Article

Exploring the Process of Digital Storytelling in Mental Health Research: A Process Evaluation of Consumer and Clinician Experiences

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Abstract

Digital storytelling is an art-based research method that has potential to engage mental health consumers and clinicians in dialogue about their lived experiences. However, few studies have examined the process of digital storytelling and people's perspectives about making digital stories. In this article, a process evaluation framework is used to explore two digital storytelling workshops conducted with mental health consumers and clinicians. Project planning and implementation documents were collated, and interviews conducted with workshop participants thematically analyzed. Data were combined with facilitator reflections and are reported using a process evaluation framework. Findings indicate that the digital storytelling process is a useful research method that can be used to create a space where power differentials between consumers and clinicians are made visible and shared dialogue can develop. Recommendations from the study include the importance of employing skilled consumer and clinician support personnel to guide the process of participation and negotiate ethical tensions to ensure participant safety.

Keywords

clinicians, consumers, digital storytelling, lived experience, mental health, mutual dialogue, participation, process evaluation

What is already known?

1. Consumers and carers should be involved in the design, planning, and provision of recovery-oriented mental health services, however, there is a dearth of research that describes methods to facilitate this.
2. Participatory processes can promote mutual dialogue between mental health consumers, carers, and clinicians to identify structural barriers and solutions in progressing a mental health service recovery focus.
3. Digital storytelling is an art-based research method that might be useful in mental health for engaging consumers, carers, and clinicians in mutual dialogue, however, there is a dearth of research in this area.

What this paper adds?

1. Knowledge of digital storytelling as a creative process that engages consumers and clinicians and enables dialogue and the safe expression and understanding of different lived experiences.
2. An understanding of how participatory processes of creating art and stories together supports the development of a space where power can be more evenly shared between consumers and clinicians.
3. Insight into the process of digital storytelling and how employing skilled consumer and clinician support personnel can support the ethical conduct of digital storytelling workshops.

Introduction

The lived experiences of people who use the mental health system are important in supporting a socially just culture and recovery-oriented services that are relevant and responsive to consumer and carer needs (Australian Health Ministers' Advisory Council, 2013; Mental Health Commission of Canada, 2012; Wallcraft et al., 2011). Despite well-established

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consumer participation policy (Australian Government, 2012; Le Boutillier et al., 2011), authors consistently argue that the contribution of consumers and carers in mental health service design, planning, and provision is largely tokenistic, with multiple barriers to meaningful input (Bee, Brooks, Fraser, & Lovell, 2015; Bennetts, Cross, & Bloomer, 2011; Rise, Solbjør, & Steinsbekk, 2014).

Under a biomedical model, mental illness is treated as biogenetic in origin, and personal experiences are often perceived as meaningless symptoms of an individual disease process (Aho, 2008; Walsh, Stevenson, Cutcliffe, & Zinck, 2008). Consumers and carers have few opportunities to tell their story, have it understood, acknowledged, and acted upon outside the purview of psychiatric symptoms and treatment (Aho, 2008; Crowe, 2006; Walsh et al., 2008).

While the need to involve consumers in all aspects of the mental health system, including research, is enshrined in global policy (Le Boutillier et al., 2011; World Health Organization, 2013), far less attention has been given to opportunities for clinicians to express their practice experiences (Borg, Karlsson, Kim, & McCormack, 2012). Almost two decades ago, Wadsworth and Epstein (1998) argued that mental health consumers and clinicians often share similar issues and concerns, but more recently, authors have identified a dearth of research studies where consumers, carers, and clinicians come together to share their experiences (Kidd, Kenny, & McKinstry, 2015a).

It is argued that participatory and collaborative research approaches have potential for consumers, carers, and clinicians to share lived experience and engage in dialogue to identify structural barriers and solutions in progressing a mental health recovery focus (Kidd et al., 2015a; Kidd, Kenny, & McKinstry, 2015b). However, Perkins and Slade (2012) argued that most mental health service models do not provide safe spaces for engaging in reciprocal dialogue, and that structured spaces for reciprocal dialogue must be deliberately constructed (Schwartz et al., 2013). This is necessary because of the difficulty in recognizing and negotiating power differentials within mental health research (Kidd et al., 2015a, 2015b).

The usefulness of arts-based research approaches to support reciprocal dialogue in mental health has been identified (Crawford, Lewis, Brown, & Manning, 2013; De Vecchi, Kenny, & Kidd, 2015). While art-based approaches have been used in mental health for some time (MacGregor, 1989), the potential of contemporary research approaches, such as digital storytelling, to create shared understandings among different mental health stakeholders has only recently been identified in a review on digital storytelling in mental health (De Vecchi, Kenny, Dickson-Swift, & Kidd, 2016). The findings of the review indicated a major knowledge gap on the process of participation and the experiences of those participating in digital storytelling in mental health services. Importantly, there was an absence of evidence on the role of digital storytelling as a research method in providing opportunities for shared dialogue between mental health consumers and clinicians. In this article, we address this gap.

Background

Digital Storytelling

Digital storytelling is an art-based facilitated group process where participants make a 2- to 5-min multimedia digital video to capture a personal story. The storyteller commonly records the story, and uses imagery and sound to convey emotive and thought-provoking messages (Lambert, 2010). Group facilitation aims to create a safe space for participants to develop a cocreated personal story through individual and group reflection, where control of the story content and context remains with the storyteller (Lambert, 2013).

Digital storytelling uses Freirean participatory methods (A. Gubrium & Turner, 2011) to support personal and group reflection. This type of listening, dialogue, and action develops relationships and knowledge built on reciprocity (Wallerstein & Auerbach, 2004). Freire (1996) theorizes that people live in relation to their world and have subjective knowledge of it, which they can use to understand and change unjust life circumstances. In the process, facilitators aim to support participants in understanding their experiences within the complex interplay of broader social, historical, political, and cultural contexts (Guse et al., 2013, pp. 214–215).

Digital Storytelling as Art-Based Methodology

Digital storytelling and digital stories have been used across health-care settings to communicate the lived experience of people marginalized by society (A. Gubrium & Turner, 2011). Studies conducted in this area are typically participatory where participants make a digital story in a group process (Cunsolo Willox, Harper, Edge, 'My Word': Storytelling Digital Media Lab, & Rigolet Inuit Community Government, 2013; Ferrari, Rice, & McKenzie, 2015; LeMarre & Rice, 2016; Njeru et al., 2015; Rice, Chandler, Harrison, Liddiard, & Ferrari, 2015) or nonparticipatory, where participants watch a digital story created by others (Christiansen, 2011; Eggenberger & Sandars, 2016; Levett-Jones, Bowen, & Morris, 2015).

Scholars propose that the process and product of digital storytelling might be useful in health-care to support personal reflection, understanding, and incorporation of lived experience perspectives into research and practice (A. C. Gubrium, Hill, & Flicker, 2014). There is an emerging body of literature on digital storytelling in the health-care field. Children living with advanced cancer made digital stories as mementos for their families, which parents reported were an emotional outlet for both that supported the children to express themselves (Akard et al., 2015). Somali and Latino people living in the United States participated in a community-based participatory research study to create digital stories to be used to educate their communities on how to live with type 2 diabetes (Njeru et al., 2015). Three women created digital stories that problematized linear, binary notions of recovery in eating disorders by depicting recovery as an ongoing embodied, social, and spiritual process, which researchers suggest could enable more empathic and nuanced understandings in care (LaMarre & Rice, 2016).

Digital storytelling has been used as a culturally appropriate participatory research methodology with indigenous people because it supports communities to cocreate data with researchers using traditional storytelling methods (Cueva et al., 2016; Cunsolo Willox et al., 2013; Njeru et al., 2015). Making digital stories with indigenous communities is described as a transformative process because people work and learn together, and share and discuss perspectives and experiences to produce knowledge that has relevance for the local community, researchers, policy makers, government, and international audiences (Cunsolo Willox et al., 2013).

In one study, where researchers examined participation in digital storytelling from a health promotion perspective (A. C. Gubrium, Fiddian-Green, Lowe, DiFulvio, & Del Toro-Mejías, 2016), young Latina women reported that working with peers, being listened to, and listening to others developed a sense of empathy and understanding toward self and others, and self-confidence. Connections grew and there was solidarity within the group (A. C. Gubrium et al., 2016). They described participation as healing, because difficult life experiences were examined and witnessed collaboratively, which enabled them to define themselves in their own words beyond discriminatory discourses (A. C. Gubrium et al., 2016).

While qualitative studies with health-care students have demonstrated that creating or watching digital stories about challenging issues in practice can develop reflection on practice, and critical thinking and empathic understanding of consumer perspectives (Christiansen, 2011; Gazarian, 2010; Levett-Jones et al., 2015; Paliadelis & Wood, 2016), little research has been conducted with experienced clinicians (see Eggenberger & Sandars, 2016; Ferrari et al., 2015).

Digital Storytelling in Mental Health Research

It has been argued that the process of participating in digital storytelling can support participants marginalized within society to understand and challenge oppressive social conditions, while voicing alternative "future selves and society" (Gubrium & Scott, 2010, p. 147). This has relevance in mental health where dominant biomedical definitions of mental illness largely subjugate the "expert by experience" knowledge base, ignoring the important social, relational, and historical aspects of human distress (Aho, 2008; Crowe, 2006; Walsh et al., 2008). Authors state that digital storytelling can provide a forum for people defined as mentally ill to represent themselves as capable, creative, knowledgeable people, and that the process supports questioning of dominant biomedical notions of disease and disability (Ferrari et al., 2015; LaMarre & Rice, 2016; Rice et al., 2015).

Kidd, Kenny, and McKinstry (2015a, 2015b) have written extensively about the need to address power in mental health services, and how the creation of participatory spaces can be a way for this to occur. The process of digital storytelling, therefore, may be a method for enabling clinicians to reflect on and voice their practical knowledge of issues in practice. Ferrari, Rice, and McKenzie (2015) proposed that digital storytelling might be useful in supporting clinicians to talk about traumatic events in their lives or at work. The collaborative and participatory approach used in digital storytelling (A. C. Gubrium et al., 2014), may be useful in mental health settings as a structured process for engaging consumers, carers, and clinicians in reciprocal dialogue (Schwartz et al., 2013) to envision and support the development of services that are recovery-oriented and socially just, bringing services in line with current policy in mental health (Australian Health Ministers' Advisory Council, 2013; Mental Health Commission of Canada, 2012; Wallcraft et al., 2011).

In a scoping review that examined the use of digital storytelling in mental health, it was identified that digital storytelling and digital stories had been used as a tool for learning skills in digital technology, communication and story development, and in the education of young people (De Vecchi et al., 2016). More importantly, it was also identified that digital storytelling and digital stories could support consumer and clinician understanding of their own and other's lived experience perspectives (De Vecchi et al., 2016). Authors propose that the creative process of making a digital story together enables consumers and clinicians to share and discuss lived experiences, which develops empathic connections between them (Ferrari et al., 2015; Rice et al., 2015). The process has been described as having potential to "advance social inclusion and justice" by creating a diversity of knowledge generated by people living with mental illness and those who care for them, challenging biomedical notions of mental illness (Rice et al., 2015, p. 515). However, the research supporting these contentions lacks an in-depth examination of the process of consumers and clinicians working together in a mixed group (Ferrari et al., 2015).

The Importance of Evaluating the Process of Digital Storytelling

While studies often contain superficial descriptions of the digital storytelling participation process, there is a dearth of research where the process is formally evaluated. The studies by A. C. Gubrium, Fiddian-Green, Lowe, DiFulvio, and Del Toro-Mejías (2016) and Ferrari et al. (2015) provide valuable insights into the participant perspective, however, they did not examine the process of participation from the perspectives of all stakeholders. The aim of this process evaluation is to explore participation in digital storytelling and investigate the potential of digital storytelling as a research method for creating a safe space for shared dialogue between mental health consumers and clinicians.

Methodology and Methods

Rationale, Research Question, and Objectives

Digital storytelling has rarely been used in mental health as a research method (De Vecchi et al., 2016), and no studies exist that describe the process of participation from the perspectives of consumers, clinicians, and workshop support personnel. The

research question was: Can the digital storytelling process be a useful participatory research method in mental health services for facilitating consumer, carer, and clinician dialogue on lived experience? There were two main objectives. The first, was to explore the digital storytelling process from the perspectives of consumers, carers, and clinicians as well as workshop support personnel. The second, was to provide commentary on the potential of digital storytelling as a research method for enabling shared dialogue between stakeholders in mental health on lived experience.

Research Paradigm

This study was located in the interpretive paradigm, where researchers work closely with participants to construct knowledge through interpreting the meanings people give to their experiences that are derived from their personal understandings and interactions with others (Lincoln, Lynham, & Guba, 2013).

Methodology

A case study approach outlined by Stake (1995) was used to guide the exploration of the process of two digital storytelling workshops conducted in Victoria, Australia, in January and August 2016. This approach was chosen because the two digital storytelling workshops presented a bounded case, and we were interested in what happened inside the workshops from the perspectives of those who participated in them (Stake, 1998). As researchers, we were involved in the process, and we describe and use our involvement in the workshops to understand participation, which aligns with a case study approach (Hyett, Kenny, & Dickson-Swift, 2014; Stake, 1995). Consistent with qualitative instrumental case study design (Stake, 1995), the purpose of our study was to understand the processes of participating in digital storytelling and how this might serve to promote dialogue between mental health consumers and clinicians. In qualitative instrumental case study design, the aim is to present thick narrative descriptions using multiple data sources that might enable readers to apply learnings from the case to their own specific context rather than produce generalizable findings (Hyett et al., 2014; Stake, 1995).

Method

Process evaluation was used to inform the case study design (Saunders, Evans, & Joshi, 2005). This type of evaluation is predicated on the need to understand why an intervention may or may not have had a positive effect (Saunders et al., 2005, p. 134). The purpose is to examine the "black box" of an intervention to understand what has happened and how this might impact on outcomes (Saunders et al., 2005, p. 134). Our case was bounded within the two digital storytelling workshops. The process evaluation framework, outlined by Saunders, Evans, and Joshi (2005), provided a structured process for organizing

Table 1. Participant Identification.

Name	Position
Billy Jean	Consumer advocate
Brigid	Consumer
Cheetah	Consumer consultant
Cleo	Consumer
Harry	Technician
Johnny Deppz	Consumer technician
Ken	Clinician
Stephanie	Consumer
Tina	Clinician
Trudy	Clinician
Will	Consumer/clinician

the data to understand why things happened across the two workshops in terms of participation.

Project planning and implementation documents, including facilitator reflections, were collated, and interviews were conducted with workshop participants. Documents included correspondence from recruiting managers, researcher meeting transcripts, and attendance records. A semistructured interview schedule guided interviews (Holloway & Wheeler, 2010), and included questions about the process of participating in a workshop. Interviews were audio recorded with participant consent and transcribed verbatim. Participants chose their own pseudonyms. Details of participants who contributed to the process evaluation are included in Table 1.

All authors read and reread the collated data and discussed the meaning to identify pertinent descriptions of participation in the digital storytelling process. Data were organized using a process evaluation framework. Ethics approval for the study was given by the participating mental health service and a university ethics committee (HREC/15/BHCG/35). For the digital storytelling workshop, an introductory session explained ethical and consent processes. Written consent was sought after researchers were satisfied that participants understood the process of the study.

The Digital Storytelling Workshops

Workshops were conducted over 3 days. Two facilitators and a technician supported participants to create their story. On the first day, introductions were made followed by a series of creative group exercises. Creative (storytelling) group exercises are designed to unite participants in the group process, relieve anxiety about how to tell a story, and promote story sharing within the group (Digital Empowerment, 2012). The technician briefly outlined how to make a digital story on the iPads provided using iMovie. As facilitators, we asked participants to begin working individually on their stories as we circulated among them providing one-to-one support in developing their story.

We invited participants to share their story with the group if they felt comfortable to do so in a "Story Circle" (Lambert, 2010, p. 9). A "Story Circle" is a group process where

storytellers are given the opportunity to share their story and receive feedback, and listen to others' stories and provide feedback (Lambert, 2010, p. 9). We continued this process reiteratively throughout the day, alternating between participants developing their stories individually, one-to-one facilitator support, and the "Story Circle" process (Lambert, 2010, p. 9). As facilitators, we encouraged participants to discuss their stories individually and within the group to develop them further, and draw out the meaning of the lived experience for that person within the broader context of their lives and social situation.

Day 2 commenced with a "Story Circle" to determine who required more support to complete their written story (Lambert, 2010, p. 9). Once participants were satisfied with their story, support was provided to record their story, find or take photos and locate music/sound effects they wanted to use, and assemble the media into a coherent story. All participants finished their stories on Day 2, and attended a third day to share their stories and celebrate their collaborative achievement (Lambert, 2013). In this final session, discussions were had about exercising caution when sharing digital stories especially in online forums.

Factors Influencing the Process of Participation in a Digital Storytelling Workshop for Consumers and Clinicians in Mental Health

We used the framework of Saunders et al. (2005) to complete the process evaluation and present findings and examples of data to illuminate key aspects of the study. Process evaluation elements used included, recruitment, reach, and exposure, which describes strategies used to recruit participants and maintain participation, the proportion of participants recruited, barriers to participation, and participant engagement with the intervention, in this case, digital storytelling (Saunders et al., 2005, pp. 139–141). Fidelity and completeness describe the quality and amount of intervention delivered (Saunders et al., 2005, pp. 139–141). Context and satisfaction describe environmental factors that may influence implementation and participant satisfaction with the intervention implementation (Saunders et al., 2005, pp. 139–141).

Recruitment, reach, and exposure. Participants were recruited to the study via correspondence with managers of consumer, carer, and clinical service networks at a rural psychiatric service and local and state community mental health services. One statewide independent advocacy body was targeted to enlist paid consumer advocate participants. Most managers targeted agreed to circulate an advertisement for the study to their constituents, however, several did not respond. A consumer agency manager, after presenting the study details to colleagues, communicated that participation in a 3-day workshop was unrealistic because of the small size of their team and competing work commitments. People self-selected to participate by contacting the researchers or attending an introductory session. Eleven people who participated in the workshops consented to be interviewed for the

study: two consumers, one consumer consultant, one consumer/clinician, and three clinicians from the local area, one consumer and one consumer advocate from state-run organizations, and the two workshop technicians. No carers responded to the advertisements. In reporting the findings, pseudonyms were chosen by participants to protect their identity.

Clinicians, Ken, Trudy, and Tina, and the consumer advocate, Billy Jean, wanted to participate in a workshop to explore the potential of digital storytelling as a tool in mental health services for sharing dialogue on lived experience. Consumers, Cleo, Stephanie, and Brigid, clinician/consumer, Will, and the consumer consultant, Cheetah, had prior experience with art-making and wanted to explore digital storytelling as a contemporary medium for expressing their journey through trauma, mental illness, and recovery.

Workshops contained more consumer than clinician participants. All participants who started a workshop completed a digital story. Several participants were unable to attend every workshop day because of personal matters. While some participants in the digital storytelling workshops knew each other and were recruited from the local area, others did not.

Fidelity and completeness. Wellness was chosen as the story topic after long discussion between research team members. We were keen to find a topic that would be of relevance to all participating as we were interested in the dialogue that might be created within the workshop. While we acknowledged that different topics might create different workshop outcomes and might inform people's perspectives of participating, we sought a topic that all could relate to. In this study, wellness was defined as the strategies that we use to keep ourselves well. For ethical purposes, all digital media remained the property of the creator and was permanently deleted from workshop iPads. No copies were kept by the research team. This protected participant privacy and confidentiality, and prevented stories being used in a context unintended by the creator. Participants were asked to bring a story or an idea for one to the workshop.

Workshops were conducted over the 3 planned days, in a quiet environment, and facilitators constructed a safe space for participants to work together. Two facilitators and two technicians supported participants. One of the facilitators had narrative therapy training, with extensive experience in facilitating mixed consumer and clinician groups in sharing dialogue and digital storytelling. One of the facilitators and one consumer technician had attended a 3-day digital storytelling workshop at the *Australian Centre for the Moving Image* in 2015, and both had conducted digital storytelling workshops together prior to this study. One of the facilitators had 5 years of experience cofacilitating mixed art therapy groups in a psychiatric unit with a registered art therapist. Reflective discussion occurred at the end of each day on how the facilitation process was being conducted. Questions about the process, raised by participants during the day or by facilitators after the sessions, were brought to the group the next day for clarification. Workshop lunch times were a place where process issues could be raised and discussed together.

Personal safety in telling lived experience stories was covered in consent documents and the introductory session. Teaching of technological skills was limited to increase the time for reflection and feedback on participant's stories throughout the process. Participants were able to reflect carefully, within and outside the group, on how and what they chose to portray about themselves and others in their story.

Most participants described digital storytelling as a way to learn introductory skills in technology and storytelling, and make a meaningful story in a supportive environment. Support was seen as essential for overcoming fears, developing confidence, and learning through exploring and playing with the digital medium and story. Cleo, a consumer, explains:

> At first, I was afraid of it cause I'm afraid of technology . . . but I was comfortable with it towards the end, I think that fear comes out of the unknown, so not knowing what you're doing . . . once someone showed me, I picked it up relatively quickly.

One participant struggled with the technology, which consumer advocate Billy Jean identified as a generational divide in skills. Consumer advocate, Billy Jean, and the technicians suggested using a structured lesson with written instructions on how to use the technology. The technicians supported participants individually when they were struggling with the technology, but some participants in the first workshop experienced frustration when waiting for technical support.

Context and satisfaction. The local area in which the workshops were conducted had limited access to artmaking groups where consumers, carers, and clinicians could work together. To enable participation of people with fluctuating mental health issues and busy schedules, participants suggested that workshops be conducted over more days with fewer hours. Participants believed that workshops should be integrated into ongoing programs for people to benefit from storytelling and technical skills development at a suitable time and place for them.

Participants developed connections early on Day 1, which continued throughout the workshops. Consumer participants described workshops as an opportunity for peer support, which enabled them to express lived experiences confidently. Participants and facilitators noted that relationships formed because participants were able to collaborate and appreciate the value of others via art and story. There was agreement that small groups, with more consumer than clinician participants, conducted in a supportive and safe environment was beneficial for creating a nonjudgmental and respectful space where participants felt safe to share. Cleo, a consumer, explains:

> I didn't feel like anyone was going to physically or emotionally harm me . . . Groups intimidate me . . . I've had bad experiences in groups before . . . I think the group treated everybody else with respect. And they were all equal. There was no "I'm a clinician and you're a consumer," and therefore you're either more important or less important.

Forming respectful alliances enabled barriers to be overcome differences to be celebrated, emotions/stories to be shared, and trust and empathy to be developed. Most participants described the process as an inclusive social outlet that brought consumers and clinicians together on a more equal basis because there was no correct way to make stories. They reported feeling united in the common purpose of story creation, and several recognized that they were making meaning of shared human experiences. It was noted that these factors had enabled a safe expression of emotions and mutual understanding of experience, and all agreed that this had promoted a sense of acceptance, connection, and solidarity. Consumer advocate Billy Jean explains:

> . . . I think it can allow someone to enter that space with you and someone might not have that lived experience, but that story you're telling might map onto some other experiences they've had . . . you can create a bit of shared space and shared understanding . . . and the contextual stuff is key . . . I think the use of imagery and music . . . can tell a story . . . that words can't . . .

Participants described digital storytelling as a creative process that enabled them to understand their own and others' beliefs, perspectives, and life experiences. Participants and facilitators identified that these factors had led to an appreciation of others' skills, creativity, and resilience. Brigid, a consumer, explains:

> When we all got together and shared experiences, that was really moving and a real eye opener to see what other people had been through, and other people's perspectives on wellness and mental health.

Feedback was important in this process because participants shared ideas, asked questions, and witnessed difficult stories together, which clarified and expanded meaning. Working together supported a nuanced expression and understanding of confusing emotional, sensory, and traumatic experiences via a poetic, metaphoric, and symbolic language. Harry, a technician, who had no previous experience in group work in mental health, explains:

> . . . I found it challenging because some of the stories were . . . emotionally resonating . . . you felt for what people go through, what's behind that outer shell that you show to the world.

The facilitation process enabled participants to engage in self and group reflection, which promoted group and self-discovery. Some participants identified personal qualities previously unrecognized. Participants indicated that digital multimedia combined with a story created a coherent, layering of meaning that captured a lived experience story. Stephanie, a consumer, explains:

> . . . it makes something complicated easy . . . To make those layers like that . . . with all the options of using multimedia . . . I thought it was a very useful tool to express my journey.

Most participants described digital storytelling as a generative process that enabled emotional distance for reflective understanding and acceptance of experiences. The digital storytelling process was described as supporting healing because it was a creative, universal, hands-on tool for communication. It was seen as a valuable tool for connecting consumers and clinicians because it was a strengths-based and empowering activity that enabled sharing of perspectives. Ken, a clinician, elaborates:

> I think that art is a place where people can make meaning and it's a way to be a balm for suffering. It's a way to be part of something bigger because there is always an audience to art . . . it is a universal, we are art makers, we are storytellers, it just connects. I can't understand why you wouldn't have art in a health service, it just doesn't make sense that we don't.

However, participants believed that historical (local) misunderstandings about the potential of artmaking, exacerbated by a biomedical service model predicated on empirical evidence, with a lack of therapeutic and participatory practices, hindered the use of art and story making in mental health. Ken, a clinician, elaborates:

> . . . one of the things I believe is that it is very class based, so if you're a public mental health nurse or if you work with people who are poor. I am sure if you went and worked in a private institution that they would be doing art all the time.

Some participants identified that exploring experience together disrupted tensions between care and control in services. Others believed that the democratic digital storytelling process exposed power imbalances because a space developed where power was more evenly distributed. Will, a consumer/clinician, explains:

> One of the things about here is that there are no masks, that mask has gone, you are who you are . . . They dissolve. It doesn't really matter, we are just . . . ordinary people who have an interest in learning, but at the same time trust, it takes a trust in each one of us, and it works.

Clinicians, Ken and Tina, identified digital storytelling as a therapeutic approach that mental health nurses could use when working with consumers and clinicians that enabled them to speak to their own experience. Participants and facilitators agreed that it was essential to resource digital storytelling workshops with skilled personnel to maintain safety in reflection and feedback, especially in inpatient units where people might not be well enough to concentrate and feel overwhelmed by technology. Most participants believed that making digital stories together supported consumers and clinicians to engage in critical dialogue, share difficult stories on issues in mental health, and understand them. In both workshops, the creative process enabled participants to speak about difficult issues encountered in mental health.

However, consumer advocate Billy Jean believed that clinician participants had protected their vulnerability, and that the group process could pressure consumers into revealing intimate stories/details that might be triggering of past traumatic experiences. He recommended that consumers be involved in determining the process protocol and clinicians be supported to tell personal stories. Ken, a clinician, noted that safe disclosure of clinician lived experiences would be difficult in the absence of a therapeutic service culture. Consumer advocate Billy Jean also thought that facilitators may have influenced the way participant stories were told and asked for more preparation for consumer safety:

> . . . that's again a safety thing around the way that story needed to be told for that person . . . telling someone how to tell their story or even just guiding them, you're in a privileged position in that situation to be the expert . . . it didn't hit me at first and I agreed . . . that would be fascinating to hear and when she did talk about it I thought it was fascinating and really powerful . . . But I worried that she left that information out for a reason.

Consumer advocate Billy Jean suggested employing an expert consumer storyteller to ensure that stories were told from a consumer perspective. While recognizing the benefits of employing a consumer/facilitator, the facilitators believed that the workshops were conducted within a safe structure. The process supported participants to tell their stories in ways that restored the centrality of their actions, values, and beliefs in the process of wellness or changing their lives rather than the actions of other people. Other participants thought the process was safe because time and support were available to choose what and how much information was divulged to protect self and other's identities. Participants and facilitators agreed that there was time throughout the 3 days for group reflection and feedback to support discussion of safety and story ownership.

All participants emphasized that ownership and control should remain with the creator of the stories because of the potential misuse by services and in online forums. While most agreed that sharing was a personal choice, clinician Trudy stated that facilitators followed guidelines to explain consent, ownership, and sharing throughout the workshop. Consumer advocate Billy Jean thought that an emphasis on ongoing consent, with peer consultation, would enhance consumer safety in sharing.

Discussion and Recommendations

This process evaluation revealed that participants, facilitators, and technicians were mostly satisfied with the digital storytelling process as an art-based research method for supporting mental health consumers and clinicians to share dialogue about lived experience. Recruitment strategies were reasonably successful, and most managers were cooperative with circulating advertisements to their constituents. All participants completed a story. It has been noted previously that recruitment and retention can be difficult in digital storytelling workshops (A. Gubrium, 2009). The suggestion of conducting workshops over flexible time frames, recommended previously (A. C. Gubrium

et al., 2014), alongside the integration of digital storytelling into existing service programs, would likely improve access for all stakeholders in mental health. If digital storytelling was made available in existing service programs, potential participants, including carers, would be more aware of the possibility to be involved. Flexibility within the participation process could be explained to them personally, and they would be supported to understand that participation was based on their ability to attend when it was possible to do so.

The importance of employing facilitators with skills in creating safe spaces for dialogue, therapeutic modalities and (digital) storytelling who can maintain group safety while accommodating the needs of participants has been highlighted in this case study, and in previous research and commentary (Ferrari et al., 2015; A. C. Gubrium et al., 2014). To ensure that participants gain maximum benefit from participation requires a fine balance of guiding reflection and feedback, supporting autonomous decision-making on story content and sharing, with the teaching of technological skills, and other factors discussed below. Ensuring that facilitators and technicians engage in an ongoing process of reflection on the implementation process can progress continual improvement in supporting participants to create a meaningful story and learn technological skills.

Overall, participants and facilitators agreed that the creative digital storytelling process enabled relationships to be built, and participants did not need to know each other for this to occur (Reed & Hill, 2010). All participants were asked to contribute equally. Defensive masks could be removed in the common purpose of making art. This enabled a mutual appreciation of skills, perspectives, beliefs, creativity, experiences, and resilience within a supportive milieu. The relational and democratic process served to decrease perceptions of power between consumers and clinicians, which led to the development of a sense of trust, equality, and solidarity. In research conducted by Ferrari et al. (2015), mental health consumers, carers, and clinicians described the digital storytelling process as healing and empowering because it provided a creative forum for mutual sharing, reflecting on, and understanding of multiple meanings in lived experience stories.

Scholars conceptualize artmaking as therapeutic because it is a human tool for expressing the inexpressible, the sublime, and tacit (Biley & Gavin, 2007). Artmaking, such as digital storytelling, has potential in mental health because it can support consumers and clinicians to make meaning of and share their experiences (Biley & Gavin, 2007). Mental health nursing is predicated on self-awareness, knowing the consumer, and understanding the shared and individual nature of human experience (Gallagher, 2007). Artmaking creates an environment for this to occur (Biley & Gavin, 2007; Gallagher, 2007). Making art in a mixed group can construct a space where consumers and clinicians develop mutual trust, respect, and understanding to unite as creative, able citizens and where opportunities for research flourish (Ferrari et al., 2015; Rice et al., 2015; Sapouna & Pamer, 2016). These factors were identified in our case study.

An ethical tension identified in this case study was that in mixed groups, consumers may expose their vulnerabilities, while clinicians might choose not to reveal them. In previous research, authors have reported that clinicians expressed emotional vulnerability with consumers (Ferrari et al., 2015; Rice et al., 2015). The use of the topic of wellness in this study might have limited participants need to express emotional vulnerability in a workshop. The possibility of triggering emotional responses from reliving traumatic experiences has been noted, and counseling must be provided as part of an ethical process (A. C. Gubrium et al., 2014). The risk of retraumatization is recognized, and facilitators need to be skilled in guiding discussions and stories. However, providing opportunities for participants to speak about their experience in their own words is important but requires support and a safe environment to do so (White, 2007).

To protect personal safety, storytellers must reflect on the meaning of their story, their preparedness for exposure and protection of others, document off-limit areas, and reassess boundaries if distress occurs (Epstein & Grey, 2011, pp. 22–23). They must also consider the permanence of digital media in online forums and reflect on the risks and benefits of exposure (Epstein & Grey, 2011). To prevent stories in mental health being misused by services and in online forums, authors advise that the creator retains ownership and control of the story (Costa et al., 2012; Epstein & Grey, 2011; Grant, 2011). Screening potential participants for possible "risks, limitations, and benefits" associated with making a digital story may be warranted (A. C. Gubrium et al., 2014, p. 1609).

While revealing a level of personal clinician vulnerability can support the development of relationship building in mental health, it is difficult for clinicians to navigate the fine balance between intimacy and professionalism (Hem & Heggen, 2003). Services and other clinicians often do not condone the disclosure of emotional vulnerability to consumers (Hem & Heggen, 2003; Wadsworth & Epstein, 1998), and some assert that it is a tactic used to maintain a culture of othering in mental health (Wadsworth & Epstein, 1998). Authors have argued that supporting clinicians to listen to and tell emotionally vulnerable stories, while maintaining personal safety, is difficult in a mental health system where discussion of issues of power and oppression are uncommon (Bloom, 2006; Kidd et al., 2015a, 2015b).

The cocreated nature of digital stories within a group process, with guidance from facilitators on narrative content, was a potential ethical tension that was identified in our case study. Facilitators need to reflect on power differentials inherent in the digital storytelling process, to recognize "whose voices are privileged and whose may be silenced" (A. C. Gubrium et al., 2014, p. 1610). While facilitators have a role in cocreating stories, they can inadvertently shape stories to resonate with an intended audience or funding body (A. C. Gubrium et al., 2014, p. 1610). To facilitate this process, storytellers must be cognizant of the broader political consequences of what and how each story is told (Epstein & Grey, 2011, p. 20). As recommended in our case study, employing a consumer/facilitator

Table 2. Recommendations With Rationale.

Recommendations	Rationale
Recruitment, reach, and exposure	
Recruit widely across community and inpatient mental health services	Facilitates recruitment of sufficient numbers and diversity of participants
Fidelity and completeness	
Provide a shared lunch and/or morning/afternoon tea	Provides a relaxed space for discussing issues and concerns with the process and in mental health services
	Develops connections and relationships
Train facilitators and technicians in the process of digital storytelling	Promotes appropriate skills of support personnel
Facilitators and technicians must reflect together at the end of each day on the implementation process	Facilitates ongoing improvement in the process of implementation
Ensure process documents and discussions cover personal safety in storytelling	Promotes safety and self-care in storytelling
Ensure time at the start of each day to address issues raised about process	Supports ethical conduct of workshops and ensures concerns are addressed in a timely manner
Provide a structured lesson with written information on technology use	Promotes acquisition of skills in technology
	Reduces frustration in technology use
Context and satisfaction	
Involve participants alongside support personnel in determining the process protocol and guidelines for consent, sharing, and ownership	Empowers participants with choice in important aspects of process
	Develops locally driven guidelines to support safety and ethical conduct
	Supports facilitators to discuss these important issues with participants
Conduct workshops over more days with fewer hours	Supports people with mental health issues and busy schedules to participate at a time suitable to them
Ensure more consumer participants than clinician participants are in the group	Supports a leveling of power and relationship development between stakeholders in mental health
Workshop spaces should be quiet and protected from outside interference	Supports the maintenance of a safe space to share stories
Groups should be kept small	Supports development of space, relationships, and time for one-to-one consultation with support personnel
Facilitators should have skills in some of therapeutic modalities, creating safe spaces for dialogue, and (digital) storytelling	Promotes the ethical conduct of workshops
Employ facilitators and technicians that are representative of group members	Promotes power balance within group
	Promotes peer support for all participants
	Supports all stakeholders to safely disclosure vulnerable stories, express emotions, and lived experiences
	Reduces risks of disclosure of sensitive issues and replication of oppressive psychiatric discourses
Employ sufficient numbers of facilitators and technicians	Promotes access to one-to-one support
	Facilitates peer support for inpatients with fluctuating mental health issues
Use a clear structure for supporting participants' story creation	Locates storytellers as active participants in their lives
Ensure sufficient time is dedicated to discussion, reflection, and feedback	Promotes understanding of individuals and group of meaning in lived experience
	Provides time to understand the implications of stories and sharing
	Supports understanding of ownership and sharing to reduce risks of stories being used out context
	Improves protection of self and others within stories
Ensure counseling is accessible should participants become distressed	Supports safety and the ethical conduct of workshops
Access consumer consultants if doubts exist as to the sharing of stories	Supports ethical and safe sharing of consumer stories

with storytelling expertise would likely direct conversations toward an examination of power and politics in psychiatric care. Participants emphasized that the created story must remain owned and controlled by storytellers because of the potential misuse by services and the risks involved in online sharing.

Stories told by consumers have been co-opted by mental health services to progress a biomedical agenda, within a dominant narrative, that aims to uphold the status quo rather than challenge it (Costa et al., 2012; Grant, 2011). Having guidelines that specify the purpose and topic of stories, what to expect from support personnel, and how stories will be shared,

and discussing these with participants throughout are recommended (A. C. Gubrium et al., 2014, p. 1610). Guidance and reflection should examine ethical issues about the need to protect self and others, the use of voice, and how a subject is being represented (A. C. Gubrium et al., 2014, p. 1610). The need for guidance on these issues was identified by participants in our study who appreciated the structured format of the workshop process. Consent for sharing stories within and outside the workshop should be formalized as part of the process, and include ongoing consent processes (A. C. Gubrium et al., 2014), with access to a consumer advocate for consultation.

Further recommendations from our study, suggest that the process would be improved by cofacilitation with an expert consumer storyteller and skilled clinician facilitator(s) working together with equal control over the process protocol. Using technicians with knowledge of the mental health system, who are, or have been consumers of mental health services, is also important. This ensures support for consumer and clinician storytellers, and limits sensitive information revealed and the reproduction of oppressive psychiatric discourses. Using consumer/facilitators in art-based approaches has the potential to develop greater consumer confidence (Taylor, Leigh-Phippard, & Grant, 2014). Maintaining a nonstigmatizing perspective in storytelling as a research method requires reflection on language to avoid uncritically using oppressive psychiatric renditions of mental distress (Epstein & Grey, 2011, p. 19); and skilled consumer and clinician facilitators working together would likely improve this process.

Researchers may also be affected by exposure to sensitive topics revealed in a digital storytelling workshop, as noted in previous research (Cunsolo Willox et al., 2013). To limit emotional fatigue, a level of researcher self-care, as well as the support, assessment, and monitoring of risk by research institutions, universities, and governance organizations, is warranted (Dickson-Swift, James, Kippen, & Liamputtong, 2008).

Making a digital story can be challenging for people with limited technological skills (Stenhouse, Tait, Hardy, & Sumner, 2013), and using a structured process with written instructions to teach the use of technology is advised (Lambert, 2010). However, in this study, we made a decision to limit the teaching of technology to increase the time for reflection and feedback, which is consistent with suggestions from other researchers (A. C. Gubrium et al., 2014). Further, having sufficient numbers of skilled support personnel, and the possibility for more support within inpatient units is important. To enhance ethical safety and promote the development of trust and respect between consumers and clinicians, groups should be kept small, protected (Digital Empowerment, 2012), contain more consumers than clinicians, and be supported by skilled facilitators. Using wellness as an initial topic was useful in developing relationships between consumers and clinicians before moving onto more complex issues in mental health. Consumer and clinician participants should be invited to develop the process protocol, with choice in the aims, purpose, time frame, learning opportunities, consent processes, and who to include in a workshop. Facilitators must remain flexible in

the time needed to create a story to meet the needs of participants for critical reflection and tackling challenges as they arise. This has previously been suggested (A. C. Gubrium et al., 2014). Recommendations for the use of digital storytelling in mental health, with a rationale, are contained in Table 2.

Limitations and Implications for Research

To our knowledge, this is the first study that explores the process of participation in digital storytelling for consumers and clinicians in mental health. Previous researchers have reported only a superficial description of the process of making them (Ferrari et al., 2015). While this case study offers new insights into the subject, the findings should be viewed with caution. This is a small case study that has examined the process of participation in two workshops only, with a limited number of participants. No carers were able to participate in a workshop, and their opinions of participating in the digital storytelling process are not represented in this study. Using one researcher to conduct the interviews may have influenced how participants responded to the research questions. However, the presence of a critical consumer and clinician voice within the interviews indicates that this effect was minimal. Wellness was a useful introductory topic for developing relationships between consumers and clinicians because they could both relate to the topic. However, we acknowledge that using a different workshop topic may have produced different views and outcomes on participation than are reported in this study. Bias may have been introduced because the technicians, facilitators, and self-selected participants may have held views in support of art-based approaches in mental health. The reluctance of some clinicians to include the arts in mental health services as a different way of interacting has been noted (Sapouna & Pamer, 2016). More research is needed in this area to build on our study findings in different mental health settings.

Conclusions

Process evaluation has been a valuable tool for unraveling the process of participation in digital storytelling from multiple stakeholder perspectives, and identifying recommendations for the use of digital storytelling in mental health research. Digital storytelling has potential to develop more reciprocal relationships between consumers and clinicians via a leveling of power within the participatory creative process. These processes can build a sense of community and solidarity between consumers and clinicians that can enable understandings of lived experience perspectives in mental health to emerge. Employing skilled consumer and clinician support personnel is important for enabling a safe and ethical process of participation. The potential to use digital storytelling as a research method that connects people in a democratic process and encourages dialogue cannot be underestimated in progressing mental health culture toward a social justice and recovery-oriented agenda.

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