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Participatory video as a novel recovery-oriented intervention in early psychosis: A pilot study.

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Introduction

The process of recovery from psychotic illnesses involves developing a narrative identity – a coherent understanding of one's experiences that is integrated it into a meaningful account of one's life (Windell & Norman, 2012). Personal narratives incorporating themes of personal agency, social worth, and illness conception can contribute to recovery, including reduced psychopathology, enhanced meta-cognition, increased social functioning, and improved psychosocial wellbeing (Lysaker et al., 2006; Lysaker et al., 2010). Participatory video is a tool to foster narrative development in marginalized groups through the promotion of self-awareness, self-expression, self-esteem, collaboration, communication, and empowerment (Shaw & Robertson, 1997; White, 2003). While it has been used to engage people with serious mental illness in discussion (van der Ham et al., 2013), we are not aware of its prior use as a clinical intervention. Thus this pilot study evaluated the feasibility, acceptability, and potential clinical utility of participatory video in fostering narrative development and promoting recovery in early psychosis.

Materials and Methods

Participants and Recruitment

Outpatients between the ages of 18 and 30 years old at the Prevention and Early Intervention Program for Psychoses (PEPP) in London, Ontario, Canada were recruited via advertisements and/or clinician referrals. Eligible participants were receiving treatment at PEPP for less than three years for a DSM-V diagnosis of a primary psychotic disorder. The study protocol was approved by the Western University Health Sciences Research Ethics Board, and all participants provided written informed consent.

Study Design and Intervention

This pilot study followed a non-randomized, repeated-measures design. Usual treatment at PEPP involves assertive case management, psychosocial interventions, and pharmacotherapy (see Norman & Manchanda, 2016). The participatory video intervention consisted of 13 semi-structured group workshops, which lasted approximately 2 hours each and occurred biweekly over 6 months (Table 1). Participants worked collaboratively to plan, film, edit, and produce documentary-style videos for the group and each individual using iPad™ tablets and applications. Workshops were facilitated by a psychiatrist and two media facilitators from ProjectVideo Inc. (http://projectvideo.tv/). Assessments were performed at baseline (T1), immediately post intervention (T2), and three months post intervention (T3).

[Insert Table 1 here]

Outcomes and Analysis

The primary outcomes were feasibility and acceptability of the intervention for a first episode psychosis population. For feasibility, participant retention from T1 to T3 was recorded, and reasons for study dropouts were described. For acceptability, attendance was recorded for 12 of 13 sessions, and participant satisfaction was measured at T2 using the Client Satisfaction Questionnaire (CSQ-8; Larsen et al., 1979). For exploratory analysis of potential clinical utility, several clinical measures of psychosocial outcomes were assessed at T1, T2, and T3. Non-parametric tests were conducted to examine differences in clinical measures across time points, with post hoc pairwise comparisons for statistically significant results. Analysis was conducted using SPSS V25 (IBM Corp. 2017) with statistical significance set at $p<.05$.

Results

Feasibility

Ten participants were recruited at T1 and four withdrew before T2, resulting in a retention rate of 60%. Reasons for withdrawal were unrelated to the study: returning to school, starting a new job, moving to another city, and an illness. The final sample consisted of 6 males with a mean age of 23 years old and who were predominantly Caucasian (n=3), single (n=5), lived with their parents (n=3), and had not completed high school (n=3).

Acceptability

Attendance records showed that 5 participants of the final sample attended 10 or more workshops: 12 (n=1), 11 (n=3), 10 (n=1), and 7 (n=1) workshops. The mean CSQ-8 total score was 27.6 (SD: 3.5), indicating a high degree of satisfaction.

Exploratory Analysis

Exploratory analysis findings are summarized in Table 2. On the Self-Stigma of Mental Illness scale, participants showed a significant decrease (p=.014) in scores from T1 (median: 130.5) to T3 (median: 105.0). On the Profile of Mood States, there was a significant decrease (p=.002) in Tension scores from T2 (median: 14.0) to T3 (median: 6.5). On the Possible Selves Interview, 'Negative Hoped-For Self' scores significantly decreased (p=.030) from T1 (median: 1.6) and T2 (median: 1.5) to T3 (median: 1.2). No other statistically significant changes were observed.

[Insert Table 2 here]

Discussion

In this pilot study, rates of retention and attendance suggest that the intervention was feasible and acceptable. Comparable rates were found in prior studies of similar interventions, such as photovoice and digital storytelling, for people with serious mental illness (Ferrari et al., 2015;

Werremeyer et al., 2016). Following the intervention, participants demonstrated notable reductions in tension. Narrative development can help in the processes of managing distress and facing challenges (Lysaker et al., 2010), as well as finding redemptive meanings in suffering and adversity (McAdams &McLean, 2013). The intervention was also associated with improvements in self-stigma, which is a prominent barrier to recovery from psychosis (Windell & Norman, 2012). Developing a coherent narrative can encourage one to reject stigmatizing views of mental illness (Lysaker et al., 2009), and participatory video provides an accessible avenue for young people to share lived experiences while challenging these views (Luttrell et al., 2012). Improvements were only detectable at the three-month follow up, which could relate to participant involvement continuing for up to one year after the last workshop. The opportunity for participants to present their videos to others may have been a significant contributor to the observed changes.

Conclusions

This pilot study is the first of its kind to implement and assess the feasibility, acceptability, and potential clinical utility of participatory video as a recovery-oriented intervention in early psychosis. The study findings suggest the possible value of participatory video and justify future research on a larger scale.

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Disclosures

The authors have no conflict of interest to declare.

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Tables

Table 1. Overview of participatory video workshop sessions

Pre-Production Workshop, Sessions 1- 4: • Group connectedness: Who are we as a group? Why did we come together? How will we work together throughout the project? • Development of group norms/expectations/roles • Explore the concept for the project, its goals, visual treatment and sources • Develop a storyboard with the participants to map out their plan for videos • Organize, manage and schedule the production shoots • Personal/Group Reflections: What role am I in the group? Why did I choose this role? What do I hope to learn through this experience?
Production Workshop, Sessions 5 - 8: • Group Check-Ins: How are we functioning as a group? What is working? What needs to change? • Film appropriate b-roll footage and conduct interviews (where necessary) • Record music (where necessary) • Record appropriate voiceover narration (where necessary) • How to share feedback to others • Personal/Group Reflections: What have I learned, am learning, will hope to learn? How has my role changed in the group? Am I comfortable with changes in the group and project so far?
Post-Production Workshop, Sessions 9 - 12: • Group Check-Ins: How are we functioning as a group? What is working? What needs to change? Are we where we thought we would be now? • Edit video • Develop graphic and music treatment • Author master versions of the video for distribution by agreed-upon deadline • Plan for how to share the final video with group and others • Personal/Group Reflections: Where do we go from here? How do want to support each other now that we are ending our time together as a group?
Final Viewing and Celebration, Session 13: • Group viewing of the final group and individual videos • Celebrating group and personal accomplishments

Table 2. Outcome scores and analysis results

Outcome Measure	Median Scores			Tests	
	T1	T2	T3	Friedman	Dunn's
Scale for the Assessment of Positive Symptoms (Andreasen, 1984a)	12.0	8.0	5.0	p=.538	NA
Scale for the Assessment of Negative Symptoms (Andreasen, 1984b)	14.0	10.5	9.0	p=.878	NA
Maryland Assessment of Recovery in SMI (Drapalski et al., 2012)	101.5	101.0	106.0	p=.183	NA
Rosenberg Self-Esteem Scale (Rosenberg, 1965)	19.0	16.0	19.5	p=.143	NA
Beck Hopelessness Scale (Beck et al., 1974)	4.5	5.0	2.0	p=.249	NA
Self-Stigma of Mental Illness (Corrigan & Kleinlein, 2005)	130.5	122.0	105.0	**p=.042**	T1 vs T2: p=.149 T2 vs T3: p=.312 T1 vs T3: **p=.014**
Social Functioning Scale (Birchwood et al., 1990)					
Engagement	102.3	105.0	105.0	p=.385	NA
Communication	111.0	105.0	117.5	p=.223	NA
Prosocial	117.5	120.0	115.3	p=.956	NA
Recreation	113.8	104.8	123.0	p=.738	NA
Employment	103.0	111.5	116.0	p=.210	NA
Independence: Competence	107.0	108.8	117.5	p=.465	NA
Independence: Performance	117.5	115.5	117.5	p=.246	NA
Profile of Mood States – Short Form (Curran et al., 1995)					
Depression	7.5	11.5	4.5	p=.554	NA
Anger	9.0	9.0	5.5	p=.565	NA
Confusion	8.0	9.5	5.0	p=.247	NA
Fatigue	7.0	10.0	5.5	p=.085	NA
Vigour	11.0	11.0	12.0	p=.113	NA
Tension	8.0	14.0	6.5	**p=.008**	T1 vs T2: p=.083 T2 vs T3: **p=.002** T1 vs T3: p=.194
Possible Selves Interview (Oyserman & Markus, 1990)					
Positive Recent Self	3.5	3.2	3.4	p=.568	NA
Negative Recent Self	2.4	2.6	1.9	p=.075	NA
Positive Future Self	4.1	3.7	3.8	p=.513	NA
Negative Future Self	2.1	1.8	1.7	p=.119	NA
Positive Hoped-For Self	4.3	4.3	4.3	p=.607	NA
Negative Hoped-For Self	1.6	1.5	1.2	**p=.038**	T1 vs T2: p=.333 T2 vs T3: **p=.030** T1 vs T3: **p=.030**
Indiana Psychiatric Illness Interview (Lysaker et al., 2002)					**Signed Rank**
Scale To Assess Narrative Development	15.5	NA	15.8	NA	p=.917
Metacognition Assessment Scale – Abbreviated	12.9	NA	9.9	NA	p=.752

Abbreviations: NA = not applicable; SMI = serious mental illness; T = time