationship had ended; *'with the current situation and child support and all that, I'm pretty skint, so getting into a book doesn't cost anything.'*

Louis also felt that self-help should be a 'do-it-yourself' option, viewing good mental health as something that could be learned from a step-by-step guide; *'it's getting advice from a book that's available to the masses. Therapies can be expensive, but if you can go and pick up a book on it and follow it through. It won't do in every case, but in a lot of cases it will be helpful.'* In Louis's highly pragmatic view *'if you want to learn about playing an instrument, you can get a guide on that, so if you want to learn about tuning your mind up then why should that be any different?'* As will be discussed in chapter six, Louis's view here mirrors the construction of the 'ideal patient' presented in chapter four.

Being able to borrow self-help books from the library was widely seen as positive by participants. Although Louis and Olivia discussed the value of owning self-help books so that they could be written in and used to refresh understanding of key

issues as required, both recognised the role of the public library in providing access to therapy for people who wanted to see if this approach would suit them. As Olivia commented, she had bought one of the recommended books, not found it helpful, and regretted spending the money on a title for which she had no use. The next time a doctor recommended a book to her, she chose to get it from the library to see whether or not it was helpful before committing to buying it. Louis was very aware that; *'the library's a good introduction. Good place to get started without having to risk your own money.'* Reading the texts led him to conclude that: *'they're the things that I would want to own, so I can pick it up whenever and refresh it.'* His experiences, in which he borrowed two books from the public library before deciding that one approach was more beneficial to him, reinforces the contribution that the public library can make to equitable and flexible access to texts.

Summary

As section 5.3.1 has shown, the interaction between the reader and the text is key. Reading is considered to be therapeutic as it can be used to:

- Distract or escape from problems or symptoms. This reading often involved re-reading familiar texts; or reading a selected genre of literature.
- Gather new perspectives and methods of coping.
- Provide information about symptoms or treatment.
- Access therapeutic resources that are not otherwise available.
- Provide catharsis or clarity.
- Empathise with characters, as a form of self-identification.
- Validate feelings and emotions.

The personal nature of reading – in which a person does not arrive at a text as a *tabula rasa* and their experiences affect their interaction with a text – makes an important contribution to understanding the therapeutic experience of reading. Interaction between a text and a person is difficult to predict, and while one book will have therapeutic value for one person, it might not have the same effect on another.

5.3.2 Bibliotherapy and the stigma surrounding mental health problems

As discussed in section 2.3.5, stigma impacts on the experience of mental health problems. One argument presented by service providers of bibliotherapy is that having schemes like BoP in the public library helps to normalise mental health problems and to reduce the associated stigma. Chloe, a manager of a bibliotherapy service in Williamstown, felt that the scheme had a positive impact, visible when

members of the bibliotherapy groups, including Ethel and Lucas, were prepared to discuss their mental health problems in public to promote the groups; *'it definitely does de-stigmatize… [They] talk openly about things in hopefully a supportive atmosphere.'*

Louis found it difficult to borrow self-help texts from the library, because of the self-stigmatization he felt; *'I didn't want to get a book like that and check it out with someone. It's a bit personal in some respects.'* Louis had not been told about BoP by his doctor, but felt that contact with a medical professional might be a better way to access these texts; *'there's more of the barrier there, going into a library and taking that first step. Whereas if you've gone to see your doctor already, then they [can] recommend it.'* He had concerns about taking the book to the library counter to borrow it; *'it is a bit of an embarrassment. You don't want to parade around in front of other library users going "oh, I'm socially anxious, so I'm getting this book out".'* Nevertheless, when Louis did pluck up the courage, he found borrowing these titles was not as difficult as he anticipated; *'it was better than I expected because there was nothing to it. It was just a case of getting a book out. [The librarians] see these books day-in, day-out. So I shouldn't really care.'*

Olivia also struggled with nervousness when she went to the library to get a recommended self-help title; *'it wasn't entirely easy, and it surprised me that I felt that way... Obviously I am aware that the rest of society does still have a stigma around mental health.'* These difficulties in accessing bibliotherapy schemes – particularly self-help texts, but also joining bibliotherapy groups – need to be considered throughout the thesis. Interactions with texts, bibliotherapy groups and the public library are shaped by participants' understanding of mental health, and their personal experience with the stigma of mental health problems. The accessibility of texts and bibliotherapy schemes is a key indicator of their success.

5.3.3 Interaction with bibliotherapy groups

As outlined in section 5.2.2, observations were made in four locations in the UK, and supplemented by interviews with group members and facilitators. Common themes regarding the different bibliotherapy group experiences emerged, showing that the bibliotherapy groups were highly valued by group members. Section 5.3.3 explores the role of the group dynamic, group facilitator, and literature read in the group, showing that these interlinked factors contribute to the perceived benefits of group membership. All three elements – the facilitator, literature and the group environment

itself – needed to be present to ensure a successful therapeutic interaction. Research published subsequent to this analysis of bibliotherapy groups also identified these aspects of group membership as integral to GIR groups on Merseyside (Billington *et al*, 2010).

5.3.3.1 Benefits of group membership

Participants found various benefits to being a member of a bibliotherapy group, including the group's role in maintaining and improving mental health; relaxation; and social interaction.

5.3.3.1.1 Maintaining and improving mental health

The aims of a bibliotherapy group are twofold; to enable people to engage with literature, which will be discussed below, and to help them to maintain their mental health. Lucas, a member of the Williamstown group, was particularly eloquent on the importance of the group in helping him to cope with his bipolar disorder; *'I'm a miserable bugger, basically. I derive a great deal of benefit from coming along, socially, but also in terms of my mental health. It helps me confront my self-destructive, melancholic tendencies.'* As previously discussed, the Williamstown group read and wrote poetry, and this process helped Lucas to express his feelings and cope with the symptoms of his bipolar disorder; *'it makes me confront my inward-looking view of the world, encapsulate the way I feel, put it down on paper. In a cathartic way, put it down for others to read. Doing it helps me confront my problems.'* Beatrice, from the Taylorbridge group, felt that group membership improved her depression after a divorce; '*It was something that was very important, something to get up to and go to when I was going through a bad time. When I needed places to go that were friendly and safe, it was indispensible.'* Virginia, also from Taylorbridge, observed that the group was of great value to helping her to cope with her long-term health conditions; *'it's been very helpful. I think it's the highlight of my week now.'*

The participants in the Smithville North group were more likely to suffer from mild to moderate mental health difficulties that were precipitated by life-changing events, rather than enduring mental health problems. The group facilitator, Leah, felt that the group filled a gap and provided a service for such people; '*[they are] dealing with ongoing life problems, ill-health, some isolation and loneliness, older age. I think it's perfect how it's pitched at that level that accommodates this particular group of people. And it may be that there aren't many services like this.'* The recognition of

the need for a wide variety of services, including those for mild to moderate mental health conditions, is important when considering the role of bibliotherapy. Leah viewed it as a service that helped to prevent people who had suffered from depression or anxiety from becoming depressed again; *'it's a holding space for people. It's something that between group meetings, they know what's coming up. I'm not saying it's their world. But it's something they set in their calendars, in their diaries, it's a holding space.'* These ideas of the bibliotherapy group as useful at different points in the experience of mental health problems – for example, as a preventative or as a continuation of treatment – will be explored in chapter six. From the perspective of bibliotherapy service providers, Leah observed that: *'keeping ten people in the community well, and their families. Think about GP costs, fewer visits to see their GP. So in real terms it probably does more than it might seem.'* While this comment is focused on the benefits to the health services rather than those for the service user, it does emphasis the beneficial outcomes. Two of these potential benefits, relaxation and social interaction, will be explored in the following sections.

5.3.3.1.2 Relaxation

Vivienne and Isaac, members of the Smithville North group, were clear that the group provided them with something that they struggled to find elsewhere – a space to relax. Their personal circumstances meant that there were many demands on their time[18] but both regarded the group as a date in their calendar that could not be missed. As Vivienne commented; *'the book group's been my one little thing for me. My time. And nothing interferes with that. Not a lot, but it's mine.'* She viewed the group as a rare opportunity to put her needs first, also discussed by Isaac; '*I'm doing something for me, what I'm enjoying doing, and not doing it for somebody else. I use it as time for me.'* Language used here by participants strongly suggests a sense of ownership of the group, also noticeable in comments regarding reading as empowerment and achievement, discussed in section 5.3.3.2.

Taking time out was a theme in the Taylorbridge group, in which participants discussed the way that the group helped them to find relief from stress. Mya observed that; '*with the books, or the poems that she reads out, it just takes you away from your thinking. Because my mind is focused on stress. My head is racing ahead of me, but whilst I'm in here, I don't think about it. I think about what I'm reading.'* Mya associated this with the escapist qualities of reading previously

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[18] See appendix two.

discussed; '*I find it brings your stress level down because it takes the pressure off in here, and you get to go into a different world.'* April responded to Mya's comments in the interview, remarking that; *'it's relaxed here. You do it in your own time, instead of pressured.'* These observations show that the atmosphere in the groups – with a focus on reading rather than discussing personal problems directly – created an environment in which participants could find respite from symptoms and take time away from other responsibilities to maintain their mental health.

5.3.3.1.3 Social benefits

The social experience of reading was highlighted by a number of group members as a benefit of belonging to the group. Isaac and Grace, two members of the Smithville group who chose to be interviewed together, felt strongly that the social aspects were important to them. Indeed, their interaction in the interview was further evidence of the value of the social relationships that were formed within the group. Despite a twenty-year difference in age, they enjoyed each other's company and sense of humour.

Both Grace and Isaac had suffered from a loss of confidence; Isaac's occurring after a breakdown and Grace's after the death of her husband and her subsequent retirement from work. Leah asked them to join the group, and they both saw it as an opportunity to continue to address the issues that had led them into counselling. Isaac expected that the group would help him to conquer his loss of confidence; *'I saw it as a good way to proceed. To get used to being with other people.'* When observing Isaac in the group, he was one of the most open group members, always ready with a joke, and often drawing quieter members of the group – myself included – into the discussion. He credited the reading group as helping him to return to this state of mind; *'it sounds silly. I went to the point where I was avoiding people, just couldn't face seeing people. The reading group actually helped me bring it out.'* His returning confidence had meant that he had started to volunteer at a local advice centre, demonstrating the measurable impact of belonging to the bibliotherapy group.

Similarly, Grace was aware of the benefits of her increased confidence;

> *'I know now I can still make conversation with a group of people, have a discussion and things like that. Even though it's only once a month I do look forward to it, and I do get a lot out of it. It has done things for me. At least in my own mind, I know I haven't lost the skills.'*

Grace found retirement to be quite a lonely time; in the bibliotherapy group she had found a comfortable environment, in which she was able to express her opinions and contribute to a discussion. Both Grace and another group member, Henry, pinpointed retirement as a life-changing event that had caused them to experience poor mental health, and the group facilitator Leah observed that this was a common occurrence amongst older people. Following his retirement, Henry felt that he had lost *'the chance of meeting other people. You seem to miss out. All the rest of the world is quite busy going about its business, and you become a bystander. You watch what's going on rather than being involved.'*

Grace echoed the importance of retirement as a life-changing event; *'my husband died. And I retired from work – big mistake – but things were changing and I couldn't cope with everything. So I took early retirement.'* Grace related these events to her referral to counselling and recruitment to the bibliotherapy group. She felt the loneliness and isolation she experienced in retirement were alleviated by the group; *'I thought: perfect opportunity. Get out, meet other people, doing something that I do like. But most importantly is getting together with other people.'* Leah thought that group-based creative bibliotherapy was something that could be valuable for older people;

> *'some people have relationship problems in older age. A few say 'well, people die. Our friends are dying, and we don't have as many friends.' So then they're stuck with a partner, in a relationship. When they come away from the relationship and have something like this [group] for themselves, something different to talk about, another interest to take that back to the relationship, that can be beneficial.'*

Henry summarised the benefits of the group for older people with his remark that: *'I think a lot of us are lonely souls. Especially after retirement, because you do miss other people's company.'* Observation of the Jonesfield 2 group in a residential home for older adults echoed this sentiment. Nevertheless, it is not just retired people who found this increased social interaction beneficial for their mental health; the bibliotherapy groups I attended also included people with long-term physical health conditions who were unable to work, and carers for people with mental or physical health conditions. As Jess, the Williamstown group facilitator, remarked; *'the social thing has been really important. People do get a lot of benefit from that, just making friends.'*

The Taylorbridge group felt that social interaction was a significant element in the success of their group, with Douglas, Mya, Rodney and Walter all commenting on it

in their group interview. Virginia also felt that one reason that she found the group to be beneficial was because; *'it gets me out, mixing with people who love reading like I do.'* When I asked Henry, from Smithville North, what motivated him to join the group, he explained that it was not just the social atmosphere; *'there were two things attracted me – the reading, which is important, and the social side of it.'* The role of the text in the group will be considered in the next section.

5.3.3.2 Role of literature in the group

Many participants were motivated to join a bibliotherapy group because it gave them the opportunity to read literature. Ethel's interest in poetry led Lucas to invite her to join the Williamstown group. Vivienne, Grace and Henry, all big readers, had been similarly recruited to the Smithville North group by Leah. Nevertheless, there was room in the groups for people with different reading habits; Violet and Isaac from Smithville North, for example, rarely read novels outside of the group. As Isaac stated; *'I've always sort-of liked reading but never ever had time for it, I used to just read autobiographies.'* Violet, another member of the Smithville North group, returned my recruitment materials to me telling me that she didn't think the project was for her because she didn't really read, aside from the book that the group read every month. While it would have been enlightening to discuss this further with Violet, she felt that she did not have anything to add to the research because of her reading habits. Thus, bibliotherapy groups have an appeal for people who do not necessarily have a life-long habit of reading.

Participants in the Taylorbridge group felt that the group influenced them to change their reading habits, encouraging them to read new things. As Rodney commented; *'I can't be bothered to read like this. If I read a book, it's just biographies.'* His view was that he normally read *'mundane'* things like the newspaper, and he did not have the opportunity to read literature outside the group. Courtney echoed this with her reflection that the group was a *'big change for me – actually listening to some poetry.'* These observations reflect those made by participants who attended other reading groups – see section 5.3.4.2 – of reading being used to introduce new perspectives on literature and the wider world.

The opportunity to read material that participants had not chosen, and might not have otherwise read, was one reason cited for enjoyment of the group. For example, Henry commented that he did not always enjoy the books the Smithville North group read, but still found benefit in reading them; *'even then I think it's worthwhile because*

at least I'm introduced to new authors, new ideas.' This was apparent when the group read *The Return* by Victoria Hislop. While Henry commented in the group that he did not enjoy the novel as a whole, he was interested in the setting of the story, the Spanish Civil War, and used this reading as a springboard to learn more. In the group meeting, there was then a discussion based on Henry's remarks about the history of Spain. The novel inspired debate and was a focus for people to talk about events and experiences in their lives and beyond. It performed the function of shaping people's experiences around a common theme, and encouraging sharing thoughts, ideas and memories.

During another observation of the Smithville North group, Isaac and Henry asked if I was going to take a copy of the book that the group would be discussing at the next meeting. I was reluctant to do so, as I was aware that Tim Butcher's *Blood River* did not look like a book I thought I would enjoy. I was swiftly informed that to read books that weren't what you would typically read was one of the aims of the group. Duly chastised, I took the book with me to read.[19] As Vivienne observed; *'the overwhelming thing was that I wanted to be taken out of my comfort zone with the books I'd fallen into the pattern of reading. So I wanted to be taken out of my own head and given something that I would never have chosen.'* Books were selected at random from the reading group stock, rather than recommended by group members. Random selection meant that sometimes, no-one would like the book chosen to read, but Vivienne still felt that it was a worthwhile experience for her, even if she did not finish the book herself; *'on some level there's always been something that we've got from it, even if it's only been the pleasure of listening to what other people have said.'* Listening to the discussion was an important aspect of the group; as Isaac told me, this sometimes meant that he regretted times he had not managed to finish reading the book; *'the past couple of times, I haven't been able to get into the book but other people have enjoyed it. When other people have been talking about it, I've thought – I think I've missed out here. Not persevering.'* The atmosphere created by the communal reading of the book meant that there was implicit encouragement to continue to read even if a person did not initially enjoy the book.

Building on ideas of empowerment discussed in 6.6.1.2, Vivienne and Isaac spoke of the sense of achievement they felt after reading the titles in the group, with Vivienne's feeling that; *'even if I never read anything else other than what's in the book group, I can think I've read a dozen books this year. That doesn't sound bad,*

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[19] For the record, I didn't like the book.

does it?' For people who might have lost confidence or have low self-esteem, the feeling of accomplishment found in reading and discussing literature can be seen as a positive outcome of joining a bibliotherapy group. As Isaac remarked; *'it gave me self-satisfaction, joining the group.'* Isaac was very clear that this discussion was part of the process of reading with the group, allowing members to develop their own ideas and opinions, while still respecting those of others;

> *'you don't have to sit there saying yes and agreeing with everything. It's like on Monday, I read the book [Blood River], and so did Henry but we differed on certain parts as to what we got out of it. But then again, we wouldn't be human beings if we didn't differ.'*

Virginia, a member of the Taylorbridge group, also believed that sharing views was important to her experience of the group; *'I like discussing it and listening to other people's opinions especially the poetry, because I think everybody finds different things in poetry.'*

Mya felt that being introduced to new literature was personally beneficial to her. She felt it helped her to think differently about her life;

> *'I like learning about different authors that I've never bothered with. It's inspired me to think differently. Seeing things in a better light. When you hear other people – you think 'how did I miss that?' You could just learn from it, it teaches you how to be a better person.'*

Mya's comments help to explain the differences between the aims of a reading group, a mental health support group, and a bibliotherapy group. While the stories and poems read within the group are not chosen to have a focus on mental health, the subject matter can impact on views and help shape perspectives. Beatrice spoke in our interview of a poem she first read in the Taylorbridge group. She recited the first few lines of the poem, *The Listeners* (De la Mare, 1912); *'Is there anybody there?' said the Traveller/ Knocking on the moonlit door'* and identified with the feelings of the loneliness she felt were expressed in the poem. The diversity of personal connections with literature, of which Beatrice and Isaac spoke, created the associated benefits recognised by Mya.

At the Taylorbridge group meeting, Norman Nicholson's poem *Rising Five* (1999) was read and discussed. The poem focused on ideas of living in the moment. Martha compared Nicholson's poem to the William Henry Davies' poem, *Leisure* (1911), reciting and contrasting its opening lines *'What is this life if, full of care/ We have no time to stand and stare'* with Nicholson's lines about a young boy wishing to be older and looking forward to his fifth birthday. Nicholson's poem was read three times;

twice before and once after the discussion. The purpose of this re-reading was to think about how a poem sounds different after discussion of personal meanings and experiences. Arlene ensured that the themes of the short story were connected to those in the poems read in the same session. In this meeting, themes of growing up in Nicholson's poem were echoed in Doris Lessing's short story T*hrough the Tunnel* (1990). Lessing's story was read with close attention to language and phrase, but discussion also broadened out into thinking about experience. For example, Arlene selected the phrase *'neither possessive nor lacking in devotion,'* from Lessing's story which described the relationship between parent and child, which precipitated a wider discussion of family relationships.

The shift from close reading of texts to discussion of wider experiences was common to all the bibliotherapy groups I attended – though in Smithville North, the reading was not as focused on language as in other groups. In Williamstown, reading Simon Armitage's poem *The Obituary* (2010) generated an intense discussion, with Lucas questioning the arrangement of the stanzas of the poem, and Donald relating the themes of the poem to a Philip Roth novel he was reading. One of the poem's themes was the relationship between mother and son, and the conversation turned to family life and relationships. Despite the intricate language, the universality of these themes enabled everyone to engage with the poem. As the members of this group were mainly mental health service users, conversation did sometimes turn to mental health. In this discussion, the group looked at the lines; *'But right from the very beginning there was an absence in Edward's life/ a craving emptiness which grew like the black pit of a dilating eye/ Where that void came from neither the teachers nor doctors could say'* connecting these ideas of an emptiness to their own experiences of mental health (Armitage, 2010).

While the poetry read by the Williamstown group was often quite powerful, Ethel felt that the group was presented a balance of sharing literature and experiences; *'it's not too intense. It's not all poetry. It's gently into poetry. I think poetry could be quite a thing for helping mental illness.'* Her impressions of the group were shaped by the facilitator, who mediated access to the poetry discussed; helped the group to engage with the themes of poetry; and to encouraged them to express their own thoughts in poetry. The next section explores the role of the facilitator in more depth.

5.3.3.3 Role of the group facilitator
In the Jonesfield and the Taylorbridge group, the emphasis was on reading literature

aloud, and the facilitator encouraged people to read in the group. In all these groups, which were now well-established, participants were willing to read aloud. Noemi, the facilitator of the Jonesfield 2 group, had a slightly different role, as she did the majority of the reading. My field notes record that Noemi is *'very good at engaging people and giving them space and time,'* important considering the circumstances of the group. As previously explored, the groups in Smithville North and Williamstown operated differently, with poetry read aloud and written in Williamstown; and Smithville North resembling a typical reading group, in which texts were taken away to read and then discussed.

Leah's role in the Smithville North group involved guiding the discussion that occurred. Her key skills included encouraging people to think about the wider context and concepts within the text. I observed group meetings at which Leah was present and ones where she was not, and found that her role was to open up the conversation, thinking about wider themes within the book and connecting them to experiences. Henry valued Leah as a facilitator within the group, remarking on her ability to resolve disputes between members; *'Leah seems to handle it very well. She realises what's going off, and without upsetting either party, she can seem to calm things down.'* These skills were particularly important for the Smithville North group, who had encountered some problems with one person who no longer attended the group after a number of confrontations with its members.

As with any group situation, some members of the bibliotherapy groups were more vocal than others. In Smithville North, Isaac was a particularly dominant participant and confident about sharing stories and experiences, while Allison was more likely to be quieter. As Vivienne observed; *'[Leah's] very good at making sure everybody's had a turn and she's got such a calm, gentle manner. It goes smoothly along really. She's very moderate and diplomatic, and everybody's opinions are valued.'* This pattern was mirrored in all the groups observed. One of the roles of the group facilitator was to ensure that the group dynamic did not shift too much in favour of the dominant person in the group. Arlene, the facilitator of the Taylorbridge group, was skilled at asking open questions such as *'do people agree?'* and *'is anyone feeling something different?'* that brought in other members to the group discussion, and made sure that one opinion was not seen as more important than another. Jess, the facilitator of the Williamstown group, was also very aware of this, commenting on balancing the mix of personalities in the group; *'it can be tricky... obviously you become more skilled at it. You acquire the ability to work with a group and you've not*

got to let one person dominate. So it's managing that. You need to encourage the people who are quiet to have their say as well.'

As many people in the groups were vulnerable and experienced low mood or anxiety, the role of the facilitator was key. Indeed, some participants in the Smithville North group stated that they would not have joined a group without being recruited by Leah, as they did not have enough confidence to walk into a room of strangers. As Isaac remarked; *'my first session down here was semi-petrified. The only thing I kept saying to myself is, at least you know Leah. That's going to be at least one friendly face. Because I didn't know what it were going to be about, I'd never actually been to a reading group.'* Leah herself felt that this was a common experience amongst members of the group; *'I've asked one or two, why did they come to this group and not to another group?' They said that if they'd seen a poster or an advert then they wouldn't have had the confidence.'* Arlene adopted a similar strategy in Taylorbridge, attending other groups associated with mental health in the area such as the local Mind creative writing group to introduce herself to people and meet people who might be interested in joining a bibliotherapy group. Having considered the key aspects of bibliotherapy groups, this section now turns to considerations of the barriers to joining a bibliotherapy group.

5.3.3.4 Reservations about bibliotherapy schemes

Throughout the interviews with participants who were not in bibliotherapy groups, I also asked for opinions on current models of bibliotherapy, including the group model and self-help book prescription schemes. While some members – for example Milly – responded positively to the suggestion of a bibliotherapy group, others such as Olivia and Nathan felt that a bibliotherapy group intervention would not be appropriate for them. Olivia responded that; *'I actually think that I'm almost less inclined to join a reading group if I'm feeling mentally fragile, because I want to be able to choose what I'm able to read at this time.'* She connected her reservations to her desire to avoid emotional literature; *if we had to read out a passage in which somebody died distressingly or something, I think I would probably feel worse, having it read out and then having to unpick it with a whole lot of other people and all the time maintain some kind of social façade.'* Nathan had slightly different reasons for rejecting the idea of a bibliotherapy group (though, as discussed in section 6.3 he was not averse to the idea of a reading group); *'I think it'd be difficult to access the group for people who are depressed, because I would think everyone would be depressed, and it would be very depressing.'* Olivia and Nathan's comments can be considered in the

context of current models of bibliotherapy, presenting some of the reasons why people might not engage with bibliotherapy groups.

Participants' views on the value of recommended booklists were varied. As will be discussed in section 5.3.5, while Serena could see the need for professionals to identify high-quality resources, other participants like Winston could not see a role for booklists. Although the public library service in Smithville operated a BoP-type scheme, mainly focused around the independent use of self-help literature without recommendation by a medical professional, the majority of those interviewed in Smithville had not heard of the scheme. I asked Louis, who had borrowed two of the recommended self-help titles after seeing publicity for this project (rather than library-led publicity) if he felt that this meant the library should do more to promote the scheme. He replied that:

> *'it's not really something that you'd want to have in your face… it's a difficult one, because the first step is always a confrontation – admitting to yourself that you might benefit from one of these books. So if you've got a big display or a poster in your face then I guess the temptation is to turn on your heel and run away because you don't want to actually confront that. You've got to be ready for it.'*

His view of the need for a gentle approach to self-help – rather than overt promotion – requires further discussion in conjunction with the academic literature about bibliotherapy which often does not investigate methods of access to the texts.

Summary

There were varied reasons for joining a bibliotherapy group and group members were diverse. The benefits of membership of a bibliotherapy group, according to participants in the research, were:

- Reading diverse literature, including:
    - A sense of achievement from reading the texts
    - Learning, including accessing new perspectives and having their world view challenged
    - Enjoyment of reading different titles
- Social interaction, with the facilitator as well as group members
- A positive impact on mental health, including:
    - Relaxation
    - Time away from other responsibilities
    - Relief from stress

The facilitator needed both an interest in literature, and people management skills. The facilitator also had a number of roles in the group, including:

- Selection of literature
- Resolution and mediation of disputes
- Recruitment of members
- Encouraging members to contribute to the discussion
- Promoting enjoyment of reading and literature.

However, some participants had reservations about joining bibliotherapy schemes, including concerns about the content of the literature, the composition of group membership, and use of booklists to recommend titles. Personal circumstances and a need to be ready to accept help were also important.

5.3.4 Interaction with the public library

During their interviews, participants were asked about their use of the public library, to contextualise their use of bibliotherapy. Six participants spoke about visits to the library as being beneficial to their mental health, regardless of whether they borrowed books on their visit. Participants also reflected on their membership of reading groups. These findings are presented here demonstrate some of the ways that people with mental health problems interact with the public library as an institution. While not strictly concerned with the experience of bibliotherapy, they focus on some aspects of the public library service that might contribute to the success or failure of a bibliotherapy intervention. Billington *et al*'s (2010) study, which examined the environment in which therapeutic reading groups took place, specified that a non-medical environment contributed more than a medical one such as a doctors' surgery, which is reinforced by the findings presented here.

While some participants were regular library users, visiting once or twice a week, many had not regularly used libraries for a significant proportion of their adult life. Several were attracted back to the library by financial constraints; Connor, for example, could not currently work because of his mental health problems; Julia had accepted a lower-paid, part-time job as her previous employment was contributing to her depression; and Louis's relationship breakdown also left him struggling financially. All three had begun to use the public library again because of these life circumstances. As Connor observed; '*I'd always bought books, and now I can't afford to buy books at all. My budget's very limited, so I started using the library again. And I think they're important, libraries are.*'

Milly observed that public library policies were not always helpful for people with mental health problems; *'I'm really bad at taking books back to the library. And if I'm low, I'm particularly bad at it. Because it's just like something that you've got to do and you know you ought to do it, and if it's hard to get out anyway – you know.'* Milly commented that because of these fines for overdue books, she often found it more cost-effective to buy second hand books. As discussed in section 2.2.4, some public libraries are recognising these challenges to access and taking steps to rectify them. Nevertheless, Milly was still one of the participants who discussed finding a benefit in visiting the public library, despite not always borrowing books from it, as discussed in the following section.

5.3.4.1 The public library as space and place

Connor, Nathan, Milly, Amelia, Julia and Silas all shared a common experience in terms of their library use and mental health. All viewed the library as a positive, welcoming environment in which they felt secure. As Connor remarked; *'I like going into libraries. They aren't necessarily quiet places anymore, but I feel comfortable just going in there and spending time in there.'* The use of the public library as a calming space was also important to Julia, who used the library to escape from the stresses of the outside world. When asked if she used libraries, she began to talk about what she used libraries for, then paused and stated; *'I might just go in.'* She continued;

> *'I might just go in with one of my own books. Because it's quiet. Once I was having a bad time at work, I used to go in around lunchtime because it would be busy in town and then you'd walk through the doors and you'd go into whichever bit and just go – quiet.'*

Julia's statement that she '*might just go in*' rather than going to the library to use a specific service exemplifies the environmental factors that people felt were of benefit in terms of their use of the public library as a space.

Perceptions of quietness in the library were a contentious issue for some participants. While Connor was happy to experience the library as a space that could not be expected to be as quiet as it perhaps used to be, Amelia felt that this was not a positive development. She commented that *'I think they are getting too noisy. They've got bloody seats, with coffee in Smithville South West library now, and when I'm in a state of hypersensitivity, I need to be somewhere very quiet, tranquil. It seems people are going in for a chat now.'* Silas commented on the changing use of

the library, though instead of seeing the increased provision of refreshments as negative, he viewed it as a positive trend, making the library a welcoming place. He observed that in his local library, Smithville East, *'there's that nice seating area. There's the cafeteria, which does really nice food, and there's computers you can use.'* Nevertheless, Silas was very clear that these features were not the only attractions of the public library;

> *'if you said to me what's the benefit of going to the library, certainly at Smithville East – that's the only one I go to – it's that calm, relaxed atmosphere in there. It's the atmosphere I find very therapeutic. A tranquil atmosphere without it being dead and you can get yourself comfortable.'*

Participants found the public library particularly welcoming as a space if they were feeling depressed or unhappy. For Amelia, libraries were *'a real place of sanctuary and really helpful on the recovery process.'* Nathan found tha*t it was a place he could go even when the rest of his life felt overwhelming;* 'the library has certainly been a good space to visit because it felt there was something there worth going to, and people were friendly and open. I hadn't realised, perhaps, how beneficial it had been.' Milly felt that the library was an accessible space throughout her depressive episodes; *'I love going into the public library, if I'm feeling low. It's like it embraces you, it's so peaceful. And to be surrounded by books and people who are there for books, it's very, very soothing, I find.'* These comments reveal that many people who participated in this research had a positive relationship with their local public library. As some of the debates about bibliotherapy are concerned with providing access to books, and ensuring a suitable location for bibliotherapy groups, these views on the public library as a calming and welcoming space provide evidence of the role that the public library might play.

5.3.4.2 Reading groups

This section considers participants' experiences with public library reading groups, considering them to be separate and distinct from bibliotherapy groups. In Smithville, the only bibliotherapy group was run at the Smithville North library, and as it was already well subscribed, it was not widely promoted in the library service. Participants who lived in Smithville were thus not widely aware of its existence or aims. Several participants instead attended a reading group of their own choosing either connected to, or independent of, the public library service. Four of the participants from Smithville – out of the twelve participants who were not members of a bibliotherapy group – mentioned that they were, or had been, members of a reading group. Two others, Nathan and Silas, expressed an interest in joining a

group. Ralph had also been a member of an NHS psychiatric outpatient group, who read a self-help book as part of their group experience.

Milly had joined a reading group with the aim of meeting more people locally, but was clear that books played a role in her decision; *'it's quite good to have the book there. Instead of just making conversation, you've got the book as an intermediary.'* Her comment recognises the importance of reading as reason for joining the group and highlights the role of the text as mediator, as in comments made by bibliotherapy group participants. Ralph and Connor's experience of being a reading group member mirrored those of people in bibliotherapy groups. Both talked of the benefits they felt they got from being challenged to read books they would not normally read. The reading group of which Ralph was a member took it in turns to nominate a book to read, and he identified this as a factor that made the group interesting as the books chosen reflected people's personalities and interests; *'the other thing is being challenged by reading things I wouldn't necessarily have chosen, and that's a really enjoyable aspect. Having insight into other people's personal little thought space, and what moves them.'*

Connor discussed the importance of the reading group to him when he was experiencing an episode of depression; *'at one point it was a significant date in my diary. I wasn't getting out much, and I wasn't doing a great deal, so that was good.'* Connor was clear that there were two aspects of reading that meant it was of great benefit to him when he was feeling low, and he felt that the reading group provided both these aspects; *'it helps with the concentration. And there's a social dimension to it as part of the reading group.'* Julia had recently joined a reading group, and her motive for doing so echoed the reasons for therapeutic reading that she expressed in the rest of her interview, namely finding escapism in reading; *'it's not terribly highbrow, or over the top. We just talk a bit about how we feel about the characters or the storyline or whatever. But it's quite relaxed, it's quite nice.'*

Nathan felt that the environment in which a reading group was conducted was very important. He had found his local library reading group to be off-putting because it was openly visible rather than in a more private space;

> *'one of the things that has put me off book groups... has been because they happen in the centre of the library and there's a sense that everyone's listening. I find that rather oppressive. It's not a safe space to explore anything in any depth – or even to disclose anything particular, because you don't know who's standing behind you.'*

The relevance of Nathan's comments to the analysis of experiences of bibliotherapy in this thesis is evident; the location of a group meeting is an integral part of the atmosphere of the group, and impacts on people's participation in the groups. Despite Nathan's reservations about the practicalities of his local reading group, he still wished to partake in the experience; *'when I was starting to feel a bit better, I would have enjoyed going to a book group. Actually, I'd still enjoy going to a book group.'*

Two of the reading groups mentioned were not directly connected to the public library, though Ralph did mention that he often borrowed the titles suggested from the library, rather than purchasing them. The reading group Connor attended was based in his local public library; and Julia's reading group borrowed reading group sets from the public library, but held their meetings elsewhere.[20] For these participants, the motivation to attend a reading group appears similar to the reasons for attending a bibliotherapy group discussed by other participants in the research. Thus, their comments may have relevance for assessing the appropriateness of current models, as participants in this research have sought out a group reading environment even where one with a direct therapeutic benefit is not available.

5.3.4.3 Interaction with public library staff
McKenna *et al* (2010) observe the importance of the interaction between librarian and user of a bibliotherapy scheme; the quality of this relationship was an unexpected factor that affected the subsequent engagement with the bibliotherapy scheme, including whether or not the service user borrowed or read the text. For these reasons, I also explored interaction between people with mental health problems and public librarians, thinking about whether a positive or negative interaction would have an effect on the experience of bibliotherapy. As considered in section 5.3.2, Olivia and Louis discussed their interaction with staff when considering their experience of borrowing self-help texts and the stigma attached to having mental health problems.

Connor stated that his relationship with staff in his local public library, Smithville East, was also very positive; *'I have a very good relationship with the staff who work in the library. There's a couple of members of staff there who are aware what my condition is, and have on occasions recommended things. They know the things that*

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[20] From Julia's comments, although she herself did not drink alcohol, this was so other members were able to do so.

I like, and have recommended books.' Nevertheless, recent staffing changes had lessened the opportunity for this staff interaction; *'they have re-structured, there have been big staffing changes and there's less time for that personal contact.'* Silas also had encountered friendly and helpful staff at the same library. In our interview, he produced a book from his bag which he was currently reading, stating that:

> *the librarian found this for me. I was reading another one on CBT which isn't so good. And she said to me, have you seen the other book on the shelf? And I said well, I couldn't find any others. And then she got this from another library for me.'*

Many participants told short anecdotes of specific examples where they felt the library staff had gone out of their way to assist – ordering books from stores or other libraries; locating titles on similar subjects; and being friendly and helpful. Olivia, a regular library user, was particularly fond of the staff at her local library [Smithville West]; *'I know that they're incredibly friendly and nice people.'* While this was the experience of most participants asked about interaction with library staff, both Nathan and Winston had a different story to tell.

Nathan stated that he had not *'identified the librarians as people to ask for advice'* about books on depression or other subjects. He thought that this was partly to do with the structure of the library, in which there was one central service point to deal with all enquiries; *'to actually feel confident asking, when people are queuing up, giving books in, you don't want to say can you recommend any Russian novels? Because that would feel like you were taking up their time.'* Nathan's previous experience with public library staff also contributed to this impression of inapproachability;

> *'I did once or twice order things. There was a slight sense of 'I have to write a postcard out as well, you know' from the librarian. A sense you're pushing a bit here. Too busy to help. 'You get all the books for free and you want to order something?' If I wasn't quite a confident person, I would just never gone back.'*

While Nathan did usually borrow books from his local library, Smithville South, and the Smithville Central library, both of which are two of the busiest libraries in Smithville, the negative attitudes Nathan felt he encountered would have impacted on any attempt to include the public library as part of a therapeutic experience.

Winston felt that his experiences with the staff in Smithville West library were not positive. When asked about his recruitment to the project, he discussed the way that he had taken my email address from the poster in the library and entered it directly into his smart phone so he could email straight away, resulting in him standing in the

entrance to the library near the posters for a longer amount of time; *'I think they thought I was trying to steal something – but that's Smithville West library.'* Evidence of Winston's view that library staff looked on him with suspicion and did not value his membership of the library was present throughout his interview, with him mentioning that library staff gave him *'a filthy look'* and feeling that *'somebody immediately suspects you of being up to no good.'* Winston was very clear that this was partly, again, due to the way in which Smithville West library was structured – it was an older building that struggled to incorporate the requirements of modern library usage – but also because he found staff attitudes to be lacking in friendliness. This clearly impacted on both Winston's current library use, and the potential interaction he might have with a bibliotherapy scheme located in a public library setting. Having assessed the role of the public library for people with mental health problems, this chapter concludes by addressing questions about what participants in the research understood about the concept of bibliotherapy itself

5.3.5 Concepts of bibliotherapy

Throughout the interviews, I asked participants if they had heard the term 'bibliotherapy' before, and what they understood by it. Not all participants had heard of bibliotherapy, but most of them were able to give a definition. Some participants, like Connor, instead turned the question back to me, then agreed with the short outline of the subject that I gave. Others, like Ralph and Louis, professed no prior knowledge, but thought that the word itself clarified its own meaning, with Louis declaring that; *'it's self-explanatory really, biblio being book and therapy being therapy, therapy through books – it's getting advice from a book.'* Ralph had not encountered the term before, but thought; *'you could work out what it meant pretty quickly.'*

Some participants had a developed sense of the meaning of bibliotherapy, including Olivia, who defined bibliotherapy as;

> '*the use of books to assist people with health problems, but perhaps more specifically with mild to moderate mental health problems. It can be self-help books or it can be reading fiction, which might be slightly formalised through a reading group or it could be the beneficial effect of reading fiction in general. Not just fiction, but narrative things and poetry.'*

However, as I recorded in my field notes about Olivia, her background meant that *'some of her comments are from the perspective of an informed bystander'* and so her definition should not necessarily be seen as a typical understanding of the term.

Nathan had heard of bibliotherapy, but his experiences with depression led him to revise his views on it. He had heard the term on a programme on Radio Four; *'it was people sending in problems to the programme, saying 'I've been dumped. Is there anything I can read to cheer me up?' With a focus on reading about people with similar problems.'* When reflecting on his own experiences with depression, he commented that: *'I couldn't read things that were too hot.'* His use of *'hot'* refers to books that he felt were too close to his own experiences; he felt unable to read about depression, even self-help books focused on alleviating symptoms. He came to the conclusion that; *'these people on the radio – initially, I was thinking you should just read about being dumped. But then I came to realise that actually, you can't quite do that if you're feeling really miserable.'* His perception that people with mental health problems could not always read about solving their problems, or people with similar experiences to themselves, is a key concept for this thesis.

Amelia and Serena interpreted the term bibliotherapy differently from other participants. They talked of bibliotherapy as having an informative focus, using books to educate themselves about their conditions and treatment. As Amelia remarked; *'I do set myself [tasks]; right I'll look into this area, and learn about this subject. It's a quest for knowledge and understanding.'* Serena felt that there were benefits to looking outside received wisdom about depression to gain understanding of ways of coping with the condition; *'the books help me open up my mental horizons, in not just thinking oh, there's one way to deal with depression. There's a lot of different perspectives out there, so it's helping me explore those perspectives.'*

Milly contrasted an institutional definition of bibliotherapy presented by mental health services with her personal understanding, questioning the texts that could be included within the definition. Her daughter also had mental health problems, and her treatment providers; *'gave us a sheet and it was a list of self-help books.'* While Milly included the titles on the booklist within her understanding of bibliotherapy, she also felt;

> *'I would not necessarily understand it to only mean that, because it's not just information books that are helpful, it would also be all kinds of fiction, and poetry, and plays. So I don't know how the term is used technically, but if I was using it myself, I would use it to refer to any book that can make you feel better.'*

Concepts of bibliotherapy as including any text that a person found useful when they were experiencing distress fitted in with Winston's definition of bibliotherapy; *'I*

expand it really; it's in the eye of the beholder.' Winston – despite his self-described status as a *'layperson'* – presented me with a detailed definition of bibliotherapy. He commented that; *'my understanding of it is using books, short stories, either on your own or with the help of a therapist, to gain some insight into your mental, emotional state. Maybe get some inspiration, motivation, therapy from the actual use of the books themselves.'* Winston was concerned with the complexities of bibliotherapy, in which the notion of prescribing or recommending titles may not always be the correct approach; *'I've seen lists of books. And I'm looking through them and I think yeah, I could see how that could work for me – oh god, that wouldn't work for me at all.'* The eclectic collection of titles discussed by Winston[21] as therapeutic does support his notion that to recommend – at least in terms of fiction – may not be appropriate in every case.

Serena, on the other hand, felt that there may be some benefits to booklists of recommended titles. She felt she had well-developed information-seeking skills and could discern high-quality self-help books from lower-quality titles. However, she recognised that not everyone would be able to locate high-quality resources, and thought a booklist might be helpful; *'bibliotherapy might be really useful for that, because then you can pick some really good [self-help books] for people. Because there are so many that are so generic. But then you find some really good ones, and it's worth the search.'*

While some participants were certain that specific titles were of importance for them personally, others had a different experience of bibliotherapy. For these participants – including Alfie, Connor, and Henry, it was not the text, but the physical act of reading itself that was important. As Connor stated; *'I don't think there's any book and I've read it and thought 'well, that's had a massive impact.' I think it's more to do with the process of reading, rather than particular books.'* This form of bibliotherapy was explored in more detail in section 5.3.1.1. Other participants, whose concept of bibliotherapy focused on their experience of the group-based model and social interaction, were discussed in sections 5.3.3 and 5.3.4.2.

To summarise, bibliotherapy was variously understood as:
- an individual emotional connection with a work of imaginative literature
- the use of the act of reading as a distraction or the reading of escapist literature to help manage mental health problems

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[21] See appendix seven, table nine.

- the social discussion of texts in a group environment
- a quest for self-education and understanding about mental health problems.

While some participants recognised the potential value of being recommended titles, others felt that the personal nature of literature meant that it could only ever be an individual journey to find titles that resonated with them. Some participants' understanding of bibliotherapy included more than one model, as shown in table 6.9. For example Vivienne found comfort in her individual connection with some titles, and also attended a bibliotherapy group which she found of benefit to her well-being. This idea that participants use more than one type of bibliotherapy is a key concept for this study, and analysis shows that different people used different forms of bibliotherapy throughout their recovery. These individual uses of bibliotherapy are presented in table 5.9.

Table 5.9: Models of bibliotherapy and participants using each model

Model of bibliotherapy	*Participants using this model of bibliotherapy*
Individual emotional connection with a work of imaginative literature [emotive bibliotherapy]	Julia, Milly, Nathan, Olivia, Ralph, Silas, Vivienne, Winston
Use of the act of reading as distraction and escapism [escapist bibliotherapy]	Alfie, Amelia, Connor, Henry, Julia, Nathan, Olivia, Ralph, Serena, Silas
Social discussion of texts [social bibliotherapy]	Ajeet, April, Beatrice, Courtney, Douglas, Ethel, Grace, Henry, Isaac, Lucas, Mya, Rodney, Virginia, Vivienne, Walter
Self-education and understanding [informational bibliotherapy]	Amelia, Louis, Milly, Olivia, Ralph, Serena, Silas

These emergent models will be taken forward and further discussed in chapter six, considering their practical application and relationship with current models and understandings of bibliotherapy.

5.4 Concluding remarks

In this chapter presenting the findings of the interview and observation study, a number of significant themes about the experience of bibliotherapy have been introduced. Bibliotherapy can be experienced individually or in a group; it can be focused on an empathetic response to a text or on information gathering and learning; it can be experienced via a personal connection to specific titles, or through the process of reading itself. Texts could be used to either confront or avoid difficult emotions, and to either provide comfort and familiarity, or to think about new perspectives and challenge existing thinking. The life circumstances and

experiences of symptoms of mental health problems also affected peoples' choice of texts. Bibliotherapy was experienced on a very personal level, though some participants had found value in being recommended titles, especially in terms of self-help texts. The outcome of an interaction between a person and a text was difficult to predict, as people do not read texts *de novo*. Symptoms of mental health problems also affected interaction with the text, on an emotional and practical level. However, this interaction between person and text is the key therapeutic component of the idea of bibliotherapy.

The experience of bibliotherapy is also affected by other contextual factors, including the use of the public library as a space and a service provider, and in the case of bibliotherapy groups, the social interaction between group members and the facilitator in the group. Participants often used more than one model of bibliotherapy as a form of support. The final word in this chapter goes to one of the research participants; Winston, who summarised the benefits of bibliotherapy to him with his statement that '*over the years, the underlying support and help has actually come much more from books than medication. I think I've had much more benefit from a well-stocked library than a well-stocked pharmacy.*'

Chapter Six: Discussion

6.1 Introduction

Chapter six collates the main findings from the two preceding chapters, contextualising them in the established literature on bibliotherapy. It will highlight the diverse understandings and uses of bibliotherapy, particularly focusing on the differences between current models and the definitions from the interview and observation studies. Building on concepts in Law's (2002) work, the chapter will contrast the design of current bibliotherapy schemes (chapter four) with the lived experience of using bibliotherapy (chapter five), exploring the complexities of both. This will address the gaps in the evidence base established as key to this study, in chapter one. Chapter six is organised around a number of themes that bring together the principal concepts from both findings chapters and relate them to the literature on bibliotherapy. The key findings presented in section 6.2 will also be explored in relation to one participant's interview narrative, with the aim of presenting a more holistic approach to analysis and maintaining a commitment to ensuring that the research participants recognise their own experiences in the analysis. Finally, the relationship between previous and emergent models of bibliotherapy will be discussed.

6.2 Key findings

These key findings aim to answer the research questions defined in section 1.2, investigating how people with mental health problems use reading as therapy; how the three main models of bibliotherapy in the UK operate; and the relationship between the operation of bibliotherapy schemes and the use of reading as therapy by people with mental health problems. In introduction to this section, the key findings and their relationship to previous chapters are outlined as follows: building on work conducted for the literature review and confirmed in analysis presented in chapter five, common outcomes are found in investigations of reading as therapy. As shown in chapter four, current models of bibliotherapy were designed in response to national agendas, and bibliotherapy schemes are based on localised understandings. Expanding on data about participants presented in section 5.2, it is clear that participants who use bibliotherapy are highly diverse. Developing the findings from the interview study discussed in section 5.3: symptoms of mental health problems impact on the reading experience; the use of bibliotherapy is related to the personal situation of the reader; the role of recommending specific titles is called into question by these findings and the public library has a role to play in

maintaining mental health. Four understandings of bibliotherapy emerged from discussions with research participants. These four understandings are:

- Readers have a personal connection with literature
- The act of reading itself is important, and readers often use literature as a form of escapism
- Bibliotherapy can have social benefits when operated in a group model
- Bibliotherapy can be used to provide information and self-help

Each of these findings will now be addressed in turn.

6.2.1 Common outcomes are found in investigations of reading as therapy

The use of reading as a form of individual therapy has a defined history, and several outcomes have been found in previous research including self-recognition in texts, and empathy (Cohen, 1992b; Gold, 1990; Rubin, 1978a; Rubin, 1978b; Shrodes, 1949). My findings confirm those of previous studies on therapeutic reading, but locate these findings in a current context and relate them to schemes operating in the UK. Updating previous studies is a key concern in the sphere of bibliotherapy, as the major analyses of bibliotherapy regarded as relevant for this study were written between twenty and sixty years ago.

Section 2.2 outlined the long and varied history of bibliotherapy, clarifying that throughout this history there have been some similar findings recorded about the outcomes of bibliotherapy focused around gaining insight, understanding and emotional clarity. The first empirical thesis on the subject, itself building on reader response theory, concluded that 'bibliotherapy may thus be defined as a process of dynamic interaction between the personality of the reader and literature' (Shrodes, 1949: 33). This Freudian study defined bibliotherapy as interaction with imaginative literature, rather than non-fiction, and identified the four main outcomes of undertaking bibliotherapy as identification, projection, catharsis, and insight (Shrodes, 1949). Rubin's (1978b) synthesis of research conducted between the 1950s and the mid-1970s examined the evolution of these concepts and the role of self-help and non-fiction. Rubin's (1978a; 1978b) work concluded that the role of bibliotherapy was to provide information, re-socialisation, insight, and behavioural change.

Cohen's (1992b) phenomenological study did not specifically address questions of mental health, but focused on the lived experience of using reading as a coping strategy. In her thesis, she reflected on her struggle to avoid using the terms

identification, projection, catharsis and insight coined by Shrodes (1949) to describe her findings (Cohen, 1992b). Cohen's (1992b) reflections on this struggle reinforce the idea that there are common themes and outcomes of investigation into therapeutic reading. A more quantitatively-based study would refer to this as the replication of previous findings. As explored in section 2.2.3, Cohen's (1992b) categories defining the benefits of bibliotherapy expand and clarify the different aspects of the use of reading; her work also confirms concepts found in Rubin's (1978a) synthesis of research. Gold's (1990) work exploring literature as a form of therapy, while not based directly on empirical study, also validates a number of factors identified in Cohen's (1992b) work, including catharsis, identification and information. Thus, it is clear that some recurrent themes connect previous theoretical and empirical research on bibliotherapy. These recurrent concepts can also be seen in the empirical research conducted for this study, with similar themes again emerging. For example, interview participant Winston's comments in section 5.3.1.1.2 referring to a text as an *'intellectual gymnasium'* directly mirror Shrodes' (1949: 136) view of literature having the potential to be a 'mental gymnasium.'[22]

Concepts emerging from this research can be related to Gold's (1990: 346-354) ten key characteristics of the use of reading in the psychotherapeutic process, discussed in section 2.2.3. For example, Alfie and Connor used reading as a form of language growth. Various participants used reading to gather life information, identify, articulate, and normalise their emotions. Gold's (1990) concept of sharing in reading can also be seen to be an outcome of the process of social bibliotherapy defined in section 6.2.9. Little evidence was found of participants using reading to model their own behaviour or to directly solve problems, but participants including Mya, Grace, and Isaac referred to changing their understanding based on their reading, which is the basis of Gold's (1990) concept of cognitive shift. However, Gold's (1990) work centred on an engagement with emotions, both positive and negative, which differs from the findings presented here. As analysed in section 5.3.1.4, participants did not always engage with emotions via their reading, and instead they used literature to escape from negative experiences. Thus, while there was some overlap between Gold's (1990) categories and the findings of this study, novel findings also emerged.

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[22] I am making a presumption here that Winston has not read Shrodes' (1949) work. The age of the work, its publication in America and limited availability in the UK (via microfilm from the British Library) suggest that the thesis has not been widely read, though the main concepts from the thesis have been disseminated in later literature.

Categories of analysis explored in chapter five include the role of reading in providing catharsis, information, empathy, and self-identification. The independent choice of similar terminology to Gold (1990), Cohen (1992), and Shrodes (1949) helps to locate this study within the context of previous research on the subject, confirming the idea of the commonality of some key findings.[23] Nevertheless, there are significant differences between this work and the context of previous studies. Past work has not examined the use of public library-based bibliotherapy schemes aimed at alleviating symptoms of mental health; and Gold (1990), Cohen (1992b), Rubin (1978b), and Shrodes (1949) were based in the USA rather than the UK. The impact of new technologies – including cCBT and e-readers – was also not a concern for previous research, and thus issues such as the role of the medium of accessing the literature have not been considered in detail. Several key findings from this study – such as the use of the act of reading itself rather than the content of the literature as a method for maintaining mental health, and the role of the public library as a space and place – have also not previously been explored in studies of bibliotherapy. Thus, one of the strengths of this research is its relationship with previous literature on bibliotherapy and mental health, which both confirms findings shared throughout the history of bibliotherapeutic studies, and differentiates them from previous findings by relating concepts identified here to a critical engagement with current UK models of bibliotherapy. The focus of sections 6.2.2 and 6.2.3 will be to highlight this critical engagement in relation to the data presented on BoP, RAYS and GIR.

6.2.2 Current models of bibliotherapy were designed in response to national agendas

Chapter four explored the emergence of three current models of bibliotherapy, and highlighted several strategic drivers to the creation of these schemes. Bibliotherapy schemes were formed in response to NHS and public library aims and policies, and this trend was discussed in section 2.2.5, assessing the wider contextual role of bibliotherapy in health care. RAYS, for example, was designed following a successful bid to the DCMS Wolfson Fund, and as considered in section 4.3.4, was allocated mainstream library funding in response to the national well-being agenda. Similarly, BoP took influence from guidance provided by NICE and NHS documents such as *Better Information, Better Choices, Better Health* (DH, 2004; NICE, 2004d).

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[23] I first read Gold's (1990) work in 2007; Shrodes' (1949) thesis in April 2009, and Cohen's (1992) thesis in December 2010, having conducted my initial data analysis in September – October 2010. Their work was thus not at the forefront of my mind as I worked with my data, and coding categories were produced in response to the data, without reference to the literature.

Interviews with those involved in providing bibliotherapy services stressed the impact of wider governmental agendas on service provision. Participants S-1 and S-4 both discussed the link between their respective schemes and government policy. The need to provide evidence-based mental health information and treatment and the rise of the well-being agenda were both discussed as important factors. However, as was considered in previous research, wider policy initiatives – such as the effect of NHS restructuring on partnership working – can also be detrimental (Brewster, 2007). These concerns are directly relevant to the role of the public library in providing these services, as they emphasise the manner in which service provision can be affected by factors other than the requirements of library users.

The implementation of these schemes in response to government and health policy complicates their effectiveness. While they are designed to fulfil wider agendas, this does not necessarily allow them to be responsive to the needs of people with mental health problems, who may benefit from using the bibliotherapy service. Relating this to the aims of Denzin's (2001) Interpretive Interactionist approach, it is therefore not evident if these schemes meet the needs of those using the services. There has been little in-depth evaluation of the use of bibliotherapy schemes in the UK, despite their rapid proliferation throughout the country. The need for independent critical investigation has been discussed and developed throughout this thesis. Changes in governmental policy, such as the growing importance of the well-being agenda, also impact on the direction of service provision. Chapter four showed that the outcomes of service provision are shaped by a number of factors, rather than just being an evidence-based process. This finding is important for those interested in policy studies, addressing questions about the appropriate application of the evidence base to policy formation.

The differences between the three current models of bibliotherapy – BoP, RAYS, and GIR – demonstrate that national agendas can be interpreted and adapted according to the aims of service providers. Despite the role of national policy in shaping the emergence of bibliotherapy schemes in the UK, the schemes themselves often differ in their response, producing highly local understandings which will be explored in the following section.

6.2.3 Bibliotherapy schemes are based on localised understandings

As considered in Juntti *et al* (2009), while policy often dictates service provision, practical experience can also dominate and produce localised understandings of policy. Chapter four outlined the three main models of bibliotherapy and within these three models, there is little agreement as to the type of intervention required – self-help or creative – or the elements necessary to facilitate this intervention. Variations include the role of the group environment, group facilitator, medical professional, and the role of the text. Individual interpretations, shaped by different actors, impact on the application of the model. For example, the divergence in the use of the RAYS model in Kirklees and Calderdale, as discussed in section 4.3.2, demonstrates that the models of bibliotherapy alter depending on those involved in running the schemes. Observations of a number of groups run in accordance with one model, such as those in Jonesfield, also established that there can be variation in response to group members. Thus, in some schemes, there is the opportunity for service user feedback and for schemes to be responsive to the needs of their users. This finding is key, as it demonstrates that it is possible for models of bibliotherapy to be adapted to meet the needs of service users, however, this does rely on having a clear picture of these service user needs.

While BoP has been nationalised in Wales, there is no national strategy for bibliotherapy in the UK, and this also leads to localised understandings and uses of this model, discussed in detail in Hicks *et al* (2006; 2010) and Brewster (2007). Over one hundred local authorities run a bibliotherapy scheme, but these vary tremendously (Frude, 2008). Examples of the elements that may vary include: the books provided within the scheme; administration of the scheme; role of partnership working; engagement with medical professionals. A lack of evaluation means that these variations are not always in response to service user feedback, but may alter because of other external pressures. However, variation may also be taken as evidence that some schemes are responsive to service user needs – for example, libraries in the metropolitan borough of Tameside (2011) now provide shorter titles with lower reading ages, online, DVD and audio resources and self-help books in community languages. As explored in chapter four, the RAYS model also altered in response to the needs of those using the service.

This section has further contextualised bibliotherapy schemes, observing that there is little agreement from service providers about how to facilitate a successful intervention. Adequate mechanisms for gathering in-depth service user feedback

would impact on assessing the appropriate elements of each scheme. While the aims of the schemes may be similar, their application in practice may differ. As discussed in section 2.2.4, Hicks *et al* (2010) regard this diversity of service provision as a 'postcode lottery' and consider the need for national bibliotherapy standards. However, the need for localised understandings and adaptable models, responsive to the needs of those who use bibliotherapy schemes has been addressed in chapters four and five. The following section addresses one of the reasons that these localised understandings may be valuable.

6.2.4 Participants who use bibliotherapy are highly diverse

Participants in this research who use bibliotherapy to help them manage their mental health problems – either via a public library-based scheme or independently – are diverse in terms of age, gender, socio-economic background, previous reading habits, severity of symptoms of mental health problems, diagnosis, and previous life experiences. The point at which they use bibliotherapy (or the timing of the intervention) and the texts they consider therapeutic also varied. This finding runs counter to a previous survey of bibliotherapy conducted by Hicks (2006), which concluded that bibliotherapy had a narrow audience. Diversity of audience is particularly relevant when considering if services meet the needs of service users, as this finding suggests that there will need to be different services to meet different people's needs.

In this thesis, the continuum of diagnoses of mental health problems ranged from people with recent diagnoses of mild depression to those who had experienced schizophrenia for most of their adult life, and also included people who had experienced symptoms of mental health problems in response to a significant event in their life, such as bereavement. The range of experiences and symptoms provides evidence that the benefits of bibliotherapy are not just limited to those with mild to moderate mental health problems as is theorised in clinical literature and current models (Grundy, 2005). The evolution of the RAYS model – which initially aimed to focus on mild conditions and now offers group interventions to people with more severe mental health problems – also offers evidence of the range of mental health problems that may benefit from bibliotherapeutic interventions (*Book chat comes to Enfield Down*, 2010). As highlighted in chapter two, there have been few trials of bibliotherapy for more severe mental health problems, mainly because of concerns about risk management. Work conducted for this study confirms that people with more enduring mental health problems find personal benefit and enjoyment in taking

part in creative bibliotherapy schemes. Billington *et al's* (2010) recent study also reached similar conclusions.

Participants used bibliotherapy at various points in their experience of mental health problems. Bibliotherapy was used to maintain good mental health by people managing long-term conditions, such as Lucas and Ethel; and as a more acute form of treatment by recently diagnosed people, including Silas and Louis. The different times at which participants found bibliotherapy to be a useful intervention supports research explored in section 2.2.2 about the use of self-help while awaiting further treatment, and will also contribute to the next section, discussing the impact of symptoms of mental health problems on the reading experience. Participants also used bibliotherapy differently as their life circumstances altered. Vivienne, for example, talked about the changing nature of her use of literature as she recovered from the impact of a bereavement.[24] This finding is also linked to those discussed in section 6.2.11, relating the use of bibliotherapy to the personal situation of the reader.

Previous research found that bibliotherapy schemes were mainly used by middle aged, female, middle class, white participants (Hicks, 2006). The remainder of this section will consider the demographic characteristics of participants in this research. Firstly, the participants in this study were more diverse in terms of age, ranging from those in their early 20s to their mid-90s. While many participants were in their 40s and 50s, bibliotherapy still appealed to people at different stages of their life. Research concludes that older adults are at a higher risk of mental health problems, and the experiences of bibliotherapy group members Henry and Grace confirm that retirement can be a difficult time of life for people, alleviated in part by joining a bibliotherapy group (Choi and Morrow-Howell, 2007). The experiences of participants, for example Louis, Serena and Olivia (all in their late 20s and early 30s) showed that younger adults can also find benefit in therapeutic reading.

In terms of gender, 61% of those who took part in observations and interviews were female, which could in part be explained by the phenomena examined in section 2.3.4, looking at the effect of gender on the likelihood of a diagnosis of mental health problems. However, the gender balance of participants who were interviewed differed, with men accounting for 52%. The majority of these men came forward

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[24] See appendix two.

independently rather than from a bibliotherapy group. Further research is needed into male use of independent therapeutic reading to ascertain if this is a preferred model.

As explored in section 5.2, the socio-economic diversity of participants was high, suggesting that the use of bibliotherapy schemes has altered since Hicks' (2006) work. While Friedli (2009) concludes that such socio-economic inequalities affect access to services, with those lower down the socio-economic scale less likely to use mental health services, this was not a finding of this research. For example, all of the groups I attended ran during the working day, positioning them as groups for people who were retired or not in regular employment. Many participants who were not in regular employment were unable to work for health reasons, with long-term physical health problems as well as mental health problems. Long-term physical health problems and the experience of mental health problems can be connected (NICE, 2009).

There was little ethnic diversity among participants in this research, with the majority of interview and group participants identified as white. Again, this suggests that further research needs to be done to ascertain the reasons that people from BME communities might not engage with library-based bibliotherapy schemes. As discussed in section 2.3.3, this may be because of cultural taboos regarding mental health problems, though further investigation is required. Previous interaction with mental health services also affects interaction with bibliotherapy schemes. Amelia, for example, listed a number of negative experiences with mental health services that led her to conclude that any interaction she was prepared to have with formal bibliotherapy schemes would need to be mediated by the public library, rather than community mental health or medical services.

As discussed in section 5.3.3.2, previous reading habits – including the inability to read because of mental health or other problems – did not have an impact on participation in bibliotherapy groups. The experience of participants like Silas shows that those who had not previously been in the habit of reading regularly still used and benefited from bibliotherapy. However, it is likely that previous reading habits may impact on the use of independent therapeutic reading for some participants in this research, and without formal library-based schemes, those who were disinclined or

unable to read – such as Ethel or Violet[25] – would not participate. Inability to read while experiencing symptoms of mental health problems will be the subject of the next section of this chapter.

6.2.5 Symptoms of mental health problems impact on the reading experience

Many participants who contributed to this research found that while they were experiencing symptoms of mental health problems, their reading habits were affected. Problems with concentration – recognised as a symptom of mental health problems such as depression – were discussed and meant that some participants were unable to read at all. Six participants in interviews mentioned a total loss of the ability to read as they experienced symptoms of mental health problems. A reduced ability to concentrate was a short-term problem for some participants, such as Nathan and Serena, but was experienced on a long-term basis by participants such as Ethel. The inability to read was a source of frustration for Ethel, who had previously enjoyed reading as a leisure activity. An inability to read when experiencing symptoms of depression has not previously been discussed in the literature on bibliotherapy. As discussed in section 5.3.1.1.1, an inability to read when experiencing symptoms of mental health problems can contribute to a lack of interaction with texts. This inability to read may be linked to high non-completion and attrition rates previously encountered in clinical trials of self-help bibliotherapy.

Symptoms of mental health problems have an impact on the provision of bibliotherapy schemes, as they mean that the application of these schemes needs to be carefully considered in relation to users. The inability to read while people are 'in crisis' or experiencing acute symptoms suggests that bibliotherapy might not be an ideal form of support. However, the five participants who were initially unable to read at all did feel that reading was an important part of the recovery process once this initial acute phase was concluded. As discussed in section 5.3.1, for some participants while the desire to read did not alter while they were experiencing symptoms of their mental health problem, but the subject of their reading did change. Nathan and Olivia both spoke in detail about the different types of books they were able to read while they were depressed.

Nevertheless, when considering the use of bibliotherapy during periods of acute distress or crisis, the experiences of Beatrice should be discussed. Beatrice felt her engagement with the Taylorbridge scheme was essential during her depressive

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[25] See appendix two.

episode[26] which provides evidence that bibliotherapy may be useful for some people at this stage in their recovery. While she spoke of crying throughout the first meeting she attended, her membership of the group was obviously of benefit to her, as she chose to travel a long distance to participate. Similarly, Olivia's discussion of an occasion when, while experiencing debilitating symptoms of depression, she found that individual reading was the only activity that she could undertake to alleviate her symptoms should be taken into account. While Olivia professed a reluctance to undertake a formal creative bibliotherapy intervention while she was severely depressed, stating that she would prefer to control her own choice of literature, her reliance on independent therapeutic reading demonstrates that it can play a role for some people at times of acute distress. Building on this initial discussion of the differing uses of bibliotherapy, the following sections of this chapter address these varied uses in more detail.

6.2.6 Four emergent understandings of bibliotherapy

Section 5.3.5 introduced four understandings of the use of bibliotherapy – emotive, escapist, informational, and social – which emerged from discussions with research participants. While chapter four examined current models of bibliotherapy (BoP, RAYS and GIR) and concluded that these models are closely tied to the type of literature (CBT-based self-help, diverse fiction and poetry, and the literary canon respectively) used within the schemes, chapter five examined uses of bibliotherapy by people with mental health problems, and determined that the use of bibliotherapy can be seen as outcome-based, rather than focused on a specific type of literature. Participants were seeking (either consciously or subconsciously) an identifiable outcome, and used a variety of literature to achieve this. Outcomes included information, understanding, relief, distraction, social support, catharsis, advice, relaxation, empathy, self-validation and escapism. These emergent understandings of bibliotherapy build on previously understood descriptions of bibliotherapy (e.g. self-help, creative), and the aim of this section will be to explore current models of bibliotherapy and relate the design of these models to the lived experience of using bibliotherapy. It will also try to summarise which aspects of the reading experience were found to be helpful and therapeutic for different participants.

The definition of four emerging understandings of bibliotherapy is a shaping framework, used to organise participants' diverse experiences. These emergent understandings are based on the interviews and observations conducted for this

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[26] See appendix two.

study; further emergent understandings of bibliotherapy may be used by people with mental health problems who did not participate in this research. As will be discussed later in this chapter, the use of bibliotherapy is highly personal. These concepts are thus not an exhaustive list of possible uses, but they do reflect experiences of participants. These emergent understandings of bibliotherapy also overlap and texts can provide both an emotional connection and information, for example. Social bibliotherapy in particular can be escapist or emotive. Participants used different forms of bibliotherapy at different points, as will be shown in detail in section 6.3.

The value of these novel concepts is reinforced by their relationship to previous studies, replicating findings discussed in section 6.2.1. User-led concepts are very important for health services; Rogers et al (2004: 45) conclude that 'greater success in implementing self-help schemes is likely if understandings elicited from patients… are incorporated into the design and implementation of such interventions.' The remainder of this section comprises of figure 6.1, exploring the relationship between text and reader, and a brief definition of each emergent understanding of bibliotherapy. These emergent understandings will then be presented in relation to participant experiences.

Four emergent types of bibliotherapy

Emotive bibliotherapy

Personal experiences impact on reading. Individual meaning established

Clarification and comprehension formulated in dialogue with reader
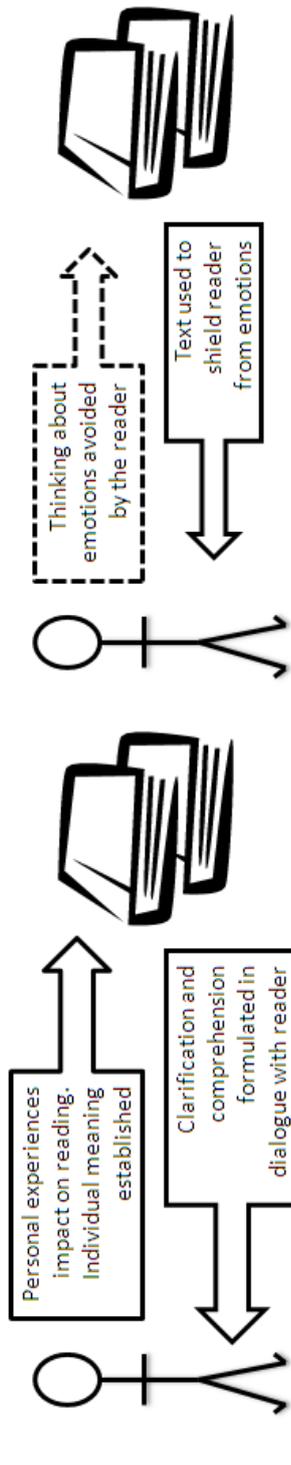
Outcome of reading: Engagement with emotions (e.g. catharsis), self-understanding and learning.

Escapist bibliotherapy

Thinking about emotions avoided by the reader

Text used to shield reader from emotions

Outcome of reading: Avoidance of symptoms/ feelings to manage symptoms.

Informational bibliotherapy

Transmission of information from text to reader

Personal experiences of reader will impact on reading but may not be acknowledged
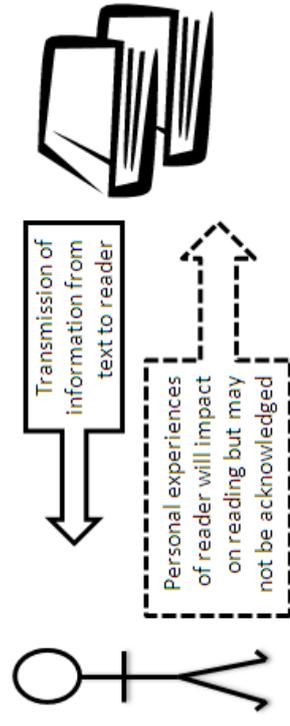
Outcome of reading: Self-understanding and learning.

Social bibliotherapy

Relationship between group members, facilitator and reader

Personal experiences of reader may impact on reading of text

Text can be used to avoid or engage with emotions
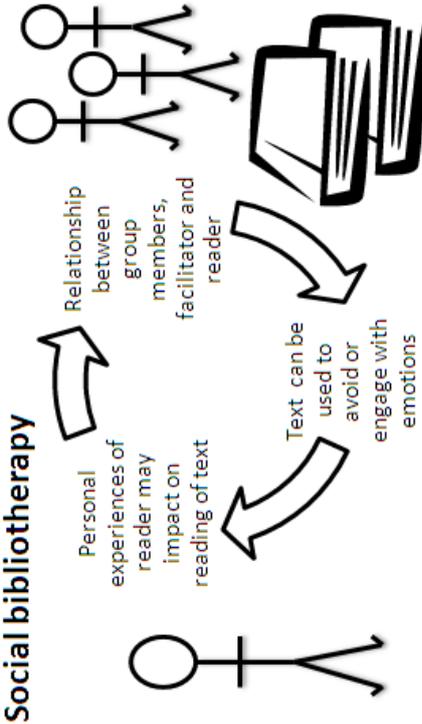
Outcome of reading: Social relationships, engagement with texts to facilitate emotions or escapism.

Key: ———— Transmission of information/ emotion

- - - - - - Information/ emotion that could be shared but is not.

Figure 6.1: Four emergent types of bibliotherapy

Emotive bibliotherapy

The establishment of an individual emotional connection with a work of literature, providing catharsis, validation of emotions, understanding of a personal situation, empathy, and self-identification. This emotional connection can provide insight and information, though it is differentiated from informational bibliotherapy. Information is encountered serendipitously in emotive bibliotherapy, rather than as part of the purposeful information seeking that forms the basis of informational bibliotherapy. Fiction or imaginative literature is usually read in emotive bibliotherapy, but non-fiction texts including those concerned with mental health are also considered by readers to be emotive texts with personal resonance. In-depth discussion of the findings on which this concept is based can be found in sections 5.3.1.3 and 5.3.3.2.

Escapist bibliotherapy

The use of the act of reading to provide distraction, manage mental health problems, provide relaxation and avoid the symptoms of mental health problems. This process can be passive or active, depending on the experience of symptoms at the time of reading. For some readers, the content is highly important, and only certain genres can be read; for others, the genre of content is irrelevant. Participants in this research often identified the value of escapist bibliotherapy in hindsight, rather than it being purposefully sought. Findings from the interview and observation studies which contributed to the formation of the concept of escapist bibliotherapy are discussed in detail in section 5.3.1.4.

Social bibliotherapy

This form of bibliotherapy can be seen in reading groups and bibliotherapy schemes such as RAYS and GIR. The interrelationship between the text, group members, and group facilitator is very important, as was explored in sections 5.3.3 and 5.3.4.2. Mental health is not typically the focus of the bibliotherapy group, though life experiences are often discussed. Beresford *et al*'s (2010: 18) research with mental health service users confirms the importance of such groups, finding that it is important that community groups are not solely focused on mental health. Social bibliotherapy can be used to provide either emotional connection with literature or escapism. The personal nature of the relationship between the reader and literature means that both emotional and escapist bibliotherapy may be experienced by different group members reading the same text at the same time.

Informational bibliotherapy

The use of reading to inform oneself about a mental health problem or life situation. As discussed above, this may have some crossover with emotive bibliotherapy. Participants who used this form of bibliotherapy felt that it was concerned with education about mental health, treatment and self-management. Included in this type of bibliotherapy is the idea of using self-help materials as a form of therapy. Section 5.3.1.5 explored the use of reading for information in relation to participants' experiences.

Returning to considerations of all four proposed models, and as was first discussed in section 5.3.5, readers do not just use one type of bibliotherapy, and while the four types are separated here for clarity, they can be considered to be interlinked and overlapping. The presentation of Nathan's varied use of bibliotherapy in section 6.3 contributes to this idea and presents an example of how bibliotherapy may fit into the life of a person with mental health problems. Participants in this research moved between these four concepts of bibliotherapy, finding different resources to be useful at different times. These outcome-based models are used in response to personal needs, and identification of this finding is vital to understanding the relationship between these models and current bibliotherapy schemes. While participants move between different uses of therapeutic reading, bibliotherapy schemes remain static, responding to the public presentation of one issue rather than reacting flexibly to different needs.

These emergent understandings of bibliotherapy can be related to the constructs of mental health discussed in part two of the literature review. Debates centred on concerns about the nature of psychiatric diagnosis, with a blurred line between distress and disorder are particularly relevant. While the biomedical model of mental health stresses the need to medically intervene, the social model recognises that there is a need to accept mental health problems as reflective of poor living conditions, and such treatments are not required. The psychological model of mental health problems locates the problem in the individual, and recommends talking therapies to improve life skills and understanding, while the holistic model encompasses each of the previously described models and focuses on treating the whole person and improving well-being. As can be seen from these brief explanations of the four types of bibliotherapy, all types of bibliotherapy can predominantly be seen as holistic – or at least socio-psychological. Bibliotherapy is first and foremost a non-medical intervention and those who subscribe to the theory

of mental health problems as illnesses requiring medication would not accept its validity as a treatment or social support. Emotive bibliotherapy, with its emphasis on emotional engagement, focuses more on providing psychological support, but the overall outcome is to improve well-being. Similarly, the aim of using escapist bibliotherapy to improve and maintain mental health is also socio-psychological.

Social bibliotherapy, with its focus on improving well-being via facilitated social interaction and engagement with the text aims to accept mental health problems as something to be managed rather than treated, and so can be seen to mirror the social model of mental health in some respects. While informational bibliotherapy can be seen as a psychological therapy, its wide use by participants reveals that it can also provide information on the social aspects of mental health problems, and to dispute biomedical constructions of mental health. Informational bibliotherapy emerges from the biomedical illness-cure model of health, but is used more broadly by participants to formulate a holistic understanding. Building on this introduction to the emergent concepts, the four types of bibliotherapy will now be discussed in turn.

6.2.7 Emergent understandings: Emotive bibliotherapy

The majority of interactions with literature discussed in interviews were informal, personal ones not facilitated by a formal scheme. Julia, for example, spoke in detail about a work of fiction that she had read independently and felt had had an impact on her life. As can be seen in appendix seven, the body of literature discussed by participants was a diverse one. Outcomes of reading specific texts are highly personal and difficult to predict. In this research, outcomes discussed included a sense of validation, identification, and a connection with the literature. Readers engaged with texts on an emotional level and these texts were used to increase understanding and learn from experiences.

Participants in the research discussed both the unique, personal connection that they found when reading literature and the importance of the universal or recognisable emotions that they experienced as an outcome of reading the text. The recognition of familiar emotions was seen as a validation of personal experiences and, as seen in section 5.3.1.3.2, encountering these experiences and emotions in the text provided reassurance and decreased loneliness. As considered in section 5.3.1.3, literature was often used to process difficult emotions. A significant proportion of this use of literature was centred on self-identification and empathy with characters.

Accordingly, there were two strands to some participants' narratives, with texts providing highly personal connections and validating universal emotions experienced by all. An internal contradiction can therefore be seen in the interview narratives analysed. While it is the personal connection that is important to those using texts as a form of bibliotherapy, it is also the universality of emotions, and the knowledge that other people have experienced them, that provides this connection. For example, Vivienne spoke about recognising her own personal experiences in literature, but felt that the power of this recognition lay in the realisation that it was not just her experience, and that others understood her emotions.

Thus, the use of reading to provide an individual emotional connection with imaginative literature is a two-way relationship, in which personal experiences shape understandings of the text, and the text can provide a validation of emotions experienced. The use of reading for cathartic purposes, and the recognition of personal emotions in the texts can be seen as consciousness changing – increasing understanding and heightening awareness of both the readers' own emotions, and their relationship with the world. Such emotional engagement relates to Nell's (1988) construction of type B readers, discussed in section 2.2.3, in which participants read to heighten consciousness and engage with emotions.

To summarise, the identification of personal experiences in the text was important to participants and can be seen as one of the purposes of reading. It was difficult to predict if an emotional connection between the text and the reader would be established, and this often depended on the life experiences of the reader and those described in the text. Emotional engagement with a specific title was seen as a key benefit by a number of participants, and could be encountered either as part of the individual reading experience, or as part of a reading group.

6.2.8 Emergent understandings: Escapist bibliotherapy

Some participants did not use literature to engage with their emotions, but instead found a different use of reading as a method of maintaining mental health. Specific titles were not always important in this instance, but the act of reading itself was seen to be of great benefit. Participants also used this process of reading as a form of escapism, reading titles unconnected with mental health to cope with unmanageable emotions. Three genres of literature were identified as particularly important forms of escapism for participants: children's fiction, narrative non-fiction

and crime genre fiction. Participants including Milly, Amelia and Ralph used reading in this way to distract them from symptoms of mental health problems. For some participants it was very important to control what was read and to avoid literature that might have had an emotional impact reflective of their own lives. Olivia and Nathan read escapist fiction to avoid unmanageable emotions during a period of acute distress. The use of literature to avoid consciousness of emotions maps onto Nell's concept of type A readers as discussed in 2.2.3.

For some participants, the focus is on the process of reading itself, rather than engagement with any specific titles, as discussed by Connor in section 5.3.1. Alfie's use of *The Pickwick Papers* as a text to distract him from unwelcome emotions provides an example of this use of reading as a coping strategy. Connor and Henry presented a narrative in which the act of reading was used on a more long-term basis to manage mental health and maintain an equilibrium, rather than to deal with an acute episode of depression or unmanageable emotion. This focus on the act of reading itself was important for some participants and can be said to be a form of escapism, specifically avoiding unwanted emotions. The use of the act of reading (differentiated from, but related to, the reading of escapist literature) to manage mental health problems was a phenomenon not previously discussed in the literature about bibliotherapy, or in previous research including the pilot study for this research. This may be because previous research focuses on discussion with public library and health care staff rather than library users.

Louis and Nathan both felt there was a point at which their focus on escapist literature could take them no further, and that there was a need to re-engage with the issues at hand, suggesting that escapism may not always be a long-term solution. As previously discussed, reading experiences may change depending on the situation, again making it difficult to predict when each type of bibliotherapy may be the most appropriate course of action for a reader.

Reading as a form of escapism and distraction is acknowledged in current models of creative bibliotherapy. Publicity materials promoting the RAYS scheme highlight notions of relaxation and escapism via literature. Escapism is not necessarily seen as a negative outcome in either creative bibliotherapy scheme, which posit relaxation as beneficial to mental health. Indeed, while the GIR model aims to engage people with more challenging literature, this is still with the aim of facilitating an escape from daily life. The narrative of getting 'caught up' in a good story is important to both

models. Reading as a form of distraction also shares some similarities with initial (circa 1920s) concepts of bibliotherapy discussed in section 2.2.1. The use of reading as a formally applied distraction therapy originated in the early days of bibliotherapy and used literature in a hospital setting with patients unable to leave hospital wards (Coomaraswamy, 1975; Peterson-Delaney, 1938). Both RAYS and GIR workers provide reading groups for patients in secure mental hospitals, providing a link with previous incarnations of institutional bibliotherapy.

Throughout this discussion of the use of the act of reading as a coping strategy for people with mental health problems, it is clear that there are significant differences in comparison with self-help models of bibliotherapy. The effectiveness of self-help bibliotherapy rests in close reading of the content of the literature, aiming to change behaviour and provide practical information about coping with mental health problems. However, as is seen here, the use of the act of reading itself can be used to manage acute symptoms or maintain mental health on a longer-term basis. Olivia and Nathan's experiences show that some participants were unable to cope with informational content about mental health and depression at times of distress. Nathan's comments about non-fiction texts about depression being '*too hot'* to read demonstrate that for some people – at some stages during their depression – self-help bibliotherapy is not an appropriate treatment and escapism may be more suitable. However, Olivia's use of various self-help titles at other points in her life demonstrates that this is not necessarily a long-term disengagement with informational or intense content.

In summary, escapist bibliotherapy can be used in response to an acute episode of symptoms of mental health problems, to provide distraction or relief; or as a longer-term strategy to provide relaxation and reduce stress. For some participants, the content of the literature read is important. It must not be too challenging or stimulating but still needs to be engaging and have a strong narrative. For other participants, the content of the literature was less important (although strong narratives were still preferred), and the act of reading was more important than specific titles.

6.2.9 Emergent understandings: Social bibliotherapy

Little research has been conducted about bibliotherapy in the group environment. While Cohen (1989) theorised that group interaction might be an effective option, she did not have the opportunity to test this in practice. The findings presented here

suggest that a combination of the group facilitator, text and group environment all contribute to the success of social bibliotherapy; research published after analysis conducted for this study supports these conclusions (Billington *et al*, 2010). Various benefits were seen by participants including increased relaxation, and maintaining and improving mental health. The interaction with literature in a social bibliotherapy group can be either emotionally engaging or escapist, though it is difficult to predict how group members will react to a piece of literature. The group dynamic will also impact on the reaction to literature.

The social discussion of texts in a group environment forms the basis of current models of creative bibliotherapy in the UK. As was seen in section 5.2, and in discussion of RAYS and GIR in chapter four, a number of slightly different models operate, but similar aims and outcomes can be seen in the case of each model. Group discussion can appeal to readers who want to heighten their consciousness of the world, introducing them to new perspectives in line with Nell's (1988) view of type B readers, or to type A readers who wish to avoid emotional engagement and escape into the world of literature. Again, this is dependent on the individual reader. While the participants in this research who engaged with formal creative bibliotherapy schemes mainly sought new experiences and used the group to interact with literature on this basis – specifically mentioned by Isaac, Mya and Vivienne amongst others – at other times, participants used literature to distract themselves. Beatrice, for example, appreciated the group as 'somewhere to go' when she was in crisis. The escapist experience of the group, mentioned by Mya in section 5.3.3.1.2, was also seen as a beneficial element of engaging with literature, even when group members were encouraged to use this engagement to reflect on their own experiences. It is clear that listening to the experiences of others can be used to both heighten consciousness and think about events in a new light, and to distract oneself from one's own experiences, avoiding consciousness of unmanageable emotions. As was discussed in detail in section 5.3.3, the literature, group facilitator and social environment of the group all interacted to provide a therapeutic experience. Based on this evidence, and comparison of observations of the Williamstown and Smithville North groups when the group facilitators were and were not in attendance, it is clear that creative group bibliotherapy relied on all three elements.

Reading groups in public libraries, particularly in geographic locations in which there was not a creative bibliotherapy scheme, were used as a form of social bibliotherapy

by some participants, as examined in section 5.3.4.2. Connor and Ralph, for example, both highlighted similar themes of social benefit in their narratives as those discussed by participants using formal bibliotherapy schemes. Milly highlighted the importance of using literature as an intermediary, observing that there was definite value to joining a reading group as opposed to a group connected with her other interests. However, all the participants who had not engaged with a formal bibliotherapy scheme discussed more traditional reading groups, in which a novel was taken away and read individually over the course of a month before being discussed in the group. As shown in section 5.3.1.1.1, this model may not be appropriate for all participants in the research, with mental health problems often having an impact on people's ability to concentrate on a text.

In summary, social bibliotherapy can be emotionally engaging or escapist. The role of the group facilitator is to mediate this engagement with literature, and to introduce readers to new texts which they may not previously have encountered. The group facilitator also manages the relationship between group members, ensuring everyone feels confident enough to contribute. Literature is also a key part of the group, and group members value its use.

6.2.10 Emergent understandings: Informational bibliotherapy

The outcomes of using informational bibliotherapy have previously been investigated from a quantitative perspective. Findings from RCTs examining CBT-based bibliotherapy suggest that the intervention is effective, but struggle to ascertain which elements are necessary for successful treatment, as explored in section 2.2.2. Section 6.2.3, which addresses the local application of national health policies also concludes that there is little agreement. The qualitative research presented for this thesis suggests that while informational bibliotherapy can be effective for some people, some caveats are necessary. The current basis in a prescription model, the focus of the scheme on CBT titles, and concerns about the titles recommended including their accessibility may limit the effectiveness of current use of informational bibliotherapy. In particular, the role of prescription requires further investigation as a factor impacting on effectiveness, as few participants had been 'prescribed' books per se (though recommendations from medical professionals were mentioned).

Section 2.2.2 of the literature review outlined a number of perceived uses of informational bibliotherapy developed from RCTs testing the effectiveness of bibliotherapy. These perceived uses can be mapped onto some personal

understandings and lived experiences of bibliotherapy, specifically those presented in section 5.3.1.5 which related to the use of reading for information and using self-help books as a form of therapy. For example, Louis' comments about the accessibility of self-help books in relation to the cost of face-to-face therapy are widely echoed in the literature on informational bibliotherapy, discussing its cost-effectiveness as an intervention (Bower *et al*, 2001; Frude, 2004a; NICE, 2004c). Louis used self-help literature while on a waiting list for face-to-face therapy and his usage reflects White's (1995: 90) conclusions about the role of bibliotherapy in offering help to those on waiting lists. Similarly, Serena's use of self-help to complement face-to-face therapy relates to a recognition of the role of bibliotherapy as an adjunct to therapy (Floyd, 2003).

Comparison can also be made between the views of those concerned with implementing BoP, and those using self-help texts. Comments from interview participant S-1 – a central figure in instigating the original BoP scheme in Wales – constructed the figure of the ideal patient, positioning the recipient of a self-help bibliotherapy prescription as someone who was comfortable following a gardening manual, recipe or car repair handbook. Informational bibliotherapy is positioned here as a one-way transmission of information, rather than an interrelationship between reader and text. The reader is expected to be able to utilise the techniques in the book and adapt them to any situation within their life.

S-1's view that the user of the bibliotherapy scheme should take personal responsibility and follow instructions can be favourably compared with Louis's use of self-help books. While Louis had not formally used the local self-help scheme, he had self-prescribed books using the recommended list. In section 5.3.1.5.2, examining the accessibility of self-help therapies, Louis was a proponent of taking individual responsibility, using self-help texts for learning and changing behaviour. He felt that the do-it-yourself approach had a number of advantages, including cost and an encouragement to self-reliance. Thus, Louis's self-construction of his use of bibliotherapy mapped onto the ideal patient described by participant S-1.

There was, however, one key difference between Louis's use of bibliotherapy and S-1's construction; the role of the medical professional as mediator between reader and text. While Louis used CBT-based books from the local prescription list, he personally selected the ones he felt would be most appropriate for him, and chose to read one book rather than another on a similar subject. Thus, the role of the

recommendation of titles in the self-help bibliotherapy scheme is brought into question. Indeed, Olivia's experiences of being recommended a title by a medical professional can also be seen to raise questions about the use of prescription as a key element of the BoP model. As was seen in section 5.3.1.5.1, Olivia referred to one title as a *'misdiagnosis'* by a medical professional. This will be further discussed in section 6.2.12.

Some comments by participants in the research contradict commonly accepted research on using bibliotherapy to provide information and self-help. For example, Alfie's recognition that using self-help texts requires motivation and concentration is not directly addressed in literature on the subject. While the academic literature acknowledges that more successful trials of self-help are conducted with volunteers rather than the general clinical population, the reasons for this are not addressed (Cuijpers, 1997; Fanner and Urquhart, 2008; Favazza, 1966). Recent research into the reading ages of popular self-help titles also refer to concerns about literacy and the accessibility of titles (Martinez *et al*, 2008). Revisions to some self-help bibliotherapy booklists aim to rectify this issue (Tameside Metropolitan Borough Council and NHS Tameside and Glossop, 2011). Informational bibliotherapy is also seen to have a high acceptability as a treatment amongst patients (Frude, 2004a). Vivienne and Connor's comments contradict this, as they would prefer either engagement with a wider corpus of imaginative literature, or a face-to-face approach to therapy. They thus rejected self-help books as a solution to their problems.

Serena, Amelia and Ralph did not feel that the current schemes using CBT-based books would be comprehensive. In their view, the quest for self-education needed to be broadened to include information that engaged with other therapeutic techniques, for example mindfulness. These participants also read and recommended numerous texts that presented the case against the biomedical model. The ethics of recommending these texts in a prescription model requires consideration, as the quality and content of these books varies immensely. Controversies about the biomedical model and concerns about the use of medication for mental health are also important to consider in relation to the health service; it is unlikely that doctors would feel comfortable recommending titles that dispute their authority (Greenberg, 2010).

Research presented in this thesis shows that participants use fiction to provide information about coping with emotional situations, as well as the more commonly

accepted model of using self-help literature to provide information. There are similarities between the demonstrable effect that an emotional connection with literature may have on self-knowledge and management of mental health problems (as discussed in section 6.2.7) and the use of information to improve knowledge and mental health. Information may be encountered serendipitously, as discussed in the work of Sheldrick-Ross (1999), Erdelez (1999) and Toyne and Usherwood (2001). Both fiction and non-fiction texts can be used to provide information and increase insight. Examples of the self-prescription of texts, access to informational resources outside of the CBT model, and the use of fiction and non-fiction to locate information thought to be helpful can all be considered to be forms of informational bibliotherapy.

To summarise, informational bibliotherapy provides access to information and therapeutic techniques that may not otherwise be easily available. Texts used were diverse, and not limited to the CBT-based titles on BoP booklists. While informational bibliotherapy was used by a number of participants, few had used BoP schemes, and the concept of 'prescribing' books was problematised by comments from participants who felt that successfully recommending titles was not possible. Sections 6.2.11 and 6.2.12 review this idea in further detail, addressing whether it is appropriate to recommend book titles in bibliotherapy schemes.

6.2.11 The use of bibliotherapy is related to the personal situation of the reader

Building on analysis in previous sections of this chapter, there are diverse and distinct ways in which bibliotherapy can be used and understood. Participants used different models of bibliotherapy depending on their symptoms, mood, ability to read and other factors previously discussed. As will be explored in section 6.3, participants did not just use one form of bibliotherapy to maintain or improve their mental health – they used different methods of bibliotherapy throughout their experience of mental health problems. Julia, for example, used emotive and escapist bibliotherapy throughout her life. Nathan's experiences, discussed in section 6.3, demonstrate that research participants were often unclear in their own minds about the type of bibliotherapy they felt they needed to access. Nathan's initial attempts to seek information were unsuccessful, and his use of escapist literature provided an unexpectedly positive outcome for him. The outcomes of bibliotherapy are highly personal and thus difficult to predict.

Considering the relationship between bibliotherapy schemes and specific titles, this thesis demonstrates that successful interaction with a text cannot be easily

predicted. The diverse nature of the reading populace means that a great variety of titles will resonate with people. While the interviews and observations highlighted several titles on which participants agreed, there is no universal trend towards a particular book being right for a person as a therapeutic resource. The variety of texts – and uses of these texts – are notable findings in light of the current operation of bibliotherapy schemes in the UK. Schemes which focus on self-help lists or literary canon-based provision of materials may limit access to titles outside of these oeuvres. Developing this concept of the highly personal nature of bibliotherapy, the next section looks in more detail about the relationship between the reader and current models of bibliotherapy, questioning the role of recommending specific titles.

6.2.12 The recommendation of specific titles is called into question

Current models of bibliotherapy are usually based on the recommendation of either fiction or self-help book titles. The success of book recommendations is complicated by the findings explored above, which examine the individual nature of the connection between literature and the reader and the diversity of participants. As is illustrated by figure 6.1, the reading experience may be considered a form of dialogue between text and reader. Rosenblatt's (1970) work, previously discussed in section 2.2.3, suggests that the reader creates their own meaning in the text and considers reading as a highly personal interaction. Further investigation on this subject is required, addressing the factors that facilitate or prevent a successful book recommendation. Participants in the research felt that it was an individual connection between their experiences in life and their reading of fiction that was important. This connection was highly personal, and could not easily be prescribed or facilitated. Participants talked of recommending books to friends, both successfully and unsuccessfully; again this interaction was difficult to predict, as explored in section 5.3.1.2.

This finding suggests that the recommendation of fiction and poetry in social bibliotherapy could often be unsuccessful, because facilitating a rewarding emotional connection with imaginative literature is difficult. Different people will not necessarily find the same texts to be useful, even if they have similar experiences. The role of the facilitator in the group situation places an additional step between reader and text, which may affect engagement. The skills required to facilitate a successful bibliotherapy recommendation have not been explored in any depth, though they were mentioned in Brewster (2007). Recommendations that come from a specific booklist are particularly likely to be problematic, as the list will be more limited than

the wider corpus of literature in general. Thus, the personal connection between reader and text may be lost.

However, the role of the facilitator is to provide access to literature that would not otherwise be read by the individual. Their role, suggesting possible titles of interest to the potential reader, can be less prescriptive and the reader may agree a title in discussion with the facilitator. Some participants felt that they enjoyed the challenge of reading texts that didn't appeal to them, and which they would not have chosen. Participants in the Smithville North group repeatedly mentioned the desire to move out of their comfort zone, and often did encounter literature with which they had an emotional connection because of recommendations. Further to this idea of providing facilitated access to literature, concepts found in the reading experience including universality, self-recognition and empathy – discussed in 6.4.3 – imply that to a certain extent, predicting the outcome of interaction is achievable.

The relevance of recommending book titles rests on the idea of whether the outcome of an interaction with literature is predictable, and this thesis has established that these outcomes are not predictable. GIR focuses on the literary canon and aims to facilitate access to timeless, classic texts that may not otherwise have been read by group members. The GIR model emphasises the achievement and self-improvement connected with reading literature, and presumes that the literature which is regarded as classic will contain the universality that sustains a personal emotional connection. GIR's ethos and choice of literature has parallels with Winston's ideas about important books being those that *'say something to each generation.'* For Winston, however, the role of the recommendation was still complicated by the personal nature of this connection with literature. Winston was adamant that there was very little point in recommending titles to people, despite his belief in the timeless nature of some literature.

The GIR model is in conflict with comments presented in section 5.3.1.2, which suggest that the act of reading is about making a personal choice to read a text and enjoying the freedom to read anything. The awareness that a text can be rejected – as discussed in Winston's dislike of *To Kill A Mockingbird* – is also important, as there needs to be space for an awareness that high regard from academics does not always correspond with enjoyment. Similarly, the rejection of modern genre fiction in the GIR model does not mean it will not appeal to some people; as Vivienne's comment *'every book's got something to give you'* shows. Implied in this statement is

a connection with Nell (1988) and Gold's (1990) observations about types of literature, concluding that readers may experience an emotional connection with any literature – from genre (or 'trash') fiction to that regarded as classic. As can be seen in appendix seven, while classic authors and texts were mentioned by participants, so too were authors regarded as modern genre fiction. For example, Alfie professed to enjoy authors as diverse as Albert Camus, Ben Elton and P.D. James. Thus, for some readers, the type of literature used to facilitate an emotional connection could be more varied than that prescribed within the GIR model.

Those facilitating access to literature in RAYS recognised this diversity, which can be seen in the use of literature in RAYS groups. Informal group observation conducted during my previous research project found that the literature used in one meeting ranged from the Quick Read title *Reading My Arse!* by Ricky Tomlinson to the poems of Raymond Carver (Brewster, 2007). The list of suggested starting points for creative bibliotherapy provided in the RAYS bibliotherapy toolkit also reinforces these ideas (Duffy *et al*, 2009). Thus, the RAYS model recognises that the emotional connections that people can find life-changing can emerge from a variety of sources.

Questioning the role of recommending specific titles also has implications for current models of self-help bibliotherapy. Olivia's view that she had been *'misdiagnosed'* and offered an inappropriate title demonstrates that the recommendation of self-help titles is not straightforward. The complicated nature of providing recommendations for literature implies that locating a helpful therapeutic non-fiction text may be difficult, as reactions to texts are difficult to predict. As considered in section 5.3.1.3, feelings experienced during interaction with imaginative literature, including empathy, self-identification, and validation can also be experienced when reading self-help texts – Louis's use of these texts provides an example. Comments by Milly, Vivienne, Winston, and Nathan – in which they used non-fiction autobiographical materials to establish an emotional connection that then facilitated further self-understanding – suggest that there is scope to investigate this topic further.

In summary, the role of recommending book titles in trying to facilitate successful bibliotherapeutic interaction is complicated by the findings presented in this thesis, including the personal interaction between reader and text, and the diversity of research participants and their experiences. While some participants saw value in directing people with mental health problems to appropriate titles, and enjoyed the challenge of reading titles they would not typically choose via a creative bibliotherapy

group, the model of prescribing a text to perform a specific role in a specific situation with a defined outcome is brought into question. Therefore, there may be a need to alter current models of bibliotherapy to make them more responsive to the needs of those using the schemes, and to think about the role of recommending titles. Building on these ideas about responsiveness to needs, the following section will show that there are further roles for the public library to play in the maintenance and treatment of mental health.

6.2.13 The public library has a role to play in maintaining mental health

Findings presented in section 5.3.4 show that the public library has a wider role to play in maintaining mental health, building on its current role as a recommender and supplier of books. Acknowledging this role is key to understanding how and why people with mental health problems use sources of support outside of traditional medical care. The public library is used by people with mental health problems to cope with their symptoms. Various factors affect this engagement with the public library, many of which were considered in the body of research discussed in section 2.2.4. Providing access to a wide variety of literature – including fiction, non-fiction, self-help, and poetry – is a key aspect of the library service that is valued by participants. The public library facilitates independent therapeutic reading, enabling participants to gain access to resources they would otherwise have been unable to read, mainly for reasons of cost.

As was explored in section 5.3.4, interaction with the public library did not just relate to the provision of books. Narratives of the use of the public library as a calming space or sanctuary were repeated throughout the interviews. The positive interaction with the library as a space as well as a service emphasises that the public library can be more than just a provider of books for people with mental health problems. Provision of a calming, welcoming, non-commercial, community space may help people to maintain good mental health. Black's (2011) study, combined with the findings of Rooney-Browne and McMenemy (2010), confirm this concept for all types of users which can be extrapolated to include mental health service users. Dowrick *et al*'s (2008) work on developing mental resilience by finding strength in ordinary activities also supports these ideas of the informal benefits of the public library. However, these perceived benefits are difficult to quantify.

All of those recruited to the project were familiar with the routines and procedures of the public library, though some participants now used the library less because it did

not meet their access needs. As discussed in section 2.2.4, Grundy's (2005) research examined the impact of unfamiliarity with the routines of the library (e.g., opening hours, fines and borrowing periods), finding that this could have an impact on accessibility of the library for people with mental health problems. Milly's comments about the difficulty she had managing fines and returning books when she felt depressed contribute to the idea that the library may not be considered to be an accessible space for all. Nevertheless, within the scope of this project, it was not possible to access further participants who were less familiar with the routines of the library to explore this finding in more detail.

Other positive factors regarding interaction with the public library were identified in this research and suggest that there may be benefits to providing bibliotherapy schemes in the public library rather than in other locations. Again, this is supported by Billington *et al*'s (2010) work. For example, locating services in the public library can be seen as a positive development, moving mental health services away from an overtly biomedical construction and aiding the de-stigmatization of mental health problems in the community. Participant S-1's construct of depression as the *'common cold'* of emotional problems, to be treated in the public library (viewed in the role of a pharmacy) rather than the doctor's surgery reinforces this notion. However, Louis and Olivia's comments – as presented in section 5.3.2 – demonstrate that stigma can still create a barrier to access.

The public library's broader role – of connecting a diverse audience with a range of literature – demonstrates its potential to support bibliotherapy as defined here. Library work including outreach schemes, improving literacy, and reader development may enable people to find the support they need to use informal therapeutic reading as well as to access bibliotherapy schemes. Experiences discussed in section 5.3.4 highlight some of the positive interactions with the public library and could be used as evidence for how the library could focus on providing services for people with mental health problems. They also emphasised some of the negative experiences that need to be avoided. As previously highlighted, the library could expand its provision of recommended booklists and recent wider role in bibliotherapy schemes, reflecting a wider engagement with literature and informational materials. However, this may depend on the needs of service users, and the skills of staff.

Considerations of health and well-being – including the expectations of treatment, hope and the association with a recognised supportive environment – are harnessed by the formalisation of bibliotherapy in a recognised scheme, and thus contribute to this discussion of the role of the public library (Pennebaker, 2003). While those who already access the library can appreciate the benefits of therapeutic reading without necessarily engaging with a formal scheme, people who were previously disengaged from reading felt able to participate in bibliotherapy groups. For example, Ethel's inability to concentrate on novels had meant that she had lost a leisure activity she enjoyed, but her reading and writing of poetry had enabled her to still use the printed word as a source of support, and had encouraged her to try listening to audiobooks, also borrowed from the public library. Similarly, Violet's use of the Smithville reading group (reported in appendix two), and Rodney, Isaac and Courtney's interaction with their respective bibliotherapy groups, facilitated access to literature that would not have been achieved independently. Thus, the public library has a role to play in this facilitated access to literature via bibliotherapy schemes, as well as providing a welcoming space and a selection of resources.

Summary

Section 6.2 has presented the main findings from the thesis, relating the current models of bibliotherapy used in the public library to emergent service user understandings. It has concluded that, while current bibliotherapy models have strengths, there is a need to address questions of how and why participants are using bibliotherapy to ensure that interactions are successful. Building on this discussion, which first brackets and then constructs an understanding of bibliotherapy in line with Denzin's (2001) aims of Interpretive Interactionism, section 6.3 aims to draw together understandings of bibliotherapy.

6.3 Emergent forms of bibliotherapy: a holistic example

As was discussed in section 3.3.4, analysis of interview transcripts was conducted both thematically and holistically. Following the thematic analysis presented in chapter five, this section aims to relate the key findings identified in this chapter – with a focus on the four emergent types of bibliotherapy – to one participant narrative. In line with Denzin's (2001: 84) view that the finished analytical product should be coherent and understandable to research participants, this section will contextualise these emergent concepts in the narrative. Using integrative examples in this manner will help to validate the models presented in previous sections of this

chapter. In Nathan's view, this will help to *'think what did I read, and what helped and what didn't.'*

Nathan's experience was chosen because his interview touched on all four emergent concepts of bibliotherapy, and explored several other key findings – including the impact of symptoms of his mental health problems; his changed use of bibliotherapy in different circumstances, related to his personal situation; and the role of the public library – which will be presented here. Nathan's use of bibliotherapy firstly was affected by his symptoms of depression. As he commented, *'when I was very depressed, I could basically do nothing.'* His initial response to feelings of depression was to try and inform himself about his symptoms, in line with the model of informational bibliotherapy, but he found this impossible: *'I bought lots of books about depression – and I found I could read none of them… I couldn't read things that were too hot.'*

Nathan's second response to his symptoms was to try and engage with his emotions – an outcome of emotive bibliotherapy – both in literature and other creative therapies such as writing: *'I tried reading some poetry… and I found that too difficult, the feelings in it too intense really, to process.'* Following this period of being unable to read at all, with his symptoms affecting his reading habits, Nathan then used reading to distance or shield himself from his emotions: *'when I started to feel a bit better, I had a voracious appetite to read, and I read detective stories of the rather old-fashioned, very safe type… I needed an element of safety and distance in the books to enjoy them.'* His use of escapist bibliotherapy was a very important coping mechanism at this time, but was not a long-term solution; as Nathan started to recover from this episode of depression, he felt that *'I am returning to myself now, because I wanted to read something that's a bit more thought-provoking.'* Nathan also discussed social bibliotherapy, stating that: *'when I was starting to feel a bit better, I would have enjoyed going to a book group,'* though he was not sure if he would feel comfortable if this group was solely focused around mental health problems.

Nathan's use of reading as a coping technique for dealing with his depression changed over time. As his symptoms started to decrease, he decided to try to engage with some of the texts he had bought to educate himself about his symptoms. Taking the example of *Sunbathing in the Rain* by Gwyneth Lewis, which Nathan had been initially unable to read, he commented that: *'it was a good book but*

I thought she doesn't quite communicate the horror of it, and interestingly when I was depressed, I couldn't tolerate even the gentle approach she made.' This changed perspective on the title demonstrates that participants' use of reading as therapy is affected by their personal situation, and that different types of bibliotherapy may be appropriate at different points in their lives.

Finally, Nathan talked about the impact of the public library on his symptoms; he felt that *'the library has certainly been a good space to visit, because it felt there was something there worth going to, and people were friendly and open… I hadn't realised, perhaps, how beneficial it had been.'* This demonstrates that literature and the library can be interlinked for people with mental health problems, with a recognition that the atmosphere of the library itself is as important as the books contained within the building. While there has not been space within this chapter to analyse Nathan's experiences in more depth, this section has aimed to demonstrate that the use of bibliotherapy can alter depending on life circumstances and symptoms, and that people can find value in accessing a variety of literature in line with their needs.

6.4 Conclusion: the relationship between previous models and emergent models

Building on the work presented in section 2.2.1 examining previous definitions of bibliotherapy, and concepts emerging from the findings presented in section 5.3.5, this section presents the relationship between the various definitions of bibliotherapy. It again outlines the three initial definitions of bibliotherapy used as the starting point for this study, based on Brewster's (2007) work and the pilot study for this research presented in section 3.4; these three initial definitions are then mapped onto the three current models of bibliotherapy operational in the UK – BoP, GIR and RAYS. Finally, these definitions are contrasted with the four understandings emerging from discussion with participants in the research project, previously presented in section 5.3.5 and discussed in section 6.2. The aim is to understand the differences between externally-designed bibliotherapy schemes and the lived experience of using bibliotherapy.

Informal bibliotherapy was considered by librarians as everyday interaction with works of information or literature. This informal bibliotherapy, by definition, does not operate within a recognised model of bibliotherapy. Librarians consider this an important but unrecognised aspect of their work. In this thesis, participants used

reading independently of formal bibliotherapy schemes to access therapeutic benefits. However, participants' conceptualisation of this reading – which could be for emotional engagement, escapism or information – was different from that of librarians in previous research. Participants in this research did confirm librarians' perspectives to some extent, as they did not recognise the provision of informal bibliotherapy as included in the role of the librarian. While participants in this research can be said to have used bibliotherapy informally, their definition was based on their own interactions with texts and not related to the work of librarians. Thus, the importance of the definition of informal bibliotherapy is called into question, as it does not address service provision from the perspective of service users. In particular, the differentiation in outcomes, thinking about the purpose of reading as to escape from or engage with emotion, is not made. As has been shown in sections 6.2 and 6.3, the differences between these two emergent models of bibliotherapy are key for participants.

Creative bibliotherapy involves interaction with literature, either individually or in a group. The interaction is facilitated by a professional, and can take several different forms ranging from a traditional book group to a reading-aloud model. It can include any imaginative literature. The two main models of creative bibliotherapy currently used in the UK differ slightly in their approach, with GIR focusing exclusively on a reading-aloud, group model, with literature taken from the literary canon. RAYS takes a more diverse approach, with group and individual work tailored to the needs of those using the scheme. Creative bibliotherapy's application in a group environment maps directly onto the use of social bibliotherapy. The role of literature, the group facilitator and the group dynamic all contribute to creating a successful therapeutic interaction. The GIR and RAYS models, as social bibliotherapy, can also be seen to achieve the outcomes of both emotive and escapist bibliotherapy, enabling users to either connect with their emotions or find relief from them. Nevertheless, as previously discussed, these current models do not fulfil all the needs of participants because their focus on specific texts limits the ways in which interaction can be shaped.

Self-help bibliotherapy is the use of non-fiction, mainly CBT-based, books to provide information and treatment for mild to moderate mental health conditions such as depression. The book may be part of a wider treatment regime, and will be read individually. This definition relates closely to the current model of BoP operational in the UK. Informational bibliotherapy has expanded this definition to include other

sources of self-help support and information, including those running contrary to the biomedical construction of mental health problems. The definition of informational bibliotherapy acknowledges that it may be difficult to recommend or prescribe a book title, because the relationship between a reader and a text is difficult to predict.

As this section shows, there is some overlap between the types of bibliotherapy used by participants and the design of current models of bibliotherapy. In particular, there can be considerable overlap between the process and outcomes of undertaking social bibliotherapy and the models of creative bibliotherapy currently being used. However, personal understandings presented by participants in this research challenge some aspects of current models. For example, the majority of participants who engaged with literature for information and self-education did not utilise a CBT-book prescription-based model to access this information. Building on previous work, concepts of informal bibliotherapy had previously only been explored from the perspective of service providers, and thus definitions are shaped around the provision of services including outreach work and reader development. Interviews with participants showed that understandings of bibliotherapy and the use of texts was more diverse than initial definitions or current models suggested, particularly for those who valued the role of books in their maintenance of their mental health, but had not accessed a formal bibliotherapy scheme. Current models concentrate on the delivery of a particular type of interaction with literature, while definitions emerging from participants' experiences focus much more on the nature of the benefits and outcomes of therapeutic reading.

The findings chapters of this thesis show that there are divergent understandings of bibliotherapy, and focus on a number of issues that may affect use of bibliotherapy, including previous experiences and socio-cultural understandings of mental health. Chapter six has connected previous understandings, current models and emergent definitions of bibliotherapy, and has demonstrated that there are a number of factors affecting these constructs. The narrative accounts and personal understandings of mental health problems presented in chapter five and in appendix two emphasise that the participants in this research subscribe to a holistic account of mental health problems. Participants also engaged with bibliotherapy at different points throughout their lives. While some participants, like Vivienne and Silas, found reading to be of value at an acute point of need, others such as Ethel and Lucas had experienced mental health problems for many years before joining a bibliotherapy group. Thus, bibliotherapy can be seen to satisfy a number of different needs, ranging from

relaxation and social support to personal understanding, self-education and emotional engagement. Enjoyment of both texts and groups can be seen as an outcome of undertaking bibliotherapy, alleviating symptoms such as the reduced capacity for enjoyment and interest which can be associated with depression and other mental health problems.

This chapter has contributed to the ongoing discussion about the framework of bibliotherapy by highlighting its key outcomes from the perspective of readers. Identification of four service user generated, outcome-based understandings of bibliotherapy may help to ascertain the role that bibliotherapy can play in treatment. Discussion of the diversity of both uses and users of bibliotherapy emphasises the necessity of adopting divergent models and ensuring that bibliotherapy schemes are responsive to the needs of service users. The final chapter of this thesis will address recommendations for future research and practice, as well as concluding the thesis by relating findings to the previously established research questions.

Chapter Seven: Conclusion

7.1 Introduction

Chapter seven draws together the preceding chapters of the thesis, connecting the initial aims and objectives with the findings of the study. The chapter presents an overview of the research before discussing the contribution to current knowledge that the thesis has made. Developing this further, the practical implications for stakeholders in bibliotherapy schemes are discussed. Limitations of the research are considered, then related to the implications of the study for future research. Finally, the thesis concludes with a service user perspective that draws together the previously presented themes.

7.2 Overview of research

Returning to the objectives first discussed in section 1.2, the thesis has critically reviewed existing literature on bibliotherapy in chapter two discussing its strengths and weaknesses and locating the current study in a wider context (objective one). It has investigated current practices of bibliotherapy in the UK, focusing on the three main models of BoP, GIR and RAYS (objective two), and has built on theoretical, document-based work with an interview and observation study of those using reading for mental health and well-being (objective three). Factors that affect engagement with bibliotherapy schemes have been established, including the effect of mental health symptoms on reading; the emotional experiences of the reader; the literature chosen; and in the case of group bibliotherapy, the facilitator and the group members (objective four). In chapter six, these findings were discussed in relation to current practice and existing literature, concluding that there are gaps between current understandings and theoretical foundations of bibliotherapy, and the actual use of reading as a supportive therapy by people with mental health problems (objective five). These gaps have implications for current models, as they indicate that changes are required to ensure that bibliotherapy is successful as a supportive therapy.

The first chapter of this thesis introduced concepts of bibliotherapy from previous research, establishing that the questions for discussion emerged from earlier work (Brewster, 2007). The research rationale was discussed and related to gaps that had been previously identified in the evidence base on bibliotherapy. These gaps were then explored in more detail in the literature review, ascertaining that problems with previous research were the lack of critical, independent evaluation of current

bibliotherapy schemes; little critical reflection on concepts; and few qualitative, in-depth investigations of the experiences of those using bibliotherapy in UK public libraries. Chapter two established that self-help bibliotherapy has been widely tested, but found to be effective only under certain conditions; and that there were problems with the evidence base investigating creative bibliotherapy including a lack of scientific rigour. The literature review also provided a context of wider concepts of mental health, which contribute to understandings of the individual experiences presented in chapter five and underpin the models of creative bibliotherapy presented in chapter six.

Following the introduction to the topic and the research study, chapter three established the methods and methodologies to be used to collect and analyse the findings presented in chapters four and five. The chapter grounded the thesis in an ethnographic, reflexive tradition, and explored the relationship between ANT as a framework for analysis and the more inductive methodologies used to collect and analyse interview data. Interpretive Interactionism, and its suitability as a structure for contrasting service user perspectives and service provision, was discussed in detail. The main methods of data collection – document analysis, interviews, participant observations, and descriptive statistics – were presented and the strengths and limitations of these methods were considered. The validity of using methods as a form of bricolage was also explored and related to the research questions, presenting a justification for using a variety of methods in order to appropriately answer these questions. Chapter three also outlined the pilot study for the research, which confirmed current definitions of bibliotherapy used in professional practice.

Chapter four critiqued the three main current models of bibliotherapy, using an ANT approach to analyse the emergence and implementation of these schemes. Analysis compared their stated aims to their outputs using a framework of problem-solution. The chapter concluded that:

- All three schemes emerged from different sectors and had different aims and objectives. The sector from which the project emerged was important for the schemes' flexibility and responsiveness to change. It also affected the texts read.

- The motivating factors for the emergence of the schemes were a combination of locally-identified needs, and responses to national governmental and

- health agendas such as the de-medicalisation of mental health treatments, patient choice, well-being, partnership working, and self-care.
- External tensions impacted on the perceived success of the projects, their evaluation methods, and their sustainability. These tensions included the cost-effectiveness of care, meeting the conditions of funding applications, and need for evidence of perceived effectiveness of the schemes.

Thus, a fragmented picture emerges of bibliotherapy in practice in the UK, with evidence about the effectiveness of the schemes applied strategically to meet wider agendas, limited evaluation of current models, and sustainability driven by factors external to the schemes. This critique of current models showed that service users' perspectives are not always taken into account in the design of bibliotherapy schemes. Chapter five presented the findings from the interview and observation studies of experiences of using bibliotherapy and reading for mental health and well-being. The chapter suggested that current understandings of the use of bibliotherapy services are limited, as the perspectives of service users are not taken into account. In contrast to the analysis of current models of bibliotherapy, chapter five ends by focusing on uses and concepts of bibliotherapy discussed by participants in this study.

Chapter five addressed the ways in which participants in this study used bibliotherapy; from this usage, four models of bibliotherapy were developed to reflect experiences of participants. These models established the outcome of the bibliotherapy intervention as the most important aspect for the participants, rather than the type of text used. Building on these concepts, the analysis presented in chapter six concluded that service providers and service users have different understandings of bibliotherapy. While some service providers focus on the type of text used, specifying that it should be CBT-based or from the literary canon, service users concentrate on the outcome of the intervention and are more catholic in their use of literature, taking advice, catharsis and empathy from any texts to meet their needs.[27] Of the three models critiqued in chapter four, the RAYS model is closest to the use of the intervention in practice by participants in this research. However, RAYS uses imaginative literature, and not the wider corpus of self-help and non-fiction literature found helpful by some participants, so this scheme would not meet all their needs.

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[27] See appendix seven.

Chapter six discussed the findings of this project in the context of the literature on bibliotherapy. It concluded that the research findings were reinforced by a long history of studies on reading and reader response, though there was a need to update the findings of previous studies in relation to recent developments in technology, mental health care and the implementation of current schemes in practice. Significant findings discussed included the need for an understanding of the impact of mental health problems on the use of services; awareness of the need for both engagement with emotions, and distance and distraction from emotions at different points in the recovery process; and the use of bibliotherapy by a diverse range of people with a wide variety of mental health diagnoses. Previous research has focused on the use of bibliotherapy for particular conditions or in relation to particular events such as bereavement, partly because of the potential ethical issues concerned with risk when considering trialling resources with people with more severe mental health conditions. In contrast, the research here examined the use of bibliotherapy in practice, with participants already using it as an independent method of coping with mental health problems. Thus, it helps to demonstrate the relevance of bibliotherapy as a psychosocial intervention for people with a wider range of mental health problems, including more enduring conditions.

Another finding, supported by previous research into bibliotherapy, concerned the personal relationship between the reader and the text, which often mapped onto experiences in their life. This personal relationship is important because it problematises the notion of successfully recommending texts to readers, suggesting that it is difficult to predict the interaction between text and reader. Current bibliotherapy schemes rest on the idea that recommendations of texts are possible and the outcome of these recommendations will be predictable, for example, that works from the literary canon or CBT-based resources will engage every reader's interest and attention. Again, the RAYS scheme is least prescriptive and most flexible, taking in a wider range of material than BoP or GIR, and accepting that service users may reject a text as unsuited to their needs.

Chapter six also established that there is still a role for the public library to play in the experience of bibliotherapy and therapeutic reading. Many participants commented on the way they used the public library as a space and place to maintain their mental health, as it represented a calm, non-commercial, welcoming space which some viewed as a sanctuary. Although there were some reservations and suggestions for

improvements, particularly in terms of the relationship between public library staff and their service users, the overall picture was broadly positive. However, some participants did criticise aspects of the library service, and such criticisms should be considered in terms of service improvements. The diversity of texts available from the public library was also appreciated as an important aspect of service provision, often used independently by readers to locate their own bibliotherapeutic materials. Those who were reluctant to engage with mental health and medical services often felt comfortable in the public library, encouraging them to seek social, personal, and de-medicalised support and join bibliotherapy groups. This thesis has demonstrated that there are many ways in which reading can be used to contribute to mental health and well-being, and these will be explored in more detail in the next section.

7.3 Contribution to current knowledge

The overall purpose of the thesis – to investigate experiences of therapeutic reading for mental health and well-being (in formal bibliotherapy schemes and independent reading) and to compare experiences to current models of bibliotherapy – has ensured that the study contributes to key debates. These include the nature of reading, particularly its use for therapeutic purposes; the identification of gaps between service provision and service use; the relationship between EBP and policy formation; the value of the public library in society; the use of qualitative methodologies in LIS.

Four outcome-based models of bibliotherapy have been proposed. The models – emotive, escapist, social, and informational bibliotherapy – make a small contribution to the theory surrounding bibliotherapy, updating previous research and locating findings in the current UK context. As discussed, the changed nature of mental health care, increasing prominence of bibliotherapy schemes in libraries, and the proliferation of new technologies mean that reviewing bibliotherapy in its current cultural context was necessary to ensure that research remains relevant. In-depth engagement with service users was not a component of previous literature on bibliotherapy. Thus, the proposed models help to focus attention on the actual, everyday usage of bibliotherapy, as opposed to previous work which imposes a top-down construction, often using RCT methodologies or reporting the therapists' perspective on bibliotherapy.

Similarly, these models contribute to a greater understanding of the changing use of reading 'reading has a history. It was not always and everywhere the same'

(Darnton, quoted in Sheldrick Ross *et al*, 2006). Several outcomes of reading defined in this thesis contribute to debates about why people read, what motivates them to read, and the benefits of reading (Elkin *et al*, 2003). People read because they enjoy reading, but also because it improves their mental health. Reading is an integral part of participants' strategy for coping with mental health issues; it is used to manage difficult emotions, and to experience catharsis, clarity, and empathy. It is not simply a leisure activity, as it has wider benefits in terms of information provision and self-understanding (Sheldrick Ross, 1998). Recent bibliotherapy schemes involving reading aloud in groups focus attention on the nature of reading itself. Manguel (1996) comments on the modern tendency for reading to be a lone silent pursuit, contrasting this with the previous role of reading as a shared experience. The analysis in this thesis of the benefits of reading aloud – which include relaxation and creating a social connection using literature as a focus for discussion – makes a small contribution to considerations of the nature of reading in relation to its societal context.

Understanding how people use reading to manage mental health problems also contributes to a wider body of literature on the use of non-medical interventions for mental health, related to the use of self-help literature and its role in Stepped Care (NICE, 2011). This thesis shows that people use reading to access information and as a form of self-help-based psychotherapy, but it has also found benefits relating to the use of group-based peer support in bibliotherapy groups, which contributes to the maintenance of mental health via shared reading.

Building on the discussions of bibliotherapy presented here, another key contribution is the finding that a wide variety of texts can be used to elicit different therapeutic experiences. There is a contrast between bibliotherapy schemes which often recommend specific titles or types of texts, and participants in this study who used a broad range of resources. Participants located useful literature by various methods including independent serendipitous discovery, again showing that participants' use of bibliotherapy is often different to current models of bibliotherapy. Examining reading for health and well-being has helped to identify the gaps between current understandings of bibliotherapy scheme providers and bibliotherapy scheme users. An awareness of these gaps is key to developing a better theoretical understanding of the processes of bibliotherapy. Previous literature has not explored the outcomes of undertaking bibliotherapy from a user perspective; this thesis has begun this process of exploration.

Drawing together the findings has demonstrated that current models of bibliotherapy and participants' usage of reading for mental health differ. Current bibliotherapy schemes harness some aspects of the use of reading for health and well-being, but other aspects used by participants in this research have not been taken into account in the design of the schemes. One of the reasons for this is because those using bibliotherapy schemes do not have an input into scheme design. Other factors which impact on this gap between design and use include the external pressures encountered by those designing the schemes, such as the need to bid for funding; the proposed aims of the schemes, which relate to the sector from which the scheme emerged; and wider governmental agendas for health and well-being.

The approach taken in this thesis has differed from that of previous research, and has included analysis of the emergence of current models of bibliotherapy. Understanding the translations that occurred to form networks and bring bibliotherapy schemes to prominence helps to demonstrate both their usefulness and their limitations. The thesis has also located bibliotherapy schemes within wider contextual debates about mental health, well-being, and the relationship between health policy and EBP. Engagement with debate about the construction of well-being is particularly timely, in light of current concerns with ascertaining and measuring national well-being (Matheson, 2011). Reflecting on the socio-political nature of policy formation in relation to bibliotherapy schemes has contributed to debates about the role of evidence in legitimising policy decisions. As Juntti *et al* (2009) consider, the sporadic and selective application of the evidence can be used to justify decisions, demonstrating the value of evidence-based discourses, but not the solidity of the evidence base.

Although this study is a small-scale project, which uses a qualitative approach to data gathering and analysis, the methodological rigour with which it was conducted means that the study contributes to LIS methodological debates. Previous criticism of LIS studies have centred on a perceived lack of engagement with critical and theoretical paradigms (Cronin, 2008; Cronin and Meho, 2009). The use of Interpretive Interactionism, supplemented by an in-depth analysis of policy using an ANT framework, demonstrates that there are benefits to engaging with wider sociological frameworks to answer some research questions.

Using an Interpretive Interactionist, ethnographic approach to contrast understandings of service provision and user experiences is a novel approach in LIS, but one with methodological rigour that has many strengths and a wider applicability for other studies examining procedure, service provision and service use. Engaging with sociological methodologies like ANT gives wider understanding of the relationship between LIS and policy. The application of this approach may be transferable to analysis of other bibliotherapy schemes, and more widely to analysis of user interaction in LIS. Analysis of gaps between service provision and service use are integral to LIS research, and this thesis presents an example of how these studies can be made more comprehensive in scope. The novel findings of the thesis demonstrate the benefits of engaging widely with interdisciplinary methods of data analysis. Thus, the thesis makes a contribution to debates about the qualitative evaluation of the use of library services.

The findings presented here also make a modest contribution to debates about the role of the public library in society. The thesis has shown that people access supportive texts independently, and so their perspective is not captured by current evaluation methods. The opportunity for autonomous and self-directed access to the public library contributes to mental health and well-being and is a strength of the public library as an institution, as discussed in section 2.2.4. Thus, this study clarifies the value of the public library in this context, emphasising that its worth stretches beyond measurable book issue and visitor statistics. This thinking about use, users and uses of the library also contributes to theories of performance measurement and wider political debates about the necessity of funding a statutory library service (Zweizig and Dervin, 1977). The methodologically rigorous nature of this study demonstrates the value of engaging with both qualitative analysis and theoretical perspectives to address issues of library use and service provision at a more meaningful, in-depth level than is typically provided by quantitative evaluation of services.

This section has explored the novel contribution made by this research project. The implications for those implementing bibliotherapy schemes will now be discussed.

7.4 Implications for stakeholders in bibliotherapy schemes

Identified stakeholders include librarians, health professionals, service users of bibliotherapy schemes, people with diagnosed mental health problems who may not yet use bibliotherapy schemes, and library users looking to improve their well-being

and prevent the experience of poor mental health. An increased awareness of the potential uses of bibliotherapy presented here will benefit all stakeholders. On a practical level, these models will help to create more service user-led models of bibliotherapy and will provide guidance on how to improve current schemes. Recent health care policy has focused on patient involvement and patient choice. This thesis emphasises the importance of gathering and understanding evidence regarding the acceptability of treatments in practice, and contributes to providing such evidence for bibliotherapy. Ensuring that services are user-centred will help to improve interaction with the service (Rogers *et al*, 2004).

Current models of bibliotherapy operating in the public library do not map directly onto service user understandings and their interaction with texts as therapy. Therefore, communication with those using the services is vital to understand their needs and use of texts. Further to this idea of consultation, closer links between those providing bibliotherapy services and the research community need to be established. The in-depth, qualitative service evaluation needed could then be conducted. Other methods of evaluation, such as questionnaires, may also be useful for gathering a wide spectrum of views.

As is shown throughout this thesis, the meaning and aims of bibliotherapy are malleable, with those instigating the schemes – and those using bibliotherapy – adapting it to meet their own needs. One of the findings of this research is that bibliotherapy produces a very personal connection between reader and book, and outcomes are difficult to predict. Thus, it would be counterintuitive to the focus of this thesis to provide detailed recommendations for specific actions. While four outcome-based models of bibliotherapy were established, this was with a caveat that participants required and used different types of bibliotherapy throughout their lives. The main implication for service providers is that they need to be aware that there should be flexibility within their models of bibliotherapy. Consultation with service users is therefore essential. The findings of this critique of bibliotherapy schemes are also applicable to other bibliotherapy schemes. In particular, the recommendation that service providers engage with people with mental health problems to establish their needs is relevant to bibliotherapy schemes in general.

People with mental health problems need to be made aware of the services offered by the public library. Outreach work may help to facilitate links between mental health service user groups and the public library. Promotion of the library may also

help people to access the supportive resources of the public library. This promotion should also be targeted to health professionals who may not have previously acknowledged these benefits. The advantages of using reading, as identified by participants in this research, include improved concentration, sociability and stress relief. These outcomes are also regarded as positive by health professionals.

The use of the public library by people with mental health problems also needs to be considered. Research presented here about the benefits of the accessibility of the library could be translated to examine emergent cost savings elsewhere in the NHS, in terms of a reduced need for medication and psychotherapy. Again, these benefits are difficult to quantify. Similarly, the benefits of providing a large collection of literature accessible for free by people with mental health problems can be seen to have health and well-being benefits. Therefore, the library as a space needs to be protected from closure and the potential wider health benefits of public library membership need to be acknowledged. This section has addressed the practical implications of the research for stakeholders. The implications for future research will now be discussed.

7.5 Limitations of the research and implications for future research

Throughout this thesis, the limitations of the research have been considered. This section aims to synthesise these limitations and address them, examining the implications for future research.

The research project has taken a highly qualitative, reflexive stance, and self-location within the data collection and analysis process was very important. Those subscribing to a model of research in which objectivity is seen as a measure of validity will consider this a weakness in the research. However, as discussed in sections 3.2, 3.2.5 and 3.3.3, care was taken to still conduct the research in a systematic and trustworthy fashion, with audio recordings and an audit trail made throughout the process to document decisions. As explored in sections 3.3.1.2 and 3.3.3, it was not possible to audio record or make notes about the observations while they were being conducted, which could be considered problematic in light of these claims. Nevertheless, these retrospectively written field notes were useful and created a richer picture of the events taking place. Interviews conducted (and recorded) with participants who were also observed confirmed that the field notes were a good representation of the group experience.

The tensions between applying a framework such as that of ANT in contrast with the inductive work conducted in the interview and observation studies could be considered to be a limitation of the study. Techniques outlined in section 3.2.5, including procedural and evaluative rigour and the use of the triangulation of multiple theories and qualitative methods, explored how these tensions were resolved to create a piece of research meeting guidelines for quality in qualitative research.

As this study is an exploratory one, aiming to investigate experiences, it has highlighted a number of areas for future research into the use of bibliotherapy by specific groups. For example, more male participants in this research used bibliotherapy independently compared with in the number of men who took part in a group. While this finding may simply reflect the sample of participants here, this finding may merit further investigation, particularly in light of the different mental health diagnoses given to men and women. The use of bibliotherapy by specific groups, such as older adults and BME communities could also be explored. Both groups made some contribution to this thesis, though few people from BME communities volunteered to participate in this research. Further investigation may establish factors affecting engagement with bibliotherapy. Research into access to therapeutic reading materials in languages other than English would also contribute to future analysis. Similarly, and in light of recent RCTs of cCBT, a study of the medium of bibliotherapy materials would also be timely; preliminary conclusions from research here show that for some people the book as an object is key to its therapeutic value, but further research is required. A comparative study of the use of bibliotherapy materials accessed via online resources or via a printed book would be appropriate. The use of e-readers to access imaginative literature could also be investigated and compared with the experience of reading printed texts.

The research presented here suggests that the timing of bibliotherapy as an intervention needs to be further considered. The findings have determined that it may be useful as an adjunct to therapy, for use while on a waiting list, as a longer-term system of support following treatment, and as a preventative, working to help people to avoid symptoms of mental health problems. However, there was not scope in this thesis to explore this use in detail, and future projects could benefit from a specific focus on the use of bibliotherapy at particular times in the lives of research participants.

The process of recommending specific book titles has not yet been clarified, and future research could investigate factors that may impact on the success or failure of the recommendation process. Several participants in this research also had long-term physical health problems, and investigation is also needed into the use of bibliotherapy for these people, ascertaining if bibliotherapy can be used for successful self-management of symptoms. Research into the connection between reading and writing for maintaining mental health should also be considered. Preliminary findings about writing emerged inductively in the data analysis process, though there was not scope to present these findings in this thesis.

A comparative study of the use of bibliotherapy would contribute to the field, particularly if focused on the UK and either Canada or the USA, where significant research has previously been conducted. Recent service innovation in Australia, with the use of the GIR model in the state of Victoria could also form the basis of a comparative study (McLaine, 2010). One intention of Billington *et al*'s (2010) work is to act as the preliminary study for an RCT focused on the use of shared reading interventions for mental health, which would also contribute to the evidence base. Similarly, further studies could contrast the differences in service provision throughout the country, examining the variations to the BoP model that have been instigated.

In conclusion, this thesis constitutes an exploratory study of bibliotherapy in practice in the UK, focusing on establishing service user perspectives and critiquing current service provision. As is shown by this section and the previous discussions of the contribution to current knowledge and implications for stakeholders, the novel findings presented in this thesis are key to improving theoretical understanding and practice. There is significant scope for future research building on this study, in particular relating to a wider assessment of the application of the proposed four outcome-based models of bibliotherapy. The methodological rigour of the study has ensured that the research objectives have been answered in an in-depth, qualitative fashion and make a substantial contribution to the field of LIS.

7.6 Closing remarks

As is appropriate in a thesis to which the experiences of the research participants contributed so much, the last word in this conclusion goes to Vivienne, whose use of literature and passion for reading had helped her to deal with difficult events throughout her life:

'That's how I cope. Out of a three hundred page book, if there's one line that says really beautifully and eloquently, or even very simply as well – it doesn't have to be complicated and flouncy words, that touches one emotion. It just stands out and you think 'yes, that's it. That's what it feels like, what I couldn't get out and explain.' I couldn't put that in words [and] that's done it there – that one sentence. And I just think that is priceless.'

In the end, whether as information, emotional engagement, escapism, or through reading in a group situation, the accessibility of literature for participants and their relationship to texts helped them to cope with difficult situations and symptoms of mental health problems, contributing to their well-being in a way that demonstrates that bibliotherapy is not only cost-effective for service providers, it is also priceless for service users.

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Appendix one: Literature review search strategy

A number of interdisciplinary databases were searched to get a diverse understanding of the roles of bibliotherapy and its relationship with mental health. These included nursing, medicine, psychology, education, the humanities, sociology, and LIS databases, listed below. These databases were searched using the search terms 'bibliotherapy'; 'reading' and 'therapy'; 'depression' and 'reading'; 'mental health' and 'reading'; and 'self-help' and 'mental health.' Wildcard operators were used to ensure that all key terms were included. Trials examining the effectiveness of computerised CBT (cCBT) – which often contains similar CBT-based content to self-help bibliotherapy texts – were excluded, after initial research found that the change in format raised separate issues for its effectiveness. A number of resources forming the basis of section 2.3, which contextualises bibliotherapy, were located in this initial search on self-help and mental health. These were supplemented by searches on specific concepts e.g. 'mental health' and 'gender'; 'mental health' and 'ethnicity'; and'mental health' and 'sociology.' The DSM-IV-TR and ICD-10 were also examined to identify symptoms and capture the acknowledged perspective on mental health. Abstracts were read to identify relevant materials and reference lists were used to explore further important conceptual literature as the project progressed. Some academic journals were directly searched for relevant content. These journals are listed in appendix one. A number of RSS alerts were placed on relevant journals and databases, including Medline, the *British Medical Journal* and *Qualitative Health Research*, to ensure that I remained up to date with current literature published after the initial search was conducted.

Accessed via CSA Illumina:
- ASSIA (Applied Social Sciences Index and Abstracts) (1987-current)
- BHI (British Humanities Index) (1962-current)
- CSA Linguistics & Language Behavior Abstracts (1973-current)
- ERIC (Educational Resources Information Center) (1966-current)
- LISA (Library and Information Sciences Abstracts) (1969-current)
- MLA International Bibliography (1926-current)
- Social Services Abstracts (1979-current)
- Sociological Abstracts (1979-current)

Accessed via Ovid:
- AMED (Allied and Complementary Medicine) (1985 – current)

- British Nursing Index (1994 – current)
- MEDLINE (1950-current)
- PsychINFO (1806 – current)

- CINAHL (Cumulative index to nursing and allied health literature) via EBSCO (1982 - current)
- Cochrane Library
- Dissertation Abstracts via ProQuest (1861 – current)
- Periodicals Archive Online
- Scopus (1966 – current)
- Web of Knowledge (1900 – current)
- Wilson Web Library Literature & Information Science Full Text (1994 – current)

Journal contents pages hand searched
- *Journal of Poetry Therapy* (2000 – 2002)
- *Body and Society* (1995 – current)
- *Journal of Creativity in Mental Health* (2006 – current)
- *Psychology and Psychotherapy* (1999 – current)
- *Behavioural and Cognitive Psychotherapy* (1998 – current)

Appendix two: Interview participant and observation group member profiles

Appendix two profiles all participants interviewed and some of the participants observed in bibliotherapy groups. Only observation participants whose actions were particularly noted in the field notes were profiled. As I only met participants in the four Jonesville groups on one occasion, I felt that I did not have enough information about them to profile them. The majority of participants in the Taylorbridge group were interviewed together, and so are profiled in the interview section.

The aim is to contextualise participants' experiences and to ensure that their comments are read with an awareness of the background of participants' lives, which – as discussed in chapter five – do not start and stop at the interview. The profiles present a version of the participants, based on the topics discussed in the interview, including considerations of symptoms of mental health problems, recruitment to the research study, methods of managing mental health problems and other significant details. If appropriate, behaviour in the bibliotherapy group environment is also discussed.

Ajeet was a member of the Taylorbridge reading group. He was interviewed by telephone, and did not disclose a diagnosed mental health problem. He was unemployed, and had young children. He told me that he joined the Taylorbridge group out of inquisitiveness, and stayed because he enjoyed it. When I attended the group, he was one of the quieter group members, though he did comment and contribute to the group. He liked the confidentiality of the group discussions, and had been attending the group for around six months. His concerns centred on finding employment, and the library using their resources to the benefit of the community; he wanted to volunteer to help children with their reading.

Alfie responded to an advert placed in a mental health service user magazine. His motivation for responding to the advert was that *'I thought having had a lot out of the services, I would give something back.'* He, like some other research participants, did not use computers, and wrote a letter to contact me, which also detailed titles he felt were important. His diagnosis was of schizophrenia and depression; he was a recovering alcoholic, and suffered from physical health problems.

When he was depressed, or craving an alcoholic drink, reading helped him to focus away from these thoughts. Reading gave him a sense of achievement. He enjoyed reading comic and classic novels. He had read some self-help titles, including the Alcoholics Anonymous 12 Step programme books, which he found helpful. His physical health conditions meant that he did not use libraries as much as he used to, instead purchasing books from charity shops. He was not in paid employment, but did volunteer for a local mental health organisation. He enjoyed writing letters and also attended a writing class.

Amelia responded to the same magazine advert as Alfie. She emailed in reply to the advert as she was a regular user of libraries and had *'lived with depression for*

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decades and have acquired various other diagnoses over the years.' Amelia had suffered from mental health problems since her teenage years, but felt that the medical treatment she had received was inadequate; she referred to herself as a *'psychiatric system survivor.'* Her perceptions of community mental health services were very negative, impacting on her understanding of bibliotherapy. She felt self-education using the library and literature was very important, and had read numerous titles disputing the conventional biomedical view of psychiatric treatment. In her view, *'a lot of the recovery is not just a recovery from mental distress; it's a recovery from the treatment of mental distress.'*

She felt that reading fiction and poetry, and attending a writing group had been beneficial for her. Amelia read widely on a number of subjects with the aim of empowering herself. When she was depressed, she found it helpful to visit the library, as it was a quiet, calm space, and to read children's books to help her to cope.

April was interviewed as part of the Taylorbridge group. She was a mature student, studying science, and said that she enjoyed the chance to read texts unconnected with her studies in the group. She was one of the more vocal group members, reading aloud and discussing with confidence. She joined the group after a library open day, and appreciated the opportunity to take unpressured time for herself within the group.

Beatrice was interviewed over the telephone, and regularly attended the Taylorbridge group. She is the only service user participant that I never met in person. When Arlene, the facilitator of the Taylorbridge group, mentioned my research, Beatrice was immediately interested in being involved, because she had very strong views on the value of reading as a therapy.

Beatrice was retired, but still undertook some voluntary work involved with literacy and reading, and was an avid reader. She had been through a bad divorce some months earlier, and valued the support of the Taylorbridge group at this time. She was a practising Christian and her faith was very important to her. She lived some distance from Taylorbridge, and had to travel to attend the group. She expressed a desire to train to run her own group, though financial constraints prevented this at the time of the interview.

Connor responded by email to a poster in his local library; *'I was having a cup of coffee there and it was. I saw it and I recognised that books have played quite a significant part in being able to manage my mental health condition.'* He had suffered from several episodes of depression, and used to *'try and continue and not acknowledge that that is an issue for me, and that has resulted in things building up and then just crashing.'* He felt that now he had this pattern more under control; *'I'm far better at dealing with crisis now than I was.'* Connor attributed this change to his openness about his condition; a good relationship with his GP; CBT; and a new-found understanding of the role of medication in managing his condition.

He was not in employment, but he undertook voluntary work, mainly based around exercise and being active in the local community; both of which he acknowledged as contributing to maintaining his mental health. Connor had travelled widely, and lived in several different countries, leading him to comment on mental health treatment and libraries elsewhere in the world. As a member of public library reading group, he viewed the social aspects of this group membership as important to his mental health. Outside the group, he read fiction, history, and politics, but felt that the act of reading was more important to him than specific titles. Connor did not feel that self-

help books had a role to play in his life; but libraries were very important to him as a community resource.

Courtney was the youngest member of the Taylorbridge group, interviewed with other group members. She was employed by the local council, and initially attended the group for work purposes. However, she enjoyed it so much that she returned whenever her work schedule would allow it. She was largely quiet during the group interview after the initial questions, though she contributed her experiences to the group meeting beforehand. She said she enjoyed the opportunity to read stories that were not the ones she would typically read, and also agreed that the social atmosphere of the group was important.

Douglas was also interviewed as part of the Taylorbridge group. He is partially sighted, and so reads the story for the group in advance via screen reading software. He contributed his opinions freely in the group, and enjoyed listening as well as sharing. He also enjoyed audio books.

Ethel was a participant in the Williamstown group. Group members wrote their own contributions as well as reading poems by different poets for inspiration. She was a prolific writer of poetry and had a strong, clever sense of humour, which often came out in her poems, and explored her views of the world as well as her views of herself.

Ethel had been diagnosed with depression, and suffered from paranoia as well as physical health problems that limited her mobility. She was one of the most vocal members of the group, and the first to be interviewed. She was good friends with Lucas, who originally encouraged her to attend the group. They met at MH1, a local mental health support service. Retired, she had also struggled with alcohol problems in her past. She talked about the group giving her confidence and cited the importance of religion and taking a spiritual path through life.

Ethel's mental health problems mean that she struggles to concentrate on novels, which she used to read, and instead reads poetry. Problems with concentration were common within the group, which is why it focused on poetry rather than prose reading. She had just started borrowing audio books from the library, which she also found manageable as they were easy to listen to in short bursts. In the group, she was sometimes restless, again because of her difficulties in concentration. She moved to the area several years ago, and occasionally spoke in the group of her feeling of not belonging in the town during discussions about the local area. She was interviewed on two separate occasions for logistical reasons, due to a fire drill which interrupted the first interview.

Grace was a participant in the Smithville North Library group. She chose to be interviewed with Isaac, another group member to whom she was very close. She cited their shared sense of humour as one of the key characteristics of their friendship. Their interview was very lively, and they obviously enjoyed each other's company. She was recruited to the group after attending some sessions with a counsellor to discuss her loneliness following the death of her husband and her retirement from work. She valued the group as a source of social support and enjoyment, and referred to it as one of the very few things she had enjoyed enough to stick at. She enjoyed reading and was a regular borrower from the library outside the group. She was quite an active, outgoing person, but stated that she lacked confidence in new situations, and so found it difficult to get involved in leisure activities.

Henry was also a participant in the Smithville North Library group. He was a retired man who lived with his wife, and was a prolific reader. He had joined the reading group after visiting a counsellor for his nerves. He talked at length about the social isolation that people face in retirement, and how this can be difficult to combat. For Henry, the twin themes of literature and a social environment attracted him to joining the reading group. Reading was very important to Henry, and he commented that it also informed other areas of his life, encouraging him to find out more about places, historical eras, and people that he had read about in literature. The reading group had also encouraged Henry to try new authors, and he very much enjoyed the discussion of the books read with the group. He commented that his wife did not enjoy reading, and so this meant he especially enjoyed being amongst a group of people who also valued this opportunity.

Isaac, also a participant in the Smithville North Library group, was very open about having a breakdown, and was still seeing a counsellor as part of his treatment. His breakdown meant that he had to leave paid employment, but he was now involved in voluntary work. He talked about demands made on him by his parents as contributing to his breakdown, and of being unable to make decisions or take responsibility when he was feeling low. He also talked about the physical symptoms of his breakdown, such as dizzy spells.

He was not a great reader before joining the reading group, but being a member had helped him to get his confidence back, given him a sense of self-satisfaction, and encouraged him to take much-needed time for himself. He enjoyed reading, and felt that the group had broadened his reading horizons, though he did not always enjoy all the books. Again, the social side of the group also contributed to his well-being, and was also helping to improve his confidence.

Julia saw a poster for the research project in a community health centre. Both she and her brother suffered from depression and used reading as a coping mechanism, which she mainly related to genetics, though she also recognised the role that life events had played in her mental health problems. She had recently realised that her depression had a chemical basis as well, and required medication to manage both her and her brother's condition. She was very open, discussing the circumstances in her life that had led her to therapy. Julia stated that she had suffered from depression on and off since the 1970s, but that the situation had worsened after the death of her young daughter around ten years after she initially began to experience symptoms; *'I did start getting depressed before I was even married or had a baby. But it was nothing like how it became.'* She felt that it was only in the past few years that she had started to come to terms with these events.

Julia had undertaken a long course of psychotherapy which she felt had also helped her to appreciate her self-worth and move forward. To maintain good mental health, she returned repeatedly to a number of books, some of which she regarded as *'escapism',* and one which was about the grief of losing a child. She practiced reiki, yoga, and tai chi, and felt that cooking and having a healthy diet helped her to remain well. She was a member of a local reading group that utilised public library books but met in other locations. She felt that the library was important as a peaceful place to go, somewhere she felt welcome when she was struggling with problems at work.

Louis was the only participant who asked to be interviewed more than once. His introduction to the research project was different to other participants, as he saw the poster advertising this study in his local library, which then inspired him to borrow some self-help books on depression and anxiety. He had a busy job in

administration, and had recently suffered a bad relationship breakdown. He had previously borrowed books from the library to help him cope with this separation, and also to inform him about caring for his young daughter. He was diagnosed with depression, and struggled with social anxiety. Louis was about to start a short course of counselling at the time of the first interview. He suggested a second interview, as he had not finished reading the self-help books he had borrowed from the library.

In the second interview, he sounded more positive - my field notes describe noticeable changes in him, appearing more focused and confident. He attributed these changes both to the counselling, and to one of the books he had read, as discussed in section 5.3.1.5.1. He used the techniques in the self-help book in his daily life, and had made numerous positive changes in his life, including joining a gym. He felt that previously he had used fiction books in some ways to avoid dealing with his problems, but that he was now making progress in the right direction.

Lucas, a member of the Williamstown group, had been diagnosed with bipolar disorder. He had regularly attended the group since its inception. Lucas had a number of neurological conditions, including headaches, and had retired from his accountancy work for reasons of ill health. He suffered from insomnia, sleeping only a few hours a night, and many of his poems were about the isolation he felt at night. Despite his relatively cheery disposition in person, he also talked about his past problem with alcohol and suicidal feelings throughout his low points.

He was keen to help with the research as he recognised the importance of helping students with their work. He was generous with his time, open and friendly, and was regarded by the group as highly intelligent, with good local knowledge. He was close to his family, especially his daughter, of whom he was very proud, and often talked of her achievements. He valued the reading group immensely, appreciating its role in maintaining his mental health, but did not really use the library outside of this, because of his problems concentrating on longer texts such as novels. He wrote poetry and regularly brought it to the group, though this work was often quite dark, and this darkness was a good-natured running joke within the group.

Milly read about the research project in the mental health service user magazine previously mentioned. She was one of the last participants to be interviewed, and spoke intelligently on a number of themes already discussed by other participants. She was interested in others' experiences as well as reflecting on her own. She had suffered from several episodes of depression, and also spoke of her daughter's mental health problems. Milly had found reading and other creative therapies including knitting, to be invaluable in enabling her to maintain good mental health. This was her main motivation for getting involved in the research project, as she felt an affinity with the topic. She was also a service user volunteer, helping to ensure the quality of mental health services in Smithville and was interested in using her experiences to make a difference to service provision. She spoke of her use of public libraries when she was feeling low, saying that she liked to visit them as a peaceful space.

Milly was very clear that to her, bibliotherapy was not just about self-help books, though she had found books about depression to be informative and useful during her low periods. She spoke of several fiction titles that were important to her, identifying potential reasons for this in the interview. When she was very low, Milly was unable to concentrate on difficult literature, but when she was interviewed, she felt well, and was able to tackle more erudite historical non-fiction.

Mya was also interviewed as part of the Taylorbridge group, and was one of the most vocal contributors to the interview. She found out about the group when Arlene, the group facilitator, attended a local Mind writing creative group. She discussed the impact of the reading group on her dyslexia and speech issues, as well as her mental health problems. She valued the Taylorbridge group immensely, and particularly enjoyed the poetry aspects of the group. She was confident to read, share her ideas, and contribute to the discussion.

Nathan also responded to a poster in his local library. He talked of one major episode of depression, from which he was still recovering. He had also had physical health problems, and it was during the diagnosis process for these problems (including an initial misdiagnosis) that depression affected his life. Throughout his depressive episode, he had struggled with a variety of anti-depressant medications, and eventually paid to see a psychiatrist as he felt unable to cope while on long waiting lists for NHS treatment. The psychiatrist altered his anti-depressant medication which had an effect on his symptoms and aided his recovery. He was motivated to take part in the research because of his '*public spirited'* nature, and also because he felt it would be interesting to explore changes in his reading habits throughout his experience of depression.

He was highly intelligent, and talked of an interest in various subjects, including fine art, politics, and psychology, in which he had no interest when he was depressed. His reaction to his diagnosis was to invest in academic texts on the treatment of depression, but he found himself unable to read any of them while ill. Instead, he read children's books and inter-war crime fiction. Nathan made regular use of the library while depressed. He had great insight into use of books to help with his condition, and some of the key themes emerging from the research (e.g. on escapism) were first recorded in my interview with Nathan.

Olivia became aware of the research project via word of mouth. She had had repeated episodes of depression and anxiety throughout her adult life. Medical professionals had recommended self-help titles to her at three points in her ongoing CBT-based treatment. She felt that two of the self-help titles had been of some use to her, but that the third was a 'misdiagnosis' and did not address the issues with which she was coping at that time. Olivia also talked about the value of fiction in maintaining her mental health at other points in her life.

She talked of the value of public libraries, and was an avid reader and borrower from the library. When she was depressed, she tended to read non-fiction historical texts, children's literature, and light *'escapist'* fiction. She did not belong to a reading group, citing time pressures in her life. Olivia felt that seeing friends, gardening, exercise, and good weather contributed to maintaining good mental health. Again, she was also a highly intelligent and educated person, discussing her condition with a clarity and level of understanding that she recognised was not always possible for her when she was highly depressed.

Ralph became aware of the research project after reading the magazine article previously mentioned, but contact was made via a mutual friend as Ralph did not have an email account. He had been diagnosed with depression, anxiety, and obsessive-compulsive disorder, and regarded his problems as chronic, but with remittances from more severe symptoms. He talked of a number of self-help titles which he had found partly useful, though he regarded self-help books as a money-making industry rather than an attempt on the part of the author to be altruistic. He mainly read non-fiction texts on philosophy, history, politics, and music. He had started to read more fiction as part of a reading group, which he had been a member

of for around two years, but in general preferred to engage with texts that made him think and were concerned with his interests.

The reading group had, however, encouraged him to read more widely and challenged him to try new authors. Ralph was involved with a mental health service user movement, and talked about the value of writing as a form of self-expression. Recently, he had started to learn about Mindfulness, and while he approached the techniques in the book with some scepticism, felt that they might be helpful. He spoke of numerous methods of maintaining good mental health, including appreciating the natural world, listening to music, and keeping in touch with friends.

Rodney was the most vocal contributor to the Taylorbridge group interview, and also expressed his opinions freely and read aloud in the group. Rodney did not discuss his mental health problems directly, but did talk around the subject with Mya. He found out about the group via another mental health service user group that he attended. He was a regular member of the group at its inception, but had not attended for a few months before recently re-joining. He talked about not necessarily liking literature outside of the group, but enjoying the social and intellectual aspects of the group. He discussed his family in detail and suggested that a similar reading aloud group for children might help those with behavioural problems, like his son.

Serena was the only participant interviewed who was not born in the UK, growing up in the USA. She had suffered from a number of episodes of depression and anxiety throughout her life, treated by various medications and talking therapies. Other members of her family also suffered from mental health problems, and she talked openly about her experiences in the USA and UK in psychiatric treatment. Again, Serena was recruited via email, having seen both a poster and magazine article.

During her most recent episode of depression and anxiety, from which she was still recovering, she developed a strong relationship with her therapeutic team, which allowed her to frame her recovery on different terms. She used books to inform and educate her about depression and treatment, talking of an academic-level interest in the subject. She described herself as goal-driven and high achieving, viewing these traits as both positive and negative influences on her life. She stated that she had recently, via reading, started to take an interest in Mindfulness, meditation, and the anti-psychiatry movement. This enabled her to look at depression differently, as a state to experience rather than an illness to be fought, and this new perspective was one she had found beneficial.

Silas was the last research participant to be interviewed. He had found a leaflet for the research project in his local library while seeking other information leaflets and books on depression. He had suffered from depression twice in his life, and was still recovering from the last episode, which had begun around four months prior to the interview. Silas was aware that his depression had been *'triggered'* by life events. He was being treated using anti-depressant medication, and self-referred to a local psychotherapy service. Silas had not spent much time reading before his depression, but now used reading in two ways – reading crime thrillers to distract himself from his problems; and reading for information about depression. He found that both of these techniques were useful in helping him to recover.

Silas was a very active person, and spoke of going walking in the countryside and playing sports to help him maintain his mental health. While he had not had much time for reading before, he felt that he had been missing out on this source of information and escapism, and was thinking of joining a reading group in the future.

He had also come to appreciate the facilities and *'tranquil atmosphere'* of his local public library since his recent depressive episode.

Virginia, a member of the Taylorbridge group, was interviewed by telephone. She had only been attending the group for a few weeks, but already found it invaluable. She was resident in a rehabilitation centre for people with enduring mental health problems. She was an avid reader, and her confidence had increased since joining the group, meaning she was now able to read aloud and contribute to the discussion. Virginia acknowledged that this had not been possible when she initially joined. She had mobility issues and so found it difficult to socialise, but the public library was accessible for her and she described the group as the highlight of her week.

Vivienne was a member of the Smithville North library reading group. She became depressed after the sudden death of her husband, and found solace in reading. She was also counselled by the group leader, who suggested that she might enjoy coming to the reading group following her treatment. She had attended the group since it began, rarely missing a session as she enjoyed the group so much.

Formerly employed in education, Vivienne had a physical health condition that meant she was unable to work. She described herself as someone who had always been an avid reader and identified a number of titles that she felt had been key in representing her experiences and helping her to cope with her situation. She valued the time she spent at the reading group as time to focus on her own enjoyment, and time off from family commitments, as she has raised her two children alone since the death of her husband. She enjoyed listening to others' opinions on books in the group, but also felt that reading was a very personal thing.

Walter was the husband of a project worker involved with the Taylorbridge group. Again, he was interviewed as part of the Taylorbridge group. Though quiet in the interview, he did discuss his enjoyment of the social, communicative aspect of the group. He worked from home, and seemed to appreciate the group as somewhere to go to have interesting discussions about literature with people.

Winston saw a poster for the project in his local library. He brought along a list of important titles with him to talk about. The titles centred on a number of important moments in his life, and our discussion focused on exploring the themes common to some of these titles, including faith, triumph over adversity and personal development. Talking about them as a corpus of literature led him to draw out several key themes, which he then related back to experiences in his life. He was diagnosed with depression around fifteen years ago, and refers to his worst episode of the condition as a period of a few years in which he can remember very little. He does not use his local library very often anymore, but sees this as a reflection of declining service standards, and he still values literature, both narrative fiction and work-related non-fiction titles.

Winston had undertaken a course of anti-depressant medication and talking therapies during his depressive episode, but felt that the value of certain books had been of benefit to him, above that of other treatments. His faith was important to him. He spoke thoughtfully and intelligently about the potential for people to use bibliotherapy to help them to cope in life, and the potential problems with this.

Williamstown Group
Ethel and Lucas, profiled above in the interview section, were also members of this group.

Donald attended all group meetings observed. He was very friendly, regularly helping other members of the group, particularly Ethel, both inside and outside the group. Despite some health problems, he was active, cheerful and involved in campaigning for service user rights. He lived with his civil partner, and often took attended literary and cultural events outside the group. He wrote poetry that he brought to the group, sometimes writing in the group itself. His poems often concerned environmental topics, such as climate change.

Eva attended the group once during the observations. She was a friend of Wayne, Janine and Sally, and very vocal. She talked about a number of events in her life, including the violent death of her ex-partner and the threatening behaviour of her father, sharing a poem she said she had written for her ex-partner's grave.

Frank was a mobile library worker in Williamstown who came to the group to observe. He only attended once, but his presence was felt by the group because he took notes throughout. This was commented on by group members, and reinforced my stance towards observation of the group.

Fred attended two groups throughout the three month observation period. He did not stay for all the group session, usually leaving after refreshments were served. He was a mental health service user who attended MH1. He liked to express his opinions, and always asked for paper on which to write a poem when Jess arrived to lead the group. He often arrived early for the group, and liked science-fiction and fantasy.

Sheri attended six of the seven sessions observed. She also attended the MH1 group, and was one of the quieter members of the group. She did not often comment on the poems, and did not bring her own writing to the group. If discussion turned away from literature to connect it to life experiences, she was more likely to contribute to the conversation. She was interested in the research project and asked many questions about it.

Wayne joined the group for two sessions more or less by chance – he was reading in the section of the library where the group normally met and invited to join. He was eager and enthusiastic about poetry. He made a big impact on the group in the two sessions he attended and many members expected him to become a regular attendee at the group, yet he was not seen again after the second session. He was a vocal contributor, discussing his own poems, expressing enthusiasm for others' poems in the group and enjoying poems read by the facilitator. He clashed with Ethel in one memorable discussion about religion and spirituality.

Wendy was a long-term group member, though physical health problems meant that she did not attend every session, and I did not meet her until the fourth observation I conducted. She was divorced, though still on good terms with her former husband. Her difficulties with mobility meant that she also used Jess's services on an individual basis, asking her to choose library books for her to read outside of the group. She did not write poetry, but commented helpfully on the poems of others. She sometimes discussed medication and side-effects with Lucas and Ethel, leaving me to conclude that she had been diagnosed with a similar condition.

Smithville North Library Group
Grace, Henry, Isaac and Vivienne, profiled above in the interview section, were also members of this group.

Allison was one of the quieter group members. She did not always read the book, usually because of a lack of time. She suffered from the same physical health condition as Vivienne, and sometimes discussed this with her. She often talked about her children and family life, and when conversation turned away from the book to wider issues, she contributed her experiences.

Esme only attended one session of the group while I was observing, but her presence was important for the dynamics of the group. She had seen Leah for counselling, who thought that Esme could benefit from the group, but Esme did not feel comfortable and so sent a letter stating that she was withdrawing from the group, and explaining why. She mainly felt the group was too serious and school-like for her. Esme was the main carer for her husband, and so struggled to socialise.

Evelyn was a newer member of the group, who was very interested in others' views. She usually read all – or most – of the book, and offered an open-minded perspective on it, occasionally challenging members to think differently about a text. She was enthusiastic and lively, and obviously enjoyed attending the group.

Ian was a regular member of the group. He often did not enjoy the books, which led to quite a lot of debate, especially when other members did like the texts. While he was only in attendance at one group meeting I observed, he was a presence at all meetings and interviews, as people discussed the fact that he did not usually like the book, but enjoyed the group and discussion. His ability to take a directly opposing view to all other members of the group was a good-natured source of humour for the group.

Rosemary was a new group member who attended the last session of my observation. Though it was not discussed, it appeared that she had been in touch with Leah before attending the group. She was open and friendly, and contributed a great deal in what was a group meeting depleted by members taking holidays. She also had a physical health problem, struggling to sit still, but was very engaged with the discussion and in tune with the views of the group despite not having read the book on this occasion.

Violet was a regular member of the group and was particularly vocal when the facilitator, Leah, was not in attendance for two meetings. She always read the book though did not always like it. Her views were quite conservative and she often led the discussion when it turned on a more nostalgic theme, as it often did.

Appendix three: Interview schedules and information sheet

Interview schedule: service users	Theme
Is it ok if I record the interview? Have you read the information sheet? Do you understand that you can change your mind about being involved with the project at any time? Have you got any questions about the project? Are you OK to sign this form to say that you've understood what is going to happen?	Before we start
To understand a bit more about you, your mental health, and your use of books for mental health. To learn more about the bibliotherapy scheme you used, if you used one, and to learn more about how libraries can improve services for people with mental health problems, based on your experiences. You don't have to answer any questions you don't feel comfortable answering. Ready to begin…?	Purpose of the interview
What made you decide to reply to the advert? Or, what made you decide to agree to be interviewed?	Involvement in research
Have you heard the term bibliotherapy before? What does the term mean to you? Does it mean anything?	Theoretical constructs
Can you tell me the story of what brought you to the bibliotherapy scheme/ group? How did you first hear about the bibliotherapy scheme/ group? Did you talk to any medical professionals about how you were feeling? If yes: What did they recommend? Did you agree with their opinion? Did you agree with what they recommended? Did you get a prescription from the doctor? Did you take the prescription to the library? Did the doctor offer you any other options? If no: Why did you choose not to? What did you initially think of the bibliotherapy scheme/ group?	Beginnings

Did your opinion change over time?	
What did you read? How did the book make you feel? Was the book helpful? Did you enjoy reading the book? Did the doctor follow up the book with you? Did anyone? What happened next – more treatment, better mental health, giving up/ leaving the system?	Reading Practicalities
How did you get involved with the group? Can you tell me about a group meeting? What happens, who reads etc. How often does the group meet? How long do you meet for? Is it always the same people who come? What do you enjoy about the group?	Group practicalities
Would you say that using RAYS/ GIR/ BoP has helped you? How has it (not) helped? Can you tell me, in as much detail as possible, how you feel it has helped?	Role of the scheme
Did you look at the website/ booklist/ leaflets? Have you read anything about the scheme in the newspaper/ seen anything on the TV?	Materials and publicity
Tell me about going to the library to get the book. How did you feel when you came into the library to get the book? Was it an easy thing to do? Did you feel comfortable coming into the library? Was it easy to find the book you wanted? Did you speak to any librarians about the scheme, or the book you were looking for? Were you happy with the way that the librarians treated you? Were the library staff helpful or not?	Role of the library
Do you use the library for other things?	General library use

What do you think of the library? Can you tell me a little bit about the way that use libraries, and the way that you feel they've contributed to your life? Or books? What kind of books do you usually get from the library? Which library do you typically go to? Can you tell me about any positive or negative experiences you have had in the library? Have you ever seen any displays on mental health in the library, recommending either fiction or non-fiction books? Have you ever been to any events to promote good mental health and well-being?	
Do you think that reading this book/ attending the group improves your mental health? What else do you do to maintain good mental health? Can you describe any other coping methods that you use when you're feeling low? What factors do you think contribute to poor mental health?	General mental health
In your opinion, what could libraries do to make these schemes better? Do you think having the scheme in the library is a good idea, or would you rather go somewhere else to get your book/ attend your group?	Improvements to the scheme?
Is there anything else you want to tell me about your experiences?	Endings

Interview Schedule: management/ facilitators	Theme
Is it ok if I record the interview? Have you read the information sheet? Do you understand that you can change your mind about being involved with the project at any time? Have you got any questions about the project? Are you OK to sign this form to say that you've understood what is going to happen?	Before we start
To understand a bit more about you, your work with the bibliotherapy scheme and your views on the use of books for mental health. You don't have to answer any questions you don't feel comfortable answering. Ready to begin…?	Purpose of the interview
When did you first hear the term bibliotherapy before? What does the term mean to you? Does it mean anything?	Theoretical constructs
How did you first hear about this scheme? What is your role in this scheme? Where did the initial impetus for the scheme come from? What were the initial aims of the scheme? Are these aims still the same? How have they altered?	Beginnings
Can you explain to me, in your own words, how the scheme works? Why do you think [funding body] choose to fund the scheme? Who did you have to get on board to make the project work? Were there any pockets of resistance to the project, or was everyone involved very supportive? What do you think the benefits of a scheme like [name of scheme] are? How do you measure the success of [name of scheme]? Qualitative? Quantitative?	Practicalities
What do you think people think when they are recommended to [name of scheme], rather than psychotherapy or medication? Have you had any feedback from people who have used the	Service user views

scheme? How has the scheme developed? Are people referred to [name of scheme]?	
Do you think that having schemes like this, run in the library, helps to reduce the stigma attached to mental health problems? Do you think that the public library is the best place to operate such a scheme?	Role of the public library
How does [name of scheme] fit into strategic plans? Does having a scheme like [name of scheme] impact on other aspects of your work? Is there any partnership work between libraries and health care? How does [name of scheme] fit into other health/ reading agendas?	Strategic/ partnerships
Can you foresee any difficulties with the scheme? What would you change about the scheme, if you could?	Improvements to the service
Is there anything else that you want to mention about your work?	Endings

Information sheet: service users, May 2010 version

Participant Information Sheet

You are being invited to take part in a research project. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask me or my supervisor if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part. Thank you for reading this.

Research Project Title: 'Read this, it's good for you': using books to improve mood and well-being

I use the term 'bibliotherapy' to talk about using books to help people improve their well-being. This can be in day-to-day life, or it can also be used to help people cope after a significant life event, such as a bereavement or divorce.

Research questions: Do books have an effect on mood and well-being?
How do library service users use books to improve their well-being?

What is the project's purpose?
The aim of the study is to analyse the experiences of library service users, and to contrast these experiences with the aims of the library service to improve services.

The research project will run from October 2008 to September 2011. Data will be collected throughout this time.

Why have I been chosen?
You have been chosen to take part in this research as you consider books to contribute to your well-being and use them to improve your mood. It is hoped that 25 – 30 people will be interviewed in total, to gather a variety of views.

Do I have to take part?
It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. You can still withdraw at any time without it affecting any benefits that you are entitled to in any way. You do not have to give a reason.

What will happen to me if I take part?

The research will be conducted as a one to one interview or in a small group, depending on your preference. The interview will last between 45 minutes and an hour and a half. The interview will take place in a quiet location, such as a library or university meeting room.

The interviews will give you the opportunity to talk about your experiences. I will ask you about your views on literature, books that are important to you, your library use, and the ways you feel books contribute to your well-being. The interview will be audio recorded, with your permission. You do not have to answer any questions that you do not feel comfortable answering. It is possible that discussing any sensitive experiences may be distressing, but you will be free to terminate the interview at any time.

What are the possible benefits of taking part?

Whilst there are no immediate benefits for those people participating in the project, your contribution will be essential to the research and will be gratefully received. The long-term benefits of this research will add to the body of knowledge on the subject and be of great benefit to public libraries.

Will my taking part in this project be kept confidential?

All the information that is collected about you during the course of the research will be kept strictly confidential.

You will not be able to be identified in any reports or publications. You will be referred to by an identification number in all documents, and any documents linking your name and identification number will be kept securely. The interviews will be digitally recorded and transcribed by the researcher. The audio recordings made during this research will be used only for analysis. No other use will be made of them without your written permission, and no one outside the project will be allowed access to the original recordings.

What will happen to the results of the research project?

The audio files and transcriptions will be referred to by the identification number, and stored on a password protected computer. Data access will be restricted to the researcher and supervisors. Some direct quotations may be included in the research

write-up but these will remain anonymous. All original data will be destroyed following the completion of this research project. The results of this research will be collated and written up in the form of a PhD thesis, and may be published in other formats at a later date.

Who is organising and funding the research? Who has ethically reviewed the project?

The research has been ethically approved by in line with the University's Ethics Review Procedure by the Department of Information Studies. The research is funded by the University of Sheffield.

Questions and complaints

Please retain this participant information sheet for reference. If you have any complaint or question, please contact the researcher (Liz Brewster, l.brewster@shef.ac.uk) or supervisors (Barbara Sen, b.a.sen@shef.ac.uk, and Andrew Cox, a.m.cox@shef.ac.uk) in the first instance.

The researcher and supervisors can be contacted by post at:

Information School, The University of Sheffield, Regent Court, 211 Portobello Street, Sheffield, S1 4DP

If you feel a complaint has not been handled to your satisfaction, you can contact the University's Registrar and Secretary at:

http://www.shef.ac.uk/registrar/index.html

or at:

Registrar and Secretary's Office, Firth Court, Western Bank, Sheffield, S10 2TN

Thank you for participating in this project!

Appendix four: Security procedures

As research participants were recruited via posters in public libraries and mental health support groups, it was suggested by the Information School Ethics Review Board that procedures should be put into place to ensure the safety of the researcher and participants. These measures were not implemented if the meeting took place in a public location, such as a departmental meeting room. If there was no suitable public location or participants requested a more private location (for reasons such as concerns about discussing personal experiences or similar), interviews were held in the participant's home.

Security in the contact period:

These procedures will be observed for all participants volunteering to take part in the project.

- Potential participants will be asked to contact the researcher via email.

- The researcher will only utilise a non-personal email address (dis-readingtherapy@lists.sheffield.ac.uk) and the departmental address as contact points.

- Once it is confirmed that potential participants meet the inclusion criteria for the study, research participants will be sent the information sheet about the project before a meeting is arranged.

Security before and during the meeting:

Once a meeting has been arranged with the participant that will take place in a potentially non-secure location, I will outline security procedures with the participant via email (this will then be confirmed with the participant in person in the first stage of the meeting).

These procedures are:

- Establishing a contact who is aware that I am conducting an interview in the home of a participant. In most cases, the contact will be my supervisors. If neither Andrew Cox nor Barbara Sen is available, my partner or another research student will be asked to be my contact person.

- This contact will be provided with a sealed envelope, containing the name, address and contact details of the research participant. The outside of the envelope will have the date and time of the meeting on it, and a time that I am expected to get in touch with the contact by.

- I will phone my contact person prior to entering the house to confirm that the meeting is taking place, and again on exiting the property. If I have not phoned my contact person by the time on the envelope, they will endeavour to call me on my mobile phone.

- If they cannot get in touch with me, they will be asked to open the envelope, and contact the police with their concerns, asking them to attend the property.

- If I feel uncomfortable or threatened during the meeting, I will excuse myself from the meeting stating that I feel unwell.

- Should I be attacked or otherwise prevented from leaving a property, I will use my mobile phone to contact the police and my contacts as appropriate.

- Once the meeting has been conducted without incident, the envelopes containing contact details of participants will be shredded.

An example of the envelope exterior is below:

Start time: 2pm, 5th October 2009 Liz to call primary contact at 1:50pm to confirm meeting Liz to call primary contact on exiting the house, or at 3:30pm, whichever is earlier. If the meeting has not concluded by 3:30pm, Liz will inform the contact then call again on exiting the house. Primary contact to call Liz at 3:35pm if call not received at 3:30pm. Primary contact to open envelope and notify police at 3:40pm if required.	Primary contact: Barbara Sen (mobile number) Secondary contact: Andrew Cox (mobile number) Liz's mobile (mobile number) *If Liz cannot reach the primary contact, she will immediately call the secondary contact. That person will call the primary contact and then take over as primary contact for the purpose of this meeting*

Security procedures outlined to research participants in email and confirmed at beginning of each meeting:

I need to alert you to the security procedures required by the University of Sheffield to enable me to conduct this study. These measures are designed to protect both of us.

When I arrive at your home, I will provide photo identification to show who I am. Before I enter your home, I will phone a contact person, to say that the meeting is going ahead. I will need to phone this contact again at a specified time, to check in. If I fail to do so, an emergency procedure will be activated and the police may be called.

Your name and address will be in a sealed envelope with two of my contacts during our meeting. They will only open this envelope in the case of an emergency. Once I exit the meeting safely, these envelopes will be shredded unopened.

If at any time you feel unsafe and wish me to leave your home, you can ask me to leave without giving a reason, and I will do so.

Appendix five: Coding framework

Bibliotherapy as a concept (BC)
- BC-institutional
- BC-personal

Interaction with bibliotherapy scheme (IWBS)
- IWBS-prescription
- IWBS-group
    - IWBS-group-recruitment
    - IWBS-group-expectations
    - IWBS-group-format
    - IWBS-group-benefits
    - IWBS-group-interaction
        - IWBS-group-interaction-negative
        - IWBS-group-interaction-positive
    - IWBS-group-motivations
    - IWBS-group-improvements-to-group
    - IWBS-group-reading
    - IWBS-group-facilitator

Interactions with texts (IWT)
- IWT-book-titles
- IWT-personal-choice
- IWT-content
    - IWT-content-challenge
    - IWT-content-safety
- IWT-emotions
    - IWT-emo-catharsis
    - IWT-emo-coping
    - IWT-emo-character-id
    - IWT-emo-inability
    - IWT-emo-universal
    - IWT-emo-validity
- IWT-escapism
- IWT-info
    - IWT-info-alt-treatment
    - IWT-info-learning
- IWT-self-help
    - IWT-self-help-negative
    - IWT-self-help-positive
    - IWT-self-help-access-to-therapy

Library use (LU)
- LU-space
- LU-staff-negative
- LU-staff-positive
- LU-reading groups

Life circumstances (LC)
- LC-diagnosis
- LC-life-changing-events
- LC-symptoms
    - LC-symptoms-book-choice-content

- LC-symptoms-book-choice-physical
- LC-treatment
- LC-maintaining-mental-health
- LC-personal-understanding
- LC-stigma
- LC-relationships
  - LC-relationships-family
  - LC-relationships-medical
  - LC-relationships-psychiatric
  - LC-relationships-service-user-organisations

Reading habits (RH)
- RH-act-of-reading
- RH-episodic-changes
- RH-lifetime
- RH-book-ownership
- RH-re-reading
- RH-social
- RH- writing

Other codes used:
- Interaction-with-technology (usually to note any mention of e-readers etc, or a disengagement with technology like email)
- Research-reflection (my reflections on recruitment and interviews)
- Research-recruitment (to the research project, as opposed to recruitment to bibliotherapy schemes etc)

Appendix six: Ethical review application documentation

This appendix contains copies of the email notification of approval gained for my pilot project, main study, and the decision made by the University Research Ethics Committee that it would not be necessary to gain NHS ethical approval before commencing research.

A: Ethical review application: pilot study

Date: Tue, 17 Mar 2009 16:38:15
From: Val Gillet <V.Gillet@sheffield.ac.uk>
To: Liz Brewster <l.brewster@sheffield.ac.uk>
Cc: Barbara Sen <B.A.Sen@sheffield.ac.uk>
Subject: Research ethics application - approved

Dear Liz,

On behalf of the University ethics reviewers who reviewed your application, I am pleased to inform you that your project was approved on ethics grounds, on the basis that you will adhere to the documents that you submitted.

If during the course of your project you need to deviate from the documents you submitted please inform me.

Written approval will be required for significant deviations from or significant changes to the approved documents. You may now commence your research.

Thanks,
Val Gillet
Ethics Co-ordinator

B: Ethical review application: main research project
NB: the suggested changes were incorporated before recruitment commenced.

Date: Thu, 30 Jul 2009 10:08:34
From: Val Gillet <V.Gillet@sheffield.ac.uk>
To: Liz Brewster <l.brewster@sheffield.ac.uk>
Cc: Barbara Sen <b.a.sen@sheffield.ac.uk>
Subject: Research ethics application - approved with suggested changes

Dear Liz,

On behalf of the University ethics reviewers who reviewed your project, I am pleased to inform you that it was approved on ethics grounds, on the basis that you will adhere to the ethics form that you submitted.

One of the reviewers made the following suggestions that you might consider:

Participant Information Sheet - Explain after "What will happen to me if I take part? The research will be conducted as a one to one interview. The interview will last between 45 minutes and an hour and a half and where the interview will take place.

Demographic questionnaire - Change: "What was your last level of education completed?" to "What is your highest level of education completed?"

I suggest you consider these comments before sending out the questionnaire.

If during the course of your project you need to deviate from the documents you submitted (other than the suggested change to the style of the questionnaire described above) please inform me.

Written approval will be required for any other significant deviations from or significant changes to the approved documents. You may now commence your research.

Thanks,
Val Gillet
Ethics Administrator

C: UREC ethics review decision
Date: Thu, 06 Aug 2009 14:23:22 +0100
From: "R.J.Hudson" <R.J.Hudson@sheffield.ac.uk>
To: Liz Brewster <l.brewster@sheffield.ac.uk>
Cc: Barbara Sen <B.A.Sen@sheffield.ac.uk>
Subject: Re: Research ethics query

Dear Liz,

The Chair of the University's Research Ethics Committee - Professor Richard Jenkins - has considered your ethics query.

Richard's advice is that your proposed research will NOT require NHS ethics approval. This is on the basis that you will not be recruiting users by virtue of their past or present treatment by, or use of, the NHS but will be recruiting prospective participants in their capacity as users of library services (moreover, it is not a condition of inclusion in your sample that participants should have been prescribed or recommended Bibliotherapy by a GP or other doctor).

The issue of service evaluation does not arise because as a PhD your proposed work involving human participants constitutes research and, therefore, requires University research ethics review and approval.

Kind regards,
Richard [Hudson]

Appendix seven: Books mentioned by participants in the research project

As participants only mentioned titles or authors, and not references to specific editions, it was felt that it was not appropriate to provide full publication details for each title. Where I consulted a specific edition of a text for reference purposes, the full reference is included in the bibliography. Participants often mentioned an author without specifying a title, especially in the case of fiction writers who had written a significant number of books, such as Ngaio Marsh or Jane Austen. Alternately, the title was mentioned but not the author – in these cases, I have endeavoured to fill in the missing information regarding authors. In some cases, participants did not mention particular titles, instead describing the book. The descriptions of the books have also been included here to ensure a complete picture of the types of titles used is presented. For clarity, titles will be split into adult and children's fiction, non-fiction – including self-help, biography and autobiography – and poetry, with texts read in bibliotherapy groups separated out from those read individually. The final table will present titles organised by individual participants.

Table 1: Adult fiction read individually by participants

Author		Title
Margery	Allingham	
Jane	Austen	
Richard	Bach	*Jonathan Livingston Seagull*
Ray	Bradbury	*The Martian Chronicles*
John	Brunner	*Shockwave Rider*
Mikhail	Bulgakov	*The Master and Margarita*
Albert	Camus	
Peter	Carey	*Oscar and Lucinda*
Agatha	Christie	
Bernard	Cornwell	*Heretic*
Patricia	Cornwell	
Edmund	Crispin	
Simon	Crump	
Charles	Dickens	*Pickwick Papers*
Umberto	Eco	*The Name of the Rose*
Ben	Elton	
David	Foster Wallace	*Infinite Jest*
Stephen	Fry	
Joyce	Grenville	*Stately as a Galleon*
L.P	Hartley	*The Go Between*
Alan	Hollinghurst	
Aldous	Huxley	*Brave New World*
P.D	James	
James	Joyce	
Richard	Kearney	*Walking at Sea Level*

Author		Title
Stephen	King	*Rita Hayworth and the Shawshank Redemption*
W.P	Kinsella	*Shoeless Joe*
Rudyard	Kipling	*Just So Stories*
Harper	Lee	*To Kill a Mockingbird*
Hilary	Mantell	
Ngaio	Marsh	
Audrey	Niffenegger	*The Time Traveler's Wife*
Joseph	O'Neill	*Netherland*
George	Orwell	
Robert	Pirsig	*Zen and the Art of Motorcycle Maintenance*
Terry	Pratchett	
Philip	Roth	
Alice	Sebold	*Lucky; The Almost Moon; The Lovely Bones*
David	Sedaris	
Carole	Shields	*Unless*
John	Steinbeck	*Of Mice and Men*
Donna	Tartt	*The Secret History*
William	Trevor	*The Story of Lucy Gault*
Jonathan	Tropper	*How to Talk to a Widower*
Louise	van Swaaji	*The Atlas of Experience*
	Various	*"Comedy books"*
	Various	*"Detective stories"*
	Various	*"1950s crime"*
Jules	Verne	*20,000 leagues Under the Sea; Eighty Days Around the World; Journey to the Centre of the Earth*
Evelyn	Waugh	*Brideshead Revisited*
H.G	Wells	
Antonia	White	*Frost in May series*
Thornton	Wilde	*Bridge at St Luis Rey*
Niall	Williams	
P.G	Wodehouse	*Jeeves and Wooster series*

Table 2: Children's fiction read individually by participants

Author		Title
Richmal	Crompton	*Just William*
Ursula	Le Guin	*Earthsea; The Tombs of Atuan*
Stephanie	Meyer	*Twilight series*
Christopher	Pasodini	*Eldest; Brisinger*
	Various	*"Children's books, and young adult books"*
Cecily	Von Ziegesar	*Gossip Girl*

Table 3: Non-fiction connected to mental health read individually by participants

Author		Title
Sue	Atkinson	*Climbing Out of Depression; Pathways through Depression*
Gillian	Butler	*Overcoming Social Anxiety and Shyness*
Melanie	Fennell	*Overcoming Low Self-Esteem*
Susan	Jeffers	*Feel the Fear and Do It Anyway*
Matthew	Johnstone	*I had a Black Dog; Living with a Black Dog*
Irving	Kirsch	*The Emperor's New Drugs.*
Robert	Leahy	*The Worry Cure*
Gwyneth	Lewis	*Sunbathing in the Rain*
Gael	Linfield	
Terry	Lynch	*Beyond Prozac: Healing Mental Distress*
Philip	Martin	*The Zen Path through Depression*
Jerry	Masson	*Against Therapy*
May	Nurrie Stearns	*Yoga for Anxiety*
	Padesky and Greenberger	*Mind over Mood*
Dorothy	Rowe	*Depression*
	Unknown	*Overcoming Depression*
	Unknown	*"Oxford handbook to depression"*
	Various	*AA literature*
	Various	*"Quite a few self-help books and also counselling and things on mental health"*
	Various	*"The equivalent of Teach Yourself or the Dummies Guide to Depression"*
	Various	*"Things recommended by Mind"*
Claire	Weekes	*Self-Help for your Nerves*
	Wigney, Eyres and Parker	*Journeys with the Black Dog: Inspirational Stories of Bringing Depression to Heel*
	Williams *et al*	*Mindful Way through Depression*
	Wilson and Branch	*Cognitive Behavioural Therapy for Dummies*
Louis	Wolpert	*Malignant Sadness*

Table 4: Non-fiction not connected to mental health, read individually by participants

Author		Title
Augusten	Burroughs	*Dry*
Julia	Cameron	*The Artist's Way*
Johnny	Cash	*Cash: the Autobiography*
Steven	Covey	
John	Emsley	*The Elements of Murder: A History of Poison*
Richard	Feynman	
L. Ron	Hubbard	*What is Scientology?*
Steven	Levy	*Hackers: Heroes of the Computer Revolution*
Paul	Morley	
General George	Patton	*War as I Knew It*
Jane	Robinson	*Bluestockings*
John	Tittensor	*Year One: A Record*
	Unknown	*"The history of mathematics"*
	Unknown	*"The history of the Byzantine empire"*
	Unknown	*"Zero, the history of the number"*
	Unknown	*"Dylan Thomas"*
	Unknown	*"Non-fiction on orthodox Judaism"*
Louise	van Swaaji	*The Atlas of Experience*
	Various	*The Bible*
	Various	*"Feminism and women and self defence"*
	Various	*"Thai cooking"*
	Various	*"Atlases and maps"*
	Various	*"Cookery books"*
	Various	*"Narrative non-fiction"*
	Various	*"Music skateboarding, other kinds of low culture or popular culture"*
	Various	*"Things related to current affairs or historical events"*
	Various	*"Things with a philosophical bent"*
Oscar	Wilde	*The Critic As An Artist*

Table 5: Poetry read by participants

Author		Title
Wendy	Cope	*Making Cocoa for Kingsley Amis*
TS	Eliot	
John	Hegley	*Glad to Wear Glasses*
Gerard	Manley Hopkins	*No Worst, There is None*
Mary	Oliver	*The Journey, Wild Geese*
Michael	Rosen	
Anne	Sexton	

Table 6: Fiction read by groups
(including fiction noted by individual participants as read in reading groups)

Author		Title
Paul	Adams	
Martin	Amis	*Night Train*
E. F.	Benson	*Mapp and Lucia*
Sam	Bourne	*The Righteous Men*
Charlotte	Bronte	*Jane Eyre*
Arthur	Conan-Doyle	*Sherlock Holmes: the Musgrave Ritual*
Tim	Gatereux	*Waiting for the Evening News*
Zoe	Heller	*Notes on A Scandal*
Victoria	Hislop	*The Return*
Khaled	Hosseini	*The Kite Runner; A Thousand Splendid Suns*
Aldous	Huxley	*Brave New World*
James	Joyce	*Eveline*
Doris	Lessing	*Through the Tunnel*
Marina	Lewycka	*A Short History of Tractors in Ukrainian*
Gregg	Matthews	*The Further Adventures of Huckleberry Finn*
Alexander	McCall Smith	
Ian	McEwan	*Atonement; On Chesil Beach*
Philippa	Pearce	*Tom's Midnight Garden**
Claire	Scobie	*Last Seen in Lhasa: The Story of an Extraordinary Friendship in Modern Tibet*
Lisa	See	*Snow Flower and the Secret Fan*
Anita	Shreve	*The Pilot's Wife*
John	Steinbeck	*The Grapes of Wrath*
Robert Louis	Stevenson	*Jekyll and Hyde*
Elizabeth	Taylor	*Mrs Palfrey at the Claremont*
Rosie	Thomas	*Iris and Ruby*
H.G	Wells	
Carlos Ruiz	Zafon	

*Children's book read by a group

Table 7: Mon-fiction read by groups

Author		Title
Tim	Butcher	*Blood River*
Anne	Dickinson	*The Mirror Within: New Look at Sexuality**
Joyce	Storey	*The House At South Road*
Jennifer	Worth	*Shadows of the Workhouse*

* Read as part of a therapeutic group

Table 8: Poetry read by groups

Author		Title
Simon	Armitage	*Cloudcuckooland; The Universal Home Doctor; Seeing Stars*
Wendy	Cope	*Giving Up Smoking*
Walter	de la Mare	*The Listeners*
Michael	Donaghy	
Carol Ann	Duffy	
Janet	Frame	*Selected Poems*
Philip	Gross	
Ted	Hughes	*The Rattle Bag: An Anthology of Poetry*
Philip	Larkin	
Mike	Longley	
Roger	McGough	
Ian	McMillan	*Yorkshire Puddings*
Les	Murray	
Norman	Nicholson	*Rising Five*
Don	Paterson	*Rain*
Jacob	Polley	*Little Gods*
Theodore	Roethke	*My Papa's Waltz*
	Various	*"A book of young adult poetry"*

Table 9: Book titles organised by individual participants

Participant	Author		Title
Alfie	Jane	Austen	
	Albert	Camus	
	Richmal	Crompton	*Just William*
	Simon	Crump	
	Charles	Dickens	*Pickwick Papers*
	TS	Eliot	
	Ben	Elton	
	P.D	James	
	James	Joyce	
	Paul	Morley	
		Unknown	*AA literature*
		Unknown	*"Dylan Thomas"*
		Various	*"Comedy books"*
	Oscar	Wilde	*The Critic As An Artist*

Participant	Author		Title
Amelia	Julia	Cameron	*The Artist's Way*
	Wendy	Cope	*Making Cocoa for Kingsley Amis*
	Jerry	Masson	*Against Therapy*
	Dorothy	Rowe	*Depression*
		Unknown	*"Feminism and women and self defence"*
		Various	*"Children's books, and young adult books"*
	Antonia	White	*Frost in May series*
Beatrice	James	Joyce	
	Michael	Rosen	
	Anne	Sexton	
Connor	Peter	Carey	*Oscar and Lucinda*
Ethel	L. Ron	Hubbard	*What is Scientology?*
Julia	Joyce	Grenville	*Stately as a Galleon**
	John	Hegley	*Glad to Wear Glasses**
	Rudyard	Kipling	*Just so stories**
	John	Tittensor	*Year One: A record**
		unknown	*"Atlases and maps"*
	Louise	van Swaaji	*The Atlas of Experience*
	Niall	Williams	
Louis	Gillian	Butler	*Overcoming Social Anxiety and Shyness**
	Susan	Jeffers	*Feel the Fear and Do It Anyway**
Milly	Sue	Atkinson	*Climbing Out of Depression; Pathways through Depression*
	Gerard	Manley Hopkins	*No Worst, There is None*
	Mary	Oliver	*The Journey, Wild Geese*
	Carole	Shields	*Unless*
	William	Trevor	*The Story of Lucy Gault*
	Louis	Wolpert	*Malignant Sadness*
Nathan	Margery	Allingham	
	Augusten	Burroughs	*Dry*
	Agatha	Christie	
	Edmund	Crispin	
	John	Emsley	*The Elements of Murder: A History of Poison*
	David	Foster Wallace	*Infinite Jest*
	Matthew	Johnstone	*I had a Black Dog*
	Ursula	Le Guin	*Earthsea; The Tombs of Atuan*
	Gwyneth	Lewis	*Sunbathing in the Rain*
	Ngaio	Marsh	

Participant	Author		Title
Nathan (continued)	Stephanie	Meyer	*Twilight series*
	Joseph	O'Neill	*Netherland*
	Christopher	Pasodini	*Eldest; Brisinger*
	Dorothy	Rowe	*Depression*
	David	Sedaris	
		Unknown	*"Oxford handbook to depression"*
		Unknown	*"Zero, the history of the number"*
		Unknown	*"Non-fiction on orthodox Judaism"*
		Unknown	*"The history of mathematics"*
		Unknown	*"The history of the Byzantine empire"*
		Various	*"quite a few self-help books and also counselling and things on mental health"*
		Various	*"the equivalent of Teach Yourself or the Dummies Guide to Depression"*
		Various	*"Things recommended by Mind"*
		Various	*"Thai cooking"*
		Various	*"Cookery books"*
		Various	*"Narrative non-fiction"*
		Various	*"Things related to current affairs or historical events"*
		Various	*"detective stories"/ "1950s crime"*
		Wigney, Eyres and Parker	*Journeys with the Black Dog: Inspirational Stories of Bringing Depression to Heel*
Olivia	Melanie	Fennell	*Overcoming Low Self-Esteem*
	Stephen	Fry	
	Ursula	Le Guin	
	Robert	Leahy	*The Worry Cure*
		Padesky and Greenberger	*Mind over Mood*
	Terry	Pratchett	
	Jane	Robinson	*Bluestockings*
		Various	*"Children's books"*
	Jules	Verne	*20,000 Leagues under the Sea; Eighty Days Around the World; Journey to the Centre of the Earth*
	Cecily	Von Ziegesar	*Gossip Girl*
	P.G	Wodehouse	*Jeeves and Wooster series*
Ralph	Richard	Bach	*Jonathan Livingston Seagull*
	Aldous	Huxley	*Brave New World*
	Matthew	Johnstone	*I had a Black Dog*
	Harper	Lee	*To Kill a Mockingbird*
	Gael	Linfield	
	John	Steinbeck	*Of Mice and Men*

Participant	Author		Title
Ralph (continued)		Various	*"Music skateboarding, other kinds of low culture or popular culture"*
		Various	*"Things with a philosophical bent"*
	Claire	Weekes	*Self-Help for your Nerves*
Serena	Irving	Kirsch	*The Emperor's New Drugs.*
	Terry	Lynch	*Beyond Prozac*
	Philip	Martin	*The Zen Path through Depression*
	May	Nurrie Stearns	*Yoga for Anxiety*
	Dorothy	Rowe	*Depression*
		Williams *et al*	*Mindful Way through Depression*
Silas	Patricia	Cornwell	
		Unknown	*Overcoming Depression*
		Wilson and Branch	*Cognitive Behavioural Therapy for Dummies**
Virginia	Bernard	Cornwell	*Heretic*
Vivienne	Richard	Kearney	*Walking at Sea Level*
	Audrey	Niffenegger	*The Time Traveler's Wife*
	Alice	Sebold	*Lucky; The Almost Moon; The Lovely Bones*
	Jonathan	Tropper	*How to Talk to a Widower**
Winston	Ray	Bradbury	*The Martian Chronicles***
	John	Brunner	*Shockwave Rider*
	Mikhail	Bulgakov	*The Master and Margarita***
	Johnny	Cash	*Cash: the Autobiography*
	Steven	Covey	
	Umberto	Eco	*The Name of the Rose***
	Richard	Feynman	
	L.P	Hartley	*The Go Between***
	Stephen	King	*Rita Hayworth and the Shawshank Redemption***
	W.P	Kinsella	*Shoeless Joe*
	Harper	Lee	*To Kill a Mockingbird*
	Steven	Levy	*Hackers: Heroes of the Computer Revolution***
	George	Orwell	
	General George	Patton	*War as I Knew It*
	Robert	Pirsig	*Zen and the Art of Motorcycle Maintenance***
		Various	*The Bible***
	Evelyn	Waugh	*Brideshead Revisited*
	H.G	Wells	
	Thornton	Wilde	*Bridge at St Luis Rey***
	P.G	Wodehouse	*Jeeves and Wooster series*

* texts brought to interview
** texts written on list brought to interview as aide memoire