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Picturing Recovery: A Photovoice Exploration of Recovery Dimensions Among People With Serious Mental Illness

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Abstract

Objectives—Recovery from mental disorders encompasses multiple interrelated dimensions. This study used photovoice to explore how individuals with serious mental illness and a history of substance abuse and homelessness envisioned their recovery. A dimensional recovery model was applied to examine how the interrelationships between recovery dimensions supported consumers' recovery journeys.

Methods—Photovoice is a participatory research method that empowers people by giving them cameras to document their experiences and inform social action. Sixteen consumers recruited from two supported housing agencies participated in six weekly sessions to which they brought photographs that they took of persons and events in their lives that reflected recovery and wellness and discussed the meaning of the photographs in individual interviews and group sessions. The authors used pile-sorting, grounded theory, and a deductive template-analytic technique to analyze narrative and visual data.

Results—Spirituality, life achievements, and receiving and providing support were the most salient themes that emerged from the analysis and illustrate beneficial interrelationships between recovery dimensions. Participants discussed how they relied on their spirituality to support their sobriety and cope with addictions—aspects of clinical recovery. Educational and vocational achievements represented gains in functioning that contributed to increasing self-esteem and self-agency and reducing self-stigma. Social dimensions of recovery, such as receiving and giving support to loved ones, rippled through consumers' lives reducing isolation and enhancing their self-worth.

Conclusions—The findings illustrate the value of participatory methods to understand what recovery signified to people with serious mental illness and how understanding the interrelationships between recovery dimensions can inform recovery-oriented services.

The recovery model has become a major force in shaping mental health services, policies, and research in the United States and other developed countries (1,2). The main tenet of recovery is that people with mental disorders have the capacity and resiliency to overcome the devastating consequences of mental illness or substance abuse—especially when given the right supports—and can develop a fulfilling life in the community (3).

Disclosures
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Although numerous conceptualizations exist, there is a consensus that recovery is a multidimensional and complex phenomenon (4). It is often described as a journey that includes objective outcomes (for example, symptom reduction and improved functioning) and subjective outcomes (for example, increased agency, hope, and empowerment) (5–7). In this article, we present findings from a photovoice project, a participatory research method that empowers people by giving them cameras to document their lives and promote social action (8). We examined how people in supported housing programs who had serious mental illnesses, such as schizophrenia, and a history of substance abuse and homelessness envision their recovery.

The study was propelled by Whitley and Drake's (7) recovery framework, which was chosen because it synthesizes existing recovery models and emerged from a project that included a population (poor, urban, and formerly homeless individuals) similar to the one in our study. This framework conceptualizes recovery as consisting of five interrelated dimensions: clinical, existential, functional, physical, and social. The clinical dimension is grounded in the medical model and refers to reductions in and control of symptoms. The existential dimension refers to factors, such as hope, responsibility, self-efficacy, empowerment, and religion or spirituality (4,5). The functional dimension captures the ability of people to actively participate in everyday activities in the community, including educational pursuits, employment, and housing. The physical dimension refers to improvements in a person's general health and includes activities that promote a healthy lifestyle. The social dimension encompasses the interpersonal and community spheres that connect the person to family members, friends, and the community at large.

This framework stipulates that there will be synergistic interrelationships between these dimensions. For example, reconnecting with a family member (social recovery) can reduce isolation and depression (clinical recovery). How these interrelationships support recovery is still an open question that has not been empirically examined. In this study, we used photovoice to address this important gap and apply this dimensional framework to illustrate how the dimensions were present in participants' recovery, to examine how interrelationships between the dimensions supported recovery, and to discuss how the interrelationships can inform recovery-oriented services.

Methods

Photovoice

Photovoice is a method that enables community members to use the power of photographs and narratives to communicate their experiences and engage in a critical dialogue to inform social action (8). The method involves a group of community members who come together to take photographs of their everyday realities, commonly around topics of interest, and use their photographs to inform group discussions (9). Photovoice has been used in areas such as education, health, and mental health to formulate solutions and actions to promote positive changes in communities (10–12).

Setting

The appropriate institutional review boards approved study procedures. Study methods have been described elsewhere (13) and are briefly summarized here. The study took place in two supported housing agencies in New York City between September and December 2010. Both agencies have innovative programs to combat homelessness and poverty. Agency A pioneered the Housing First approach in which consumers are offered apartments scattered throughout the community and are not required to participate in psychiatric or substance abuse treatments as a condition for housing (14). Agency B follows a single-site housing

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model where people with and without serious mental illness live alongside one another and are connected to off-site services (for example, case management). Partnering with these two agencies enabled us to explore recovery issues across two dominant supported housing approaches.

Sample

A purposive sample of 16 tenants living with serious mental illness, eight from each agency, was recruited. Staff at each agency nominated between eight and ten residents who were 18 years of age or older, English speaking, capable of providing informed consent, and interested in participating in a six-week program to learn how to take photographs in their communities and discuss issues of health and wellness. All participants contacted agreed to participate.

Procedures

Two photovoice groups were conducted, one at each agency. Members of the research staff and peer leaders from each agency cofacilitated the groups. Each group session lasted 90 minutes, had eight participants, and met for six consecutive weeks. In session 1, participants completed a self-reported survey that collected demographic, health, and mental health information. We then introduced photovoice, discussed ethics and safety issues related to taking photographs in the community, and practiced taking photographs. At the end of the session, we instructed participants to take photographs for the following session about what they did to stay healthy.

Sessions 2 to 6 consisted of individual photo-elicitation interviews and group dialogues. As each participant arrived, he or she sat with a research staff member to download the pictures and to select and print one photograph that represented the theme for that week. The individual then participated in a photo-elicitation interview using questions such as “What’s the story this photo tells?” to discuss the meaning of the selected photo. At the end of the interview, each participant titled the photograph.

We then conducted a group dialogue using the standard S-H-O-W-E-D technique (15). During the final ten minutes of the group, we summarized topics discussed, and through a group consensus process participants voted on the theme for next week’s photo assignment. [Details about the S-H-O-W-E-D technique and a list of themes chosen by each group are presented in an online data supplement to this article.] All photo-elicitation interviews and group dialogues were audiorecorded and transcribed.

Data analysis

Descriptive statistics were used to summarize sample characteristics. An analytical working group composed of three team members—a master’s-level social worker, a doctoral-level social work researcher, and a community organizer employed as a member of our research team—conducted qualitative data analyses. Details about the analytical procedures are presented elsewhere (13). Briefly, an inductive process, including pile-sorting techniques (16) and the constant comparative method derived from grounded theory (17), was used to develop a code book for the entire project. Atlas.ti software (18) was used to code all data. For the analysis reported here, we used a deductive template-analytic technique (19) based on the recovery dimensions stipulated in Whitley and Drake’s model (7) to selectively code recovery narratives and derive recovery themes. We used established strategies, such as triangulation, prolonged engagement, and member-checking activities, to enhance the trustworthiness of our analysis (20).

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Results

Sample characteristics

Most of the 16 participants were men (N=9) and either African American or Hispanic (N=14) (Table 1). The majority reported a diagnosis of schizophrenia, major depression, or bipolar disorder (N=15) and a history of substance dependence (N=9). Most participants (N=15) attended more than half of the weekly sessions. Twelve attended all photo-elicitation interviews, and 11 attended all group discussions. Missed sessions were confined to two participants at site A and one participant at site B.

Recovery dimensions

The five recovery dimensions were present in participants' photographs and narratives. Spirituality, life achievements, and receiving and providing support were the most salient themes that emerged from our analysis and illustrate beneficial interrelationships between recovery dimensions (Table 2).

Spirituality

Among participants from both sites, spirituality played an important role in recovery. Many relied on their faith to support their sobriety and cope with their addictions—aspects of clinical recovery. Faith and prayer were sources of strength to stay away from drugs, as described by an African-American man in his photo-elicitation interview: "I like to praise God. God makes me stronger and do the right thing. I pray to forget drugs, for peace of mind, the things you need to keep you alive. A long time I was a smoking crack addict and then I praised God [to] help forget the crack, that's how I get my peace of mind by praying."

Many talked about having an intimate relationship with God through daily prayers, meditation, and reading the Bible. Participants discussed how these practices, along with conventional mental health treatments, were part of their daily routine and viewed as healthy ways to cope with stress. Prayer was described as a way to "cleanse the soul," "to clear things," and "to get that stress off of you." These personal relationships with God were also exemplified by a photo titled "Security" by an African-American woman who talked about how she relied on prayer and attending services to recharge her spirit and give her direction. [The photo and a transcript of the photo-elicitation interview are presented in the online data supplement to this article.]

Life achievements

Educational and vocational achievements—elements of functional recovery—were frequently mentioned as key events that contributed to participants' recovery. These events were concrete validation of their efforts and motivated them to continue working toward their recovery. As expressed by an African-American woman who described in a group session her enrollment in a community college, these achievements proved to her that "it's never too late to keep trying, to keep growing."

Many participants discussed how going back to school, graduating from vocational programs, or finding employment restored a sense of purpose and self-worth. For example, an African-American man took a photo of his certificate of completion from a community support program and titled the photo "Focus Towards Achievement." When asked what this meant during the photo-elicitation interview, he responded: "It tells people I have accomplished something. By me achieving something that makes me feel good, I feel confident. If you want to learn anything you put your mind to it, you can achieve anything in the community, that's achievement because you're on your way to healing."

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Life achievements helped many combat the stigma that they internalized for being a person with a psychiatric disability and a history of homelessness. This was best captured by an African-American man discussing in a group session what it meant to graduate from a peer specialist program: “Society says that we can’t function in society. This certificate proves that’s a myth. It takes all the things that used to hold me back, that I had to deal with, and turns it around from a negative into a positive.… And I’m in the healing process from a lot of stigma that society has put on me, a lot of self-stigma that I placed upon myself, and I’m actually living in society and doing productive things, so I’m healing, and I’m putting that stigma to rest.”

Receiving and providing support

Participants’ photographs and narratives illustrated how the social dimensions of recovery that are related to receiving and giving support to friends, peers, and family members had many positive benefits. A supportive network of friends and family members helped many with their clinical recovery by reducing isolation and depression and preventing relapse. Supportive networks provided emotional and instrumental support during times of need. For example, one non-Hispanic white woman talked about how her friend helped her out when she got sick by making her tea, buying groceries, and cooking.

Many discussed how these social networks helped shift unhealthy behaviors. For instance, a Hispanic man treated for cancer described in his photo-elicitation interview how his girlfriend encouraged him to be more physically active and to be in a healthier frame of mind. He observed, “Because of all the motivation she gives me. She keeps me young. [Laughs.] For one thing she’s younger than me so she got more motivation— she likes to exercise.” The interviewer asked whether the participant exercised with her, and the man responded, “Sometimes; I do push-ups, sit ups, sometimes we ride a bike.” When asked whether it was helpful to have someone to exercise with, the participant responded, ”Yeah, ‘cause if it wasn’t for her I wouldn’t do nothing. She says you’re getting old, you’re sick, you gotta keep your spirit up—she always gives me that push.”

Many participants discussed the benefits they got from providing support to loved ones. The act of being there for someone they care about enabled them to feel needed and to use their experiences to help peers through their recovery. In the words of an African-American man, providing peer support is all about “inspiring hope” that recovery is possible. Reconnecting with family, particularly children or grandchildren and trying to be a positive influence in their lives also supported participants’ recovery. This was best captured by a photograph titled “My Baby” by an African-American man who discussed how his son is his inspiration for his recovery. [The photo and a transcript of the photo-elicitation interview are presented in the online data supplement to this article.]

Discussion

Our findings illustrate the value of using photovoice to examine consumers’ thoughts and feelings about recovery. This methodology helps consumers and others understand the complexities of recovery by enabling consumers to take an active role in the knowledge generation process. It uses narrative and photographic approaches to capture aspects of consumers’ everyday lives that are not easily accessible with traditional research methods, such as surveys, that rely mostly on a person’s verbal skills and abilities to communicate and that can be experienced as impersonal and intimidating to participants (21). Our findings captured what recovery signified to participants and point toward important interrelationships between recovery dimensions that can inform traditional mental health and recovery-oriented services.

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Spirituality, an aspect of existential recovery, was central to participants' recovery, and it helped sustain positive clinical outcomes. Our findings overlap with those of other studies that have shown how people with serious mental illness use spirituality and religion to cope with their illness (22,23). Religion and spirituality can impart meaning and a sense of consistency, hope, and security in a person's life, particularly during times of suffering (24). Sacred writings can provide role models and examples of coping with adversity, which support clinical and existential recovery (25). Although our participants did not discuss the social benefits linked to participating in religious services, a religious congregation is a supportive community that can increase socialization, shift negative social norms, and reduce isolation (25,26).

Traditional mental health and recovery-oriented services can harness the benefits of spirituality and religion by encouraging therapeutic aspects of clients' beliefs and spirituality, incorporating religious practices into treatment, and partnering with religious entities to engage and retain clients (26). Because most mental health programs have limited resources, future work should examine the best strategies to integrate spirituality into mental health care and the impacts of such integration on recovery (27).

Life achievements were central to participants' recovery because they represented concrete functional gains that contributed to existential dimensions of recovery. The relationship between functional and existential recovery is commonly conceptualized as secondary gains (for example, self-efficacy) (7). The link we found between functional and existential recovery suggests something more complex. Our data point toward a reciprocal relationship between these dimensions because life achievements provided participants with meaning and purpose in their lives, which further contributed to and reinforced functional gains. This interrelationship also enhances ontological security— that is, a sense of constancy that serves as a "secure platform for identity development and self-actualization" (28). Life achievements were tangible experiences that restored participants' hope, direction, and security, which are often lost in mental illness. Although we did not find that the interrelationship between functional and existential dimensions contributed to other recovery dimensions, it is plausible that this interrelationship can lead to reductions in symptoms and improved well-being. Recovery-oriented services such as supported employment and vocational programs should attend to and foster functional and existential dimensions given their synergistic relationship.

Life achievements also helped reduce participants' self-stigma (29,30), because these experiences represented evidence of their personal value, determination, and worth beyond their psychiatric disabilities. These achievements suggest that the recovery journey may entail biographical shifts in which people living with a chronic illness engage in reconstructing, recomposing, reinforcing, or restoring their sense of self to cope with disruptions in their functional and identity development (31–33). Achievements signified a critical juncture that enabled participants to dismiss society's stigmatizing attitudes toward and beliefs about people with mental illness and help to "reorganize their biographies and construct the hope necessary to go on" (32). Biographical shifts were also internalized by the positive influence of participants' social relationships, as evidenced by the inspiration some participants drew from reconnecting and being part of their children's lives and from providing support to peers.

The framework of biographical shifts suggests that traditional and recovery-oriented services can facilitate multiple dimensions of recovery by providing people the opportunities to engage in this biographical work, particularly as it relates to helping people heal from self-stigma, increase self-efficacy, and instill hope. Recovery centers and consumer-operated services serve as critical entities for this type of work because they provide an array of

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services in a “hopeful, supportive, welcoming and non-stigmatizing environment,” which is often unavailable in traditional mental health services (34).

The theme of receiving and providing support illustrates how this social dimension can create positive ripples through a person’s life. Supportive networks influence clinical recovery by reducing isolation and depression. These networks are an important social asset that is often strained or lost when a person has a serious mental illness (35). Positive social networks are critical for the everyday work of recovery (36). Traditional and recovery-oriented services should strengthen social dimensions of recovery given the multiple benefits that these social assets have across recovery dimensions. Services such as support groups, peer-led interventions, and social activities are all approaches that can be used to enhance social dimensions of recovery in the community.

Several study limitations should be noted. Our findings should be interpreted with caution because our sample comprised a small group of participants selected by agency staff. However, the comments we received from providers at the two agencies and other tenants of the housing programs who attended the social-action activities generated by this project, such as photo exhibits and staff presentations, indicate that our findings resonated with consumers’ experiences. In addition, we did not include people with limited English proficiency. Future studies should consider the recovery journeys of this population.

Conclusions

The study illustrates the value of photovoice in understanding what recovery signifies to consumers. This methodology can also be used as a clinical approach to help consumers reflect on their recovery, share their experiences with peers, and shape their personal narratives. Our application of a dimensional recovery model to consumers’ visual and narrative data revealed beneficial interrelationships between recovery dimensions. Considering these interrelationships in the development, implementation, and evaluation of recovery-oriented services can produce more responsive services that empower consumers with the opportunities to achieve the promise of recovery.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

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Table 1

Characteristics of 16 study participants with serious mental illness who enrolled in photovoice groups at two sites

	Site A (N=8)		Site B (N=8)		Total (N=16)	
Characteristics	N	%	N	%	N	%
Demographic						
Age (M±SD)	52.0±9.5		60±14.3		56±12.0	
Female	3	38	4	50	7	44
Race-ethnicity						
Non-Hispanic white	1	13	1	13	2	13
African American	6	75	5	63	11	69
Hispanic	1	13	2	25	3	19
Employed	1	13	4	50	5	31
Mental disorder[a]						
Depression	4	50	1	13	5	31
Schizophrenia	4	50	1	13	5	31
Bipolar disorder	4	50	1	13	5	31
Substance use disorder	6	75	3	38	9	56
Health condition[a]						
Hypertension	3	38	5	63	8	50
Diabetes	3	38	4	50	7	44
High cholesterol	2	25	2	25	4	25
Asthma	1	13	1	13	2	13
Cancer	0	—	2	25	2	13
Attendance						
All photo-elicitation interviews	6	75	6	75	12	75
All group discussions	4	50	7	88	11	69
3 or more sessions[b]	7	88	8	100	15	94

[a]By patient self-report

[b]Includes attendance at a photo-elicitation or a group session

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Table 2

Summary of findings from the analysis of photovoice narrative and visual data

Theme	Key points	Recovery dimensions present in theme	Interrelationship of recovery dimensions
Spirituality	Supports sobriety; provides healthy coping mechanisms; provides a path to recovery and wellness	Existential and clinical	Existential dimension supports clinical dimension
Achievements	Validation of participant's efforts; restores sense of purpose, self-worth, and personal agency; combats self-stigma	Functional and existential	Reciprocal relationship between functional and existential
Receiving and providing support	Reduces isolation and relapse; source of emotional and instrumental support; shifts maladaptive norms and habits; inspires hope; positive influence on others	Social, clinical, physical, and existential	Social dimension supports clinical, physical, and existential dimensions