Faculty of Health and Medicine

RECOVERY SNAPSHOTS:
A PHOTOGRAPHIC EXPLORATION OF ROMANIAN MENTAL HEALTH SERVICE USERS' EXPERIENCE OF RECOVERY

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This thesis is submitted in partial fulfilment of the requirements for the degree of Doctor of Philosophy. The candidate has already achieved 180 credits for assessment of taught modules within the blended learning PhD programme

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I declare that this thesis is my own work and has not been submitted for the award of a higher degree elsewhere.

List of abbreviations and acronyms

CASP	Critical Appraisal Skills Programme
CEC	Commission of the European Communities
CINAHL	The Cumulative Index to Nursing and Allied Health Literature
DCP	Division of Clinical Psychology (The British Psychological Society)
DSM	Diagnostic and Statistical Manual of Mental Disorders
e.g.	*exempli gratia* (Latin for "for example")
ECT	electro-convulsive therapy
et al.	*et alia* (Latin for "and others")
etc.	*et cetera* (Latin for "and other similar things")
i.e.	*id est* (Latin for "in other words")
ICD	International Classifications of Diseases (World Health Organisation)
IPA	Interpretative Phenomenological Analysis
NICE	National Institute for Health and Clinical Excellence
PICO	Problem/Patient/Population, Intervention/Indicator, Comparison, Outcome (evidence-based model for framing a research question)
Rom.	Romanian translation
SAMHSA	The Substance Abuse and Mental Health Services Administration (branch of the U.S. Department of Health and Human Services)
SPICE	Setting, Population/Perspective, Intervention, Comparison, and Evaluation (framework for defining research questions)
SPIDER	Sample, Phenomenon of Interest, Design, Evaluation, and Research type (framework for defining research questions)
UN	United Nations
WHO	World Health Organization

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Abstract

Background: Following post-communist social and economic changes, Romania is currently transitioning from institutionalised mental health services to a recovery-focused approach. Within this context, it is important to understand the perspective of Romanian service users on recovery from mental distress, an aspect that appears to be under-researched in this country.

Aim: This study aimed to explore the lived experience of recovery from mental distress and identify the meanings that Romanian mental health service users attach to recovery, along with investigating potential socio-economic, cultural, and historical particularities of recovery in their accounts.

Method: The theoretical core of this study was the recovery framework that conceptualises mental distress as a human, rather than a medicalised, experience. For this reason, a qualitative phenomenological design was employed to explore recovery from the perspective of fifteen adults with mental health problems selected purposively from a community day centre in Romania. The phenomenological methodology was enriched with elements of photography (workshops and photo-elicitation interviews) to elicit experiences and meanings of recovery.

Findings: The outcome of this study was a better understanding of the experience of recovery in Romanian adults living with mental distress, as a complex and multi-dimensional phenomenon including medical, psychological, social, spiritual, existential, and occupational aspects. The key recovery themes (and subthemes) identified through Interpretative Phenomenological Analysis corroborated with participant-generated photography were:

awakening (overcoming sedation, emergence of self beyond illness, and liberation), healing (medical, psychological, and spiritual), and reconstructing life (keeping busy, rebuilding social networks, and cultivating hope).

Discussion: This study revealed a cultural dimension of recovery in Romanian mental health service users that adds to the knowledge emerging from the current recovery frameworks. Additionally, it showed that recovery cannot be fully understood unless situated in a socio-political, cultural, and historical context, a dimension insufficiently evidenced in the recovery models. The use of participant-generated photography was crucial to capturing the picture of recovery through deep insights and visual representations that elicited rich narrative accounts. The role of photographs in facilitating and supporting recovery from mental distress was also discussed, along with limitations and challenges, and recommendations for photography-based recovery research and practice. Therefore, although conducted in Romania, this study may inform recovery research and practice in international contexts.

Chapter 1. Introduction

This introductory chapter outlines the researcher's rationale for conducting a photographic exploration of recovery in Romanian mental health service users by drawing on his personal and professional experiences, and background information on photography-based recovery research that sets the scene for the systematic literature review (Chapter 3). Finally, the research question, aim, and objectives are introduced, followed by an overview of this thesis.

1.1. Rationale for the research

1.1.1. A personal rationale

Photography was my faithful companion through various life events, including the post-communist depression following the Romanian Revolution in 1989. The creative world of photography provided me with a comforting distance from a reality that was far from the glorious capitalism promised by the Romanian political leaders. Not for long though, as I was to discover, some years ago, another reality concealed by stereotypes and stigma – the world of mental distress. I was volunteering for a mental health charity in Romania at the time. My role involved teaching a group of mental health service users photography skills as part of a vocational project. While they were enthusiastically learning to master photography, I became fascinated with their world expressed through unique pictures and touching narratives. I realised then the potential of photography in exploring human experiences often difficult to express in words, that provided those living with mental distress with a voice. Public reactions to service users' photographs showcased in a small community exhibition at

the end of the project proved that it was not only me hearing the voices of mental distress expressed through creative images, which further inspired me to combine photography and mental health.

My transition from a psychiatry-based education in Romania to a recovery-oriented approach in the United Kingdom, where I studied a master's course in Mental Health Practice (Leeds Beckett University), opened new avenues for researching photography as a tool for exploring lived experiences of mental distress. I discovered though that I didn't reinvent the wheel, as much as I wanted; my research revealed that photography and mental health had been happily married for decades, with remarkable therapeutic and methodological outcomes. I gradually became familiar with phototherapy (Weiser, 1993, 2004), photovoice (Wang & Burris, 1997), and therapeutic photography (DeCoster & Dickerson, 2013), in which I undertook professional training. Subsequently, I developed a skills-based programme to help mental health professionals explore emotions in people with psychosis through photography, which led to my initial doctoral research proposal. From there onward, the process revealed itself steadily evolving into this thesis.

Behind the scenes, the line between my professional experiences and personal life was rather blurry. A couple of years before I embarked my PhD journey, I was diagnosed with Ocular Myasthenia Gravis, a rare neuromuscular disorder with unpredictable prognosis. Ironically for a photographer, this condition degenerated in vision difficulties and experiences difficult to understand and verbalise. For this reason, I decided to re-enact my new reality through photography (Photo 1) that helped me accept my new identity shaped by illness. I found inspiration in the work of Jo Spence (Dennett, 2009, Spence, 1983), a British photographer

and photo-therapist who documented her battle with cancer in innovative and evocative images.

Photo 1: Collage of pictures re-enacting the researcher's experience of living with Myasthenia Gravis (©Lucian Milasan)

I believe that the process of producing such personal images resembles somehow the experience of those attempting to capture their mental distress in visual representations – reluctant at the beginning, illuminating at the end. Without exploring my own experience, I would probably not be able to fully understand the intrapersonal and intimate connections created through photography. For me, like the service users I worked with, photography became a second voice, without which my hidden world would not exist, buried in denial and the darkness behind my closed eyes.

Photography may not be able to steal people's soul, as naively believed by some pre-modern cultures, but it can certainly capture their unique experiences and open windows to inner worlds, perceptions, memories, thoughts, and emotions. This is the value of images on which

I capitalised in this thesis, guided by a strong desire to make a difference to recovery practice and research through photography.

It was clear from the scoping stage of this study that recovery was an under-researched topic in Romania, possibly because of the general attitude in this country to conceal mental health issues behind the walls of gulag-type institutions during communism (Loue, 2013). Hence, a research gap that I aimed to address, while giving something back to my home country. Living and working in the mental health sector in Romania until 2008 presented some advantages in terms of my understanding of the socio-political, cultural, and economic realities before and after the Revolution in 1989 – a major historical event marking the country's transition from communism to capitalism (Siani-Davies, 2007). However, on my return to Romania for research purposes, I (referred to in this thesis as "the researcher") was to discover new realities developed over the past ten years whilst I was residing in the United Kingdom. This helped me look at the research phenomenon with fresh eyes, gradually opened by deep insights gained from the research participants to whom I trusted my understanding, and whose expert knowledge and authentic experiences of mental distress and recovery are at the heart of this thesis.

1.1.2. Background

This study aims to contribute to the body of literature exploring subjective experiences of recovery from mental distress, which witnessed a surge over the past decade (Beck, Heffernan, Law, McCusker, Bentall, & Morrison, 2012, Eisenstadt, Monteiro, Diniz, & Chaves, 2012, Hamm, Leonhardt, Ridenour, Lysaker, & Lysaker, 2018). This exploration was facilitated by the growing interest in, and increasing use of, qualitative methodologies in health research

(Green & Thorogood, 2018). During a digital age in which photography is widely accessible through various electronic devices, visual methods have found a fertile ground in mental health research due to their potential to explore a wide range of experiences (Corredor-Álvarez & Íñiguez-Rueda, 2016, Erdner & Magnusson, 2011, Fernandes et al., 2018, Maniam, Kumaran, Lee, Koh, & Subramaniam, 2016), from the perspective of people living with mental distress emphasised in this thesis. Furthermore, visual methods are recommended for their advantage to reveal multi-layered information and symbolic representations of phenomena leading to enhanced understanding (Glaw, Inder, Kable, & Hazelton, 2017). Such methods include a wide range of photographic techniques from photo-elicitation (Harper, 2002, Sibeoni et al., 2017), to photovoice (Werremeyer, Aalgaard-Kelly, & Skoy, 2016, Vélez-Grau, 2019), auto-photography (Noland, 2006), photo-narratives (Sitvast, Abma, & Widdershoven, 2010), digital story-telling (De Vecchi, Kenny, Dickson-Swift, & Kidd, 2017), and photo-essay (Sile, 2018), some of which are detailed in *Chapter 3: Literature review*.

Although this thesis is not focused on the therapeutic value of photographs (Gibson, 2017, 2018, Loewenthal, 2013), the potential of photography to support wellbeing along with other artistic media (Stickley & Eades, 2013) is acknowledged here. A recent review commissioned by the World Health Organisation (WHO) conducted by Fancourt and Finn (2019) emphasised the benefits of arts (including photography) for health, by encouraging health-promoting behaviours, reducing the impact of trauma and the risk of cognitive decline, and improving the quality of care. In the context of this thesis, such aspects are essential for potentially promoting and supporting recovery from mental distress, as previously shown by Stickley, Wright, and Slade (2018). For this reason, investigating the helpfulness of photography in recovery was incorporated in the research objectives presented in the next section.

1.2. Research question, aim and objectives

1.2.1. Research question

Based on the rationale for this study, the following research question was developed iteratively: What are the subjective experiences and meanings of recovery from mental distress as lived by Romanian mental health service users?

1.2.2. Aim

The research question was translated into an aim, namely to explore the subjective experiences and meanings of recovery from mental distress from the perspective of Romanian adults with mental health problems, through participant-generated photography.

1.2.3. Research objectives

In order to achieve the research aim, the researcher (1) systematically reviewed and synthesised the literature on the use of photography in recovery research; (2) identified, through participant-generated photography, experiences and meanings of recovery from mental distress in Romanian mental health service users; (3) sought, in participants' photographs, potential socio-economic, cultural, and historical particularities of recovery in Romania; (4) investigated participants' perspective on the potential of photography to support and promote recovery.

1.3. Overview of the thesis

The subsequent chapters of this thesis were developed with a focus on the research question, aim and objectives, which guided the design and conduct of this study.

Chapter 2: Conceptualising recovery defines the key concepts of "mental distress" and "recovery" and critically discusses the complexity of mental health terminology often seen as conflictual between a bio-medical approach and a psycho-social dimension that is increasingly prominent in mental health care. The recovery framework to which this thesis subscribes is then presented and justified by highlighting the recovery models on which the researcher drew upon. As this study aims to capture the particularities of recovery in Romania, the cultural dimension of this phenomenon is explored along with a presentation of the state of mental health care in this country. Particularities in terms of language, legislation, research, and practices of mental health in Romania are discussed, with relevance for understanding the context of this study.

Chapter 3: Literature review consists of a systematic review of photography-based recovery research that informed this study and provided the researcher with the necessary knowledge, tools, and methods to conduct the fieldwork. The systematic approach is described stage by stage from formulating the review question onto justifying the method and design, and appraising the quality of the included studies. The outcome of this review is a dual thematic synthesis of photography-based methodologies in recovery research and recovery themes identified in photography-based research, which provided a valuable lens for discussing the findings of this study.

Chapter 4: Methodology outlines the constructivist/interpretivist epistemological and ontological underpinnings of the research, providing a justification for the use of a phenomenological approach. Photography as a research technique is discussed with emphasis on combining it with phenomenology in order to methodologically enhance this study. This is followed by a presentation of the research design, from recruitment methods to data collection and analysis, including a detailed description of the photographic activities conducted by the researcher. Consideration is also given to the issues of research reliability and validity, reflexivity, and ethical aspects.

Chapter 5: Findings is a narrative of participants' experiences and meanings of recovery presented in three overarching themes (awakening, healing, and reconstructing life) and nine corresponding subthemes. Drawing on the Interpretative Phenomenological Analysis (IPA), this chapter is focused on the meanings attached by participants to their experiences of recovery, aided by photography. Hence, the format of this chapter is a sequence of researcher's interpretations illustrated with participants' quotes and visual contributions.

Chapter 6: Discussion is structured around the key themes of recovery identified in the previous chapter, with a focus on the researcher's interpretation of participants' making sense of their experiences, in line with the principle of double hermeneutic. Additional layers of interpretation are generated by the researcher with reference to the theoretical framework of recovery described in *Chapter 2: Conceptualising recovery*. Particular attention is given to outlining the cultural, social, and political particularities of recovery in Romanian mental health service users. The understanding of recovery is enhanced through discussions of the complexity and multi-dimensionality of this phenomenon identified through phenomenological analysis and participants' photographic accounts. This process includes

reflections on the use of images throughout the project, with emphasis on the role of photography in exploring, but also supporting and facilitating recovery.

Chapter 7: Conclusions summarises this thesis by revisiting the research aim and objectives in light of what was achieved at the end of the project. The original contributions to knowledge are highlighted in what concerns both the exploration of recovery in Romanian mental health users and the use of photography as research tool. Strengths and limitations are reflected upon, and directions for further recovery research and practice are recommended.

Chapter 2. Conceptualising recovery

This chapter defines the concepts of mental distress and recovery, and outlines the theoretical framework to which this thesis subscribes by drawing on recovery models that were influential for this thesis. Recovery is then critically reflected upon through a cultural lens, including the context of the Romanian mental health system where the research was conducted.

2.1. Defining mental distress

Defining mental distress is a challenging task due to its multiple terminologies and understandings advanced throughout the time. Although presenting a history of this concept is not the purpose of this chapter, it is worth mentioning that mental distress was long placed in the realm of religion and "moral treatments" (Koenig & Larson, 2001) before becoming the subject of biomedical sciences during the mid-nineteenth century as abnormal and deviant behaviours (Alexander & Selesnick, 1977, Bentall, 2003). Since then, the most widely used terminology to describe mental distress is "mental illness" situated at the centre of psychiatric taxonomies (Hoff, 2015). Despite intense criticism of the Kraepelian nosology of mental disorders perceived as being too heterogeneous (Craddock & Owen, 2010), psychiatry continues to reinforce a system that pathologises people's distressful experiences (Horwitz & Wakefield, 2007). For example, "major depressive disorder", "generalized anxiety disorder", "bipolar disorder", "borderline personality disorder", and "schizophrenia" are reflected in the Diagnostic and Statistical Manual of Mental Disorders (DSM-V; American Psychiatric Association, 2013) and International Classifications of Diseases (ICD-10; WHO, 1992) as a set

of standardised symptoms. Such a categorical system is claimed to support psychiatrists and researchers develop a common language for conceptualising mental illnesses (van Heugten – van der Kloet & van Heugten, 2015). However, it is argued that psychiatric diagnoses are meaningless, invalid, and unreliable due to little evidence that they are indeed discrete entities (Jablensky, 2016), along with practical and philosophical inadequacies (Kinderman, Read, Moncrieff, & Bentall, 2012). Moreover, they could be detrimental to those suffering from mental distress by exacerbating stigma (Corrigan, 2007) and reinforcing issues of power in relation to mental health professionals (Johnstone & Boyle, 2018). Additionally, diagnostic criteria promote a reductionist discourse that defines individual experiences of mental distress in terms of "illnesses, chemical imbalances, and broken brains" (Adame & Knudson, 2007, p. 157). The British Psychological Society's Division of Clinical Psychology (DCP, 2013) outlines the conceptual and empirical limitations of psychiatric diagnoses, including the subjectivity of psychiatric assessments and their tendency to normalise people's feelings and behaviours. Such criticism may have contributed to an alternative and less stigmatising language of distress. In contrast with medicalised terms such as "disorder", "syndrome", "deficiency", "deficit", "dysfunctionality", which may not necessarily reflect the extent of lived experiences of mental health problems, a new terminology emerged. For example, mental health is "psychologised" rather than "pathologised" (Johnstone, 2018, Pattyn, Verhaeghe, Sercu, & Bracke, 2013), which indicates a recognition of mental distress as a human experience beyond biomedical parameters.

This view is shared throughout this thesis in line with a phenomenological approach and emphasis on the lived experience of individuals recovering from mental distress. Consequently, mental distress is conceptualised here as a set of heterogenous experiences

including “strong or overwhelming emotional states […] that disrupt everyday life and prevent people from functioning” (Cromby, Harper, & Reavey, 2013, p. 9). Although such experiences are described in the literature as “psychopathology”, “mental disorders” and, more generically, “mental illness”, “mental distress” is the terminology of choice in this thesis as a conceptual rather than simply linguistic preference.

2.2. Recovery between clinical and personal experience

The way recovery is conceptualised was a defining factor for this study, although the multiple views on this experience initially posed some challenges to the researcher who levitated amongst nebulous and conflicting understandings of recovery, elaborated upon in this section.

The concept of recovery was introduced into the mental health discourse by individuals with lived experiences of psychiatry during the service user movement in 1980s (Allott, Loganathan, & Fulford, 2002). Following the feminist and civil rights movements in the 1960s-1970s, along with the process of deinstitutionalisation, psychiatry survivors started to share their stories of recovery beyond their role of psychiatric patients (Chamberlin, 1978, Deegan, 1988, Leete, 1989). As a result, recovery became increasingly popular amongst mental health service providers, policy-makers, and researchers who started to develop a more nuanced understanding of this experience in the 1990s. Recovery has been since guiding the reformation of mental health policy and service provision worldwide, but not without challenges including the multitude of perspectives on recovery that made the advance of recovery-oriented mental health services inconsistent (Ellison, Belanger, Niles, Evans, & Bauer, 2018). Hence, the need for a clear conceptualisation of recovery and its underpinning

philosophy in order to understand this phenomenon and address it effectively in mental health research and practice (Silverstein & Bellack, 2008). Conceptual clarity becomes even more important in light of evidence indicating a predictive relationship between individuals' understanding and expectations of recovery, their health outcomes, and help-seeking behaviours (Carter, Read, Pyle, & Morrison, 2017).

Adopting a working definition of recovery in this thesis was hindered by disparities between views on clinical and personal recovery marked by confusion and disagreements (Slade, 2009). On the one hand, recovery is traditionally seen from a biomedical perspective focused on normalising behaviours (i.e. symptom alleviation, reduction of relapse rates, and decreased frequency of hospital admissions) (Addington, Penn, Woods, Addington, & Perkins, 2008). On the other hand, recovery is concerned with a sense of wellbeing not conditioned by symptom remission, as emphasised by user-led research (Pitt, Kilbride, Nothard, Welford, & Morrison, 2007). Law and Morrison (2014) confirmed the highest consensus among service users for recovery as "achievement of a personally acceptable quality of life" (p. 40). This perspective contrasts with biomedical models that extrapolate understandings of recovery as applicable to physical health (mental illness as a brain disease) and consider ongoing pharmacology essential for recovery or "cure" (Nasrallah, Targum, Tandon, McCombs, & Ross, 2005). This is despite medical treatments often being shown to be unhelpful or even harmful, potentially exacerbating mental distress (Bellack, 2006, Sharfstein, 2005, Slade et al., 2014). Furthermore, recovery expectations of people with mental health problems have been historically considered very low (Allott et al., 2007), although research indicates that clinical recovery (i.e. remission of symptoms) is possible for a considerable percent of individuals diagnosed with severe mental illnesses (Jääskeläinen et al., 2013, Slade & Longden, 2015). Of

course, this depends on how recovery was measured at different times, which explains the significant variation of recovery rates between the 1930's Great Depression in the United States, for example, and modern outcomes that appear superior (Salzer, Brusilovskiy, & Townley, 2018).

Constantly throughout the history of psychiatry, the clinical model has been driven by expert professionals assessing patients' degree of functionality according to predefined outcome measures reinforcing the dichotomy between "recovered" and "not recovered" (Wood, Price, Morrison, & Haddock, 2010). Unlike the clinical perspective, the view of individuals living with mental distress is anchored in their personal experiences and narratives (Deegan, 2002, Mead & Copeland, 2000). As a result, the recovery journey appears unique to each individual, which may explain why finding a universal definition for recovery is a challenging task (Allott et al., 2007). Recovery appears to be more than a mere return to a previous condition, which is unrealistic according to Morrison et al. (2016) due to the continuous process of transformation, adaptation, and rebuilding of self. This idea is best reflected in Anthony's (1993) definition of recovery as "a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and/or roles […] a way of living a satisfying, hopeful, and contributing life even with limitations caused by the illness" (p. 21). In light of this, personal recovery is an individualised approach that enables people with mental health problems to lead their own journey towards a meaningful life (Slade, 2009).

In conclusion, understanding recovery as a personal experience and interactional process occurring between "a person's strengths, vulnerabilities, resources, and the environment" (Onken, Dumont, Ridgway, Dornan, & Ralph, 2002, p. 3), allows for an exploration of the research phenomenon beyond the medical parameters of illness and disability, in a

psychological, socio-economic, and cultural context. The voice and experiences of mental health service users, historically muted by a biomedical model favouring the clinical expertise (Fisher & Spiro, 2010), are central to this research project. Hence, the researcher's decision to subscribe to the recovery framework outlined in the next section as the theoretical foundation of this thesis.

2.3. Subscribing to a recovery framework

The theoretical background underpinning this thesis is the recovery framework, understood here as an umbrella term encompassing various recovery models originating primarily from English-speaking countries. For the purpose of this thesis, five recovery models that provided the lens for exploring the recovery processes of Romanian mental health service users are presented below and synthesised in Appendix 1: (1) The Strengths Model (Rapp & Goscha, 2012); (2) The Tidal Model (Barker & Buchanan-Barker, 2005); (3) Ralph and Corrigan's (2005) conceptual model of recovery; (4) Whitley and Drake's (2010) dimensional approach to recovery; and (5) CHIME framework for personal recovery (Leamy, Bird, Le Boutillier, Williams, & Slade, 2011).

The Strengths Model

In line with the conceptualisation of recovery from a service user perspective outlined in the previous section, Rapp and Goscha's (2012) Strengths Model of recovery is influential toward the theoretical basis of this thesis. This is due to its focus on psychosocial aspects such as empowerment, growth, and achievement rather than abnormality, weakness, and vulnerability that contribute in authors' opinion to the oppression of those living with mental health problems. Rapp and Goscha (2012) provide a valuable framework for understanding

mental distress and recovery beyond the limitations of the deficit-based models which attribute mental health problems to deficiencies within individuals remediable through the pharmacological management of symptoms (Anglin & Polanco-Roman, 2017). In respect of this, Rapp and Goscha's (2012) vision echoes Antonovsky's (1979) salutogenesis model focused on the origins of health rather than disease, positing that life experiences shape individuals' sense of coherence and meaningfulness, which is decisive for mobilising resources to understand, and cope with, stressors (Mittelmark et al., 2017). The Strengths Model postulates that all individuals have unique skills, hopes, goals, and potential, which are key to overcoming their problems and achieving their desired recovery outcomes (Brun & Rapp, 2001). As a result, individuals have the capability to recover, reclaim, and transform their lives through personal abilities. Rapp and Goscha (2012) place particular emphasis on community that plays an important role in the process of recovery as the main source of support.

The Tidal Model

If Rapp and Goscha's (2012) model appears more practical in nature, possibly because it was developed with social workers in mind, Barker & Buchanan-Barker (2010) advance a more philosophical approach to recovery. Coined the Tidal Model, their framework echoes the Strengths Model's empowering stance by helping people take ownership of their life narrative, develop awareness of their circumstances in light of their experience of distress, and apply this knowledge to making positive choices in life. As with the Strengths Model, the Tidal approach claims that empowerment inherently involves a shift of power between mental health professionals and their clients by democratising the act of mental health care (Barker & Buchanan-Barker, 2010). The authors detach their model from a "treatment" approach understood as a reparative intervention to change the person. Therefore, the Tidal

Model is critical toward the paternalism of the psychiatric system that involves "the colonization of the personal experience of problems of human living" (Barker, 2003, p. 96) and a reductionist view providing only a freeze-frame of individuals' circumstances through formal and standardised diagnostic screening. The Tidal Model reinforces people's personhood on three dimensions – self, others, and world of experience – by acknowledging their narrative accounts (Barker, 2001). Therefore, rediscovering mental health on a personal, social, and environmental level is not only necessary, but also imperative. Particularly helpful in this process is the use of metaphors, especially water-based (hence the name of the model), to understand individual journeys "undertaken on an ocean of experience" (Barker & Buchanan-Barker, 2005, p. 9), in their fluid or "tidal" existence symbolising internal and external influences that shape individuals' identity (Barker, 2002). For a thesis using photography that is inherently metaphorical (Mykytka, 2016), this model adds a novel dimension with potential to illuminate experiences of recovery on a symbolic level, complementary to more pragmatic models of recovery.

Ralph and Corrigan's (2005) recovery model

Recovery is conceptualised in this thesis as a processual phenomenon rather than outcome, which is partly reflected in Ralph and Corrigan's (2005) model of recovery encompassing six phases in between which individuals move iteratively, non-linearly, and reflexively: despair and anguish, awakening and instillation of hope, developing insight, taking action, making a determined commitment to achieve wellbeing, and accomplishing wellbeing. However, unlike other recovery models, Ralph and Corrigan (2005) suggest that process and outcome are part of the same continuum in the sense that recovery processes are possible due to, but at the same time conducive to, recovery outcomes (e.g. striving for a normal life). Ralph and

Corrigan (2005) distinguish between internal (cognitive, emotional, spiritual), and external domains of recovery (activity, social relationships, and support), which helped with interrogating experiences of recovery on various levels throughout this project. Uncommonly, spirituality is considered as a distinctive dimension of recovery in this model, which was particularly relevant for research conducted in Romania, a country in which religion is central to many people's life and identity (Stan & Turcescu, 2007).

Whitley and Drake's (2010) recovery model

The dimensional approach to recovery advanced by Whitley and Drake (2010) informed this thesis through its five superordinate areas of recovery that became potential lenses to guide data collection and analysis: clinical recovery; existential recovery (hope, empowerment, agency, and spiritual well-being); functional recovery (employment, education, and adequate housing); physical recovery; and social recovery (relationships and community engagement). While existential, functional, and social elements of recovery are common to other recovery models, clinical recovery appears to be a dimension that is often opposed to personal recovery (Slade, 2009). This is an aspect that encouraged the researcher's reflection and challenged his initial assumptions of recovery as a purely psychological phenomenon, resulting in new lines of thinking pursued while conducting the fieldwork.

CHIME framework for personal recovery

Equally influential for shaping the theoretical background of this thesis, the CHIME framework for personal recovery (Leamy et al., 2011) was advanced by its authors as a conceptual model structured around five recovery processes: connectedness, hope and optimism, identity, meaning in life, and empowerment. These resulted from a systematic review of 97 recovery

studies conducted in 13 countries, the vast majority (90%) being English-speaking countries, which may limit the cultural validity of this model. The CHIME framework portrays recovery as an active, individual, and unique process developed on a non-linear journey. Leamy et al. (2011) identified five recovery stages: pre-contemplation, contemplation, preparation, action, maintenance and growth, which resemble those proposed by Andresen, Oades, and Caputi (2003): moratorium, awareness, preparation, rebuilding, and growth. Leamy et al. (2011) reveal that recovery studies originating in Black and Minority Ethnic communities emphasise spirituality and stigma, and identify culturally specific factors and collectivist notions of recovery as key themes for this population. Such findings suggest the need for cultural sensitivity in recovery models whose universal dimensions (e.g. empowerment, identity, hope), must be applied cautiously in diverse populations, as discussed in the next section.

The list of recovery models presented in this section is by no means exhaustive. SAMHSA (2006) recovery model, Andresen, Oades, and Caputi (2003), and Jacobson and Greenley (2001) share similar views on recovery as a personal experience understood beyond pathology and the need to cure a disorder. However, due to the word constraints of this paper, a limited number of models were proposed here to illustrate the recovery framework for exploring the research phenomenon through subjective enquiries, in line with the aim of this thesis. The selection of models is also illustrative of the multiple avenues for investigating the experience of recovery as a personal, social, psychological, and clinical phenomenon, which further informed the methodology, data collection, and analysis.

The researcher made the decision to follow a broader recovery discourse instead of one single recovery model after identifying a common vision centred on personhood, empowerment,

values and strengths, meaning, and hope for recovery. Additionally, the particularities of each model (Appendix 1) provided valuable avenues for inquiry while conducting the research (e.g. use of metaphors, situatedness of recovery, and spirituality), in order to reach a comprehensive understanding of the experience of recovery in the research participants. Finally, the researcher considered that remaining open to more theoretical influences may prevent building rigid preconceptions about the research inquiry that could have hindered the phenomenological attitude that governed this thesis.

It was noted previously that most of the recovery models were developed in Anglophone countries without being validated culturally (Chiu, Ho, Lo, & Yiu, 2010), although some of them (e.g. Leamy et al., 2011) were incorporated in cultural studies of recovery (Brijnath, 2015), but not in Romania. While a model of recovery that accounts for culture would have been ideal for the purpose of this thesis, culture is nonetheless an important factor of recovery considered here and discussed separately in the following section.

2.4. Cultural dimensions of recovery

Mental distress is a complex phenomenon interweaved in the cultural fabric of a society. Culture is understood here not only as ethnic or racial identity, but also in terms of society and its values, believes, customs, and ways of life (Lebrón, 2013). All these have a major influence on how mental distress is understood, accepted, and addressed (Çam & Uğuryol, 2019). Additionally, stigma and discrimination in relation to mental distress are believed to be determined culturally (Bracke, Delaruelle, & Verhaeghe, 2019). This is illustrated by the case of renaming “schizophrenia” in Japan from “mind-split-disease” to “integration disorder” following pressure from patients’ family groups (Sato, 2006). Although still preserving medical

connotations, the new terminology is believed to reduce the ambiguity of the old term and the stereotypical image of schizophrenia associated with inhumane treatments in the past. While schizophrenia was previously regarded as hereditary and impossible to recover, the new concept adopted by Japanese mental health services describes the condition as treatable to the extent of full and lasting recovery (Sartorius et al., 2014). This example shows not only the role of terminology in supporting and facilitating recovery (Kemp & Howard, 2017), but also the cultural context of mental distress and recovery. However, it is still uncertain to what extent cultural factors influence perspectives on recovery, due to the lack of research on this subject (Rudnick, 2012). This appears be the case in Romania, where person-centred service delivery models are claimed to be introduced without a prior understanding of the service users' view on recovery, and rely mainly on imported recovery measures from English-speaking countries (Shields-Zeeman et al., 2020).

Exploring cultural understandings of recovery is a major scientific challenge, but nonetheless imperative (Slade et al., 2012). O'Hagan (2004) points out the importance of acknowledging "cultural diversity and a connection to one's own culture as a key to recovery" (p. 2). In the context of increased demands for cultural competencies in mental health (Bhui, Warfa, Edonya, McKenzie, & Bhugra, 2007), understanding recovery from a cultural perspective is essential due to its association with different meanings in various cultures (Eltaiba & Harries, 2015, Ng, Pearson, Lam, Law, Chiu, & Chen, 2008, Thara, 2012). For instance, it is suggested that the values of personal recovery are perceived differently in collectivist societies like Romania (Albu, 2017), where the emphasis is placed on the role of the extended family as opposed to the Western individualism that promotes independence (Slade et al., 2014). On the same note, Tse, Tang, and Kan (2012) debate the concept of empowerment central to

Anglophone recovery frameworks that may be interpreted by Chinese people as a challenge to the respect for authority and opposed to a fatalism historically ingrained in traditional philosophies. Hence, the criticism of recovery frameworks for giving insufficient attention to cultural contexts of recovery (Price-Robertson, Obradovic, & Morgan, 2016). As a result, there are calls for developing culture-sensitive recovery models (Leung, 2015), in light of research conducted internationally that reinforces the cultural determination of recovery (Boucher, Groleau, & Whitley, 2019, Chiu et al., 2010, Gopal & Henderson, 2015, Lapsley, Nikora, & Black, 2002). An exception is Davidson, Borg, Marin, Topor, Mezzina, & Sells's (2005) multi-cultural study that found no significant differences in the recovery processes in USA, Italy, Norway, and Sweden.

In what concerns Romania and other East-European countries, the socio-economic transformations and cultural shifts of the post-communist era shaped the provision of mental health services from institutionalised to community-based approaches (Andronic & Andronic, 2017). Within this context, capturing the cultural nuances of recovery is important for understanding people's view on health and illness, and their help-seeking behaviours (Gopalkrishnan, 2018), but also for the reformation of mental health services (WHO, 2017).

2.5. The state of mental health recovery in Romania

Exploring and understanding lived experiences of distress is a novel area of research in Romania where psychosocial research, regarded as "reactionary" science, was suppressed in this country during communism (Bosomitu, 2007, Radhakrishnan, 1991). As a result, Romanian studies in mental health appear to be sparse (Bucur & Adams, 2010) and ethically flawed (Loue & Chiscop, 2014), and the experience of mental distress as lived by service users

is rarely revealed (Friedman, 2016). The focus of Romanian researchers seems to be on the perspectives of psychiatrists (Țebeanu & Macarie, 2013), medical students (Popescu, Buzoianu, Suciu, & Armean, 2017), and public attitudes towards mental illness (Neacșu, 2013, Stănculescu, Niţulescu, Preotesi, Ciumăgeanu, & Sfetcu, 2008, Todor, 2013), indicating high levels of stigma and misunderstanding in what concerns this topic.

The language of Romanian researchers denotes a strong biomedical perspective that promotes "mental health […] curable like any other diseases" (Kelemen, 2017, p. 215), possibly inherited from the communist ideology that advanced medical explanations for various brain "diseases" (Marks & Savelli, 2015). This is also reflected in the Romanian legislation (Legea 487/2002, Ministerul Sănătății, 2006) that abounds with words and expressions such as: "mental deficiency/imbalance" (*deficiență/echilibru mintal)*, "mental disorders" (*tulburări mintale*), "mental illness/mentally ill person" (*boală mintală*/*bolnav mintal*), "mental handicap" (*handicap mintal*), "diagnosis/diagnosed" (*diagnostic/ diagnosticat*), "remission of symptomatology" (*remiterea simptomatologiei*). Even the most accurate terms to translate "recovery" into Romanian (i.e. "recuperation", Rom. *recuperare*), carry strong pathological connotations linked to physical illnesses.

Historically, Romania is a country with a long and troubled history of institutionalisation during communism (Mundt et al., 2012), from which it inherited a strongly medicalised mental health system. Mental health care was (and continues to be) provided mainly in overcrowded large-scale psychiatric hospitals, outdated, and incapable of providing quality care (Tătaru, 2005), which is the case with other East-European countries (Krupchanka & Winkler, 2016). The Romanian psychiatric system is summarised by Kohrt and Mendenhall (2015) as a "complicated marriage of biological understandings of mental illness with an

inherited institutional infrastructure, lack of public interest in community mental health care, and a poorly funded mental health and social services system" (p. 192). The current situation is marked by profound socio-economic changes caused by the country's transition from socialism to capitalism, including austerity measures leading to poverty, which contributed to increasing numbers of Romanians being diagnosed with mental health problems (Florescu et al., 2009).

The reliance on the psychiatric expertise continues to dictate the main directions of mental health practice in Romania, which makes some authors question whether the mental health care climate in this country is indeed conducive to a real reform as proclaimed by national policies (Winkler et al., 2017). On a similar note, Friedman (2009) states that Romanian psychiatrists have constructed a new category of patients called "social cases" (Rom. *cazuri sociale*) who face a series of challenges to survive outside of mental institutions because of poverty and an underdeveloped welfare system. For this reason, they are not discharged and inhabit the mental health system for long periods of time, although this is shown to be detrimental to their mental health.

In this context, the shift of accent from "patient" to "person" promoted by the Romanian legislation (Ministerul Sănătății, 2016) appears to be rather tokenistic, possibly introduced under the pressure of international community (WHO, 2015), and urgency to align with the European standards in mental health care (CEC, 2005) prior to Romania becoming a member of the European Union in 2007. Therefore, it is uncertain how the reformation of the Romanian mental health system will be implemented without a clear recovery framework while preserving a heavily medicalised approach to mental health (Tătaru, 2005), lacking trained staff (Ionescu, 2005), and dedicated funding from governmental authorities

(Vlădescu, Scintee, Olsavsky, Hernandez-Quevedo, & Sagan, 2016). While the view of service users is key to shaping mental health services (Bryant, Tibbs, & Clark, 2011, Wilson & Daly, 2007), the involvement and expert knowledge of Romanians living with mental distress does not appear to be accounted for in this process. This issue warrants investigation by exploring people's subjective experiences of distress and recovery, further encouraged by recent research suggesting that individuals' understanding of their experiences has important consequences on health behaviours (Carter et al., 2017).

Based on the existing literature on mental health in Romania, the researcher's initial assumption was that recovery is generally seen in this country as a medicalised experience reinforced by the psychiatric expertise. However, informed by the theoretical background and various conceptualisations of recovery outlined in this chapter, new lines of enquiry around recovery as a multi-layered experience were developed, along with how to optimally incorporate photography to capture this variety of meanings. For this purpose, the recovery framework was explored through the lens of photography-based research reviewed in the next chapter.

Chapter 3. Literature review

3.1. Introduction. Review aim and objectives

This chapter is a bridge between the theoretical framework from the previous section and the methodological background, hence its dual focus on photography-based techniques and recovery. The overall aim of this chapter, which is also one of the research objectives of this thesis, is to identify and systematically review the evidence of using photography-based methods in researching lived experiences of recovery from mental distress. This task was considered necessary at the inception of this thesis to help the researcher justify the decisions made throughout the data collection and analysis, initially hindered by literature that appeared to be highly fragmented and diverse. However, a number of reviews are worth mentioning. Fraser and al Sayah (2011) reviewed arts-based methods (including photography) in health research, but, as with the work of Stickley, Wright, and Slade (2018) and Fancourt and Finn (2019), the role of photography cannot be distinguished from other artistic media such as drawing, painting, theatre, and creative writing. Han and Oliffe (2016) carried out a review drawing preliminary conclusions and recommendations on using participatory photography in mental health research, but their focus was rather narrow on only one photographic approach (photovoice). Finally, Saita and Tramontano (2018) and Buchan (2020) explored the therapeutic dimension of various types of photography, incongruent with the focus of this thesis which, nonetheless, acknowledges the therapeutic value of photography that cannot be completely separated from the topic of recovery.

Along with photography-based methods, the findings from literature are also synthesised in this chapter in the form of recurrent themes of recovery to facilitate the discussion of the results of this thesis in a wider research context.

3.2. Method

This review was designed as an accountable and replicable process, informed by the current literature on conducting a systematic literature review (Aveyard, Payne, & Preston, 2016, Boland, Cherry, & Dickson, 2014, Booth, Sutton, & Papaiannou, 2016), and based on a protocol that was peer-reviewed and published on PROSPERO (CRD42019130370).

A thematic synthesis approach (Thomas & Harden, 2008) was selected as an optimal review method widely used to integrate findings from qualitative research on people's experiences (Harden et al., 2004, Wood & Alsawy, 2018), compatible with the type of studies identified during the scoping phase. Although thematic synthesis is criticised for lacking methodological transparency (Dixon-Woods, Agarwal, Jones, Young, & Sutton, 2005), the steps for this approach are clearly outlined by Thomas and Harden (2008) and were followed closely by the researcher: (1) coding the text line-by-line; (2) developing descriptive themes; (3) generating analytical themes. Alternative approaches such as meta-ethnography (Noblit & Hare, 1988) and framework synthesis (Gough, Thomas, & Oliver, 2012) were rejected because of their focus on building theories. Narrative synthesis approaches (Popay et al., 2006) were also dismissed due to their limitations in identifying commonalities (Barnett-Page & Thomas, 2009), which was essential for this review.

3.3. Design

3.3.1. Operationalisation

The review was operationalised using the SPIDER framework: Sample, Phenomenon of Interest, Design, Evaluation, and Research type (Cooke, Smith, & Booth, 2012). SPICE (Setting, Population/Perspective, Intervention, Comparison, and Evaluation) (Booth, 2016) was initially considered, but dismissed because of its emphasis on intervention and comparison, incompatible with the aim of this review. It is acknowledged here that the SPIDER framework is less sensitive compared to other frameworks (e.g. PICO) (Methley, Campbell, Chew-Graham, McNally, & Cheraghi-Sohi, 2014). However, building on SPIDER framework's greater specificity (Methley et al., 2014), broader searches were conducted to compensate for this shortcoming.

3.3.2. Inclusion and exclusion criteria

Potentially relevant studies were selected based on the inclusion and exclusion criteria outlined in Appendix 2. In summary, studies focused on people with mental health problems were included, but not those addressing physical health issues, neurodegenerative disorders, or dual diagnoses, if the emphasis was not on recovery from mental distress. In line with the review aim, studies exploring recovery from mental distress from participants' perspective were included only if photography-based methods were employed. Only qualitative and mixed-method studies were included after it was clear at the scoping stage that quantitative studies appear to be unsuitable because of their positivist epistemology and incompatibility with the exploration of rich life experiences (Bryman, 2016). Both English and Romanian studies were included, and no date filters were applied, as per the justification in Appendix 2.

3.3.3. Search strategy

Preliminary searches were carried out to investigate the volume and distribution of the literature published on photography and recovery. Searches on PROSPERO and the Cochrane database did not reveal any similar reviews, indicating a potential knowledge gap. Generic searches were conducted on CINAHL (The Cumulative Index to Nursing and Allied Health Literature) and Medline, using a combination of broad search terms (e.g. "mental health" or "mental distress", "recovery", and "photography") (Appendix 3). To optimise searches and reduce bias, multiple perspectives and conceptualisations of recovery were considered (e.g. biomedical and psychosocial) and alternative terms were included (e.g. "mental illness", which appears to be used by researchers interchangeably with "mental distress" or "mental health problems"). Romanian journals (e.g. *Romanian Journal of Psychiatry*), were also manually searched at this stage, but no relevant Romanian studies were identified, reinforcing the claim of a research gap in the area of recovery in this country.

Development of keywords and search terms

The search strategy was developed by applying the 'pearl-growing' technique (Schlosser, Wendt, Bhavnani, & Nail-Chiwetalu, 2006) to five key articles identified during the scoping stage (Appendix 4). The search terms were expanded through synonyms and keywords from relevant articles identified through preliminary searches (Appendix 5). Particular attention was given to issues with database indexing of qualitative research (e.g. Medline using significantly fewer indexing terms for qualitative research compared to CINAHL) (Wright, Golder, & Lewis-Light, 2015). This potential shortcoming was addressed by broadening the searches to a simple three-line filter shown to be as effective as a complex free-text search of

48 terms (Flemming & Briggs, 2007). Furthermore, the search syntax was refined iteratively using Boolean operators (AND, OR, NOT, and truncation symbols), to narrow or broaden the results (Appendix 6). The search strategy was developed with guidance from information specialists at Lancaster University and feedback from the supervisory team. Alterations to the search syntax were recorded in a memo format to enhance the trustworthiness and reproducibility of the search results, and make the review process more systematic (Booth, 2016).

Database searches

The final search strategy (Appendix 6) was adapted for six cross-disciplinary electronic databases (CINAHL, Medline, Web of Science, Scopus, PsycINFO, Arts & Humanities) with different foci (e.g. nursing, medicine, psychology, and arts), to reflect multiple perspectives and conceptualisations of recovery.

Complementary search strategies

Searching electronic databases only is considered insufficient for covering the evidence needed for systematic reviews (Greenhalgh & Peacock, 2005). Therefore, additional search strategies were conducted to minimise the risk of missing relevant items such as manually searching the reference lists, citation search, hand searching of online journals (*Arts & Health*), and grey literature (*Opengrey.eu, Greylit.org,* and *Grey Matters*).

3.3.4. Study selection

Following electronic database and complementary searches, studies potentially addressing the experience of recovery through photography-based methods were retained. Studies with

unclear focus, design or methodology were also included for clarification. After removing duplicates, potentially relevant articles were screened for title and abstract, against the inclusion and exclusion criteria (Appendix 2). A Microsoft Excel® spreadsheet was used to record eligible articles (Appendices 7.1 & 7.2), and references were stored electronically using a reference manager. If articles met the inclusion criteria or clarification was needed, the full-text version was reviewed following the same procedure. Title, abstract, and full-text screenings were undertaken by the researcher with guidance from the supervisory team to ensure optimal selection of the articles. The screening process is illustrated in Fig. 1.

3.3.5. Data extraction

Data were extracted manually using a bespoke 13-point data extraction form (Appendix 8) adapted from NICE (2007), including key information for the aim of this review: study context and focus, participant characteristics, theoretical perspectives, photographic methods and their incorporation in the study design, participants' involvement in photography-based activities, researcher's role, findings, challenges and limitations, and suggestions for future research.

3.3.6. Quality appraisal

The quality of the included articles was appraised through the CASP (2017) qualitative checklist focused on eight areas of appraisal: research design, sampling strategy, data collection, reflexivity, ethical issues, data analysis, findings, and research value. Although no scoring system was used for non-validation reasons (Papaioannou, Sutton, Carroll, Booth, & Wong, 2010), and no articles were excluded based on this criterion, the quality assessment was tabulated (Appendix 9) and critically discussed at the end of this chapter.

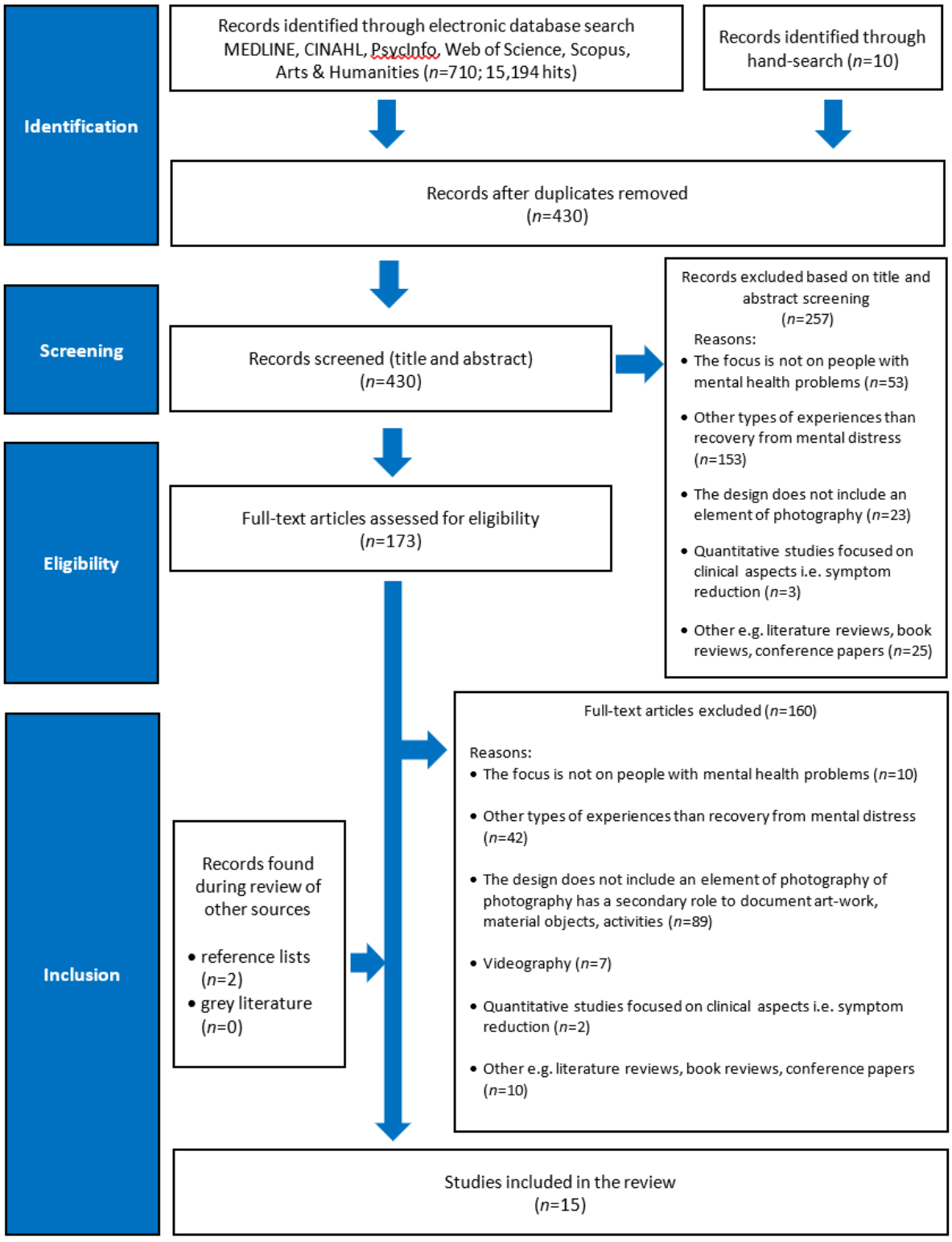

Fig. 1. PRISMA flow diagram illustrating the stages of the literature review process (adapted from Moher et al., 2015)

3.4. Results

From a total of 430 articles screened for title and abstract (after the duplicates were removed), fifteen articles (summarised in Appendix 10) were selected for synthesis (n=13 from electronic database searches, and n=2 identified through hand-searching reference lists of relevant articles).

The vast majority (n=14) were conducted in English-speaking countries: United States of America (n=6), Canada (n=4), Australia (n=2), United Kingdom (n=2), and one in the Netherlands, supporting the idea that recovery models are primarily a product of the Anglophone mental health systems (Llewellyn-Beardsley et al., 2019), although this claim may be biased by selecting only articles in English.

In terms of setting, mental health services targeted by photography-based research varied from inpatient (mental health hospitals), to outpatient (mental health clinics), and community services (supported housing, day centres, and community mental health teams).

Fourteen studies included in this review were qualitative (phenomenological, grounded theory, and participatory action research) and one mixed-methods, indicating the subjective nature of the inquiry into the experience of recovery facilitated by relatively small samples recruited purposively or conveniently (4-31 participants, average of 15 participants per study).

Most of the studies included in this review were predominantly guided by the recovery framework more generically, as advanced in this thesis, but also focused on particular recovery models (e.g. Leamy et al., 2011, Whitley & Drake, 2010). Nonetheless, they share the same principle that “mental health recovery implies more than a reduction in symptoms

and increased functioning" (Tran Smith, Padgett, Choy-Brown, & Henwood, 2015, p. 109). Without exception, the selected articles defined recovery as a transformative journey, a non-linear developmental process focused on personal growth, empowerment, and regaining personal autonomy by living a meaningful, fulfilling, and contributing life.

3.5. Synthesis

The synthesis presented in this section aligns with the aim of this review to inform the thesis on the use of photography in exploring the experience of recovery from mental distress. This includes the most frequently used photography techniques, but also uncommon approaches, the rationale for incorporating photography in recovery research, benefits of using photography as a research tool, along with challenges and limitations, and, finally, a thematic analysis to elucidate the meaning of recovery in photography-based research.

3.5.1. Types of photography-based methods in recovery research

This review revealed that experiences and meanings of recovery from mental distress tend to be explored mainly through photovoice (n=9) and photo-elicitation (n=4). As an exception, Sitvast (2015) used photographs taken of participants by a member of the research team, and Larivière et al. (2015) used existing photographs from magazines.

Photovoice

As defined by Wang & Burris (1997), photovoice is "a process by which people can identify, represent, and enhance their community through a specific photographic technique" (p. 369). This method is claimed to be ideal for research with marginalised individuals living with

mental distress because it helps them voice their strengths and concerns (Carlson, Engebretson, & Chamberlain, 2006).

Photovoice consists of issuing cameras to the research participants and inviting them to take pictures representative of their needs and experiences (Wang & Burris, 1997). This stage is similar to photo-elicitation (presented below), hence the overlaps between these two methods (Johnson, Sharkey, & Dean, 2011). However, an analysis of the way photovoice was implemented revealed that group work (4-10 participants) was more prevalent in recovery research, while photo-elicitation was predominantly individual. This captures the essence of photovoice as a platform for dialogue for community members whose collective voice around issues of interest is a catalyst for social change (Wang & Burris, 1997), which may explain the methodological affiliation of photovoice to participatory action research (Sitter, 2017). However, there are some exceptions with photovoice being implemented in individual interviews (Duff, 2012, Yates, Holmes, & Priest, 2012). Either way, photovoice appears to be a collaborative research method claimed to attenuate power differentials in research, preserving the person-centred principles that established this method (Clements, 2012). Therefore, it is not surprising that photovoice is highly compatible with qualitative methodologies relying on reflexivity and rich data from participants' perspective (Braun & Clarke, 2013). Ultimately, photovoice is based on the understanding that people are agents of change and experts in their own lives and experiences (Wang, 2003).

A typical photovoice session starts with an orientation activity to train participants on using cameras, explain the photovoice principles and ethical aspects of photography. The subsequent groups are focused on critical discussions exploring participants' subjective experiences and meanings of recovery through photography. It is generally acknowledged

that the use of a minimal set of instructions confers participants more agency and control over their own narrative accounts (Tran Smith et al., 2015).

Recovery photo-missions can be either pre-established (Mizock, Russinova, & Shani, 2014) or flow freely from one activity to the next (Cabassa, Nicasio, & Whitley, 2013), frequently accompanied by written narratives that enhance participants' messages of recovery. The final product of photovoice activities is usually a set of creative pictures, personalised photo-books (Anderson Clarke & Warner, 2016), photo-journals (Duff, 2012) or photo-diaries (Yates et al., 2012), life-books (Greco, Lambert, & Park, 2017), and portfolios of personal recovery themes (Quaglietti, 2018). Additionally, participants are frequently involved in community photo-exhibitions (Clements, 2012, Horsfall, Patton, & Carrington, 2018, Mizock et al., 2014, Sitvast, 2015), demonstrating that photovoice is suitable for both eliciting knowledge about recovery and disseminating this knowledge to initiate social action. Therefore, photovoice stands out for its potential to empower participants who are often seen as co-researchers making decisions on the research design and conduct, and how they portray their recovery (Greco et al., 2017).

Photo-elicitation

Photo-elicitation is the process of inserting a photograph in a research interview to generate verbal discussion by evoking feelings, thoughts, and memories (Harper, 2002). This method is often preferred to conventional interviews, partly because visual images have the potential to trigger deeper parts of human consciousness compared to words alone (Glaw et al., 2017), due to areas of the human brain that process visual stimuli being, from an evolutionary perspective, older than those processing verbal information (Harper, 2002).

An analysis of the recovery studies included in this review revealed some particularities in using photo-elicitation compared to photovoice. Firstly, photo-elicitation appears to be suited for generating rather than disseminating knowledge. Nonetheless, it appears valuable for reflexivity and mutuality between the researcher and the researched (Piat, Seida, Sabetti, & Padgett, 2017). Secondly, in terms of implementation, photo-elicitation is most frequently combined with individual interviews, and less commonly used in focus groups (Lal, Ungar, Malla, Frankish, & Suto, 2014). Finally, photo-elicitation was successfully implemented with both participant-generated photographs and images provided by the researcher (Larivière et al., 2015).

Despite some authors pointing out the lack of guidance for the use of photo-elicitation and analysis of photographs (Wall, Higgins, Hall, & Woolner, 2013), this method holds potential for "articulating subjective, or relatively intangible experiences that are less well captured by traditional research methods" (Piat et al., 2017, p. 72), resulting in a deep understanding of the experience of recovery. The typical steps of the photo-elicitation process that informed the design of this research project are summarised in Appendix 11, based on the studies included in this review.

3.5.2. Rationale for using photography-based methods in recovery research

The authors included in this review appear to use photographs mainly for enhancing the understanding of personal experiences of recovery, in line with qualitative methodologies aiming for rich accounts (Anderson Clarke & Warner, 2016, Cabassa et al., 2013, Clements, 2012, Duff, 2012). Furthermore, photographs are described as powerful tools for story-telling (Horsfall et al., 2018) that facilitate expression of thoughts, feelings, and memories as part of

recovery narratives. Additionally, images are regarded as effective instruments in constructing and communicating meaning (Sitvast, 2015), therefore bridging the knowledge gap, but also cancelling any issues of power, between the researcher and the researched (Notley et al., 2012). As a result, research participants are occasionally involved as co-researchers and co-facilitators of photography groups, making decisions (Greco et al., 2017), and initiating social change (Anderson Clarke & Warner, 2016). In the spirit of empowerment that is central to recovery models (Leamy et al., 2011), individuals are engaged in a critical dialogue elicited by photographs (Cabassa et al., 2013, Greco et al., 2017), often materialised in disseminating knowledge about recovery within local communities (Clements, 2012, Mizock et al., 2014). Finally, the versatility and accessibility of photography, perceived as an enjoyable occupation by participants, is another reason for authors to incorporate images in a variety of contexts and settings (Cabassa et al., 2013), and with people from various cultural backgrounds, of different ages and literacy levels (Anderson Clarke & Warner, 2016, Mizock et al., 2014).

3.5.3. Outcomes of photography-based methods in recovery research

Outcomes for researchers

The main outcome of incorporating photography in recovery research, as reported in the reviewed literature, is an enhanced understanding of recovery supported by photographs that facilitate participants' examination of thoughts and feelings about their lived experiences. On this note, Cabassa et al. (2013) and Piat et al. (2017) argue that recovery dimensions present in participants' imagery would have not been accessible with conventional research methods. Adding a visual element to recovery research is claimed to

enrich data and provide a tool for triangulation for researchers (Yates et al., 2012). For example, Greco et al. (2017) highlighted discrepancies between a participant's verbal account and his visual contribution which helped with elucidating the experience. Therefore, photographs are considered the basis for in-depth interviews to elicit thoughts, reflections, and recovery narratives (Cabassa et al., 2013, Clements, 2012, Mizock et al., 2014, Piat et al., 2017, Sitvast, 2015) that support the expression of authentic recovery messages (Horsfall et al., 2018), sometimes metaphorically (Piat et al., 2017, Quaglietti, 2018).

As an exception, Yates et al. (2012) pointed out that the contribution of photographic data was uncertain, variable, and difficult to assess if not compared to situations in which such methods are not present. However, the same authors acknowledge that photography provided a scaffolding for structuring interviews and focus on participants' subjective experiences rather than professionals' expertise.

Outcomes for research participants

Interestingly, the benefits for research participants involved in photography-based recovery research are more evident in photovoice studies, while photo-elicitation appears to be more instrumental to researchers. A possible explanation may be provided by the participative nature of photovoice research that has a prominent social action element attached to it (Sitter, 2017). Furthermore, photovoice research predominantly uses group work, in which creative and problem-solving processes are enhanced while participants help each other with technology, critically reflect on, and discuss, their experiences of recovery (Greco et al., 2017).

Regardless of the method used, photography appears to be more than a simple recreational activity for participants. It has been reported to be a "motivating and creative outlet"

(Anderson Clarke & Warner, 2016, p. 413) that helps participants cope with their distress by engaging in meaningful and purposeful activities beneficial for expressing emotions in a safe environment (Anderson Clarke & Warner, 2016, Greco et al., 2017, Horsfall et al., 2018, Quaglietti, 2018). Hence, the fine line between photography as methodological and therapeutic tool noted in the included studies.

Furthermore, deep understandings of recovery seem to benefit research participants by enabling them to take an active stance in the process of generating knowledge (Cabassa et al., 2013). Reflecting on their experience, shaping their own personal narratives, and sharing knowledge with the researchers, peers, and local communities, proves to be empowering for research participants and, consequently, support their recovery (Horsfall et al., 2018, Quaglietti, 2018).

In conclusion, the outcomes for participants suggest that photography is not only a research tool for exploring experiences of recovery; it is a coping strategy that itself can be supportive of recovery from mental distress by facilitating positive changes in people's emotions, thoughts, and actions. Quaglietti (2018) claims that such a creative milieu is conducive to emotional growth, hope, and self-discovery, and provides a "distraction from symptoms and worries associated with mental illness" (p. 227). On the same note, Sitvast (2015) suggests that photographs may become "scripts for further recovery", "reminders [for participants] of wishes and values in life" (p. 145). Critical reflections on recovery and meaning making contributed to participants reconceptualising their experience, resituating themselves as human beings, and rebuilding their personal identity despite the burden of mental distress (Piat et al., 2017).

3.5.4. Themes of recovery in photography-based research

The recovery themes reported in the selected literature were analysed following Thomas and Harden's (2008) guidance on conducting a thematic synthesis (described in the previous sections). The aim was to nuance the recovery framework presented in *Chapter 2: Conceptualising recovery* through the lens of photographic methods, and provide a context for discussing the findings of this study. Self-discovery, meaningful exchanges, situatedness, and coping while hoping were identified as key themes of recovery discussed in the subsequent subsections.

Self-discovery

According to Sitvast (2015), recovery is a "journey of discovery" (p. 142) best illustrated in one of his participants' photo-story that captured his existential metamorphosis throughout the research project. Photography contributes to this process by aiding participants' exploration of their identities in the context of their recovery. This involves moving beyond old identities (Tran Smith et al., 2015), reminiscent of Goffman's (1963) "spoiled identities", which are reconstructed, reshaped, reimagined, and reinforced through "personal value, determination and worth beyond their psychiatric disabilities" (Cabassa et al., 2013, p. 6). Human qualities such as perseverance and self-acceptance (Horsfall et al., 2018) surface during this journey of self-discovery as part of positive identities and normalised self (Lal et al., 2014). Defining oneself or "individuation" (Larivière et al., 2015) appears to be an exercise of self-assertion and development of the belief that one has value. For Mizock et al. (2014), the transformative dimension of this revelation is evident from a perspective of overcoming losses associated with mental illness. Within this context, transformation of self,

strength, self-reflection, awareness, readiness for change, and determination, are defining for unique and autonomous identities. As a result, recovery is revealed as "a process of identity development and affirmation", as expressed by a research participant in Mizock et al.'s (2014, p. 1488) study. Photographic representations of self as blossoming flowers to suggest personal renewal and growth (Quaglietti, 2018), and roads or open skies symbolising new beginnings and regaining a sense of identity (Tran Smith et al., 2015), offer opportunities for participants to "feel accepted for positive valued aspects of their personhood" (Sitvast, 2015, p. 144). Therefore, photography appears to be an ideal tool that supported and facilitated participants' (re)definition of self as an essential part of their recovery in the studies included in this synthesis.

Meaningful exchanges

Most of the selected articles portray recovery as a journey punctuated by meaningful exchanges with people (family, friends, peers, mental health professionals), local communities, nature, pets, but also spiritual entities. Anderson Clarke and Warner (2016) emphasise caring relationships as key to recovery through positive effects on emotions, while revealing a "sense of purpose, feelings of selflessness and joy" (p. 411). As a result, participants appear to be part of an exchange that is emotionally and instrumentally beneficial for all those involved (e.g. providing support to significant others, helping and inspiring peers throughout their recovery, which leads to behavioural changes and increased motivation for life and recovery). This aspect is evident in numerous pictures of family members taken by the participants in Cabassa et al.'s (2013) study, "playing pool with a buddy, visiting relatives, picking up a dog at the asylum (and taking it home for keeping)"

(Sitvast, 2015, p. 144), or, more symbolically, in the form of hands as metaphor for giving and receiving support (Quaglietti, 2018).

Duff (2012) also stresses the role of social encounters in promoting and supporting recovery through material and affective resources such as feelings of belonging, acceptance, and understanding. According to Horsfall et al. (2018), belonging and connectedness, understood by the authors more broadly in relation to people, communities, and nature, are conducive to a sense of wellbeing. This process is reinforced by people's contribution to the social capital of their communities, which provides them with meaning and a way of coping with social stigma: "people perceive themselves as functioning and contributing members of social and community networks" (Horsfall et al., 2018, p. 310). "A sense of reciprocity and equivalence" (Sitvast, 2015, p. 141) is born from community engagement which is developed along with a feeling of normalcy linked to identity transformation discussed in the previous section. This may be due to participants' strengths becoming more important than perceived "deficits" (Horsfall et al., 2018) in need of "reparation" (Sitvast, 2015). Larivière et al. (2015) provide a more nuanced analysis of social networks in the context of recovery as opportunities for meaningful roles and activities, jobs, carrying out projects, and responsibilities that participants seek to recover, but also as conflictual and dysfunctional relationships that hinder the process of recovery. This point of view is supported by Tran Smith et al. (2015) who concluded: "social relationships are important and provide support in a variety of ways, but they can also increase stress through non-support and outright conflict" (p. 113). In the context of meaningful relationships contributing to hope and empowerment understood by Sitvast (2015) as "shared search for sources of strength" (p.

142), re-establishing a sense of collective purpose, social integration, and companionship (Yates et al., 2012), becomes central to the recovery journey.

Situatedness

Situatedness was identified as a key theme in the selected articles that appear to contextualise recovery in space (i.e. exploration of recovery places through photography) (Duff, 2012, Horsfall et al., 2018, Piat et al., 2017, Tran Smith et al., 2015, Yates et al., 2012), and time through photo-narratives that situate the processes of recovery in a meaningful sequence of "biographic shifts" (Cabassa et al., 2013, p. 6). Sitvast (2015) claims that discovering what is important for people with mental health problems involves going "out of your normal way, and in the case of institutionalised clients, literally away from the terrains of the institute" (p. 144). This may be due to experiences of illness following a process of disconnection and displacement that adds to the losses endured by those living with mental distress (Duff, 2012).

The journey of recovery follows spatial and temporal coordinates that help with locating and defining the meanings attributed to this experience. As a result, recovery is described in photography-based research as an "ecological process" (Yates et al., 2012, p. 104) translated into a certain degree of control that individuals have over their environment. The importance of place in this process is highlighted in studies in which this dimension was central (Duff, 2012, Horsfall et al., 2018, Tran Smith et al., 2015, Yates et al., 2012), but not only (Anderson Clarke and Warner, 2016, Greco et al., 2017, Notley et al., 2012). Natural resources in particular rank highest on the list of "enabling" or "therapeutic landscapes" (Duff, 2012, p. 1388) that promote positive emotions and general wellbeing through multisensorial experiences, along with a sense of freedom and space for reflection: "participants expressed

feeling a type of peace or mental escape when being surrounded by nature" (Anderson Clarke & Warner, 2016, p. 412). Water is a recurring element "relaxing and essential for recovery" (Anderson Clarke & Warner, 2016, p. 413), as well as gardens that are nurtured by participants, therefore contributing to their sense of achievement, pride, and belonging. Moreover, nature provides people with a metaphorical language of recovery (e.g. gardens as symbols of growth, transformation, and resilience) (Piat et al., 2017). Connectedness to nature appears to be at least as important as social connections which, in some cases, overlap (e.g. places mediating sociality, shaping social interactions and community participation) (Duff, 2012). Local communities also provide material and affective resources that are beneficial for recovery (Yates et al., 2012). Places depicted in participants' photographs (e.g. charity shops, libraries, bookshops, churches) are associated with deep meanings of recovery, as more intimate places are: "The home environment played a key role in recovery by providing a place to relax, recuperate, and feel secure" (Yates et al., 2012, p. 108). In this context, photography helps with exploring the naturalistic lifeworld of the research participants; through the viewfinder of their cameras, seemingly mundane objects convey intimacy, safety, comfort, and become "markers of ontological security and a platform for identity reconstruction" (Tran Smith et al., 2015, p. 111). Positive changes in environment are translated into positive changes in self (e.g. independence) in a photographic study of recovery and housing (Piat et al., 2017). Conversely, environmental barriers to recovery are also encompassed in this theme (e.g. the effects of urban stress or shared housing on mental wellbeing), which may explain people's conceptualisation of recovery as escapism to positive environments (Yates et al., 2012).

Coping while hoping

Recovery work is characterised in the selected studies by doing something helpful and meaningful while charging with optimism and hope, which appears to be the catalyst for action and responsibility taking for one's recovery. A wide range of coping strategies are employed by research participants as evidenced in their photographs. Self-care (e.g. eating healthily, keeping hydrated, exercising, and reinforcing a daily routine), was identified as a subtheme linked to regaining a reasonable degree of autonomy and independence (Anderson Clarke & Warner, 2016, Larivière et al., 2015, Notley et al., 2012). Another subtheme refers to engaging with occupations that give people meaning and help them reframe their illness narrative: "Participants also identified keeping busy, or having something to do more generally as being important for their emotional well-being" (Lal et al., 2014, p. 27). From leisure and recreational activities such as music, cooking, reading, engaging with artwork (Anderson Clarke & Warner, 2016, Greco et al., 2017), to educational and vocational achievements (Cabassa et al., 2013, Larivière et al., 2015), action-oriented states emphasise the functional dimension of recovery or "biting into life again", as described by a participant in Larivière et al.'s (2015, p. 561) study. This translates into stress reduction and increased quality of life (Anderson Clarke & Warner, 2016), validation and motivation for recovery work, combating stigma (Cabassa et al., 2013), increased prospects for change and return to good mental health (Duff, 2012), resilience and a sense of life renewal, improving life skills (Horsfall et al., 2018), choice and empowerment (Notley et al., 2012). However, Yates et al. (2012) emphasise that "recovery is not just about enjoying periods of reduced distress – it involves changing the very things that cause distress" (p. 111), such as stigma, poor quality relationships, and inadequate housing. For some participants,

therapy plays a crucial role in this process that assisted them with managing emotions and letting go of a past burdened with losses (Larivière et al., 2015). For others, spirituality puts things in perspective and helps them face adversity while constructing "meaning and a sense of consistency, hope, and security" (Cabassa et al., 2013, p. 6). Quaglietti (2018) illustrates this process as "moving from withdrawal to active participation in life […] from alienation to purpose" (p. 226), in which internal and external recovery strategies provide participants with meaning and hope that recovery is possible and within their capabilities.

Although recovery themes identified in photography-based research are presented separately in this section, they are interlinked and draw on each other. For example, the process of self-discovery does not take place in isolation; relationship with others, which are situated in a physical and social context, have a profound influence on one's identity; identity is also shaped by various occupations and roles assumed by individuals living with mental distress, along with their engagement at community level, therefore providing opportunities for meaningful exchanges with others. The systematic review process contributed to shaping the researcher's analytical skills and working with large amounts of data coded line by line, which was a useful exercise for analysing the dataset generated during the data collection.

3.6. Discussion

The literature on using photography in recovery research appears to be multidisciplinary and diverse in design, methodology, and findings. All the included studies (except for one) were conducted in Anglophone countries, which may be indicative of a paradigm shift in mental health services toward the concept of personal recovery in the English-speaking world

(Whitley, 2014). Participant-generated photography in the form of photovoice and photo-elicitation seems to be the main candidate for recovery research, but researcher-generated photography (Sitvast, 2015) or photographs from other sources (Larivière et al., 2015, Greco et al., 2017) have also been utilised. Various age categories of participants (9 to 70 years old), their diverse demographic characteristics, and mental health problems suggest the versatility of photography in researching recovery in a wide range of populations.

Regardless of the methodology used, photography yields outcomes that support the personal dimension of recovery beyond the clinical aspects related to symptomatology and medical treatments (Slade, 2009), in line with the recovery framework of this thesis outlined in *Chapter 2*. Although this review advanced some recovery themes different than those captured by the recovery models (e.g. situatedness of recovery processes), a number of overlaps were noted (e.g. social connectedness, hope and optimism, identity, meaning in life, and empowerment). However, photographic studies appear to nuance some of these dimensions. For example, giving care and support is a dimension that is not always present in recovery models that commonly portray mental health service users as beneficiaries of services rather than givers (Myers et al., 2016). The included studies cited many instances in which participants contributed to the social capital of their communities and families through meaningful material and affective exchanges. Another important aspect that is not evidenced in the current recovery models is the role of place in recovery emerging from a significant number of studies (Duff, 2012, Horsfall et al., 2018, Tran Smith et al., 2015, Yates et al., 2012). Recovery is conceptualised by participants as a transformative journey situated in environments that shape the very meaning and experience of recovery. In this context, services are particularly important to maintain people's hope for recovery although they may

not fully recover clinically (Myers et al., 2016). This aspect may reflect the shortcomings of some recovery models being prescriptive in the sense of imposing "an order on human growth and development which may not fit some people's experiences" (Slade, 2009, p. 80). Hence, the importance of understanding such experiences in a socio-cultural context. In conclusion, this review provides additional layers of understanding to more established themes of recovery while suggesting some novel dimensions that may complement the existing knowledge and opening avenues for exploration (e.g. recovery and spirituality), pursued at the later stages of this study.

Although the literature included in this review was considered overall informative and valuable (Appendix 9), some areas of improvement were identified, which further guided the design and conduct of this thesis. For example, a quarter of the studies have not clearly mentioned the theoretical perspectives that guided the research process, which may impact on the research reliability and overall credibility (Collingridge & Gantt, 2008). A larger proportion of the selected articles (8 out of 15) have not included sufficient information on the analytic process from photographs to recovery themes that seem to "emerge" in most of the cases rather than being identified following rigorous steps, which occasionally resulted in unclear statements of the research findings. Only a minority of studies advanced thematic (Anderson Clarke & Warner, 2016) or content analysis of images (Tran Smith et al., 2015), hermeneutic analysis (Sitvast, 2015), iconographic analysis (Mizock et al., 2014), and pile sorting techniques (Cabassa et al., 2013) as potential avenues for enhancing the analytical value of images and corroborating them with textual data. Additionally, while participants' involvement was transparent in most of the studies, researchers' positionality in the photographic process was not always clearly defined, which may explain the lack of reflection

on the research process. Furthermore, engaging participants in the research design was rather uncommon although this could have ensured that findings reflected participants' voice rather than researchers' interpretation of photographic representations (Mizock et al., 2014). Except for one study (Yates et al., 2012), participants were not consulted at the initial stages of data analysis, which is seen as a limitation by Sitvast (2015). Finally, only a few articles mentioned ethical considerations specifically related to photography (e.g. maintaining confidentiality and safety when taking pictures in the community) (Anderson Clarke and Warner, 2016, Cabassa et al., 2013, Horsfall et al., 2018). The limitations and challenges of using photography in recovery research also seem to be under-reported, although a series of issues have been emphasised in other areas of health research using photography: generating and analysing photographic data, adapting photography projects to researching children, confidentiality and copyright, disseminating participant-generated photographs (Balmer, Griffiths, & Dunn, 2015, Poku, Caress, & Kirk, 2019, Shell, 2014).

3.7. Conclusions

This review is potentially unique in its aim to systematically synthesise the existing literature on using photography in recovery research and discuss how this may add to the current recovery framework. The included articles were identified through comprehensive and replicable search strategies of multidisciplinary electronic databases that may inform future research on the outcomes of different photographic techniques on facilitating and supporting recovery from mental distress. Selecting articles in English only may be a limitation in terms of accurately reflecting the cultural aspects and practices of recovery emphasised by Haroz et al. (2017). Additionally, including audio-videography studies could have made this review

more comprehensive, but at the same time it would have risked impacting on the quality and depth of the synthesis due to the high number of studies included.

In conclusion, this literature review synthesised the use of photographic methods to explore recovery from mental distress, the way they were implemented, their benefits, findings, but also their limitations. All these informed the later stages of this thesis both methodologically (photography-based methods incorporated in data collection and analysis), and conceptually (understanding of recovery processes). The latter provided a nuanced recovery landscape further referred to in *Chapter 6: Discussion*, where the findings of this thesis are placed in a wider research context.

Chapter 4. Methodology

4.1. Introduction

Experiences and meanings of recovery in Romanian mental health service users were inductively explored using a qualitative phenomenological research design, under the assumption that mental distress is a deep human experience conceptualised by individuals in relation to their lifeworld (Gwinner, Knox, & Brough, 2013).

The following sections outline the rationale for a qualitative phenomenological methodology, including epistemological and ontological considerations. The research methods are then presented along with a justification for: recruiting participants purposively; incorporating photography-based workshops and photo-elicitation interviews in data collection; and selecting Interpretative Phenomenological Analysis (IPA, Smith, Flower, & Larkin, 2009) as the main analytical tool. Finally, research validity and trustworthiness are addressed, along with the researcher's reflexivity, in order to demonstrate rigour and quality assurance in conducting this study.

4.2. Rationale for a qualitative phenomenological design

4.2.1. Justification for a qualitative approach

Mental health research has been long dominated by a positivist approach claimed to reduce experiences of distress to objective, scientifically measurable, observable, and verifiable units (Tolman, 2013). Despite advancing the progress of mental health research and practice, quantitative research presents some limitations with regard to capturing the richness of

personal meanings, experiences, and values, which are the object of qualitative research (Silverman, 2017), and must be considered by evidence-based medicine as a legitimate source of knowledge to challenge the institutional power of medicine (Goldenberg, 2006).

Without reinforcing the dichotomy between qualitative and quantitative research, regarded here as part of a continuum and fit to serve different research purposes (Christensen & Dahl, 1997), qualitative research was selected as the core design of this thesis. Bowling (2014) claims that qualitative methods are essential for exploring under-researched and complex phenomena requiring insightful data that are not subjectable to quantification or statistical measurements. Translating subjective experiences into statistical data may risk oversimplifying and potentially omitting essential information for answering the research question (Rolfe, 2013). Despite being criticised as unscientific, biased, anecdotal, or lacking rigour (Anderson, 2010), qualitative methods provide an optimal framework for the study of recovery by allowing the researcher to generate knowledge based on participants' consciousness, language, and experiences, and understand the research phenomenon from their stance (Braun & Clarke, 2013). Silverman (2017) considers participants' view on reality more relevant than the presence or absence of numerical data in qualitative research. This aspect is evident from the constructivist/interpretivist theoretical framework presented next, which guided this study from formulating the research question, to data collection and analysis.

4.2.2. Subscribing to a constructivist/interpretivist paradigm

The choice of methodology cannot be justified without a rationale for situating the research within a philosophical system of thinking (Darlaston-Jones, 2007), including references to

epistemology (i.e. knowledge assumptions underlying the research), and ontology (i.e. the nature of reality, existence or being) (Crotty, 1998). The paradigm to which a study subscribes must be formulated explicitly, otherwise the researcher remains "innocently unaware of the deeper meaning and commitments of what they say or how they conduct their research" (Pring, 2000, p. 89). To avoid this, attention was paid to the researcher's philosophical positionality in relation to knowledge production, as suggested by Savin-Baden and Howell-Major (2013). From this perspective, the research process described in this chapter is anchored in a constructivist/interpretivist philosophy.

Constructivism is concerned with revealing knowledge created by social actors from personal experiences, hence the pluralistic nature of reality posited by this paradigm (Schwandt, 2008). From an epistemological point of view, constructivism offers a fertile ground for this thesis that explores subjective experiences of recovery through the lens of the research participants, along with their meanings socially constructed through interactions with others and their lifeworld (i.e. "worldmaking"; Goodman, 1984, p. 29). It is this understanding (*Verstehen*) of participants' perspectives on recovery that guided the research process, instead of a universal explanation of this phenomenon and its causal relationships (*Erklären*) (Dilthey, 1976). Such worlds of meaning embedded in the research participants' language and actions are open to interpretation, which is the key to understanding from an interpretivist stance (Schwandt, 2008). Interpretivists repudiate empirical frameworks employed by positivists and distinguish between social (subjective) and natural (objective) sciences reflected methodologically in inductive qualitative and deductive quantitative research, respectively (Bryman, 2016). Additionally, interpretivists picture social reality as intersubjective and negotiable in terms of meaning exchange between individuals (Sandberg, 2005). This perspective reflects a relativist

ontology conceptualising reality as a subjective experience that does not exist outside of consciousness (Denzin & Lincoln, 2005), in contrast with critical realism and a "real" world independent of human perceptions (Kozhevnikov & Vincent, 2019). Hence, the assumption that the research participants in this study hold different meanings and experiences of recovery that need to be captured in their complexity, rather than reducing them to rigid categories and drawing on measurable and objectively known worldviews (Crotty, 1998). On this basis, the knowledge in this thesis is generated inductively with findings originating from participant data in the form of a pattern of meanings or themes (Ormston, Spencer, Barnard, & Snape, 2013).

4.2.3. Rationale for an interpretative phenomenological approach

In order to explore the experience of recovery from mental distress as lived by Romanian mental health service users, the researcher, of Romanian nationality himself, returned to his home country and immersed himself in a group of mental health service users for eight weeks. From the beginning, the research process involved going "back to the things themselves", as postulated by Husserl (2001[1900/1901], p. 168), to experience with the research participants and draw on their knowledge of recovery. Lincoln and Guba (1985) describe this approach as "naturalistic inquiry" in which the researcher relies on observations, descriptions, and interpretations of the research participants' experiences in their own social and cultural environment.

In this context, phenomenology was selected as the chief methodology for this thesis mainly for its commitment to study "personal experience and understanding of the nature of human consciousness" (Polgar & Thomas, 2013, p. 78). This philosophical and methodological

approach has been successfully employed in mental health research revealing enhanced understanding of the experience and meanings of mental distress shared by the research participants (Picton, Moxham, & Patterson, 2017).

A phenomenological approach was selected at the inception of this study after dismissing alternative qualitative designs deemed unsuitable for the research aim. For example, grounded theory in its constructive framework advanced by Charmaz (2000), would have provided a theoretical explanation of recovery, rather than supporting the understanding of the experiential and existential aspects of this phenomenon. Alternatively, a narrative approach was initially considered in combination with photography (Harrison, 2002), acknowledging that experiences of recovery are inherently embedded in participants' narratives. However, because the focus would have been on the construction of recovery stories instead of interpreting the meanings attached to the research phenomenon by participants (Creswell, 2013), the researcher decided that narrative inquiry was incompatible with the focus of this thesis. Visual ethnography was potentially another methodological avenue concerned with revealing meanings through film and photography (Pink, 2013), in the context of a cultural and geographical group (Goulding, 2005). However, this method proved to be unfeasible for fieldwork conducted abroad by one researcher, with complex logistics, extensive time and financial resources.

Another important decision that delineated the methodological framework of this thesis was the incorporation of Heidegger's interpretative phenomenology instead of a Husserlian descriptive phenomenological approach.

The transcendental phenomenology founded by Husserl (1931) consisted of a system of discovering knowledge influenced by Hegel's concept of unfolding phenomenal

consciousness by "describing what one perceives, senses, and knows in one's immediate awareness and experience" (Moustakas, 1994, p. 26). Husserl was also influenced by Descartes' concept of "Epoche" i.e. "refraining from judgement" or "consciousness suspended" (Kuspit, 1964, p. 30). He translated this concept into the "phenomenological attitude", in which suppositions are eliminated ("bracketed"), leading to a pre-reflective transcendental ego "apparently empty of content" (Lewis & Staehler, 2010, p. 19). In other words, looking at human experiences from a fresh, naïve perspective, beyond assumptions and preconceptions of the researched phenomena (Tufford & Newman, 2012).

Husserl's philosophy was targeted by criticism that culminated with Heidegger's (1962) advancement of a hermeneutic approach concerned with the interpretation rather than description of conscious awareness. Heidegger refuted Husserl's principle of bracketing, considering that prior understanding of the researched phenomenon is essential for interpreting it (Leung, 2011). As Heidegger framed it, understanding is never objective, without presuppositions and is determined of "the context of our disposition and involvement in the world" (Johnson, 2000, p. 23). Furthermore, Heidegger's understanding of the world is not limited to consciousness and assumes human experience as being shaped by socio-economic, cultural, and historical factors (Heidegger, 1962), which is particularly relevant for this study conducted in Romania.

According to Heidegger (1962), the researcher's role is to establish meaning while "being-in-the-world" (*Dasein*) of those involved. His stance was met with criticism by Husserlian scholars arguing that researcher's interference in the research process introduces bias (Giorgi, 2011), although some consider that complete bracketing cannot be achieved (Colaizzi, 1978). Despite criticism, a Heideggerian perspective is adopted here in line with the expected

outcome of this thesis, namely a deep understanding of the meanings of recovery from mental distress through reflection and interpretation, without necessarily leaving aside researcher's knowledge and preconceptions. Furthermore, Heidegger's (1962) warning to "never allow our […] fore-conception to be presented to us by fancies and popular conceptions, but rather to make the scientific theme secure by working out the fore-structures in terms of the things themselves" (p. 195), is considered here reflexively. Equally important in this context is Smith et al.'s (2009) claim that by engaging with the phenomenon under investigation, the researcher may be in a better position to acknowledge and reflect on such preconceptions and potential biases. Self-reflexivity is therefore crucial in understanding the complexities and nuances of the hermeneutic dialogue between the interpreter and the interpreted, as illustrated in Heidegger's work echoed by Gadamer (1976). This aspect was materialised by the researcher in a fieldwork diary (Appendix 36) in which the research process was constantly revisited and reflected upon.

The hermeneutic circle

Husserl advanced phenomenology as a type of science uncontaminated by subjectivity, for which reason he was classed as positivist in disguise striving for scientific rigour by placing the researcher in a vacuum (Lowes & Prowse, 2001, McConnell-Henry, Chapman, & Francis, 2009). Conversely, Heidegger reinforced the subjective and interpretative nature of human experience and prior knowledge that ensures that researchers ask pertinent questions to guide their inquiry (Moody, 1990). On this note, Gadamer (1960/1990) stated that "only the person who knows how to ask questions is able to persist in his questioning [and] preserve his orientation towards openness" (p. 367). Constant questioning and re-examination of data

results in the "hermeneutic circle" (Fig. 2), one of the theoretical and methodological tenets of interpretative phenomenology.

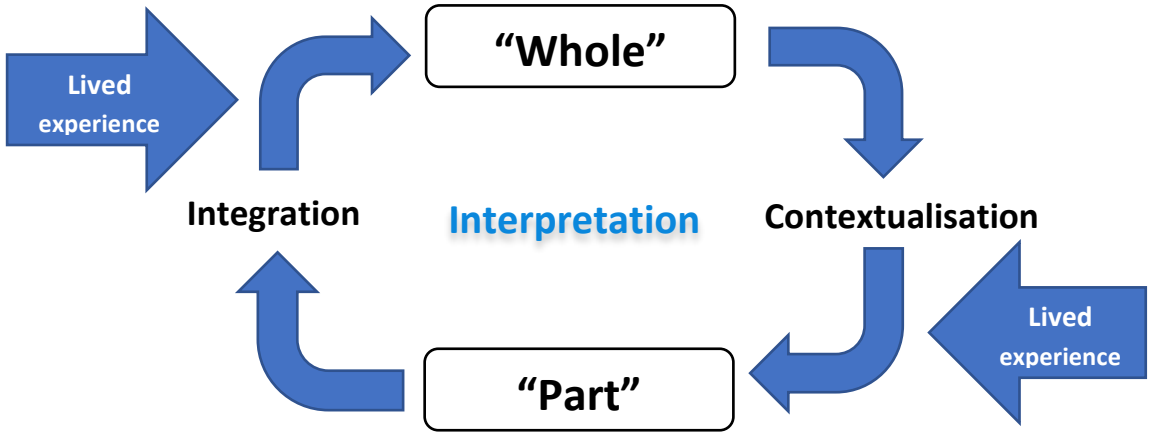

Fig. 2: The hermeneutic circle (adapted from Bontekoe, 1996)

The hermeneutic circle is a concept introduced by Schleiermacher (in Cercel & Șerban, 2015) and further developed by Heidegger to elucidate the *Dasein* or deriving meaning from *being-in-the-world* (Mulhall, 2005). The metaphor of hermeneutic circle describes the experience of understanding "the whole through grasping its parts and comprehending the meaning of the parts divining the whole" (Crotty, 1998, p. 92). The more the hermeneutical circle expands, the better the phenomenon is understood, by adding layer after layer of meaning constructed through constant interactions between the researcher and the researched (Patterson & Higgs, 2005). This infinite circularity in relation to understanding was heavily criticised for its ambiguity (Mueller-Volmer, 1988, Shklar, 2004). Therefore, the hermeneutical circle is conceptualised in other academic sources as a spiral to illustrate the journey to deeper levels of understanding (Motahari, 2008).

Regardless of how it is represented, the hermeneutic circle is seen here as a "return to our Being, which presents itself to us initially in a nebulous and undeveloped fashion, and then seeks to unfold that pre-understanding, make explicit what is implicit, and grasp the meaning of Being itself", as described by Crotty (1998, p. 97). This emphasises Heidegger's concern with ontology and existence by constantly striving to uncover the meaning of being (McConnell et al., 2009). This aspect is essential for this thesis aiming to reveal meanings of recovery as part of a wide life experience (*Dasein*) situated in a socio-cultural context, which needs to be unpacked and interpreted in order to reach understanding.

4.2.4. Interpretative Phenomenological Analysis

Following on the previous section, an interpretative phenomenological approach was selected to address the aim of this thesis to explore meanings of recovery in Romanian mental health service users and how they made sense of their experiences. Interpretative Phenomenological Analysis originates in psychology research in the United Kingdom (Smith, 1996) and is committed to "the examination of how people make sense of their major life experiences" (Smith et al., 2009, p. 1). This involves immediate, but also latent meanings illuminated through reflection, analytical thinking, and interpretation of experiences (Smith et al., 2009).

Double hermeneutic

Experience is defined here in Diltheian terms as a "comprehensive unit which is made up of parts of a life, linked by a common meaning" (Mueller-Vollmer, 1988, p. 150). Access to such experiences depends on what participants disclose to the researcher, based on their understanding. Their account is then interpreted by the researcher in order to illuminate the

phenomena (Smith et al., 2009). In other words, the researcher attempts to make sense of the participants' making sense of their experiences, hence the "concomitant production of meaning and meaning-making within the research process" (Mills, Durepos, & Wiebe, 2010, p. 322). This two-stage interpretation process is coined as "double hermeneutic" by Giddens (1987, in Rennie, 2012), who explains that, unlike natural sciences centred on the relationship subject-object (single hermeneutic), human sciences draw on the relationship subject-subject (double hermeneutic). This dual association between single and double hermeneutic with natural and social sciences, respectively, is considered outdated by Cunliffe (2011), who advises for methodical pluralism and acceptance of "qualitative research as a craft rather than a scientific endeavour" (p. 648). Nonetheless, double hermeneutic (Fig. 3) is crucial in understanding the researcher's dual role in IPA: as a human being, a dimension shared with research participants, and expert, with his own pre-understanding and experiential skills brought into the process "self-consciously and systematically" (Smith et al., 2009, p. 3).

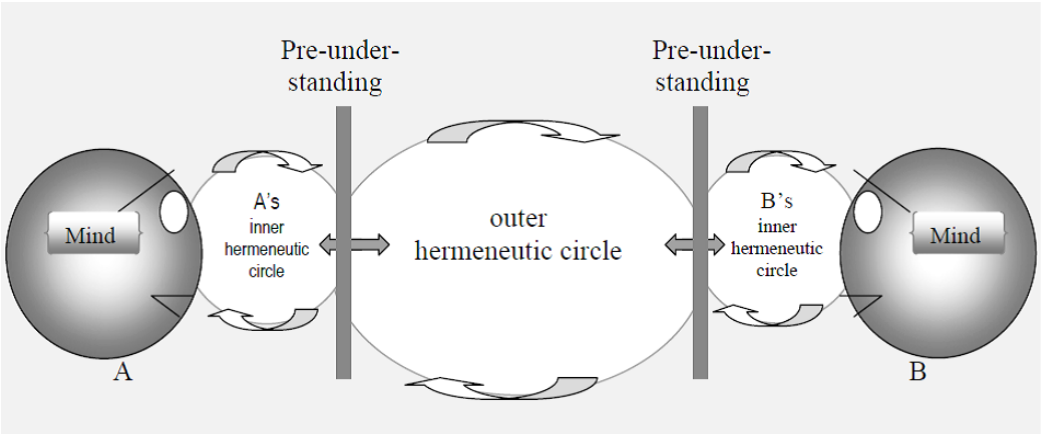

Fig. 3: Illustration of the double hermeneutic (Nørreklit, 2006)

Brogden (2010) draws attention on the effect of double hermeneutic on the research context that is not meaning-neutral (i.e. the researcher and the researched are actively engaged in both generating knowledge and interpreting meanings filtered by their pre-understanding).

Applied to this study, the focus is on participants' pre-understanding of their experience of recovery, but also on understanding (and interpreting) how they acquired this pre-understanding (Nørreklit, 2006), and how it may influence their recovery behaviours.

Idiography

Idiography is another dimension of IPA (Smith et al., 2009) concerned with the study of the particular as opposed to general (nomothetic), a distinction that is philosophically rooted in the differences between post-positivism and positivism (Crotty, 1998). "Particular" is understood here as both detail (following an in-depth analysis) and understanding recovery from the stance of particular individuals, in a particular context (Smith et al., 2009). Hence, the recommendation for utilising small samples in IPA (Smith & Osborn, 2003). However, IPA does not exclude generalizations, but it situates them in particular instances of lived experiences, therefore emphasising rich and insightful case studies (Smith, 2004).

IPA has been criticised for attributing meaning from text alone following ambiguous methods that are somehow unrelated to the phenomenological tradition (Giorgi, 2011, Morley, 2019, Sousa, 2008), therefore being more "hermetic" than "hermeneutic" (Paley, 2018, p. 30). Further criticism is generated by adepts of thematic analysis (Braun & Clarke, 2006), who consider IPA relatively limited in terms of methodological consistency. Despite criticism, IPA was chosen here over a thematic analysis approach for its strong theoretical and philosophical roots and methodological soundness (Pringle, Drummond, McLafferty, & Hendry, 2011), and enhanced level of interpretation and analysis through the process of double hermeneutic (Shinebourne, 2011), in line with the aim of this thesis. Therefore, IPA is applied here as an "adaptable and accessible approach to phenomenological research intended to give a

complete and in-depth account that privileges the individual" (Pringle et al., 2011, p. 20). Brocki and Wearden (2006) argue in their review of IPA studies that this method is applicable to a plethora of research topics including studies of subjective and cultural experiences of mental distress (Chambers et al., 2015, Sihre et al., 2019, Tuffour, Simpson, & Reynolds, 2019), although they emphasised the lack of interpretation in several studies. Furthermore, IPA was successfully combined with participant-generated photography by Reid, Elliot, Witayarat, and Wilson-Smith (2018), resulting in aesthetically and insightfully enriched representations of participants' lived experiences. The methodological and theoretical pluralism of IPA is supported by Dennison (2019) in line with multi-perspectival designs (i.e. using multiple points of view to investigate the same phenomenon) and processes of this method (Larkin, Shaw, & Flowers, 2018). On this note, combining IPA with visual methodologies may bridge new horizons for phenomenological research and enhanced understanding of lived experiences. Additionally, a hybrid approach may address some of the limitations of IPA, namely its reliance on language and participants' ability to articulate complex experiences, thoughts, and emotions (Willig, 2013).

4.2.5. Combining phenomenology and photography

Photography as a medium for recalling and making meaning of lived experiences was embedded in the phenomenological background of this thesis. If phenomenology means "the appearance of things" to consciousness, photography (Greek *photos* = "light"; *graphein* = "to draw") can be regarded as "drawing light" into something or generating insight by bringing the subject to light (Keifer-Boyd, Emme & Jagodzinski, 2008). Hence, the role of the "conscious photographer" to exercise "photographic seeing" that becomes a way of "phenomenological seeing" (Chan-fai, 2004, p. 261). Photographs evocative of feelings,

thoughts, memories, and experiences have been encapsulated by Steinert (1952) in the concept of Subjective Photography (*Subjektive Fotografie*). His conceptualisation marked the transition from photography as documentary tool and accurate instrument of science, to subjective and aesthetic medium, humanised and individualised. In other words, the role of photography shifted from positivist evidence of an objective reality to carrier of symbols and expressions open to interpretation. Probably uncoincidentally, this transformation took place in the 1950s when Sartre's existential phenomenology was propagating, which makes Hugunin (1988) reflect on the theoretical kinship between photography and phenomenology.

In the spirit of relativist ontology, photography has the ability to creatively frame the world in infinite unique views, enhancing the object of perception to higher levels of consciousness. The outcome of this transformative process is coined by Steinert (1952, in Hugunin, 1988) as "representative photographic creation" in which "the subject is no longer photographed for what it is *per se*, but is subordinated to personal transformative vision via photographic means" (p. 159). Furthermore, the object photographically brought into consciousness reveals complex relationships with the lifeworld, described by Sartre (1972, in Hugunin, 1988) as an "idiosyncratic interiorization of the exterior" (p. 165) through experiential insight. Barthes (1981) completes this argument in his seminal work *Camera Lucida* by emphasising that "a photograph is literally an emanation of the referent" (p. 80), allowing for access to first-hand knowledge and interpretation.

Photography is considered here also for its potential to explore a range of nonverbal aspects and situational dimensions impossible to reveal by relying on spoken language only (Kirova & Emme, 2008, Wiedel, 1995). Fasoli (2003) reflects on photography as a "distinctly different

and potentially richer new way of telling" (p. 36), that may address some of the limitations of interpretative phenomenology criticised for relying excessively on language (Regan, 2015).

In conclusion, the phenomenological framework of this thesis was enriched through photography to elicit thoughts and feelings attached by participants to their recovery, or what Emme (1989) calls "lens meaning" (p. 26). Corroborated with the knowledge from the literature review (*Chapter 3*), it is premised here that the interplay between words and images facilitates the intersubjective construction of meanings and individual understanding of recovery, as argued by Plunkett, Leipert, and Ray (2013). They further claim that combining phenomenology and photography results in strengthening each other methodologically by deepening and expanding understanding. It is the same conclusion reached by Reid et al. (2018) who found that photo-elicitation contributed to enhancing the accounts of lived experiences by facilitating access to research participants' metaphorical and interpretative world of meaning. Finally, the process of taking photographs has been shown to facilitate critical thinking and, consequently, help elucidating the meaning of lived experiences, therefore fitting with phenomenological research (Reid et al., 2018).

4.3. Method

This section introduces the geographical location and the description of the research site, followed by a presentation of the recruitment, data collection and analysis, along with justifying the selection of methods to explore Romanian mental health service users' experience of recovery through photography.

4.3.1. Geographical location and setting of the research

Romania

The research project was conducted in Romania (Fig. 4), an Eastern European country and member of the European Union since 2007. Historically, Romania was part of the communist bloc for 45 years until the Revolution in 1989, as with its neighbouring countries: Hungary, Serbia, Bulgaria, Ukraine, and Republic of Moldavia. Romania has a population of approximately 19 million (World Population Review, 2020) in continuous decline since 1990 mainly due decreasing birth rates, pro-abortion policies, and migration (Surd & Kantor, 2014). The main ethnic groups are Romanians (84%), Hungarians (6%), Roma population (3%), Germans and other ethnic minorities (1%). The official language is Romanian and the capital city is Bucharest (București), followed by Iași, Timișoara, and Cluj-Napoca (where the research was conducted), as major urban areas. Cluj-Napoca (Fig. 5) is the seat of Cluj County, located in the heart of Transylvania, a major historic, cultural, academic, and economic hub, with a diverse population of over 400,000 people.

Fig. 4: Map of Romania in Europe (Source: Google Maps®)

Fig. 5: Map of Romania and the geographical location of the research site (Source: Google Maps®)

The research site

The research participants were recruited from a community day centre in Cluj-Napoca, a branch of a Romanian non-governmental organisation whose mission is to offer social alternatives for adults with mental health problems and support their social and vocational reintegration. With over 25 years' experience in delivering community mental health services, the organisation is active in four Romanian cities. However, due to financial difficulties and the current socio-economic climate in Romania, the services provided by the host organisation have been considerably reduced over the past years, currently addressing the needs of 30 people. The research contact person (gatekeeper) was the social worker and the only employee at the day centre who facilitated the researcher's access to the site consisting of one modest room that hosted both the office and a small activity area.

4.3.2. Recruitment

The research project was advertised at the targeted community mental health day centre through recruitment posters (Appendices 12.1 & 12.2) in May 2019. Information sheets

explaining the aim and project activities (Appendices 13.1 & 13.2) were made available to prospective participants. Although the inclusion/exclusion criteria (Appendix 16) did not differentiate between different types of mental distress, most of the participants reported a diagnosis of schizophrenia/psychosis. According to the host organisation eligibility criteria, the service users were in recovery – understood by the staff at the day centre as reduced symptomatology and compliance with psychiatric medication (an aspect reflected upon in *Chapter 6: Discussion*).

Purposive selection of participants

The research participants were selected purposively based on their experience and knowledge of recovery from mental distress, a technique widely used in qualitative research for selecting information rich cases to reflect the phenomenon of interest (Patton, 2015). A purposive sample is a nonprobability sample also referred to as "judgmental" or "expert" sample, which relies on subjective methods to select participants (Battaglia, 2008, p. 645). In this case, the decision to recruit the participants was made by the researcher, based on the inclusion criteria (Appendix 16), in collaboration with the gatekeeper at the host organisation in Romania to minimise the researcher's judgement bias (Etikan, Musa, & Alkassim, 2016). The demographic characteristics of the research participants are summarised in Appendix 18.

Sample size

Fifteen (seven female and eight male) participants aged 28-63 were recruited to take part in photography workshops and/or semi-structured photo-elicitation interviews. The number of participants is in line with Smith et al.'s (2009) recommendations for a relatively small group that allows for an in-depth approach of data generated, while producing sufficient

information for a detailed account of individual experiences. Pietkiewicz and Smith (2012) estimate that samples larger than fifteen participants are less common for IPA studies potentially impacting on the examination of similarities and differences between participants. Furthermore, the amount of qualitative data would be overwhelming for larger samples, and the researcher would risk inclining towards breadth instead of depth of knowledge, in contradiction with fundamental principles of IPA (i.e. idiography) (Smith et al., 2009).

4.3.3. Data collection

Textual and visual data were collected by the researcher between June and August 2019 (see research schedule in Appendix 37). Data collection consisted of a combination of photography workshops (Stage 1) and semi-structured photo-elicitation interviews (Stage 2), informed by the knowledge developed by the researcher in *Chapter 3: Literature review*. Participants were offered the choice of attending either photography workshops or photo-elicitation interviews (or both), depending on their preferences. They were provided with digital photo cameras and instructions prior to commencing the project activities, and were invited to take pictures of objects or people (with written consent) representative of their experience of recovery. Images were then brought to the photography workshops/individual interviews, and critically discussed. Although no restrictions were set regarding the number of pictures taken, participants were encouraged to select three-five images per activity to facilitate deep reflection and prevent data repetition.

Data collection took place at the mental health day centre in Romania described in the previous section, an environment that was familiar to the research participants and a milestone on their recovery journey, as revealed throughout the project. The gatekeeper at

the day centre shadowed the researcher during the group activities and individual interviews, intervening when necessary. Research participants' experience throughout the project is illustrated in Appendix 17.

Stage 1: Photography workshops

The first stage of data collection consisted of four weekly photography workshops (two-hour each) involving eleven (five female and six male) service users. The number was slightly higher than the recommended eight participants per group (Carlsen & Glenton, 2011) because non-attendance was factored in this study, although the participation rate at the end of the project was 89% (average of 10 participants per workshop). However, this aspect did not impact on the group dynamics and depth of discussions, allowing participants to voice their experiences.

The workshops were focused on eliciting experiences of recovery through photography and facilitated the exchange of perspectives on this topic, in line with the Heideggerian interpretative phenomenology and social construction of meanings (Conroy, 2003). The group activities aimed at gradually illuminating participants' (and researcher's) understanding of recovery from one workshop to the next. This was achieved by constantly enhancing the dialogical interpretation and consciousness-raising process in those involved through photography (Plunkett et al., 2013). As a result, the group dynamics evolved to increased dialogue between participants who collectively interpreted their photographs and the meanings behind them in the final workshops, in contrast with individual accounts that were predominant in the first two workshops (despite the researcher's attempts to engage participants in small group activities). Furthermore, reduced interventions from the researcher (and gatekeeper) towards the final workshop were also noted, which was

interpreted as participants' voice and understanding becoming more evident. A detailed analysis of how photography contributed to this process is presented in *Chapter 6: Discussion*.

Stage 2: Photo-elicitation interviews

A total of twelve (five female and seven male) participants, of which eight were also involved in photography workshops, took part in semi-structured interviews (30-90 minutes) conducted at the day centre. Interviews were incorporated in the study design due to their effectiveness as data collection tools in qualitative phenomenological research (Spiers & Smith, 2017). Interviews were informed by, and explored in depth, relevant lines of enquiry identified during the group activities. However, the researcher remained open to new potential recovery themes arising at this stage.

As with the photography workshops, interviewees were equipped with photo cameras and invited to take pictures representing their experience of recovery (or, alternatively, refer to photographs taken during the workshops), in order to generate deep verbal discussion and insights on recovery. Following feedback from the gatekeeper, the researcher acknowledged that some participants had issues with verbally articulating their experiences, attributed by Sandhu, Ives, Birchwood, and Upthegrove (2013) to complex, distressful, and confusing life events difficult to recall in conventional interviews. Hence, the combination of interviews and photo-elicitation as a strategy aimed at enhancing data collection by facilitating a deeper level of reflective thinking than words alone (as discussed in *Chapter 2: Literature review*), also demonstrated in multi-sensory research (Bingley & Milligan, 2007). Photo-interviews have been shown to address cognitive and language barriers, frequently reported in people with mental health problems (Erdner & Magnusson, 2011). Furthermore, a hybrid approach of

words and images is known to help participants overcome repetition and fatigue that are common in qualitative interviews (Harper, 2002). Plunkett et al. (2013) claim that this approach helps participants communicate more effectively with the researcher around sensitive topics difficult to explore in group settings, which may explain why some of the research participants in this study chose to participate in one-to-one interviews only. Methodologically, interviews are known to address some of the limitations of group approaches in qualitative research (e.g. logistical challenges to organising focus groups, complex interactions that may hinder data collection and analysis, and limited depth) (Braun & Clarke, 2013). Therefore, combining interviews with a group approach helped with consolidating and triangulating the data, allowing for different perspectives to be considered (Carter, Bryant-Lukosius, DiCenso, Blythe, & Neville, 2014).

Feedback and reflection group

To enhance the research quality and ensure participants' involvement in the development of recovery themes, a reflection and feedback group (1 ½ hours) was organised at the end of the series of photography workshops. This additional activity gave the ten participants involved the opportunity to address, through discussions, any misinterpretations or disagreements regarding the researcher's understanding of their experience of recovery based on the topics explored during the workshops. Data gathered during the feedback and reflection group informed the data analysis, including the role of photography in supporting and facilitating recovery, in line with the research objectives.

The photo-elicitation interviews, photography workshops, and feedback and reflection group were audio-recorded, transcribed verbatim, and translated by the researcher from Romanian

into English. Pseudonymised transcripts were checked for semantic and orthographic accuracy before uploading them onto the ATLAS.ti software package for analysis.

4.3.4. Data analysis

Data analysis started during the data collection phase when participants interpreted the meanings identified in their accounts of recovery, supported by photographs and questions from the researcher (Appendix 19), gatekeeper, and their peers. The research participants were also involved in drawing preliminary key themes of recovery during the final two photography workshops, which informed the data analysis along with commentaries and further layers of understanding unpacked in the reflection and feedback group.

Textual data was analysed by the researcher following the step-by-step approach to IPA recommended by Smith et al. (2009), summarised in Appendix 20. Although the visual material was not analysed *per se* by the researcher, participants were invited to reflect on, and interpret, their own photographs during the workshops and photo-elicitation interviews. The researcher aimed to stay close to participants' meanings and understanding to reduce interpretation bias (Neusar, 2014), which created some tensions when further layers of analytical interpretation were generated later in the process.

The preliminary data analysis was focused on the four areas of recovery negotiated by the researcher and participants during the feedback and reflection group: medical, socio-professional, existential, and creative recovery (Appendix 22). Participants were invited to reflect on the early findings as part of a group exercise in which they had the opportunity to confront their knowledge with researcher's understanding of recovery cumulated throughout the workshop series. This was also an opportunity for those involved to address the

researcher's misinterpretations or misunderstandings that could have affected data analysis. Building on the data collected and reflected upon together with the research participants, the key recovery themes were iteratively developed by the researcher with input from the supervisory team through continuous refinement (Appendices 22-24), aided by photographs (Appendices 25-32). The final recovery themes (Appendix 33) are presented in *Chapter 5: Findings* and further interpreted, discussed, and situated in the wide context of recovery literature in *Chapter 6: Discussion*.

4.4. Research reliability and validity

This study subscribes to Silverman's (2017) definitions of reliability (i.e. the consistency of applying the analytic tools, reflected in the methodological and analytical audit trails), and validity (i.e. the extent to which findings truthfully represent the research phenomena, being supported by participants' original accounts). Reliability and validity were achieved by the researcher through several strategies, as informed by the current literature on rigour in qualitative research (Barbour, 2001, 2008).

Firstly, a fieldwork diary (Appendix 36) was kept to enhance the researcher's reflexivity and transparency in decision-making throughout the research process. Comments and reflections before, during, and after project activities provided valuable insights for identifying and critically discussing recovery themes drawing on participants' narratives and images of recovery. Although bracketing was not considered here as important as in other phenomenological approaches (e.g. Husserlian), the researcher constantly revisited the project activities with a focus on participants' *Dasein* ("being-in-the-world") and interpretations, thus enhancing analytic rigour (Oliffe, Bottorff, Kelly, & Halpin, 2008).

Particular attention was given to the researcher's positionality in line with the IPA approach (Smith et al., 2009) and inherent biases originating in his personal experiences and knowledge acquired prior to data collection and analysis. While such potential biases were acknowledged and reflected upon in the fieldwork diary (Appendix 36), understanding was generated through a fusion of the researcher's and research participants' horizons of knowledge (double hermeneutics).

Secondly, actively involving service users in the process of data collection and preliminary analysis as experts with first-hand experience of recovery (which is also one of the shortcomings of photography-based research identified in *Chapter 2: Literature review*), adds credibility to the research findings. Furthermore, this aligns with the phenomenological underpinnings of this thesis and the principle of double hermeneutics (Brogden, 2010). Nørreklit (2006) claims that the dialogical interaction between the subject and the object of the research is essential as they co-inform each other leading to common horizons of understanding. Participants and the researcher were constantly involved in the meaning-making and interpretative process, suggested to strengthen the relationship between them (Rhodes & Fitzgerald, 2006). This was also aimed to reduce the bias caused by the researcher's presence (Tran Smith et al., 2015), therefore enhancing the quality of the data collected (Sibeoni et al., 2017). Furthermore, the interplay between the researcher and participants was emphasised to balance the participant-researcher power dynamics by democratising the knowledge construction (Balazs & Morello-Frosch, 2013).

Thirdly, incorporating photographs in the research activities is known to support the validation of knowledge or triangulation between different sources, bringing different insights

to the research process (Yates et al., 2012), an aspect elaborated upon in *Chapter 6: Discussion*.

Finally, participants had the opportunity to clarify the meanings of recovery behind their images throughout the project in order to minimise the researcher's misunderstandings and misinterpretations. Hence, minimising the influence of the researcher's agenda and presuppositions shown to impact the quality of research (Plunkett et al., 2013). This stance aligns with the constructivist epistemology and the principle of double hermeneutics to which this thesis subscribes, and the assumption that participants' interpretation and making sense of their own experiences is as important as the context of the researcher (Smith et al., 2009). From an ethical point of view, this ensures that the findings of the research accurately reflect the voice of participants, which is essential for a study of lived experiences.

4.5. Ethical considerations

This research project was granted ethical approval from the Faculty of Health and Medicine Research Ethics Committee at Lancaster University (Appendix 38), and permission from the host organisation in Romania (Appendix 39). Ethical conduct was ensured throughout the project starting with the recruitment stage when prospective participants were fully informed about the nature and aim of the research through *Participant information sheets* (Appendices 13.1 & 13.2). All participants consented to voluntarily take part in the study fully aware of the activities being audio-recorded and the project disseminated in the ways described in the *Consent form* (Appendices 15.1 & 15.2). The research participants were invited to choose their own pseudonyms to protect their identity, which helped with identifying their textual and visual contributions throughout the project. For the same reason, participants were told

that photographs depicting recognisable faces (taken with written consent) would be blurred, although this was shown to decontextualize information (Wiles et al., 2008). Considering the emotional nature of the project, psychological support provided by the social worker at the day centre in Romania was available to participants, although this was not required during the project.

Transcripts of project activities were pseudonymised and stored securely on Lancaster University Box (subsequently transferred to OneDrive), to which only the researcher and his supervisors had access. Paper copies (e.g. demographic sheets, consent forms), were disposed of securely (shredded) once an electronic copy was added to the project folders on an encrypted password-protected laptop, as detailed in the ethics application approved by Lancaster University. No complaints from the research participants were received. On the contrary, they provided the researcher with overwhelmingly positive feedback on how the study benefitted their mental health.

4.6. Conclusion

This chapter outlined how the research was conducted and led to the findings presented next. The methodological lens was a decisive factor for both bridging the fieldwork and the theoretical framework that guided this thesis, and generating an appropriate volume of rich qualitative data required to illuminate the experience and meanings of recovery in Romanian mental health service users.

Chapter 5. Findings

5.1. Introduction

Following the Interpretative Phenomenological Analysis of the four photography workshops and twelve interview transcripts totalling 22 hours of audio-recording and 89 images (selected from a total of 1,118), three key recovery themes – awakening, healing, and reconstructing life – were identified along with their corresponding subthemes (Appendix 33). This process was informed by participants' interpretation of the preliminary findings during the feedback and reflection group (Appendix 22) aided by their photographs (Appendices 25-32). Data were analysed using Atlas.ti® qualitative analysis software (initial coding), combined with Microsoft Excel® spreadsheets (theme clustering). Quotations from participants' narratives (identified here through their chosen pseudonyms) are included along with photographs that elicited discussions, to demonstrate how phenomenological interpretations were generated (Smith et al., 2009). The themes identified here reflect both commonalities of the experience of recovery in Romanian mental health service users, but also uncommon experiences highlighted through the use of idiography in IPA.

5.2. Themes of recovery

5.2.1. Awakening

Awakening was a common theme identified in the accounts of thirteen participants, initially conceptualised as an act of becoming aware of life beyond the limitations brought by mental distress. However, critical discussions of individual experiences elicited by participant-

generated photographs, revealed a more nuanced understanding – from physically awakening from the sedation caused by psychiatric treatments to a more symbolic awakening of consciousness and freedom.

Overcoming sedation

Awakening to life was described by participants as a process consisting partly of overcoming a state of sedation from strong and debilitating psychiatric treatments, which added to the burden of mental distress. To illustrate this, participants talked about times when their dosage of psychiatric medication was at its highest, causing them constant sleepiness and "*lacking life"* (Robert), which reflected the degree to which medical treatments interfered with their daily routine. Iaco used the word "*floppy*" to describe his experience of medication side effects that he counteracted by keeping himself as productive and useful as possible. The same word was used by Deirdre who explained her state of lethargy induced by medication through a picture of a pigeon resting on the pavement (Photo 2).

Photo 2: "*This is a pigeon – floppy like me […] These pills make us sleepy*." (Deirdre, Workshop 2)

This state of torpor attributed to sedation from psychiatric treatments was also noted by the researcher in participants' overall presence during the project activities, their subdued interactions, low-pitched voice difficult sometimes to distinguish from the recordings, and slow speech punctuated by restful silences.

The effects of sedation appear to be even more severe for Rodion, whose psychiatric treatment triggered upsetting side-effects that stopped him from pursuing the things he enjoyed. As a result, Rodion's passion for sport, one of his main coping mechanisms, was significantly impacted:

> *"I was sitting like those old people with Parkinson* […] *shaking and lacking concentration because it* [the medication] *diminishes your mental faculties."* (Rodion, Interview)

Inspired by a photograph of the entrance to day centre (Photo 3), Ioana used the metaphor "*dark side*" to refer to the time spent on a psychiatric ward, when she first became unwell. For her, awakening appears to be from a nightmare that she could hardly recall because of her half-conscious state heavily sedated with medication and electroconvulsive therapy (ECT). The contrasting *"bright side*" represents, uncoincidentally, the day centre that played an instrumental role in her process of awakening to life through social and occupational activities.

Photo 3: "*The dark side is the period when I was admitted. I don't remember many things that happened then*." (Ioana, Workshop 4)

Building on Ioana's metaphor, awakening appears to be the return to light, an interpretation reinforced by Robert in a picture of a sunset timidly emerging in the dark skies after a violent storm whose intensity was reflective of his levels of distress (Photo 4).

Photo 4: "*I have a worry, a fear when the dark is coming*" (Robert, Workshop 2)

Agnes added to the understanding of recovery as overcoming sedation through her expressive picture of a snail (Photo 5), as sluggish in movement as she portrayed herself during times of depression.

Photo 5: *"I was a snail because I was moving so slowly in life…"*
(Agnes, Workshop 3)

Agnes's "*slow motion*" can be linked to the side-effects of her psychiatric treatment that she described as increasingly "*heavier, stronger, and higher* [in dosage]", that severely affected her cognition, physical and social mobility, and, consequently, her promising life prospects that she developed as a hard-working student. Agnes interpreted the darkness in her photograph as a metaphor for depression, for the times when she *"was lost and wasn't open to light."* Similarly to her peers, Agnes seems to conceptualise recovery as a state of reaching for light; the sunshine and the green grass for which Agnes imagined that the snail was craving become in her view a metaphor for life. This idea appears in numerous other chromatically rich pictures of flowers bathing in the sun, clouds caressed by soothing light, and nature returning to life (Appendix 32.2), through which Agnes and other participants suggested

increased sensorial experiences and awareness of their surroundings, which seem to accompany their process of recovery, along with a reduction of psychiatric treatments.

Emergence of self beyond illness

The journey through darkness and mental distress resulted for some participants in a process of discovery of self emerging from a sense of being in the world, feeling and thinking beyond the fluid boundaries of illness:

> *"I gradually started to find myself, to feel that I am useful, determined, and able to make decisions."* (Iaco, Interview)

For Iaco, the process of awakening of self took place by gradually becoming aware of his skills and potential for "doing" things, but also recovering his reason impacted by illness. Maybe not coincidentally, he talked about becoming himself while looking at his photograph of an owl-shaped object that he made at the day centre (Photo 6).

Photo 6: "*The owl represents wisdom.*" (Iaco, Interview)

The owl, fully awake and bursting with colour, symbolises wisdom, that Iaco, the oldest participant, acquired through decades spent dealing with the effects of severe mental health problems and burdensome psychiatric treatments, which helped him gain a deeper understanding of self in a rich life's context. Iaco's pragmatic view on recovery is echoed by Robert, who talked about discovering himself while gradually getting involved with different activities shortly after overcoming the sedative effects of his medication, energised by an emerging desire to achieve:

> *"I increasingly felt the need to take part in the activities here, at the day centre. And, gradually, I felt an awakening inside, that I can do this and even more!"* (Robert, Interview)

For other participants, awakening of "feeling" is more prominent than "doing". For instance, Agnes chose to take pictures of clouds and a dazingly bright sun (Photo 7) to represent the passage from a self (mis)shaped by negative feelings and past trauma to a positive state of mind capable to take in the beauty of the outside, but also internal, world.

Photographic metaphors also punctuated Loredana's account of recovery to describe a feeling of awakening or returning to life similar to nature being reinvigorated during springtime, as elicited by a decorative object that she photographed (Photo 8). Loredana interpreted recovery as renewed appetite for life, but also as an awakening sense of goodness that she discovered through religion, indicating a moral dimension of self and recovery.

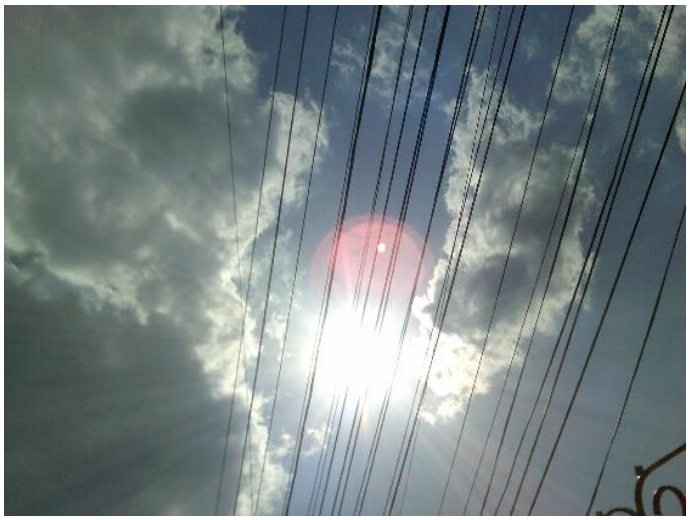

Photo 7: "*The clouds mean sadness or depression. And the sun means something bright that brings light to that sadness*."

(Agnes, Workshop 2)

Photo 8: *"It* [the photograph] *gave me a feeling of spring. I like spring when trees are coming back to life, blossoming… it gives me a feeling of happiness."* (Loredana, Interview)

Agnes's and Loredana's images in which nature becomes a vector carrying deep messages of recovery resonated with Robert's metaphysical interpretation of recovery as awakening of his "*soul*" through positive emotions. For Robert, recovery was the joy of discovering life in the

shadows of illness, an eye open to a new world charged with intensity, creative potential, and beauty waiting to be discovered and explored, as he experienced while taking a picture of a rainbow from his balcony (Photo 9).

Photo 9: *"After rainy and stormy days, there's an awakening in my soul that gives me wings. It makes me feel alive."* (Robert, Interview)

The change of weather was an analogy used by Robert to portray recovery as a passage from a timid self to a sudden willingness to connect with the world by developing communication skills. As with other participants, the viewfinder of Robert's camera supported this process of discovery by connecting his inner eye to realities in which he found himself and were representative for his recovery:

"The colours of the rainbow as reflected by the sun… the sunshine coming through the clouds… the joy of seeing nice places, people, the nature, the change of weather…" (Robert, Interview)

From a compositional point of view, particular attention to detail and symbols was noted by the researcher in participants' images, suggesting enhanced alertness to their internal world and the surrounding environment, which can be interpreted here as an expression of awakening of senses, consciousness, and being in the world. This contrasts with the visual scarcity in pictures illustrating medical treatments and experiences of hospitalisation. For example, while nature photographs taken by Robert and Agnes were metaphorical windows to their self and being, the half-curtained window of the psychiatric hospital in Ioana's photograph (Photo 10) conveyed a sense of austerity and confinement from self and the external world, that not many participants were willing to describe in words or images.

Photo 10: "*I was alone there at the hospital, and everyone was ignoring me*." (Ioana, Workshop 4)

While in some participants' accounts awakening was synonymous with opening one's eyes to light (metaphor for life), for others, awakening was a process of self-discovery that revealed human qualities preserved despite the dramatic changes brought by illness:

"*Recovery means to keep certain human qualities.*"

(Rodion, Workshop 3)

Rodion further explained that being human was about collecting the things done throughout one's life and the memories that define a person, which encompasses awakening of both instrumental (doing) and existential (being) dimensions of self. A repertoire of such human qualities that shape the personhood emerged in other recovery narratives, revealing "*courage to carry on*", "*patience*" (Tincuta), "*dignity*", "*self-respect*" (Robert), "*will-power*", "*perseverance*", "*self-motivation*" (Deirdre), and "*love*" (Mihai), as essential to recovery.

While some participants (Cristi, Emilian) stated that illness and medical treatments did not change their identity, others developed a new sense of self moulded in their lived experiences of distress. In Deirdre's case, the awakening of a unique self shaped by past losses and relieved from external expectations and comparisons with other people was expressed in a photograph in which she chose to represent herself as a crow, with potential reference to her negative personality that she verbalised throughout the project (Photo 11).

Photo 11: *"*[Recovery is] *not to have any unrealistic expectations from life and from ourselves, not to compare ourselves with others. Each has his own life and we cannot imitate what others do. We cannot live their experiences."* (Deirdre, Workshop 2)

Deirdre, like other participants, seemed to awake to an existence of which she took ownership, although she suggested a compromise ("*settling for less*") possibly due to the socio-professional limitations caused by her becoming unwell. Nonetheless, this process was guided by self-acceptance and "*coming to terms with ourselves*".

Moreover, increased awareness of self as a human being with unique consciousness was indicated in Deirdre's account by her spontaneous and deeply philosophical reflection that life was valuable beyond illness and the havoc it caused, including the loss of a romantic relationship and employment:

> *"Every life, no matter how much it deviates from the norm, is valuable. I mean even if we have a mental illness […] we have a life and we have to enjoy it."* (Deirdre, Workshop 2)

Liberation

Recovery as awakening can be interpreted not only as openness to one's self, but also to the society, a perspective potentially influenced by the phenomenological design of this thesis centred around the Heideggerian existentialism and contextualised *being-in-the-world* (*Dasein*). Recovery as liberation is understood here as an emerging sense of freedom from the painful chains of illness, but also from the societal constraints. This was metaphorically represented by Iaco in a photograph of a painting depicting the Statue of Liberty (Photo 12), a well-known symbol of freedom and opportunities for people seeking a better life.

Photo 12: *"It doesn't matter how ill or schizophrenic you are. If you feel some freedom, you can concentrate better on the things that need to be done."* (Iaco, Interview)

Deep in reflection throughout the interview, Iaco seemed to open his eyes to the outside world and construct his "*own vision of this world*", as he put it, unsullied by totalitarian regimes or corrupt societies that he witnessed throughout his troubled and oppressed life. Probably this explains why Iaco became an active citizen deeply aware of social issues such as corruption and political manipulation, and exercised his right to vote in order to change governments that he classed as shameful and dysfunctional.

Freedom was equally important to Emilian's recovery, particularly freedom of thinking (Photo 13) and freedom of choice that emerged from his narrative of awakening as a free human being after acknowledging his limited opportunities to build a decent life in Romania, which influenced his decision to migrate to the United Kingdom a few years ago.

Photo 13: *"To recover means to think freely* [Rom. "gândește liber" engraved on the statue]*. No one tells you how to think. You can make choices and do things the way you want.*" (Emilian, Interview)

Emilian's message can also be interpreted from the perspective of his distressful experiences of hearing voices that sometimes dictated his thinking and behaviour, but also in the context of a tense relationship with his father, whose exacerbated authority hindered Emilian's sense of freedom and life choices at times. This was a common occurrence in the narratives of Cristi, Mariana, and Daniela, suggesting liberation from the family constraints as a possible dimension of recovery for some participants.

Rodion linked his understanding of freedom in relation to recovery to his psychiatric experience elicited by a photo of a metallic fence obstructing the panoramic view of the city and, symbolically, of life (Photo 14). Bars become a metaphor for limitation, associated by Rodion with the side-effects of anti-psychotic medication that he was reluctant to take, but also with the obstacles that he faced while trying to secure employment and build a family. Another potential interpretative lens was found in his story of confinement while being

hospitalised against his will on several occasions and sedated with psychiatric medication and false hopes of clinical recovery.

Photo 14: *"There is freedom if you know how to see it. But you have to go on the other side of the bars. There are always bars… sometimes useful for protecting people, but useless when people are in search for something."* (Rodion, Interview)

Although predominantly personal, recovery as liberation was occasionally described by participants as a collective and political act. Deirdre, one of the most vocal members of the group, pointed to awakening of self in the wider community, while pondering over one of Robert's photographs (Photo 15). In other words, the realisation that individuals do not "*take steps in illness and life*" in isolation, but as members of a larger group with latent power to change things in society. Her message was constructed using the collective pronouns "*we*", "*us*", suggesting a sense of unity, uncommon in participants' narratives possibly due to lacking a collective voice. Collectiveness is only hinted at in other participants' narratives, in which the concept of community and empowerment appears to be limited mainly to peers and staff at the day centre.

Photo 15 (Robert, Workshop 3): *"We can imagine that we take the steps in illness and life wearing this shoe. I mean we make loads of noise! […] An army of foot-soldiers* [says this in English]. *Yes, we are talking about an army, so it is not only an individual, it is about us as a group and probably as a community."* (Deirdre, Workshop 3)

Ioana took this message to another level and verbalised recovery as liberation from the prescriptions of the psychiatric system. Although recovery appears to be a verdict expressed unquestionably by the psychiatrist, Ioana indicated that she built her own opinion on this matter; while her psychiatrist continued to be pessimistic about the prognosis of her illness, Ioana strongly believed that she recovered, mainly because she had a job and a healthy routine. Furthermore, she questioned her psychiatric diagnosis and contemplated stopping her medication to test the hypothesis that she may have been misdiagnosed, despite the benefits of medication that she acknowledged numerous times:

"He [the psychiatrist] *said that I won't recovery anyway. My opinion is that I can recover* […] *I thought I may not even be ill, that I've been misdiagnosed."* (Ioana, Workshop 1)

The psychiatric practice and diagnosis are critically reflected on by other participants (Daniela, Mariana), opposed more or less overtly to doctors' expertise. The concept of power in relation to psychiatry appears therefore to be challenged, potentially suggesting an emerging voice of mental health service users beyond the realm of psychiatry, elaborated on in *Chapter 6: Discussion*. For Iaco, freedom in relation to treatment was also important, based on a contract that implies consent and negotiation of the treatment with a specialist while accounting for his feelings:

"*I am the one who feels. I feel the effect of the medication"*

(Iaco, Interview),

interpreted here as the service users being more than passive receptacles of medication and medical expertise, but also sources of thoughts and emotions attached to their treatment. This may further explain the complex nature of recovery as medical, but also psychological, explored in the next section.

5.2.2. Healing

The language used by participants throughout the project revealed "healing" as one of the most frequently used terms to describe recovery from mental distress. Beyond the apparent dichotomy ("healed"/"not healed") generated by participants through critical discussions, it was noticed by the researcher that not all of them were able to find a clear-cut answer to the question whether they recovered or not. The explanation for this was found in the complexity and various understandings of "healing". For some participants, medical treatments played an instrumental role in this process; for others spiritual healing seemed to be more prominent; while some participants talked about healing of emotional "*wounds*" left behind

by illness. Following these directions in participants' photographic accounts and based on their initial interpretation of the preliminary findings (Appendix 22), medical, spiritual, and psychological healing are advanced here as subthemes.

Medical healing

Medical treatments were frequently mentioned by participants in relation to their experience of recovery which was equivalent for some with a reduction of symptoms:

> *"Recovery is about not hearing voices* […] *They* [voices] *have been decreasing in intensity since I got ill eight years ago… Before, they were there non-stop. Now, only sometimes."* (Emilian, Interview)

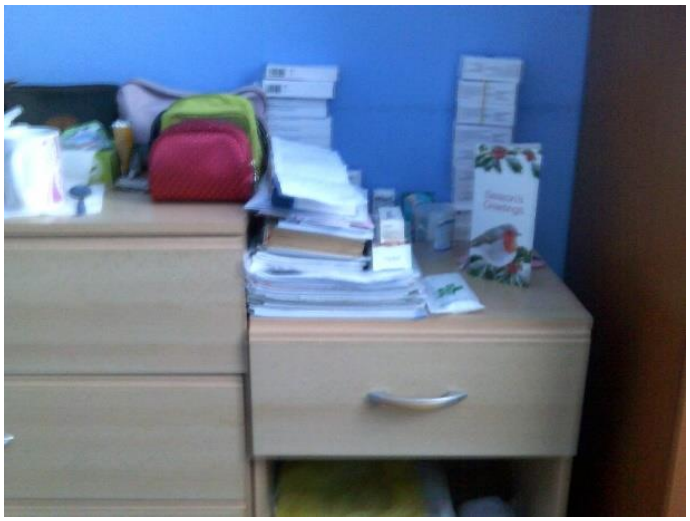

Photo 16: *"My opinion is that there is recovery from this illness. If you take your treatment and comply, you can live a normal life."*

(Ioana, Workshop 2)

Despite a reduced number of photographs on this topic, experiences of medication and encounters with mental health professionals were critically discussed, revealing a wide range

of perspectives. Medical healing was particularly evident in the narratives of Ioana, Loredana and Emilian. To illustrate this aspect, Ioana took a picture (Photo 16) of her medication "corner" consisting of an impressive number of medicine boxes and prescriptions arranged meticulously to reflect her strict routine of taking medication throughout the day.

Participants' view on medication and its helpfulness for their recovery varied widely on a spectrum from a way to normalise life (Ioana) through benefits such as calming or relaxing effects (Cristi, Daniela, Emilian, Johnny, Loredana, Mihai) that "*ameliorate*" the illness (Robert):

> *"The psychiatrist prescribed me the right medication and I felt the difference very quickly. My anxiety decreased and I was more confident about walking on the street."* (Daniela, Interview),

to fighting distressful and burdensome side effects of medical treatments discussed mostly in interviews (that may have provided participants with a safer space for disclosure):

> *"I was so scared of the* [side] *effects… I've never had anything like that* […] *I simply couldn't concentrate. I was just lying in bed."*
>
> (Rodion, Interview)

Participants' experiences of hospitalisation were also diverse. For Ioana (Photo 17), Loredana, Tincuta, and Daniela, hospitalisation was key to finding the "right" treatment, although this happened in most of the cases after many trials and errors.

In this context, recovery was sometimes supported by encounters with highly competent and compassionate mental health professionals, as evidenced in Daniela's account reinforced by

a visual metaphor of a handrail (Photo 18) that she chose to symbolise trust, stability, and support – something (or someone) "*to hold on*".

Photo 17 (Ioana, Workshop 4): "*They admitted me to the hospital and gave me medication, treatment, and I recovered*." (Loredana, interview)

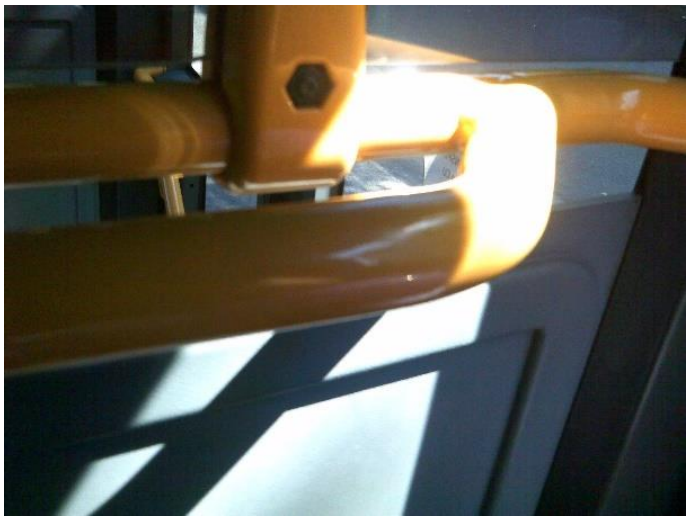

Photo 18: *"She* [the psychiatrist] *was the only one who stopped by my bed and asked me face-to-face 'How are you feeling?'* […] *It was the first person I trusted because she believed in what she was saying. I was feeling better emotionally knowing that someone's there."*

(Daniela, Interview)

For others, such positive experiences were rather uncommon. The rule deducted from participants' accounts was that psychiatrists seem to be more preoccupied with "patients" complying with the prescribed medical treatments (nonetheless, helpful for some participants):

"Well, it's more about taking your medication there [at the hospital]*."*

(Tincuta, Interview)

Such practices suggest a limited approach to recovery within the medical profession, which may explain why some participants didn't consider themselves "healed" despite complying with medication and experiencing a reduction of symptoms, suggesting that the clinical dimension was only one perspective on recovery:

"I'm quite far from being recovered although the only treatment I take at the moment is an injection." (Raul, Interview)

This argument was nuanced by Robert who stated that recovery may take place although "*the illness remains*". Although he used a medical term ("*wounds*") to describe his mental distress, his narrative indicated that recovery did not refer only to "*body*", but also to his "*soul*", as poetically expressed in a poem specially written for his interview:

"It's nice when there's peace in my soul / Even if there are shadows in the basement." (Robert, Interview)

With such diverse conceptualisations and experiences of medical treatments and hospitalisation, it was not surprising that participants' degree of compliance with psychiatric

medication varied widely, from taking the medication almost religiously "*as prescribed by the doctor*" (Tincuta), to those reluctant to take it for various reasons, mainly side-effects (Rodion). As a result, tensions between some participants were noted, along with new understandings of recovery generated through critical group discussions. For Emilian, for instance, taking medication was "*compulsory*" despite his numerous attempts to discontinue his psychiatric treatment, which may be further linked to his interpretation of recovery as freedom:

> *"I'd like life to be like that one day without having to take medication to calm myself down."* (Emilian, Workshop 2)

Emilian acknowledged that medication helped him prevent his "*mind being all over the place*", sleeping problems, hearing voices, "*feeling worse*", and "*very stressed*". However, recovery described by Emilian as a process of "*getting rid of this illness*" was conditioned in his view by not relying on medication, which may provide rich insights into compliance behaviours and their link to individuals' own conceptualisation of recovery:

> *"They say that you are going to feel worse because of the* [withdrawal] *effects, or that the illness may relapse. And we are afraid not to take it* [medication] *to see how our bodies work, if we recovered."* (Emilian, Workshop 1)

Ioana also contemplated discontinuing her medication, although she described it as key to her recovery, which can be attributed to her doubts on whether she was misdiagnosed, a hypothesis that she wanted to test:

"Sometimes I'm thinking that I don't have schizophrenia because I feel well after taking the medication, and many times I'm thinking that I could stop taking the medication and see if I go through another crisis or I recovered." (Ioana, Interview)

Uncommonly, some participants rely on alternative "healing" routes to address their mental health problems, possibly due to the perceived limitations of medication. For example, Loredana attempted to address her mental health issues with plant-based treatments:

"I went to a lady […] *she gave me some plants to help me recover. I tried them and I gave up my medication. I was a bit better, but then it got worse."* (Loredana, Interview)

Such experiences may shed some light on the cultural perspectives of "healing" and recovery, and how traditional or alternative remedial routes may impact on compliance with the psychiatric treatments.

Psychological healing

Participants' narratives revealed mental distress as a psychological experience characterised by a deterioration of thoughts and feelings, expressed through verbal and visual language that varied widely, as reflected in their photographic metaphors of distress (Appendix 30). However, some commonalities were noted. For example, Robert referred to distress as "*wounded feelings*" elicited by a picture of a derelict wall during a warm-up exercise; similarly, spots on a white fabric symbolically described Iaco's inner universe stained by "*wounds*" that he still tried to understand and heal after decades of living with mental health problems

(Photo 19); "*wounds of the soul*" was also Agnes's conceptualisation of her sadness in relation to past trauma subtly expressed in her picture depicting a willow (Photo 20).

Photo 19: "*There's something on my soul… I have a wound, these spots* [in the picture] *it's like you can feel something there crying inside you.*" (Iaco, Interview)

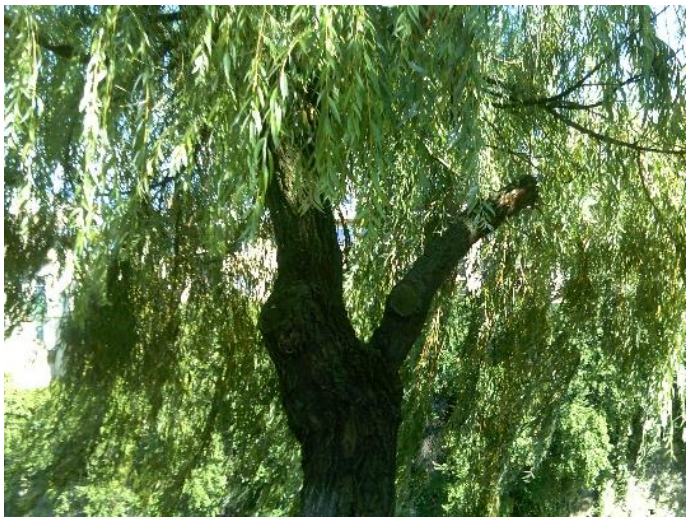

Photo 20: *"The branches of the willow hang… It reminds me of all the sadness and the negative and bad states I've been through. And the wounds… the wounds of the soul... that make me weep like a weeping willow."* (Agnes, Workshop 2)

For others, distress was the equivalent of an agitated state of mind, experienced by Daniela as panic attacks accompanied by physiological signs:

"I was feeling breathless… big lumps in my throat… I was suffocating… sweating… agitated." (Daniela, Interview)

Anxiety was expressively visualised by Robert as a storm approaching, disturbing darkness that clouded his mind, that he captured along with his intense feelings in a dramatic photograph (Photo 4). More specific, Rodion's anxiety revolved around his fear of cancer, understandable when placed in his account of many years of working in a toxic environment during communism.

Along with feelings, participants' thoughts were also distressful in various forms ranging from negative thinking,

"The idea of inferiority, of incapacity […] *ideas of worthlessness that build numerous nests in the tangled forest of a tormented psyche."*

(Deirdre, Workshop 4),

irrational thoughts and behaviours linked to hearing voices,

"When I am inside the church, I keep my hand like this and stand in one leg […] *It's stupid… my voices make me do that."*

(Emilian, Interview),

to more extreme suicidal ideation or "*dark thoughts*" verbalised mostly during the interviews, in which a greater degree of disclosure was noted compared to group settings:

"I was thinking of jumping off the building that I was living in… I didn't want to live anymore." (Loredana, Interview)

Exploring participants' diverse experiences and meanings attributed to their distress was essential for understanding their making sense of recovery as psychological "healing". As a result, distress was represented not only by their symptomatology, but also by the psychological "*torment*" caused by living with such experiences, as Deirdre put it. While illness was described by participants during the first workshop using medicalised terms (e.g. "*illness*", "*disease*", "*disorder*", "*syndrome*", "*relapse*", "*episode*", "*schizophrenia*"), multiple meanings of distress took shape over the subsequent workshops, aided by photography (as reflected upon in *Chapter 6: Discussion*).

Photo 21: *"I wanted to capture this construction here because it represents recovery. The waterfall goes inside and keeps the water clean. Recovery is maintaining a positive psychological state and energy, joy and happiness even if you have regressive feelings, dark thoughts, anything that hinders a normal health."* (Robert, Workshop 2)

Distressful feelings and thoughts seem to be subjectable to a process of "*cleansing*" illustrated by Robert in an image of a sluice keeping the troubled waters under control (Photo 21). Mirroring Robert's choice of turbulent waters as an expression of distress (Photo 22), Deirdre talked about recovery as a psychological process of improving her thinking and self-esteem profoundly affected by mental breakdowns with consequences on her personal and professional life.

Photo 22: "*The turbulent waters represent struggle and the illness. But at the same time, it* [the water] *is white, I mean this negative state of mind maybe be sieved into good feelings*." (Deirdre, Workshop 3)

Robert reiterated the idea of recovery as "*cleansing*" of thoughts and feelings in his picture of clouds on a clear sky, and a hardly noticeable device for purifying the air (Photo 23). The blue sky was a metaphor also chosen by Agnes to represent her recovery as transition from "*sadness*" (dark clouds) to more positive and "*bright*" feelings (sunshine) (Photo 7).

Photo 23: "*Recovery means cleansing, refreshing… maintaining a good state of mind.*" (Robert, Interview)

For other participants, understanding recovery was influenced by external knowledge. For instance, Emilian advanced an explanation that he learned from his psychiatrist – recovery as "*bringing together*" a "*mind that is split in many parts*", echoing the etymology of the word "schizophrenia" (i.e. "split mind"). Building on this idea, Deirdre described recovery as

> "[…] *being whole in your mind, structured, harmonious, without rough edges, organised.*" (Deirdre, Workshop 3)

Deirdre's view was potentially influenced by her personal development through reading self-help books in English and accessing therapy in the past, as her making sense of recovery resonated with basic principles of cognitive-behavioural therapy (e.g. the inter-relational nature of thoughts, feelings, and behaviours), interweaved with deep philosophical reflections through which Deirdre explored her own psychological distress:

"Nietzsche said that there is no fact, only interpretations […] *I believe that I am in a certain way and this defines my life and limits my actions*." (Deirdre, Workshop 4)

Deirdre's deep understanding of psychological recovery contrasted with her limited exploration of medical treatments that she portrayed more negatively in terms of side-effects. However, she occasionally referred to emotional healing using medical language (e.g. mending a "*fractured personality*"), similarly to Iaco, for whom addressing mental health "*deficiencies*" took priority. It is worth mentioning that most of participants have never accessed psychotherapeutic services, including Raul, who described this as an obstacle to his recovery. In this context, it is not surprising that participants frequently used the terms "psychotherapy" and "psychiatry" interchangeably, an aspect noted in a number of interviews in which the word "recovery" was specifically associated with the physical health domain:

"Therapy includes the psychological side, while recovery [Rom. recuperare] *means physical* [or body] *recovery."* (Iaco, Interview)

However, this did not stop participants from seeking multi-disciplinary support, suggesting their perception of recovery a multifaceted process:

"If I knew where that deficiency comes from, then I could treat it. And this is why I ask for help from the social worker, the doctor, psychologist." (Iaco, Interview)

It was noted that the number of participants reporting psychological healing was slightly lower compared to medical healing. While the depth of insight elicited by photographs was

nonetheless remarkable, this difference may be indicative of the predominance of a medical understanding of recovery influenced by psychiatric services being the main (and only) route of treatment for most of the participants.

Spiritual healing

Spirituality was a recurring dimension identified in participants' photographs and recovery narratives that provided a valuable framework for understanding the meanings attributed by the research participants to recovery processes within the Romanian cultural context.

Emilian's recovery narrative was probably the most representative for this subtheme. He chose to illustrate the role of faith in his recovery in a photograph taken while attending the religious service at his church (Photo 24).

Photo 24 (blurred unintentionally from camera): *"Recovery means to have a better relationship with God* […] *I am happy that God loves me and shows me what to do… He guides me step by step* […] *I pray to Him, I trust Him… I pray so He will heal me one day."*

(Emilian, Interview)

Hindered by a conflictual relationship with his father, Emilian's recovery found a fertile ground in the Christian religion and church that he perceived as a source of love, acceptance, and belonging, referred to as a "*rain of blessings*" that facilitated his process of "*getting better*". Emilian's journey through dark thoughts appears to be guided by God to whom Emilian surrendered faithfully and hopefully, giving the impression that his own actions faded passively in front of divine forces that he invokes through prayer.

Daniela, whose mental health was severely impacted by childhood trauma and an abusive home environment, also found refuge in religion. As a trainee nurse, she talked about recovery holistically as the fulfilment of various needs, including the "*freedom to practice religion*" that was restricted during communism. Being part of a religious community helped Daniela to overcome her social phobia through exposure to the church congregation (Photo 25) where she used to sing and play the piano. This establishment also gave her a feeling of connectedness and (self-)acceptance, that guided her recovery by improving her relationship with self, other people, and God.

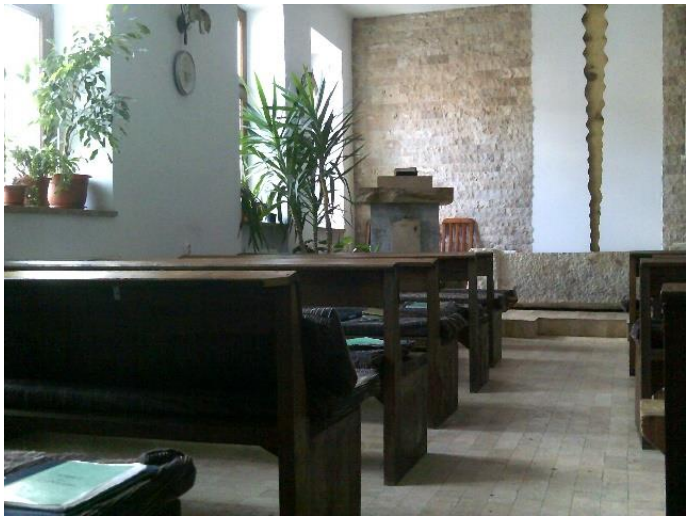

Photo 25: *"I found a community there* [at the church] *that brought everyone together and protected us."* (Daniela, Interview)

As with Emilian's story, Daniela revealed spiritual resources such as Bible study, praying, and building personal connections with God as crucial steps to finding herself and coming to terms with her mental health problems. Consequently, such practices were conducive to recovery, that is associated by Daniela with discovering her own worth and self-esteem through Christian values and reflection:

> *"Unlike God, I saw myself in a horrible way* […] *I didn't appreciate myself and there* [at the church] *I was told and I read that He loves me and He made me, and if He made me, then I must have some value."* (Daniela, Interview)

The religious connotations of recovery from mental distress were also illustrated in Loredana's story, elicited by a photograph of a wall decoration (Photo 8) that reminded her of Easter. The significance of this religious holiday is paramount for the Christian faith that commemorates the Resurrection of Christ and His victory over death and darkness, illuminating potential interpretations of recovery as a victory over illness guided by faith and hope:

> *"Spring is when we celebrate Easter, and I go to church and pray, and God gives me courage."* (Loredana, Interview)

Praying and reading the Bible are revealed in Loredana's account as strategies of distraction from distressful obsessive thoughts that she managed to calm down by engaging in a meaningful relationship with the divinity that, unlike those around, "listens" to her voice:

"I like to go to church and say 'Our Father…'; I say it on the street as well wherever I go. It makes me forget about this burden […] *And I calm down because God listens to me and gives me health."*

(Loredana, Interview)

Praying is also an opportunity to express her gratitude for recovery and people in her life, providing an example of positive psychology applied by Loredana most likely from lived experience rather than therapeutic knowledge. Ultimately, for Loredana, *"to recover means to believe in God",* which may explain why she sought the advice of a priest prior to seeing a doctor when she first experienced a mental breakdown. Religious practices such as going to church regularly, praying, or fasting, seem to support recovery by strengthening will and hope, providing peace of mind, but also a sense of routine, and social opportunities, that were present, albeit subtly, in the narratives of Tincuta, Cristi, and Ioana, in the form of verbal statements, but also visual representations of recovery (Photos 26 & 27).

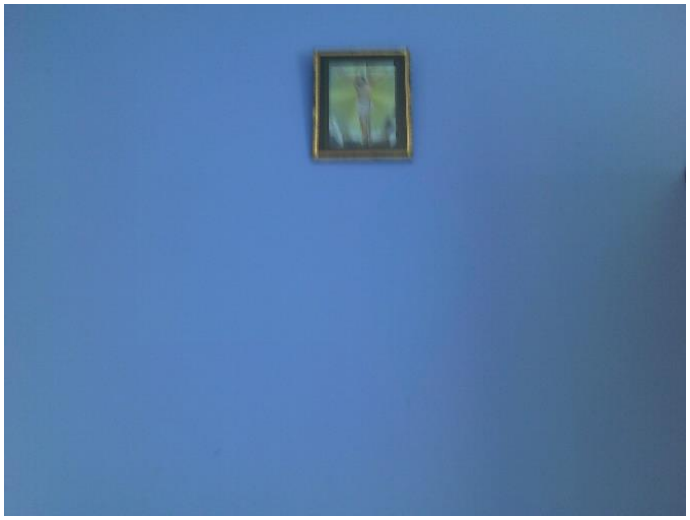

Photo 26: *"This picture* [of a religious painting] *was taken in my room.* […] *I do pray. I don't go to church on Sunday, but I do pray at home."* (Ioana, Workshop 4)

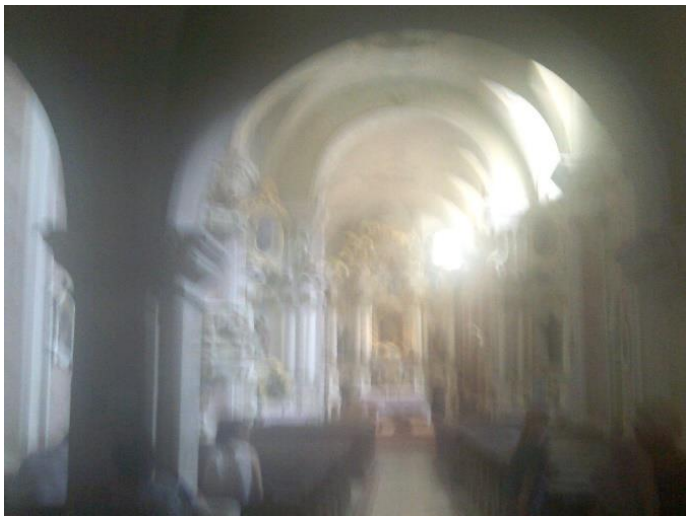

Photo 27: *"I went to church with* [the name of a service user]. *I also go to church with my mum every Sunday."* (Cristi, Workshop 4)

Religion as an avenue to recovery is not only about active involvement in Christian practices, but also a source of language and rich metaphors illustrating the burden and magnitude of living with mental distress compared by some participants with the biblical Golgotha (Photo 28).

Photo 28: *"As a symbol of pain, the cross is ramified into a tree or a multitude of crosses indicating the self-torture imposed by the mental illness."* (Deirdre, Workshop 4)

In conclusion, recovery as a journey of healing was represented by participants through a spectrum of meanings and visual representations reflective of their diverse lifeworlds and experiences, choices and preferences, which guided their recovery behaviours, further explored in *Chapter 6: Discussion* along with how the researcher made sense of participants' making sense of their experiences.

5.2.3. Reconstructing life

Awakening to life and healing were accompanied, in most of participants' verbal and visual narratives, by a process of existential reconfiguration around the parameters of illness and health. This dimension was illustrated by Daniela in a photograph taken during an ordinary bus trip (Photo 29) representing a symbolic journey of recovery from social phobia and panic attacks triggered by public transportation. In this image, the walls, normally seen as obstacles, were metaphorically interpreted by Daniela as protection against falls or relapses provided by the protective boundaries of the day centre where she started to rebuild her life, like most of the participants.

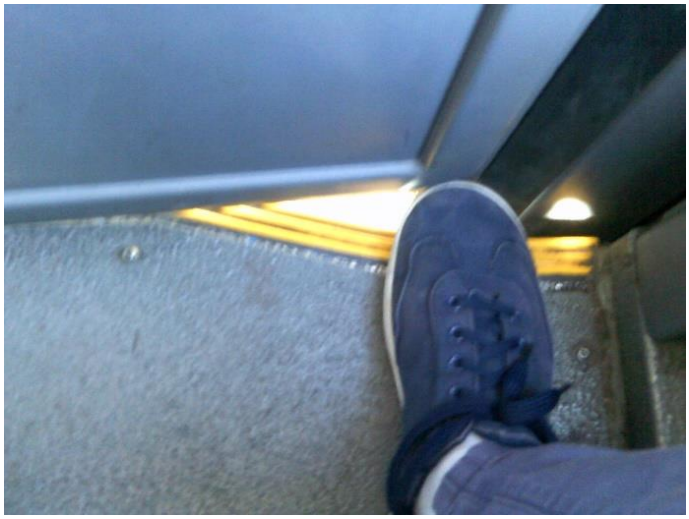

Photo 29: *"The fact that I came here* [at the day centre] *was a protective wall and finding balance."* (Daniela, Interview)

In Daniela's case, life reconstruction took place while erecting social, professional, and personal scaffoldings to support a "*fresh start*" in life. Although not explicitly expressed by other participants, their accounts echoed this process of rebuilding life on different dimensions presented here as subthemes: keeping busy, rebuilding social networks, and cultivating hope. The processual nature of life reconstruction is emphasised here rather than recovery as an end point because, once reconstructed, life can collapse again under the burden of reoccurring distressful experiences, as pointed out by some participants.

Keeping busy

The most prominent area in which participants' life reconstruction took place was finding a meaningful occupation or "keeping busy" – the most common subtheme identified in all participants' accounts. Participants conceptualised recovery as securing employment or getting involved with different activities at the day centre, at home, and occasionally within their communities.

Finding a job was the essence of recovery for most of the research participants, although their demographic data revealed that all of them (except for one) were unemployed for a considerable period of time and accessed "ill health" pensions (Rom. "pensie de boală/handicap"). It is important to note that some service users lost their jobs following a deterioration of their mental health problems, therefore potentially understanding recovery as compensation for such losses:

> *"Recovery means to have a workplace. And there isn't anything like that* [in my life] *at the moment* […] *I had a job before, I had more things, while now… I just don't feel up to it."* (Deirdre, Workshop 2)

This perspective was shared by older participants for whom employment status was an indicator of recovery:

"Recovery depends on whether you find a job […] *To be recovered means to work, even if it was only four hours."* (Raul, Interview)

Apparently menial jobs and modest pay generated self-esteem and a change of perspective in participants who seemed to reconceptualise recovery in line with their levels of activity:

"I am recovering in the sense that I can work […] *I care for an old lady in* [the name of the district] *and I help her. I mean I do her shopping and she gives me 10 lei* [£2] *per hour."* (Ioana, Interview)

Photo 30: *"Working* [having a job] *is the sunlight here."*

(Robert, Interview)

When asked to define recovery, Robert also reinforced the importance of a job that he metaphorically represented through the sunlight in his photo of a tree (Photo 30). Building on his visualisation, one could infer that a job is conducive to productivity, personal and

professional growth, the same way light provides a key element to the growth of the tree photographed by Robert.

Other participants enthusiastically elaborated on this topic, revealing their understanding of recovery in terms of gaining employment. Rodion, for instance, turned his passion for painting (Photo 31) into a small lucrative business, guided by the belief that work is therapeutic and key to independent life, which can be further linked to his interpretation of recovery as an expression of freedom.

Photo 31: *"Work gives you the feeling that you don't depend on doctors or medication that much, that you are not someone who cannot do anything and who is defeated by something from the inside."* (Rodion, Workshop 4)

Another layer of understanding of recovery in the context of occupations was added by Iaco, a participant in his sixties with varied work experience, who revealed the therapeutic valences of employment while conveying a sense of pride in his achievements during the interview:

"I developed a hobby from tailoring. I developed from one level to the next and now everything I make does me so good. It is a therapy!"

(Iaco, Interview)

Work was also therapeutic for Daniela, whose job as a trainee nurse at a local hospital exposed her to social stimuli and helped her reduce debilitating levels of social phobia. When asked about the meaning of her job in relation to recovery, Daniela pointed out a sense of agency, empowerment, independence, and increased quality of life:

"My job means financial stability, which is important for living an independent life, now that I am not living with my parents anymore. It helps me rent better accommodation. Also, professionally, because it is my first official job […] *and when I see that I do the right thing, my self-esteem gets better."* (Daniela, Interview)

In the spirit of empowering others, Iaco, a veteran of the day centre, has proactively facilitated jobs for other service users, liaising with small businesses within the local community. Although not supported by visuals, his narrative talked about a work culture shared by his peers that goes hand in hand with instilling responsibility that he previously linked to freedom:

"There was a time when I collaborated with an entrepreneur who was specialised in leather […] *We* [service users] *worked there for about six months. We were drawing patterns, cutting them with scissors. They* [service users] *were so keen to do a good job. It's all about responsibility!"* (Iaco, Interview)

Along with developing new skills, a sense of achievement and reward, but also a source of income to supplement their small pensions, work appeared to give participants a feeling of usefulness and being valued in society, which subsequently helped them combat the guilt and stigma (internalised or by association) caused by their reliance on benefits:

> *"You know, people talk if you don't do anything… I feel guilty sometimes because I don't work. And that thought bothers me. It's not just about me, it's my family as well… You are important to the society if you work."* (Loredana, Interview)

However, beyond the multiple advantages of having a job (e.g. financial, social, and professional), employment was occasionally described by participants as a source of stress leading to relapses and hospital admissions, followed by losing jobs and stable sources of income, which generated further distress, trauma, and deterioration of mental health. This dimension was evident in participants who worked in toxic environments during communism (Iaco, Loredana, Raul, and Rodion). In their stories, recovery appears to be not only improvement of mental health on a personal level, but also recovering a life contaminated on a societal level by the harsh realities of the communist era – a dimension expanded on in *Chapter 6: Discussion*.

Participants' experiences of recovery as keeping busy also included a wide range of creative, sportive, and lucrative activities at the day centre that was revealed as a veritable recovery hub.

Photo 32 (Ioana, not selected): *"It* [recovery] *is about finding an activity that supports us* […] *we get out of the illness through a hobby."* (Robert, Workshop 3)

Ultimately, to find and maintain an enjoyable occupation is what defines a person, as explained by Rodion while contemplating his picture of a fisherman (Photo 33) that he chose to reflect the role of being focused on doing something meaningful while recovering.

Photo 33: "*He* [the fisherman] *is looking ahead. That's all that matters. If he loses this vital concentration, he's almost like in the grip of illness*." (Rodion, Workshop 3)

Participants' narratives revealed various occupations that, unlike employment pursued partly because of social obligation and financial constraints, were fuelled by a sense of freedom, choice, enjoyment, achievement, and belonging. This idea was summed up by Deirdre in a manifesto for recovering a "*varied life*", elicited by a photo taken by Emilian during his walk around one of his favourite urban spots (Photo 34).

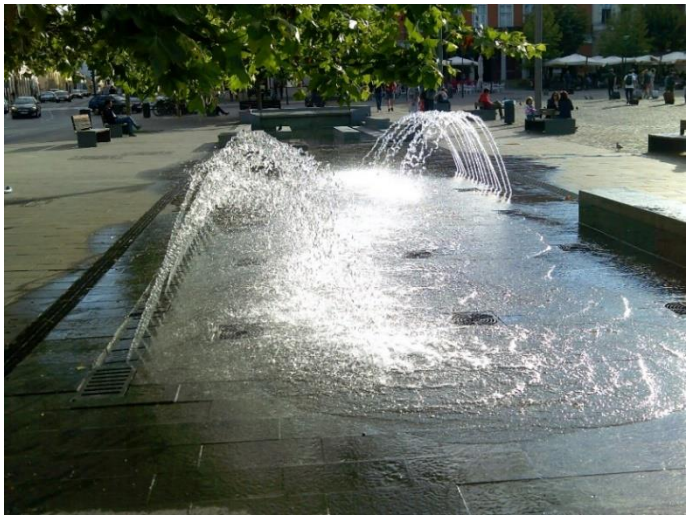

Photo 34 (Emilian, Workshop 3): *"There are so many possibilities to diversify our life through various stimuli! You can go to the theatre, walk in the park, go to the movies. There are many, many possibilities to enrich your life, to develop it."* (Deirdre, Workshop 3)

For example, reading or bibliotherapy was described as a coping mechanism by a number of participants (Deirdre, Raul, Mariana, Ioana, and Robert) who tried to escape a reality marked by mental distress through fantasy worlds and imagination. To reflect this, Deirdre chose a bookmark as a significant object for her recovery during a photographic exercise (Photo 35). On the same note, Robert captured an entire series of photographs of books (Photo 36), to illustrate reading as escapism, relaxation, and therapy, but also a tool that helped him improve

his vocabulary and, consequently, his empathy and communication skills, which he considered essential for his recovery.

Photo 35: *"*[Reading is] *a way to escape from the day-to-day world to the universe of books. You are immersed in another world when you read fiction* [...] *I don't think about my problems anymore."* (Deirdre, Workshop 1)

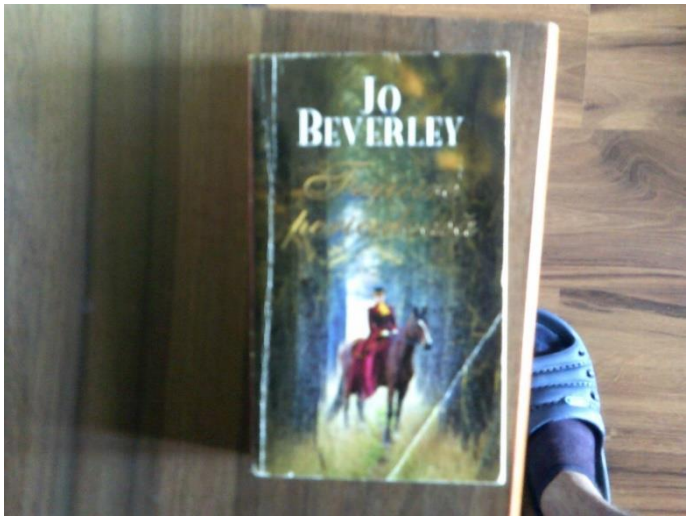

Photo 36: *"It* [reading] *means living together with the characters in a book* […] *It is also my passion for words… words that I remember and use to communicate with people."* (Robert, Interview)

At least as popular as reading, artistic activities usually taking place at the day centre guided the recovery of many participants through cathartic qualities (Photo 37, 38, & 39).

Photo 37 (Agnes, not selected): *"Drawing relaxes me. I go back home in a good mood."* (Mariana, Interview)

Photo 38: "*And then I was involved in music. That's what this picture is about. It was taken at the church, but it is more symbolic,* [representing] *the idea of exposure*." (Daniela, Interview)

Photo 39: *"My paintings represent me* […] *I paint, and I find this very relaxing."* (Rodion, Interview)

Through music and drama, occasionally performed in public, participants exposed themselves to new social challenges described as beneficial for their recovery and reintegration in the community.

Along with creative activities, sports, walking, or being active in general, contribute to building a healthy daily routine and setting recovery goals for some participants. Under the slogan "*mens sana in corpore sano*" (Latin for "healthy mind in healthy body"), Rodion enumerated an impressive array of sports (e.g. swimming, jogging, cycling, table tennis, and basketball) that support his recovery by helping him stay focused and excelling at things that he is good at. For the same reason, Emilian, Robert, and Mariana joined the service users to play basketball every Friday (Photo 40), describing sport as an opportunity to socialise.

Photo 40: "*I feel that we are a collective, we do something we like*."

(Emilian, Interview)

Similarly, Johhny and Cristi talked about riding the stationary bicycle in park every day (Photo 41), which helped them "*forget about the thoughts*", feelings of anger, and illness, emphasising sport as a distraction from the cognitive and emotional challenges caused by mental distress.

Photo 41 (Johnny, Workshop 2): *"It's about sport, being active* [...] *if you go out and exercise, you stop thinking about illness."*

(Cristi, Interview)

When asked to elaborate on the role of sports in recovery, Ioana constructed an analogy between body and mind, also used by Rodion to justify the reason behind his healthy life choices illustrated in a picture that he took while jogging in the park to "*oxygenate*" his brain (Photo 42).

"Being active is important for people because we are made of blood, flesh, bones, muscle that have to be used the same way the brain is."

(Ioana, Workshop 1)

Photo 42*: "If your body is deteriorating, then your brain is deteriorating too."* (Rodion, Interview)

In conclusion, a variety of activities supportive of recovery were illustrated in participants' photographs, which may be a reflection of their diverse coping strategies, choices, and perceptions of what is helpful for their mental health. This wide range of routines that enrich participants' daily existence contrasted with the lack of programs of activities in their psychiatric recovery plans, further elaborated on in *Chapter 6: Discussion*:

"You can't feel that there is any recovery program really. I mean there's not a lot going on [at the hospital]*."* (Ioana, Interview)

Rebuilding social networks

The social dimension of recovery was identified in the narratives of ten research participants who suggested that the process of recovery did not happen in isolation, but through (re)connection with their families, friends, peers, and the wider community:

"Recovery means to have a good relationship with others […] making contact easily with new people, getting along with your carers, husband, wife, children, parents." (Deirdre, Workshop 3)

Therefore, communication becomes essential to initiating and maintaining relationships:

"You heal through communication with others."

(Deirdre, Workshop 1)

To express this idea, Deirdre took a picture of birds that seem to be engaged in a conversation (Photo 11), including a crow that she chose to represent herself and emphasise her being different (mainly because of her mental health problems), but nonetheless willing to become easily tolerated by others. Therefore, her focus was on improving relationships despite the challenges associated with her mental distress (e.g. social withdrawal, loss, negative thinking, and emotional instability).

According to the same participant, social connections are "*remedy to loneliness"*, which helped prevent further deterioration of her mental health. Therefore, she set a recovery goal

"*to be more balanced mentally and keep afloat*", supported by her family and friends who became instrumental to her recovery journey. On the same note, feelings of unconditional love reciprocated by significant others, also nurtured Iaco's recovery:

> *"My kids don't accept that I am ill, but they love me. My kids, my wife, other people, they all love me. It's a big step forward this one, when you are loved."* (Iaco, Interview)

Further insight on recovery as a process of social reconstruction was added by Robert, who photographed a table and benches in a quiet corner of his favourite park (Photo 43) to symbolise the importance of communication for recovery, along with feelings of togetherness and belonging that contrasted with the social withdrawal that accompanied his mental distress.

Photo 43: *"To recover means to live adequately* […] *together with other people, belonging, communicating."* (Robert, Interview)

Robert's metaphor resembled Agnes's representation of communication in a group around the table (possible reference to the photography workshop and various members' attitude toward recovery), using carefully chosen leaves at different stages of decay – from green leaves that are "*full of life*" to withered ones that "*lack hope*" (Photo 44).

Photo 44: *"I tried to take a picture of more leaves together representing a group of people communicating with each other."*

(Agnes, Picture Selection)

The idea of belonginess was reiterated by Robert in his poem of recovery entitled "*Life at the day centre*", in which he candidly stated:

"People so dear, such a nice place [the day centre]

Wait for you warmly, such a quiet space.

All you want is to discover them,

To keep them in your memories, to cherish them."

(Robert, Interview)

Being more open and communicative was a recovery goal for Robert that motivated him to make new friendships at the day centre and realise how beneficial and empowering peer support was for his recovery and his retaking ownership of a life affected by distressful experiences, but also for developing assertiveness. Prompted by Photo 15, Robert stated:

> *"*[The name of a former service user] *was an important 'shoe' for me […] who taught me how to take steps in life, to make my choices, my decisions, when to say 'no' and when to say 'yes'."*
>
> (Robert, Workshop 3)

Participants' perception of families and their role in recovery varied from being supportive:

> *"My mum and my sister were there for me and told me 'don't be upset, it's going to be okay'."* (Loredana, Interview),

to being obstacles that need to be addressed:

> *"I hope to get better mentally. I mean not to have any more arguments…. less mean people in my family."* (Mariana, Interview)

In a similar situation, Cristi chose to symbolise his family in a picture depicting a bunch of roses (Photo 45), whose thorns may symbolise (although not specifically stated) disagreements with his family, perceived by this participant as controlling at times and conflicting with his own desires and social aspirations. Despite this, Cristi acknowledged the efforts of his family in the process of care and recovery predominantly from an instrumental perspective (family as a source of material support, but also safety).

Photo 45: "*My mum and my dad help me a lot… to take care of myself, to be careful where I am going, to make sure I don't come back home late*." (Cristi, Interview)

Such experiences were echoed by Emilian's relationship with his dad that, although not expressed visually, transpired from his narrative as being damaging to his mental health through toxic criticism and verbal abuse:

"My dad is telling me off… he curses me, swears at me, argues with me all the time […] *He criticises every single step I make and tells me 'that's not good enough'."* (Emilian, Interview)

Situated at the same end of the spectrum, Daniela portrayed her family as being unsupportive to recovery, again, not evoked by photographs, but nonetheless illustrative of the lack of parental love and attachment, with life-long consequences on her psychological health. Such insights put in perspective the extent of distress experienced by individuals amplified by their home environments:

"My parents were arguing every single day. And my dad used to drink… and we [Daniela and her sister] *were physically abused* […] *It wasn't a safe space at all… no love and affection, which I needed so much."* (Daniela, Interview)

Conversely, Robert chose to represent his family and their helpfulness and patience during his recovery in a picture of a chessboard on which he identified himself with a white pawn strategically placed and defended by other pieces symbolising his family members (Photo 46). Robert concluded this metaphorical incursion into his family by associating the chessboard with the "*comfortable living conditions*" in his flat and his home environment as a "*source of friendship and communication".*

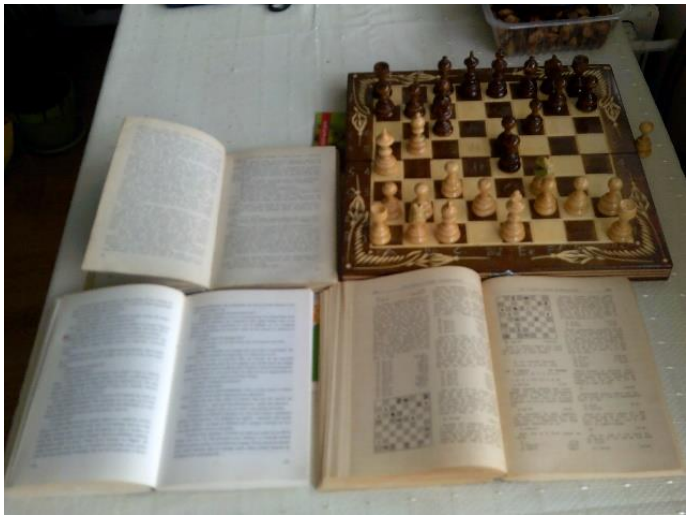

Photo 46: "*I'm all defended… No one can capture me* [laughs][…] *My brothers* [points to the bishops on the chessboard] *C3… my mum and my dad – the queen and the king* [laughs]". (Robert, Interview)

In summary, families contributed to the life reconstruction of some participants by nourishing them affectively with "*love, attention, understanding*" (Mihai, Workshop 4), while for others

families played a more instrumental role in relation to basic care, administering the psychiatric treatment, and accompanying them to doctors' appointments. In contrast, some families themselves seem to be in need for reconstruction in order to provide an appropriate emotional foundation and safe environment for rebuilding the lives of their loved ones.

Cultivating hope

Hope is the essential ingredient to reconstructing a life impacted by the loss of health, jobs, and relationships, identified in the accounts of twelve of participants. A dimension interlinked with other themes such as awakening (emerging hope) or healing (hope for "getting better"), hope in relation to recovery was more prominent during the final workshop, when participants talked passionately about their plans and aspirations for the future. Building on Daniela's metaphor of walls as protection, hope appears to be the mortar that holds together the bricks for the foundation of a renewed life "cracked" occasionally by the devastating effects of the illness.

Sources of hope are multiple, mirroring what participants considered important for their recovery. For instance, Loredana was spiritually charged with hope through a strong relationship with God, discussed in relation to spiritual healing, also present in Emilian's narrative:

"God gives me courage and charges me with hope."

(Loredana, Interview)

Asked to elaborate further, Loredana talked about hope to maintain her current level of health that allows her to perform daily tasks apparently banal, but nonetheless meaningful to her:

"I hope it's going to be as good as it is now. So I can cook, go shopping, do the cleaning." (Loredana, Interview)

For Ioana, hope was associated with the life at the day centre, a milestone to her and other participants' recovery. Also suggested by the light that happened to fall on the logo of the day centre (Photo 3), Ioana hoped that this place would continue to run activities for many years despite having been scaled down recently because of financial issues:

"I can see the light… it means good news in the sense that the day centre will continue to exist." (Ioana, Workshop 4)

On the same note, Mariana's recovery message aimed to instil hope in other service users at the day centre, indicating once more how important peer support was for her stability and mental health:

"I am happy being here [at the day centre] *with you all. And I hope it'll stay like this forever."* (Mariana, Interview)

For a number of participants (Cristi, Emilian, Mihai, Johnny), hope seemed to be associated with improving their mental health understood as reduced voices, improved sleep and mood, and better anger management. Emilian, for example, hoped that he did not always have to rely on psychiatric medication, perceived as an indicator of persisting illness:

"I wrote a note on the fridge… not to rely on medication one day." (Emilian, Interview)

More uncommonly, in Rodion's case, hope was inspired by his psychiatrist, both on a personal and professional level (regaining his ability to work), also revealing hopes for a psychiatric system dominated by an overall negative perception of recovery, as described by the research participants:

"My psychiatrist told me that it [mental health] *can be recovered and that I could work if I'm feeling up to it."* (Rodion, Workshop 1)

Hopes for recovery were also related to personal development translated in Robert's account in social openness and communication, and continuous amelioration of mental health, reiterating that medical treatments only cannot entirely address recovery:

"I wish my illness ameliorates even further, so I can feel better, healthier, in the future." (Robert, Workshop 4)

Robert represented this idea visually in a picture of blooming orchids (Photo 47), which is self-explanatory for his openness and flourishing personhood.

Photo 47: "*I am feeling better, I mean more open, communicative*."

(Robert, Workshop 4)

Probably uncoincidentally, despite his predilection for outdoor pictures, Robert chose a plant that requires special care and is normally cultivated at home, an environment that he described as crucial for his recovery.

Echoing Robert, Deirdre's hopes for recovery are linked to her supportive family and coexist with anxieties triggered by the uncertainty of a future when her parents would eventually leave this world, a concern also shared by Loredana:

"I am thinking about myself, what's going to be when my parents won't be here anymore… that I have to manage it all by myself […]*"*

(Deirdre, Workshop 3)

But even Deirdre, a rather pessimistic member of the group with regard to recovery, reflected on hopes for the future while talking about her picture of a river flowing like life, as she interpreted it (Photo 22):

"And life continues to flow like a river. It carries on, regardless whether we drown or not [...] *Well, I said that the final point is death* [laughs]*. But we can also say that it flows to better things in the future: better state of mind, better self-esteem… I mean hope dies last!"* (Deirdre, Workshop 3)

Hopes are also harboured by nature, as expressed in Agnes's picture of the silver lining skies (Photo 48). As with Daniela's photograph of a dark corner pierced by light on the bus (Photo 29), hope is seen by Agnes as a transition to a better place in life. It is not a passive process,

but one that requires perseverance and will-power while processing past traumas that triggered mental health problems.

Photo 48: *"You have to try to have a good future. You have to fight a little."* (Agnes, Workshop 2)

For other participants, future was materialised in pragmatic plans that they hoped to achieve. For instance, Daniela's aspirations were related to her passion for music portrayed as therapy, but also a potential career as a stage performer, which would be her ultimate challenge in terms of battling with her social anxiety:

> *"Well, I have some plans with my music… When she* [the music teacher] *saw what level I am at, she said that she'd like us to perform together on stage in the future."* (Daniela, Interview)

Daniela, whose optimism and enthusiasm during the interview were highly contagious, was building on her recent small therapeutic and professional successes and worked hard toward her "*dream job*" as a nurse in the Emergency Department at a local hospital. Furthermore, she

hoped to build a family and buy a house together with her partner, which seemed to have restored her motivation for life and made her more responsible (Photo 49).

Hope (or lack of) was omnipresent in participants' stories of recovery, elicited or not by their visual contributions, overtly or more subtly, but certainly nuanced, in line with their recovery trajectories. In other words, as with other themes, hope seems to hold different meanings for different service users who related to this concept on a more abstract level (hope as an idea), emotional (hope as a source of positive feelings), or practical (hope as concrete plans for the future).

Photo 49*: "I have a relationship now and I keep thinking about future* […] *If things get serious, I'd like to contribute financially* [by] *finding a job in a state hospital so he* [partner] *doesn't have to cover all the expenses* [laughs]*."* (Daniela, Interview)

5.3. Conclusion

Although the key themes and subthemes of recovery were presented in this chapter in separate sections, they were enhanced analytically by drawing on complex links illustrated in Appendix 35, as suggested by Smith et al. (2009). The iterative process of theme development and exploration of both breadth and depth resulting from the double hermeneutic led to a constellation of meanings of recovery indicating a highly complex phenomenon intersected with various areas of life (personal, professional, social, cultural, and political). Hence, the challenges experienced by the researcher at the initial data analysis stages best described by a "messiness" of data (Appendix 23) tangled in multiple descriptions and interpretations of recovery. However, guided by participants' explanations and insightful photographs, while striving for deep levels of analytical thinking, recovery themes were identified acknowledging that the thematic structure advanced here is only one of the multiple lenses through which the dataset could be explored.

Chapter 6. Discussion

In line with the IPA background and the aim of the thesis, this chapter provides an additional layer of interpretation to the research participants' meanings of recovery encompassed in the three key themes – awakening, healing, and reconstructing life. Following the principle of double hermeneutics, the findings are revisited by the researcher to deepen the understanding on how participants made sense of their experiences of recovery and how this understanding may have shaped their behaviours and perception of recovery. The findings are discussed in a wider research context with reference to the recovery framework that guided this thesis and published literature on this topic. The role of photography in this process is also discussed in terms of both benefits and limitations identified throughout the study. Particular attention is given to potential social, cultural, and political influences on participants' conceptualisation of recovery, as stated in the research objectives.

Common to all the themes identified in this study is a spectral distribution of meanings within the same category representing participants' various and sometimes conflicting views (e.g. medical treatments or social relationships as main ingredients to recovery, but also barriers). This variety of meanings identified through IPA applied to both group and individual levels often created analytical tensions when the researcher attempted to interpret them, but nonetheless contributed to deepening the understanding of the researched phenomenon.

6.1. Awakening

More than half of the research participants narrated experiences of recovery as a gradual process of overcoming a state of physical, but also emotional, volitional, and cognitive lethargy induced by psychiatric treatments – the first and the only route of treatment for most of them, which may reflect the medicalisation of the mental health care system in Romania. Participants' responsiveness to treatment, usually translated into a reduction of symptoms after experimenting (or being experimented on) various types of medication, contrasted with their unresponsiveness to life and aspects meaningful to them e.g. education, occupations, and relationships. As reinforced by some participants, this idea raises some questions around the limitations of medication in addressing recovery in all its complexity. Moreover, the sedative effects of psychiatric medications profoundly affected some participants' identity and perception of their social roles through a lens of inactivity and idleness. Loredana, for example, contemplated her status as "unproductive" or dormant member of her community that fuelled people's comments and gossip, which could be interpreted as a precipitator of her paranoia, for which she was, ironically, treated with psychiatric medication. However, Loredana, like other participants, gradually broke this vicious cycle by developing a sense of awareness of her experiences of distress as human and existential rather than purely medical, linked to a troubled life history (child neglect, abuse and trauma, divorce, and job loss). However, Loredana, like other participants, used a predominantly medicalised language of distress (e.g. mental "illness" or "disease", Rom. "boală") possibly inherited from interactions with psychiatrists, but also from the media. Nonetheless, participants have shown a degree of detachment from a psychiatric perspective focused on problems (e.g. diagnosis, illness, disorder, deficiency, and dysfunctionality) by finding their own solutions based on strengths,

skills, and life aspirations that did not seem to be sufficiently acknowledged, in their opinion, by a psychiatric system whose authority is timidly questioned by some participants. Such ambivalent attitudes toward psychiatry may suggest why the process of recovery as awakening of thoughts, feelings, and awareness of self, others, and the world, appears to take place at the day centre where the staff implemented a more humanistic and holistic care approach with regards to service users' complex needs. Although the gatekeeper at the day centre admitted that they did not subscribe to any particular recovery framework, their philosophy and practice that emphasise service users' personal abilities resembled Rapp and Goscha's (2012) Strengths Model discussed in *Chapter 2*, despite strong links between the day centre and the local psychiatric services.

Although hospitalisation was a taboo subject possibly because of the negative memories and emotions associated with this experience, it transpired from participants' accounts that they often underwent treatments administered compulsorily and involuntarily, which affected their trust in the benefits of psychiatric care and diminished their hopes to be "cured". This aspect may be linked to debates on sedation as "chemical straightjacket" (Mossman, 2002, p. 1033), but also to issues of power and freedom indicated by participants' experiences in relation to psychiatric treatments, which continue to remain controversial in mental health care (Bassman, 2005). This line of thought may explain why medical recovery was not prominent in the narrative of some research participants or touched upon only subtly. Rodion, for example, indirectly reflected on this dimension elicited by a photograph of a metallic fence echoing the idea of confinement (Photo 14) and raised the rhetorical question on which side of the "fence" he situated himself – interpreted by the researcher as service users fluctuating between being administered psychiatric medication aimed at normalising

pathological behaviours, and accepting psychiatric medication as a way to free themselves from distressful experiences in the absence of other therapeutic means (e.g. psychotherapy).

The particularities of recovery as a process of awakening consciousness were identified by the researcher through an analysis of the socio-cultural and political context of Romania. One aspect evident in participants' accounts was their awareness of the deeply flawed traditional ways of delivering mental health care, which made them seek help from faith healers or rely on traditional plant-based treatments. Although some of them were aware of psychotherapy as a possible treatment route, this was not affordable for most of them due to it being delivered privately. This provided valuable insight into the harsh socio-economic realities in this country (e.g. poverty) (Photo 50), conducive to feelings of distress, hopelessness, and resignation, pathologised by the psychiatric system and treated pharmacologically.

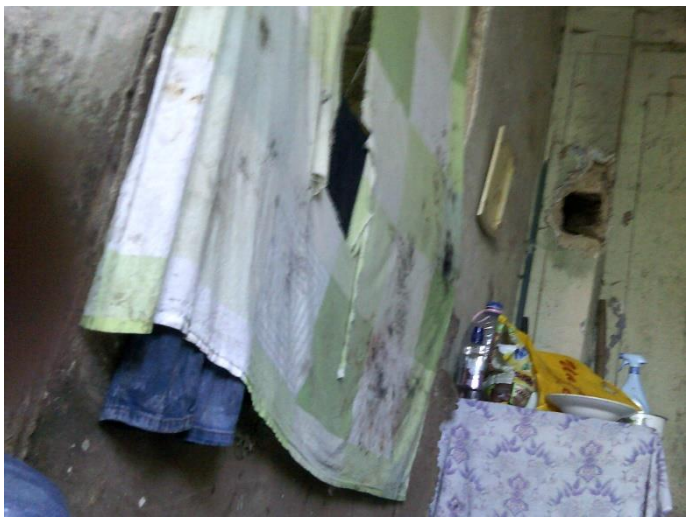

Photo 50: Degrading living conditions depicted by one of the research participants (Mariana, not selected)

Some participants critically reflected on the psychiatric practices during and after the communist regime, with deep reflections on the first generation of antipsychotic medication

and degrading experiences of hospitalisation including ECT, along with stigma and disempowerment (e.g. difficulties with accessing employment once diagnosed with severe mental illness). The interpretation of recovery in a wider societal, political, and historical context revealed this phenomenon as a process of restoration of mental health service users' voice muted by oppression and inhumane psychiatric practices during communism, as described by some research participants. In Iaco's narrative, for example, the psychiatric and political oppression merge in a disturbing experience of persecution by the "Securitate" (i.e. secret police in communist Romania). This led to him being involuntarily hospitalised and diagnosed with paranoid schizophrenia and subjected to ECT treatments aimed at "erasing" from memory his "non-conformist" ideals of freedom – a concept that appears central to his understanding of recovery. Such narratives gave this study a historical flavour specific to Eastern-European countries (Breemer ter Stege, 1991, Krupchanka & Winkler, 2016, Roberts, 2002), although the process may be also reminiscent of the psychiatric survivors' movement in the 1980s during which service users' stories of psychiatric oppression, but also hope, emerged (Campbell & Schraiber, 1989, Sartorius, 1983). At the time, Romania was still under the influence of communism that promoted psychiatric care delivered in large-scale hospitals resembling Goffman's (1961) "total institutions", some of them still functional in Romania. In such a dramatic historical context followed by post-communist social and political unrest, it is not surprising that service users' movement in Romania is underdeveloped (Knapp, McDaid, Mossialos, & Thornicroft, 2007) and relies almost exclusively on the alliance between non-governmental organisations and those living with mental health problems (Hayward & Cutler, 2007). Romanian service users' limited empowerment and social action at community level may explain why, unlike the recovery models developed in English-speaking countries in which empowerment is a pillar of recovery (Leamy et al., 2011, Whitley & Drake, 2010), this

dimension was not particularly prominent in participants' narratives. As an exception, Deirdre suggested that service users could potentially form an army of "*foot soldiers*" marching on the streets and making "*noise*" (i.e. protest), with potential reference to their voice insufficiently heard in society. Although vague, Deirdre's message may be interpreted as an expression of freedom of will, speech, and opinion, claimed to be met with ignorance in people with psychosis (Meynen, 2010, Stenlund, 2017).

On a personal level, central to participants' experience of recovery as awakening was their transition from an "ill" self to a consciousness shaped by existential and spiritual values and beliefs that lie beyond the constraints of mental "illness". This finding was facilitated by the phenomenological approach to this thesis and the visual methodology which allowed those involved to access memories and lived experiences to which they attached meanings and symbols. The researcher's understanding of participants' journey from ill- to well-being was illuminated by their explanations of distress, not necessarily in terms of diagnoses (which some participants could not even remember), but in relation to traumatic life events arising from their narratives, which revealed recovery as a profound human experience interweaved with their personhood. For example, Deirdre was not the same person since she had lost her relationship that left her with emotional scars; Raul and Rodion had to readjust their lives after losing their jobs which defined their status as productive members of society; Robert became a different person i.e. more withdrawn, after giving up his geography degree that provided him with meaning and hopes for a career. As a result, their social roles diminished, which appears to have reinforced their negative perception of self, hence their understanding of recovery as a restoration of what was lost to illness. Some participants went through a process of reassessment of what was left after the havoc caused by their mental distress and

experienced an awakening of hope in light of various possibilities to fulfil their life. Interpreted through a recovery framework perspective (Ralph & Corrigan, 2005), this process consists of a gradual development of self from the stage of anguish or desperation caused by mental distress that dominated their identity, to insight or understanding that change was possible through enhanced creativity and spirituality, developing new interests, and (re)building support networks. This process is referred to in the recovery literature as "identity restoration" (SAMHSA, 2006) or "re-establishment" (Andresen et al., 2003), while Leamy et al. (2011) advance the idea of recovery as "redefining a positive sense of identity" (p. 448). However, dichotomies such as "positive"/"negative" identities are avoided here because of the risk of reinforcing labelling, stigma, a negative perception of self, and a sense of inadequacy or incompetency – a lesson learned by the researcher throughout this study from inadvertently using categories such as "recovered"/"not recovered", "healed"/"not healed", understood subjectively by the research participants, as illustrated in the next section.

6.2. Healing

Healing, one of the most frequent meanings attributed by participants to their experience of recovery, is traditionally viewed as "cure", as posited by the medical model of mental health that considers mental "illness" treatable like any other physical disease (Kiesler, 1999). This perspective, still embraced by some Romanian authors (Kelemen, 2017) and, potentially, practitioners, was also the initial understanding gained by the researcher after an analysis of the language used by participants (e.g. "disorder", "illness", "symptoms", etc.). However, following critical discussions elicited by participant-generated photography, the researcher and the researched reached a more nuanced understanding of recovery as psychological and spiritual healing, at least as relevant as clinical recovery.

Medical healing

Most of the participants in this study acknowledged the benefits of medical treatments mainly in terms of reduction of symptoms and frequency of hospital admissions, not without debates around the side-effects of psychiatric medication. Participants' understanding of medical healing appears to be influenced by their encounters with psychiatrists, whose expertise and authority to declare patients "in remission" or "relapsed" was rarely overtly questioned by the research participants throughout the project. However, based on the researcher's observations, there is a possibility that participants' disclosure of medication was slightly biased toward positives because of the presence of their social worker during the project activities (whose responsibility was partly to monitor service users' compliance with psychiatric treatments and liaise with their psychiatrist). Moreover, according to the day centre's criteria, service users were considered "in recovery" only if they responded well to the prescribed medication and showed reduced (or no) symptomatology. Nonetheless, the researcher noted that most of the participants portrayed the medical dimension as co-existing with other forms of recovery (i.e. psychological, vocational, social, and spiritual). This finding is in line with research suggesting that pharmacological approaches only partly address the complex needs of mental health service users (Piat, Sabetti, & Bloom, 2009, Shooter, 2003), also reflected in Whitley and Drake's (2010) multi-dimensional model of recovery. In contrast with participants' nuanced understanding, their recovery plans signed off by their psychiatrists emphasised the medical dimension without accounting for social and psychological needs. This may explain why participants followed almost identical lines of treatment consisting of anti-psychotic medication, despite them holding unique and subjective perceptions of distress and treatment. Emilian, for example, associated medication

with a reminder that he was still not recovered; Robert took his medication regularly, but was convinced that "*the illness remains*" because his "*soul*" is still "*wounded*"; Raul responded well to the psychiatric treatment, but still did not have a job, therefore did not consider himself fully recovered. Understanding such perceptions may be key to explaining a wide range of outcomes and behaviours related to psychiatric medication, including reducing or even discontinuing medication without seeking medical advice, relying on the expertise of peers who better understand feelings and sensations compared to psychiatrists, use of substances to self-medicate, seeking advice from a faith leader before, or instead of, accessing specialist support.

The importance of medical treatments is not shared by the recovery framework that guided this thesis, except for Whitley and Drake's (2010) model of recovery which considers the clinical dimension in understanding recovery. Moreover, the recovery framework is claimed to reinforce a dichotomy between personal and clinical recovery (Slade, 2009). However, participants' personal accounts of recovery in this study cannot be divorced from their positive or negative personal experiences of medication that are inextricably linked to subjective identities, values, beliefs, and behaviours. This interpretation may help with tailoring psychiatric treatments and lead to more comprehensive recovery plans instead of one-size-treatments that may not fit all (Hawley & Feetam, 2010), especially when culture is involved (Huang & Zane, 2016, Jimenez, Bartels, Cardenas, Dhaliwal, & Alegria, 2012).

Psychological healing

The research participants shared verbal and visual accounts charged with intense feelings and deep thoughts throughout the project, despite the emotional expression being generally viewed as diminished in people with psychosis (Birchwood, 2003, Gumley, Gillham, Taylor, & Schwannauer, 2013). Interestingly, the emotional dimension of participants' distress was increasingly evident toward the end of the project, in contrast with participants' medical perspective on mental "illness" during the first photography workshop. It may be claimed that creating a safe space for disclosure and trust building may have contributed to this outcome. However, the role of photography as a facilitator of emotional expression cannot be ignored, therefore is discussed separately later in this chapter.

The researcher and research participants were gradually illuminated throughout the project that recovery was not necessarily the restoration of previous levels of functioning (more or less achievable); instead, recovery consisted of restoring positive thoughts and feelings to counteract experiences of distress generally understood by participants as a cumulation of negative emotions and cognitions most frequently caused by traumatic life events, expressed metaphorically in their photographs (Appendix 30). For Daniela, psychotherapy represented the catalyst for positive thinking, which she described as crucial in addressing her depression, suicidal ideation, and anxieties by changing her frame of mind and becoming more engaged socially, professionally, and educationally. However, psychotherapy was a rather uncommon route of treatment for the research participants possibly because it was not available at the day centre for a number of years. However, some participants (Raul) were convinced that specialist psychological interventions would have made a difference to their recovery journey, if timely accessed. The researcher noted that the term "psychotherapy" was used

interchangeably with “psychiatry” by some participants, which may indicate their limited understanding of various treatment routes and possibly blurry boundaries between psychological and psychiatric services. The underdevelopment of psychotherapeutic services in Romania can be explained by the interdiction of social work and psychological education during communism (1947-1989), with the Romanian College of Psychologists being officially founded relatively late in 2004 (Dima & Bucuță, 2012). Limitations in this area may account for service users in Romania relying exclusively on medical treatments, despite psychotherapy being widely recognised internationally as essential for supporting recovery in people with mental health problems (Lysaker & Roe, 2012). This may pose some challenges in terms of achieving a recovery-oriented approach to mental health care in Romania (Friedman, 2016), as promoted by the current legislative framework in this country (Ministerul Sănătății, 2016).

Unable to address distressing thoughts and feelings (e.g. inferiority, incapacity, worthlessness, unresolved past trauma), it was not surprising that some of the participants didn’t see themselves fully recovered, despite progress with symptom management and compliance with psychiatric treatments. This illuminated some of the pessimistic attitudes toward recovery expressed by participants like Deirdre, leading to increased hopelessness and a vicious circle of negative thinking which, consequently, caused additional mental distress. However, participants recognised, supported by their photographs, the importance of thoughts and emotions in recovery as a non-linear passage from “*dark thoughts*” to positive thinking, from “*sadness*” to happiness, and from “*anger*” and “*anxiety*” to a state of “*calm*”. This processual nature of recovery as psychological restoration, as opposed to reparative pharmacological interventions, is emphasised by models of recovery (Barker & Buchanan-Barker, 2005), that are critical towards the paternalism of psychiatric systems. However,

participants' medicalised language of mental distress (e.g. "illness" or "disease"; Rom. "boală") appears to be visibly influenced by psychiatry, which may be an expression of the psychiatric profession continuing to somatise psychological experiences, therefore blurring the boundaries between psychological distress and physical illness (Kinderman, 2014).

Lacking a local culture and language of psychotherapy, Deirdre and other participants occasionally used English terms to explain psychological processes they encountered in self-help books or on the Internet e.g. "*cognitive-behavioural therapy*", "*self-therapy*", "*life skills*", "*live and let live*". Additionally, participants constructed their own language of recovery aided by photographs (Appendix 29) and metaphors (e.g. healing the "*wounds of the soul*" – Robert, calming a "*tormented psyche*" or "*something crying inside me*" – Iaco, and mending a "*fractured personality*" – Deirdre). Such personal insights reflecting a wide range of unique and profound experiences of distress were essential for understanding and capturing recovery as a personal experience filtered through deep feeling and thoughts.

Spiritual healing

Spiritual awareness was highlighted in the recovery narratives and participant-generated pictures in relation to hope for the future, sense of purpose, and meaning in life. Within this study's context, spirituality is synonym with the beliefs and religious practices of Christianity. Although less frequently mentioned compared to medical and psychological experiences, spirituality was nonetheless the cornerstone of recovery for half of the participants. This finding was somehow unsurprising considering that religion plays an important role in the Romanian society, which is predominantly Christian Orthodox (90%), with 15% of the population considering "God's will" the main cause of mental illness (Stănculescu et al., 2008).

Nonetheless, participants' religious experiences varying from existential (God as meaning in life), to functional (practicing religion as indicator of recovery), social (belonging to a religious community) and ritualistic (going to church regularly, praying), were rather illuminating and added a cultural understanding of recovery experienced by the research participants in relation to their belief systems. Subsumed by some of the current recovery models to the wider concept of meaning in life (Leamy et al., 2011) or existential recovery (Whitley & Drake, 2010), spirituality appears to stand out in this study as a separate theme of recovery. From this perspective, the findings align with cultural studies conducted worldwide that emphasise spirituality as key to mental health recovery (Eltaiba & Harries, 2015, Ho et al., 2016, Islam, Rabiee, & Singh, 2015).

Recovery appears in participants' narratives and visuals as a spiritual revival that occasionally influenced their help-seeking behaviours. For example, Loredana contacted her priest for advice when she first experienced mental health problems. Although this was an isolated account (highlighted through IPA techniques focused on participants' idiosyncratic experiences), it showed to what extent spirituality has the potential to guide individuals on their road to recovery through beliefs and practices. This aspect was also highlighted in a national survey in Romania (Stănculescu et al., 2008) indicating that 60-70% of the population would recommend the priest/church to address mental health problems. Recovery as a religious experience may be interpreted here as conducive to passive behaviours in the sense of participants relying on divine forces to "heal" or "save" them from an illness for which they could not find a "cure" within the psychiatric system. This aspect may partly contribute to service users lacking social action and empowerment, along with a sense of fatalism perceived by the researcher from participants' narratives of mental illness talking of the "cross" that

people have to bear throughout their lives, with reference to Christ's Calvary. Hence, the idea of tacitly accepting rather than addressing mental suffering. Through a religious lens, participants' recovery appears almost hyperbolised to an existential experience that transcended their immediate lifeworld, taking cosmic proportions and linking to external benevolent (or punitive) forces whose magnitude exceeds any psychiatric knowledge and treatments. The idea of Christianity in relation to recovery in Romanian mental health users also brought a moral dimension to this phenomenon translated in people becoming "good" again in thinking and behaviours affected by illness, as an expression of normalising life. On this note, conflicts were noted between participants' will to be "good" and unusual, incontrollable, and unacceptable behaviours (e.g. Emilian standing in one leg during the religious service stating that "*voices made me do that*"), that projected their experiences of distress under the influence of "evil" forces, occasionally subjected to exorcism by Orthodox priests in Romania (see Tanacu case in Capelle-Pogăcean, 2020).

6.3. Reconstructing life

In light of participants' narratives in this study, recovery did not refer only to *being* and *feeling*, but also *doing*, as revealed by various and meaningful occupations that spoke volumes about participants reconstructing (or attempting to reconstruct) their life despite some of them still experiencing mental distress. For instance, Rodion was focused on his passion for painting that brought him an additional income (Photo 39); Deirdre diversified her life through reading fiction and self-help books (Photo 35); Robert was dedicated to developing his vocabulary and communication skills that facilitated openness, an important dimension of his recovery (Photo 45). Life reconstruction seems possible to them and other participants due to their

increasing acceptance of, and adaptability to, a life shaped by mental distress. From a recovery framework perspective (Ralph & Corrigan, 2005), participants whose understanding revolved around being socially and occupationally active, can be placed at the stage of taking action and making a determined commitment to achieve both internal recovery (emotional, physical, and spiritual), but also external (engagement with activities, social relationships, and support). Whitley and Drake (2010) describe this stage as "functional recovery" in which employment, education, and housing are complementary areas to clinical, existential, and physical recovery.

As highlighted in the literature reviewed in *Chapter 3*, Participants' photographs were a veritable glimpse into their lifeworld and a diary of daily routines (e.g. cooking, exercising, watching TV), apparently menial, but nonetheless meaningful to them. Regaining employment, a goal perceived as unrealistic by most of the participants due to the severity of their mental health problems, stood out as their most relevant criterion for recovery (summed up in the researcher's reflection diary as "*I work, therefore I recovered*"). However, employment was also one of the most critically discussed areas of recovery during the photography workshops due to some participants experiencing distress and even trauma as a result of being in employment, which generated tensions leading to a better understanding for both the researcher and participants.

One potential interpretation of recovery as employment was found in the historical background of Romania, a country with no (declared) unemployment and an exacerbated cult for working classes during the communism era (Chirot, 1978), in which work was ideologically the ultimate expression of people's power (Maftei, 2014). This idea was prominent especially in the narratives of older participants for whom being occupationally inactive added to their

mental health stigma reinforced by derogatory terminologies used by policymakers (e.g. “handicap” or “invalidity” pensions; Rom. “pensie de handicap/invaliditate”, to which service users were referred once diagnosed with severe mental health problems). Alternative interpretations were provided by the socio-economic context of the study with statistics showing one of the lowest unemployment rates in the country for the region where the study was conducted (Ministerul Muncii, 2019). However, it is estimated that the rate of unemployment among mental health service users in Romania is three times higher than the rate of unemployment at national level (Micluția, Junjan, & Popescu, 2004). Corroborated with the bio-medical model of the psychiatric services focused on restoring individuals’ functional levels, work was identified as an important indicator ingrained in the mentality of the research participants, along with their need for a stable income. Finally, finding employment abroad, which became the aspiration of many Romanians (including Emilian and Ioana) after the Revolution in 1989, may be further linked to restoring some participants’ personal and professional lives that have not been fulfilled in their home country due to the challenging economic and political climate (Sandu, 2005). Migration was associated by Emilian and Ioana with high levels of distress caused by acculturation, social isolation, and traumatic experiences, including political persecution by the communist regime in Iaco’s case. Such findings add to the existing research on migration and mental health conducted in Romania (Botezat & Pfeiffer, 2014, Micluția, Junjan, Popescu, & Țigan, 2007) and elsewhere (Bhugra, 2004, González-Castro & Ubillos, 2011). Therefore, for some participants recovery consisted of readjusting to the harsh realities of their home country to which they returned disillusioned and mentally unwell, while mending the broken dreams of living a better life abroad. This aspect is relevant for the socio-political climate of recovery in Romania, a country with 3.4 million people (almost 20% of the population) migrating between 2005-2017, placing

the country on the second place in the world, after Syria, by emigration growth rate (UN, 2016).

At least as important as employment, engaging with creative activities (e.g. writing, painting, drawing, music), were highlighted by participants as conducive to their recovery through various cathartic properties. For some of them, art represented a source of positive experiences (e.g. enjoyment, having fun), but also the opportunity to express feelings of distress, therefore a potential impromptu substitute for lacking psychotherapeutic services. For others, arts were a form of escapism and distraction from challenging thoughts and emotions caused by distress, but also an opportunity to socialise with people sharing similar interests and experiences of distress, leading to peer support. Such findings align with arts-based research showing positive outcomes for people with mental health problems such as increased self-confidence, self-esteem, and communication skills (Lloyd, Wong, & Petchkovsky, 2007, Sapouna & Pamer, 2014, Stickley, Wright, & Slade, 2018).

Regardless of their nature (creative, sportive, and recreational), most of the activities described by participants took place at the day centre. This was a source of reflection for the researcher on both the importance of this establishment for participants' recovery, but also service users' dependency on this resource and the risk of being re-institutionalised. The latter was suggested by the long history of accessing services at the day centre by some participants (more than 20 years), whose commitment to activities organised there appears to contrast dramatically with their limited engagement at family and community level. This may be problematic in the context of community work potentially playing a crucial role in supporting the recovery processes (Rapp & Goscha, 2012). Furthermore, it may explain why empowerment, understood here in terms of people's choice and control with impact on their

lives and communities (WHO, 2010), was not particularly pronounced in this study, albeit omnipresent in recovery frameworks (Leamy et al., 2011) and research reviewed in *Chapter 3*. This reflection can be further linked to the socio-political context of oppression in Romania, in which people with mental health problems previously consigned to psychiatric asylums ("internat") continue to be misunderstood, stigmatised, and discriminated by the general public (Micluția et al., 2004). Such negative aspects with impact on their freedom of choice were also noted in relation to their families that were occasionally portrayed by participants as infantilising and controlling (or over-protective). In some cases (e.g. Cristi, Johnny), families appear to be appendices to a psychiatric system concerned with monitoring participants' medical treatments and closely observing any unusual and abnormal behaviours that they promptly report during psychiatric appointments (in which they speak on behalf of their loved ones, potentially disempowering them further).

Nonetheless, social networks (family, friends, and peers) was an area of life considered pivotal to recovery by most of the participants, in line with the existing recovery models (Leamy et al., 2011, Whitley & Drake, 2010). However, this aspect presented some particularities in this study conducted in Romania, a country with a family-oriented culture in which the researcher initially assumed that the nuclear and extended family would play an instrumental role to the mental health care of their members. This view was contradicted by half of the research participants who placed the family among the main sources of distress in the form of psychological, verbal, and physical abuse, trauma, conflictual relationships, and controlling environments inducing a sense of persecution in some cases. Restoring broken families or at least finding a psychological resolution for past and present family issues was therefore attributed by participants to recovery, which became a process that encompassed not only

their personhood, but also their relationship with families and the wider community, in line with findings highlighted in the literature review (Tran Smith et al., 2015).

In conclusion, although family relationships were motivational and resourceful outlets for the recovery of a number of participants through emotional and practical support, they could also hinder the recovery journey by aggravating mental distress in individuals, also pointed out by Tew, Ramon, Slade, Bird, Melton, and Le Boutillier (2011). The concept of friends and peers at the day centre (called "colleagues" by participants, possibly reminiscing of more professional relationships or just reinforcing a sense of camaraderie), merged in most of their accounts, portraying the service also central to their social life. This may explain some of their anxieties that the day centre may be further scaled down or even closed in the future. Although peer support was explicitly mentioned only sporadically by participants, it was nonetheless clear from their interactions (observed by the researcher during and in between activities) that there was a strong bond between them illustrated by "collaborative" photographs (Photo 54).

Another aspect learned by the researcher from participants' verbal and visual accounts was that reconstruction of life cannot take place without nurturing hope – from hopes to achieve on a personal or professional level, to being able to leave the past behind and enjoying better health in the future, both physically and emotionally. Sources of hope for participants are as multiple as their places of recovery (Appendices 32.1 & 32.2): the day centre, a major point of reference for their recovery where they are accepted and united through a sense of belonging; nature metaphorically conveying growth, revival, and regeneration; supportive social relationships and home environments; psychiatrists or other mental health professionals who are compassionate and understanding of mental suffering; or even the

television, where some participants found out that recovery was possible. Dimensions of hope were evident even in research participants who were initially pessimistic about their ability to recover, possibly influenced by their negative experience of mental health care in psychiatric hospitals. The variety of their perspectives explored from case to case through IPA, emphasised the need for individualised approaches to recovery plans that should include hope as understood by individuals rather than reinforcing a generic sense of optimism promoted by recovery models (Leamy et al., 2011) that may not be representative for all mental health service users.

The themes of recovery identified in this study – awakening, healing, and reconstructing life – may suggest various stages of recovery. However, this thesis did not advance a theoretical model of recovery, despite the researcher noting that participants were situated at different levels of recovery at the time of conducting this study, according to their understanding of the concept. The emphasis here is on how participants conceptualised this experience, which was not necessarily in stages, but portrayed as a stream of life that flows non-linearly from being well to illness, and potentially vice versa.

6.4. Lessons learned from using a photography-based methodology

The identification and interpretation of recovery themes in this thesis was supported by embedding participant-generated photography within a phenomenological design. Participants' visual accounts of recovery facilitated not only their expression of feelings and thoughts on this topic, but also researcher's in-depth understanding of the meanings attributed by participants to their experiences, sometimes difficult to verbalise (judging from the numerous pauses and hesitations noted during transcriptions). Photographs represented

a common ground between participants (and the researcher) from the start of the project, generating critical reflection and construction of meanings, often metaphorically (Appendices 29 & 30). Furthermore, using photography cancelled (or at least minimised) any power issues in relation to the expertise and authority of the researcher who gave participants control over various tasks (e.g. photo-missions, maintenance of photo cameras, picture selection, collaborative photo collage), exercised with various degrees of independence by those involved.

Probably the project would have not reflected the depth of phenomenological understanding of recovery if photography was not incorporated in the research process as a window to participants' lifeworld. This statement is partly based on the only non-photographic interview with a participant (Raul) who expressed his interest in the project, but without taking pictures, due to his previous negative experiences with photography (exacerbated perfectionism and disappointment as a result of failing to produce images of good quality). This was an indication that photography does not work for everyone. Nonetheless informative, and used here as an example rather than a generalisation, the interview with Raul (the shortest in the project) did not offer the richness of insight into his experience of recovery noted in photo-elicitation interviews, despite Raul being one of the most verbally expressive participants. Photography certainly helped service users to express themselves verbally, including those initially not recommended for recruitment by the gatekeeper mainly because of their limited verbal skills. Indeed, the contribution of one of the group participants with such difficulties (Mihai) was not particularly rich. However, he only took part in group activities, while some other participants (Cristi, Johnny) with similar difficulties, expressed themselves more freely in photo-elicitation interviews, suggesting that individual approaches could be more

appropriate for some participants. In all instances, photography helped with the flow of data collection by replacing potentially awkward silences with time for reflection and "looking at pictures", usually followed promptly by new lines of thought. Hence, the most relevant participant quotes being elicited by photographs that reinforced recovery messages and provided the researcher with a source of triangulation (i.e. corroborating meanings from verbal and visual contributions), also highlighted in the literature (Yates et al., 2012). For this reason, participants were encouraged to travel from a concrete perspective (i.e. indexical signifiers) to photographic metaphors (iconic/symbolic referents) (Chandler, 2007), to enhance the interpretative dimension of the study. However, on reflection, the researcher realised that visual data depicting concrete realities was at least as valuable as symbols of recovery and mental distress. For example, Mihai took a picture of the path that he follows daily to the day centre (Photo 51) to emphasise the importance of this place for his mental health, rather than capturing a metaphoric road to recovery.

Photo 51: "*This is my road to the day centre*" (Mihai, Workshop 4)

Equally important were the benefits of photography perceived by participants in terms of supporting and facilitating their recovery, explored in line with the research objectives of this

thesis. The link between photography and recovery was critically discussed in a reflection and feedback group at the end of the data collection. Participants' insights varied widely, but a series of commonalities were noted along with uncommon perspectives on how photography could help the processes of recovery.

For instance, Rodion, passionate about painting and visual expression in general, emphasised the role of photographs in illustrating mental distress difficult to explain in words, and the possibility to share them with his psychiatrist for enhanced understanding of his experience:

> *"Photography could be another way through which they* [people with mental health problems] *could show their hallucinations, their illness… And it could be evidence for the doctors as well."*
>
> (Rodion, Feedback & Reflection Group)

Agnes, inclined to express personal feelings through nature photography, shared this perspective, which made Tincuta talk about photography as *"the expression of the human soul"* in constant chase for "*beauty and art*". From a plethora of photographic elements, colour stood out for its cathartic properties that "*give life*" (Mariana) and *"have a positive effect on your psyche"* (Deirdre) such as revitalisation or change of mood (as long it is not red – the colour of trauma in Deirdre's opinion).

For other participants, photography was beneficial to mental health by providing them with a meaningful occupation, in line with meanings of recovery as "*doing things*", "*occupying time*" (Emilian), which also distracted them from obsessive thoughts and hearing voices. It may be an individual occupation or one that brings people together; beyond the boundaries of the

photography workshops, Cristi and Robert decided, without any instructions, to go for a walk and take pictures together (Photo 52), suggesting photography as a potential social avenue.

Photo 52 (collaboration between Cristi and Robert): *I was there* [in the park] *with Robert* [pseudonym]*. I like walking with him and taking pictures like this one here."* (Cristi, Interview)

For Robert, taking part in this project was an opportunity to learn to socialise better, which consequently facilitated his recovery that was equivalent for him with "*openness*", "*communication*", and "*belonging*". Some other participants involved family members in taking their pictures, portraying photography as a social activity which gave them meaning, but also pleasant memories (e.g. Robert chased rainbows with his father; Johnny organised a fun photo-session with his parents; Cristi asked his mother to take a picture of him in the swimming pool; Mariana gathered her friends in the park for a photo shoot) (pictures of people are not shown here due to lack of written consent). Considering that recovery means rebuilding social networks for a number of participants, photography may provide valuable encounters for people who share the same passion along with capturing unique and

meaningful instances in their life. Daniela is collecting such memories in a special folder in which she documents positive daily aspects, including achievements in relation to her mental health, that fuel her confidence and self-esteem:

> *"I created a habit of taking pictures of positive things… I have a folder on my computer called 'Special Moments'. And every time I access it, it gives me such a good feeling! I even have a picture of myself in a lift when I managed to overcome my phobia of lifts* [laughs]*."*
>
> (Daniela, Interview)

On several occasions, photography workshops became support groups with participants encouraging and inspiring each other, complimenting their photographs, but also helping each other with the technology. This emphasised the empowering and cathartic effect of photography conducive to a positive mood and relaxed atmosphere during the workshops, but also a safe space for disclosure, which was crucial for the data collection.

However, a series of limitations and challenges were noted in relation to photography, an aspect that is not commonly reported in the photography-based research discussed in *Chapter 3: Literature review*. For example, some participants (Cristi, Johnny) were so enthusiastic about using photo cameras that they often lost focus of the research topic that had to be repeatedly reinforced by the researcher. Other participants (Emilian, Rodion) were more captivated by the technical side of photography, which soon became their main area of interest, along with resolving the inherent technical issues encountered throughout the process. In other words, photography was a distraction that occasionally worked, at least apparently, against the researcher. On reflection, distractions were described by participants as potential mechanisms that helped them cope with distressful thoughts and feelings. Hence,

the blurry boundaries between photography as facilitator for recovery and hindrance to the research process. Another challenge was presented by participants taking pictures of people without written consent, despite rules being constantly reiterated by the researcher throughout the project. While these pictures elicited valuable insights on participants' social networks, they were not included in the dataset of this project. Finally, because the participants were provided with budget digital cameras, the quality of the pictures may pose some challenges for disseminating the research findings when high-resolution images are required.

Despite such challenges, photography is shown in this study to support recovery as a mean to create something meaningful to participants, in line with the phenomenological dimension of reinforcing participants' sense of being-in-the-world through visual references. Photographs were often a catalyst for participants' thoughts and emotions, and meanings constructed at individual and group level, facilitated by, but also strengthening, the phenomenological approach through a critical exploration of meanings and experiences of recovery. The meanings attributed by participants to photography were varied and complex – from a social perspective (opportunity for building or consolidating friendships), creative and aesthetic (mindful explorations of the beautiful things in participants' lifeworld), or existential (contemplating life and its meanings through photographs), but also occupational (photography as a hobby). In a variety of forms and shapes, photography links to the identified dimensions of recovery that can be supported and documented visually and creatively in a space of deep reflection. Photography may have not been conducive to increased participation and social change at community level in this study, as reported in a number of photographic studies reviewed in this thesis (Mizock et al., 2014), although this

was initially considered as an initial avenue for this project. Nonetheless, participants took ownership of their photographic work to the best of their abilities accepted and recognised by the researcher. They expressed a sense of pride and accomplishment at the end of the project, but also enhanced understanding of their own experiences:

> *"For me it* [the project] *was something interesting. I managed to get to better know my colleagues and understand this illness."* (Ioana, Feedback & Reflection Group)

This understanding may be due to adding a creative dimension to the already existing stories of recovery, brought to consciousness through photography, as further explained by Ioana:

> *"I like linking pictures to words and stories."* (Ioana, Feedback & Reflection Group)

In conclusion, photography appears to add to the emotional and functional/instrumental dimensions of recovery (recovery as "feeling" "being", and "doing"), resulting in enhanced emotional expression and enriched daily routines (e.g. "*experimenting new things*" – Emilian). Ultimately, recovery means to "*diversify life*", as stated by Deirdre, and photography facilitated this diversity as a therapeutic, occupational, aesthetic, and highly enjoyable medium, but also an umbrella for collaborative and potentially empowering activities, as demonstrated by participants involved in creating the final collage of pictures and messages of recovery (Photo 53).

Photo 53 (taken by the researcher with participants' consent): The research participants working on the final collage of pictures and messages of recovery (Photography Workshop 4)

Chapter 7. Conclusions

7.1. Concluding remarks

The aim of this qualitative phenomenological study was to explore the subjective experience and meanings of recovery from mental distress from the perspective of Romanian adults with mental health problems, by using participant-generated photography. The first and foremost finding of this thesis is the experience of recovery as a multi-layered phenomenon. While the complex nature of recovery is unanimously reflected in the recovery models (Leamy et al., 2011, Whitley and Drake, 2010), this study is unique by bringing a variety of perspectives on recovery (i.e. medical, psychosocial, occupational, and spiritual), as experienced by Romanian mental health service users and illustrated in their photographs. Some of these dimensions overlap with areas of recovery presented in *Chapter 2: Conceptualising recovery* and *Chapter 3: Literature review* (e.g. self/identity, hope, social connections), suggesting that recovery may have, to a certain extent, a universal understanding shared by individuals from various cultures and systems of mental health care. Nonetheless, this thesis is original for a number of reasons. Firstly, it captures and interprets the experience and meanings of recovery in Romanian mental health service users, a topic that has not been investigated so far in this country, opening potential research avenues for this type of inquiry that could potentially inform the mental health reform in Romania. By researching socio-economic, cultural, political, and historical particularities of recovery from mental distress, this study adds to the international body of literature looking at such experiences through a contextualised lens, therefore contributing to a shortage of cultural recovery studies pointed out by Slade et al. (2014). Secondly, although photography-based research methods have been utilised in

Romania (Scârneci-Domnişoru, 2017, Soriano-Ayala, Cala, & Ruiz-Salvador, 2020), they were not employed specifically in relation to mental health recovery. Thirdly, the international literature on photography-based methods in recovery research was systematically reviewed in *Chapter 3: Literature review*, which also contributes to the knowledge in this area through a synthesis of the most common photographic techniques and their benefits for researchers, but also for supporting and promoting recovery. Finally, this thesis adds further methodological insight into photography-based research through reflections and lessons learned throughout the research process, particularly in relation to using photography in phenomenological research, but also the extent to which photography can facilitate recovery.

In spite of commonalities with recovery research conducted in English-speaking countries revealing recovery as a complex, multi-faceted, and non-linear process (Davidson, Roe, Andres-Hyman, & Ridgway, 2010, Kravetz & Roe, 2007), several particularities in this study suggest that a full understanding of recovery processes cannot be divorced from the socio-economic, political, and cultural context (therefore beyond the personal, social, and environmental factors suggested in literature reviewed in *Chapter 3*). As a consequence, importing recovery models to culturally diverse populations may not be a straight forward process. For example, from the stance of the research participants, recovery as awakening does not take place at personal and inter-personal levels only, as suggested by the current literature (Leamy et al., 2011), but also at the confluence between personal life and the historic and socio-political circumstances. The Romanian Revolution in 1989 which marked the end of the communist regime appears to be a point of reference particularly for older participants, for whom recovery seems to follow a journey interlinked with the historical parcourse of the country. Psychiatric treatments and practices during and after the

communism gave their narratives an authentic flavour that enhanced the understanding of meanings attributed to recovery through a lens of oppression. For younger participants, the current socio-economic climate in Romania, with all the challenges brought by the transition to capitalism (e.g. unemployment, housing situation, poverty, declining quality of life, corruption), was prominent in relation to recovering a life that is equally affected by both mental illness and the wider socio-economic challenges. As a result, the responsibility for recovery needs to be shared equally between individuals, mental health professionals, and governments through appropriate policies that acknowledge the importance of socio-economic factors on mental distress and recovery. Some participants referred to recovery as a process that involves awakening as activism with service users ("*an army of foot soldiers*", Deirdre) ready to march the streets to "*make noise*" (i.e. protest, make their voice heard) and become more engaged in terms of civic responsibility and social participation. Although timidly expressed, this view portrays the latent potential of the Romanian service users to voice their concerns and seek representativeness outside the walls of their day centre which remains, nonetheless, the cornerstone of recovery for most of the participants. While the benefits of the community mental health centre for service users' mental health were evident in both their narratives and photographs, the long history of accessing the day centre in some cases raised questions around the risk of deinstitutionalisation in Romania (i.e. shift from large-scale psychiatric institutions to community care), being mutated into a process of re-institutionalisation (i.e. participants becoming dependent on community services). This may be due to insufficient focus of Romanian mental health services on empowering people to live independent lives. Participants' status of "beneficiaries" (Rom. "beneficiari") of mental health services may reinforce the image of service users as receivers rather than contributors to a system of care that continues to be, similarly to their family structure and religion,

patriarchal and prescriptive. It was revealed in this study that participants were not only receivers of treatments and services, but also sources of creative potential and skills from which local communities would greatly benefit while empowering those living with mental health problems and, consequently, supporting their recovery.

The "healing" dimension of recovery also seems to be culturally determined, echoing the biomedical approach inherited from the communist regime that appears to dominate the mental health care in Romania. Nonetheless, psychological and spiritual dimensions of healing were emphasised throughout the project, indicating participants' awareness of them being more than simple receptacles of psychiatric medication. Spirituality as Christian beliefs, practices, and rituals (unsurprising for a country predominantly Christian-Orthodox), is particularly relevant in the cultural discourse around recovery in Romania. The impact of people's beliefs on their help-seeking behaviours (e.g. recovery or healing pursued through faith leaders and passive reliance on divine powers) was evident in a number of narratives. Finally, recovery understood by participants as restoring a life affected by distressful experiences, is guided by universal values such as hope and meaningful occupations (i.e. regaining abilities and skills or developing new ones), but also a better future for a country that is still searching for its post-communist identity and stability.

The analysis of participants' understanding of recovery, facilitated by the phenomenological interpretative and photographic techniques, revealed employment as the chief indicator of one's recovery. This was yet another dimension that was explored from a cultural and political situatedness point of view, suggesting that areas of recovery highlighted in the literature need not to be generalised to various context without first being contextualised (i.e. meanings of

recovery attributed by individuals in a wide historical, socio-economic, political, and cultural context).

In conclusion, the meanings attached to recovery by the research participants appear to be multiple and complex, in line with their diverse experiences of distress, mental health systems, and life in general, illustrated ideographically through IPA and photography. For some participants, the medical dimension was more prominent, while for others keeping busy through employment and meaningful occupations, practicing religion, or addressing negative feelings and thoughts, took priority. Regardless of the meanings of recovery, the understanding of this phenomenon as a process specific to individuals rather than a standardised set of values is emphasised here. Photography workshops and photo-elicitation interviews played a crucial role in the in-depth exploration of the research phenomenon, eliciting rich insights and narratives. As a results, the phenomenological approach adopted here was enhanced by visually contextualising participants' lived experiences, meanings, and interpretations of recovery. Furthermore, photography was highlighted in this study as a creative platform with potential in facilitating and supporting recovery, as indicated by the positive feedback from, and benefits identified by, those involved.

7.2. Limitations

Except for the limited generalisability of this study in terms of prevalence of the research phenomenon, which is not the purpose of qualitative research (Ritchie, Lewis, McNaughton-Nicholls, & Ormston, 2014), a series of aspects were identified by the researcher and reflected upon in the fieldwork diary (Appendix 36).

Firstly, despite being of Romanian origins himself, the language was one of the main challenges for the researcher from the inception of the project. More specifically, Romanian language lacks the equivalent of the English word “recovery”, which was central to this thesis. The closest term identified by the researcher was “recuperation” (Rom. “recuperare”), which denotes a medical perspective, therefore risking to bias participants’ view on recovery. However, the language was negotiated during the project. Participants’ words were given attention and paraphrased by the researcher who developed a new language of recovery combining terms such as “healing”, “awakening”, “rebuilding life”, “getting better”, with “mental illness” (synonymous with “mental disease” in Romanian), used by the researcher despite his preference for non-medical terminologies. The photography-based phenomenological methodology helped with building the linguistic bridge (both verbally and visually) between the researcher and the researched, with the former becoming immersed in the lived experiences brought by participants into consciousness and, subsequently, into the research process. As a result, the translation of the transcripts from Romanian to English, although challenging at times in terms of accurately capturing the fine linguistic nuances, did not significantly impact on participants’ voice coming through this study. Also, it did not induce translation bias (Kirkpatrick & van Teijlingen, 2009), or at least this was minimised by the researcher through constant reflection.

Secondly, the researcher’s initial plan was to involve participants as co-researchers from the early stages of the project “geared towards planning and conducting the research process *with* those people whose lifeworld and meaningful actions are under study” (Bergold & Thomas, 2012). However, this was not materialised due to participants expressing a degree of reluctance about making decisions and taking responsibility in co-designing the research

activities, which could have potentially caused them distress. This was interpreted by the researcher in light of participants' limited levels of engagement and disempowerment in general, as pointed out in relation to their family and community participation. A certain level of disempowerment in the research participants was noted in the context of parents and carers, staff at the day centre, and psychiatrists frequently making decisions on the participants' behalf. Although this project offered avenues for a participatory action research, this idea was left open by the researcher who used alternative methodologies not specifically aimed at social change (i.e. photo-elicitation instead of photovoice), as informed by the literature review in *Chapter 2*. The project activities proved nonetheless enjoyable for participants, regarded as "experts" in their lived experience of recovery, whose wellbeing and choice were central to the researcher's approach throughout the process.

Thirdly, the findings of this study are only a snapshot of recovery that reflects individual experiences and perspectives on the researched phenomenon during a relatively short period of time (approximately two months). Some of the participants may still be in recovery long after the completion of the project or may go through a deterioration of their mental health while facing new challenges. Similarly, other participants with a negative view on recovery at the time of conducting the project may improve in the future and hold a completely different opinion, shaped by more positive experiences. While a longitudinal study may have offered a better vantage point on recovery throughout time, this study explored the depths of this phenomenon, which may be equally important and informative for future research.

Finally, the lessons learned from dealing with unexpected challenges in the fieldwork may contribute to advancing knowledge in the area of multi-disciplinary research combining

photography with qualitative approaches, by informing future research on possible areas of improvement.

7.3. Implications for practice

This thesis captured a cultural dimension of recovery from the perspective of a group of Romanian individuals living with mental distress and may be relevant for advancing the development of recovery frameworks and recovery-oriented practice that are under-developed in this country.

Understanding what recovery means to Romanian service users potentially contributes to the development of culturally sensitive recovery tools and more comprehensive recovery plans in the Romanian mental health system. The need for therapy to support psychological "healing", vocational support towards gaining employment, facilitating social participation, and acknowledging spiritual resources, are only a few areas that need to be delineated in mapping the recovery journey of Romanian mental health users, alternatively to, or complementarily with, their psychiatric treatments. Participants' ambivalence around families as facilitators of, or barriers to, recovery may be also valuable for mental health practice to either build therapeutic partnerships with resourceful families or support the family context to become more conducive to the recovery of their loved ones.

Furthermore, this research project suggests that incorporating photography in various activities with people recovering from mental health problems may give professionals (and service users) a creative tool to explore and better understand recovery. This is crucial for designing a care plan that mirrors individuals' experiences of distress and perspectives on

recovery, in line with the mental health service development goals set by the current legislation in Romania.

7.4. Directions for further research

This study was conducted soundly and steps to ensure reliability and validity were taken throughout the research process. However, the findings cannot be generalised to all mental health service users in Romania, partly because the qualitative methodology is not designed to address this aspect (Ritchie et al., 2014). By using IPA, the focus of this study was on both commonalities which can be seen as a generalisation of themes in participants' accounts (Smith et al., 2009), and particularities, equally important in understanding participants' experience and meanings of recovery. Nonetheless, the study opened some lines of enquiry that may be further explored in large-scale quantitative or mixed-methods studies. For example, a survey structured around the main dimensions of recovery highlighted in this study (e.g. medical, psychosocial, spiritual, and vocational), may offer an avenue for generalising the findings to a larger sample of Romanian mental health service users across a wider geographical spread and mental health settings (e.g. inpatient units). Furthermore, this may lead to developing a culturally sensitive recovery model that accounts for the particularities of the Romanian mental health context. Finally, the research strategy employed in this study can be replicated in other countries from the former communist bloc (and not only), with a view of capturing and comparing the particularities of recovery in similar (or different) cultural contexts. Photography is recommended here in addition to qualitative methods for strengthening the qualitative research methodology in exploring the complex meanings of recovery.

7.5. Final personal reflections

This research project was an eye-opener for both the research participants and myself in what concerns recovery in Romanian mental health service users. The intense four-year PhD journey intermingled with major positive and negative events in my life has constantly challenged and strengthen my resilience levels, but also opened unexpected avenues for pursuing an academic career as a researcher and lecturer. It is a privileged role in which the research experience and findings acquired throughout this thesis have already paved the route for curriculum development in my department including the importance of service users' perspective and voice in the process of recovery, elicited through novel and creative research methods. Radical changes in the way I conceptualise and conduct research took place during this process leading to my increased academic confidence and participation in international conferences, submitting articles for journal publication, writing book chapters on photo-elicitation, and networking with international researchers sharing similar interests. Aside from the academic dimension, my hope is that the voice of the research participants in this study will reach, through dissemination, mental health professionals and policy-makers in Romania to create local impact and translate some of the study findings into practice.

Probably no words, but a picture (Photo 54) that speaks to me through the language that I learned from the research participants, would be more suitable to mark the end of this journey that remains open to new layers of knowledge that I aim to add by taking recovery research to new levels and inspire others to do the same.

Photo 54 (Rodion, not selected): The road to recovery does not necessarily get better once the burden (i.e. symptomatology) is dropped; the road needs to be paved with meaning, support, and hope that it continues as smoothly as possible, punctuated with new vantage points and therapeutic encounters (researcher's interpretation)

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Appendix 1: Summary of commonalities and particularities of the recovery models selected for the purpose of this thesis under the umbrella term "recovery framework"

Models of recovery	General description	Commonalities	Particularities
1. The Strengths Model (Rapp & Goscha, 2012)	Principles: • People have the capacity to recover, reclaim & transform their lives through positive choices • Focus on individual strengths rather than deficits • The community is viewed as an oasis of resources therefore community work is pivotal to recovery • The consumer is directing the helping process • The worker-client relationship is essential	Recovery is: • Complex and multi-layered • Non-linear • Processual (as opposed to outcome) • Understood subjectively (therefore difficult to measure) • Driven by individuals	• Ecological perspective (contextualisation of recovery in community)
2. The Tidal Model (Barker & Buchanan- Barker, 2005)	Philosophical assumptions: • Belief in the virtue of curiosity (genuine interest in human experiences) • Focus on resourcefulness rather than problems, deficits or weaknesses • Respect for the people's wishes instead of being paternalistic • Acceptance of crisis as an opportunity for growth • Acknowledgment of goals that belong to the person • The virtue of pursuing elegance (the simplest possible means should be sought)		• Emphasis on the power of metaphors that people use to describe their experiences
3. Ralph & Corrigan's (2005) recovery model	Domains of recovery: • Internal: cognitive, emotional, spiritual, physical • External: activity, self-care, social relationships, social support • Stages of recovery: anguish; awakening; insight; action plan; determined commitment to become well; wellbeing/empowerment		• Spirituality as a distinctive dimension of recovery • Recovery as process and outcome

4. Whitley & Drake's (2010) dimensional approach to recovery	Dimensions of recovery: • clinical recovery – experiencing improvements in symptoms • existential recovery – having a sense of hope, empowerment, agency, and spiritual well-being • functional recovery – obtaining and maintaining valued societal roles and responsibilities, including employment, education, and stable housing • physical recovery – pursuing better health and a healthy lifestyle • social recovery – experiencing enhanced and meaningful relationships and integration with family, friends, and the wider community.	Focus on: • Understanding individual experiences • Personhood/identity • Strengths (as opposed to deficit) • Empowerment • Meaning • Hope (possibility to recover)	• Clinical recovery is seen as a dimension of recovery
5. CHIME framework for personal recovery (Leamy et al., 2011)	Recovery processes: • connectedness • hope and optimism about the future • identity • meaning in life • empowerment		• Culturally specific facilitating factors and collectivist notions of recovery in BME communities

Appendix 2: Summary and justification of criteria for including/excluding articles identified through literature searches

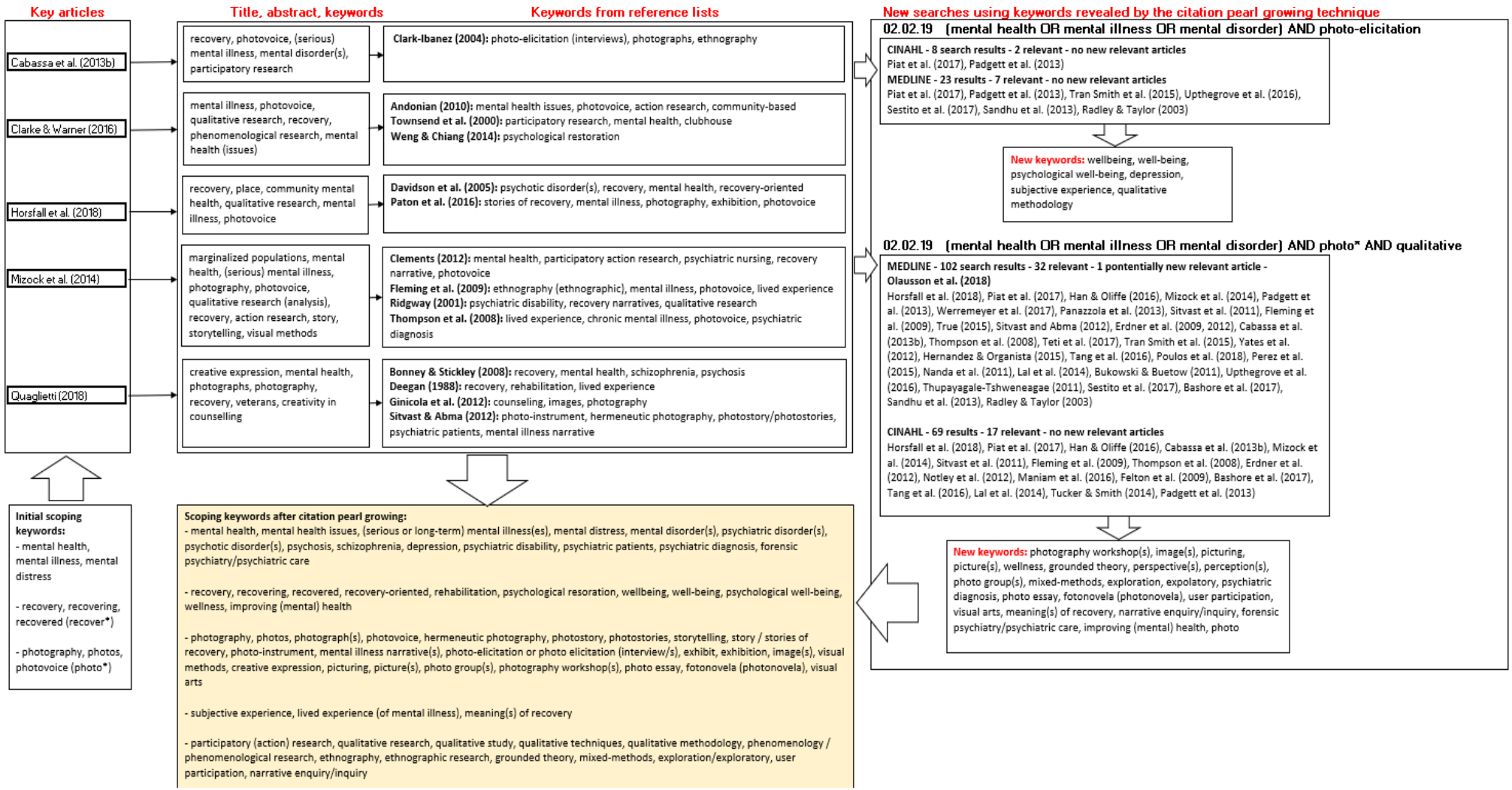
SPIDER Framework	Include	Exclude	Justification
Sample	• People with mental health problems (regardless of type of distress, age, sex, ethnicity etc.)	• People with physical health issues only or dual diagnoses (e.g. mental health combined with physical health issues or substance abuse if the focus is not on the recovery from mental distress). Also, exclude people with developmental and neurodegenerative disorders.	The sample needs to reflect the phenomenon of interest as stated in the review aim and include participants with a personal experience of recovery from mental distress rather than clinical recovery and symptom reduction
Phenomenon of **I**nterest	• Recovery from mental distress	• Other types of recovery than from mental health issues e.g. recovery from physical illnesses (cancer) or substance abuse (if it is not clear whether the recovery is from mental distress).	Inclusion of other types of recovery may lead to inconclusive findings outside the focus of the review enquiry. If recovery is a subtheme rather than the focus of a study, the article is still included but only data from the relevant subtheme are extracted and included in the findings.
Design	• Study design includes photography-based methods that elicit experiences of recovery from mental distress	• Design does not include photography e.g. other arts-based approaches, or photography has only a secondary role e.g. documenting arts-based projects	The design of the included studies is dictated by the aim of the review that is to synthesise photography-based methods that elicit experiences of recovery from mental distress and not simply document (i.e. taking pictures of recovery projects and activities employing other recovery approaches e.g. art-therapy, gardening, pet therapy etc.). Include studies that use photography-based data collection/analysis methods in their design on their own or in conjunction with other approaches (e.g. creative writing, or other research techniques such as interviews, focus groups, etc.).
Evaluation	• From the perspective of people recovering from mental distress	• From the perspective of mental health practitioners, family, carers, etc.	Inclusion of studies in which pictures reflect participants' recovery process. Also, include research that employs pre-existing pictures (not taken by participants) as long as they are used to elicit the experience of recovery and the voice of the research participants.
Research	• Qualitative and mixed-methods studies	Quantitative studies	Quantitative studies are focused on intervention and measurement rather than

			rich description of the research phenomenon, therefore excluded.
Language	• English • Romanian	• Other languages (except for English and Romanian)	Although the review aims to include evidence published worldwide, non-English studies (except for Romanian) are excluded due to the researcher being unable to translate them.
Types of literature	• Primary studies / articles published in academic journals (parent studies)	• Conference papers, literature reviews, dissertations, PhD theses, books, in-press articles	Literature reviews will be considered for manual citation searches.
Date restriction	No date restriction is applied as the review aims to capture the myriad of photography-based methods and how they have evolved over time in recovery work in the mental health arena. It is acknowledged here that recovery-oriented approaches are relatively recent, but there is no particular date that can be used that reflects this movement occurring at different stages in different countries. Also, this is an original review, so it does not intend to update existing reviews with evidence starting a particular date.		

Appendix 3: Example of preliminary searches conducted on CINAHL and Medline as part of the systematic literature review process

Date	Database	Years covered	Search terms	Results	Potentially relevant
09/01/2019	CINAHL	from inception to present	mental distress AND photography AND recovery	0	0
12/01/2019	Medline	from inception to present	mental distress AND photography AND recovery	0	0
09/01/2019	CINAHL	from inception to present	mental distress AND photography	4	2
12/01/2019	Medline	from inception to present	mental distress AND photography	5	3
09/01/2019	CINAHL	from inception to present	mental health AND photography AND recovery	15	7
12/01/2019	Medline	from inception to present	mental health AND photography AND recovery	17	12
09/01/2019	CINAHL	from inception to present	mental illness AND photography AND recovery	7	5
12/01/2019	Medline	from inception to present	mental illness AND photography AND recovery	9	6
09/01/2019	CINAHL	from inception to present	mental health AND photography	132	18
12/01/2019	Medline	from inception to present	mental health AND photography	133	34
09/01/2019	CINAHL	from inception to present	mental illness AND photography	39	14
12/01/2019	Medline	from inception to present	mental illness AND photography	37	21
25/01/2019	CINAHL	from inception to present	(mental distress OR mental health OR mental illness) AND recover* AND photo*	34	18
25/01/2019	Medline	from inception to present	(mental distress OR mental health OR mental illness) AND recover* AND photo*	66	17
25/01/2019	CINAHL	from inception to present	(mental distress OR mental health OR mental illness) AND photo*	362	48
25/01/2019	Medline	from inception to present	(mental distress OR mental health OR mental illness) AND photo*	1442	49

Appendix 4: Development of the systematic review search strategy using the 'pearl-growing' technique (Schlosser, Wendt, Bhavnani, & Nail-Chiwetalu, 2006)



Appendix 5: Development of keywords and synonyms to optimise the systematic review search strategy (Aromataris & Riitano, 2014)

Framework	Description	Main keywords	Synonyms / secondary keywords
Sample	People with a lived experience of mental distress	Mental distress	Mental health problem(s), Mental health issues(s), Mental illness/illnesses Mentally ill, Mental disease/diseases, Mental disorder(s) Psychiatric disorder(s), Psychiatric diagnosis/diagnoses Depression, Anxiety, Bipolar disorder, Psychosis/psychotic, Schizophrenia/schizophrenic
Phenomenon of **I**nterest	Recovery from mental distress	Recovery	Recovering, Recovered Rehabilitation Mental well-being (wellbeing)
Design	Data collection (or analysis) methods that incorporate an element of photography	Photography	Photo-elicitation Photovoice Photo narrative(s) Photo story/stories Photo novella Photo ethnography Photo instrument Image(s) Photo(s) Visual method(s)
Evaluation	Experience (from the perspective of people with mental health problems)	Experience(s)	Experiencing Lived experience(s) Perspective Lifeworld(s)
Research	Qualitative (e.g. phenomenological) or mixed methods	Qualitative Mixed-methods	Phenomenology/Phenomenological Interpretive Analysis/IPA Grounded Theory Ethnography/Ethnographic

Appendix 6: Development of the systematic review search strategy using the SPIDER framework (Cooke et al., 2012)

S	"mental distress" OR "mental health" OR "mental health problem*" OR "mental health issue*" OR "mental illness" OR "mentally ill" OR "mental disease*" OR "mental disorder*" OR "psychiatric disorder*" OR "psychiatric illness*" OR "psychiatric diagnos*" OR "psychiatric disability" OR "psychiatric patient*" OR "forensic psychiatry" OR "psychiatric care" OR "depressi*" OR "anxiety" OR "bipolar disorder" OR "psychosis" OR "psychotic disorder*" OR "schizophreni*"
	(AND)
PI	"recover*" OR "recovery-oriented" OR "rehabilitation" OR "psychological restoration" OR "wellbeing" OR "well-being" OR "improving health" OR "wellness"
	(AND)
D	"photo*" OR "picture*" OR "image*" OR "visual art" OR "visual method*" OR "video*" OR "film*" OR "art*" OR "creativ*" OR "hermeneutic*"
	(AND)
E	"experience*" OR "lived" OR "subjective" OR "perspective*" OR "explor*" OR "user participation" OR "meaning*" OR "lifeworld*"
	(OR)
R	"qualitative" OR "phenomenolog*" or "IPA" or "interpret* analysis" OR "participatory action research" OR "participatory research" OR "action research" OR "grounded theory" OR "narrative *nquiry" OR "ethnograph*"
	(NOT)
	"body image" OR "light therapy" OR "video games" OR "videogames" OR "music*" OR "theat*" OR "danc*" OR "neuroimaging" OR "neurolog*" OR "MRI" OR "palliative" OR "eating disorder*" OR "brain injur*" OR "cancer" OR "coronary" OR "artery disease*" OR "cardi*" OR "stroke" OR "multiple sclerosis" OR "dementia" OR "Alzheimer" OR "autism"

Appendix 7.1: Example of screening tool for titles and abstracts of potentially relevant articles to be included in the systematic review

		Include						Exclude								
Author (s)	Year	People with mental health problems	Recovery from mental distress	Design includes an element of photography (including videograph	From the perspective of people recovering from mental distress	Qualitative or mixed-methods studies	Language - English/Romanian	People with physical health issues only or dual diagnoses	Other experiences than recovery from mental health issu	Design does not include photograph	From the perspective of mental health practitioners, family, carers, etc.	Quantitative studies	Language - non-English/non-Romanian	Include/exclude/refer to full tex	Reason for exclusion	Notes
Ådnanes et al.	2018	Yes	No	Not clear	Yes	Yes	Yes	No	Yes	Not clear	No	No	No	Exclude	The focus is not on the recovery from mental distress	
Abbotts & Spence	2013	Not clear	Not clear	Not clear	Not clear	Yes	Yes	Not clear	Not clear	Not clear	No	No	No	Refer to full text		
Adame & Knudson	2008	Yes	Yes	Not clear	Yes	Not clear	Yes	No	No	Not clear	No	Not clear	No	Refer to full text		
Adekeye et al.	2014	No	No	Yes	Yes	Yes	Yes	No	Yes	No	No	No	No	Exclude	The focus is not on the recovery from mental distress	Participants are not people with mental health problems
Aitken et al.	2013	Yes	Yes	Not clear	Not clear	Not clear	Yes	No	No	Not clear	Not clear	Not clear	No	Refer to full text		Possible review of the literature. Check whether diaries include photographs
Alexander et al.	2016	Yes	Yes	Not clear	Not clear	Not clear	Yes	No	No	Not clear	Not clear	Not clear	No	Refer to full text		Do diaries include photographs?
Allen & Armitage	2017	No	No	Yes	No	Not clear	Yes	No	Yes	No	Not clear	Not clear	No	Exclude	The focus is not on the recovery from mental distress	Participants are not people with mental health problems
Amerikaner et al.	1980	Not clear	No	Yes	Not clear	Not clear	Yes	Not clear	Yes	No	Not clear	Not clear	No	Exclude	The focus is not on the recovery from mental distress	
Andalibi et al.	2015	Not clear	No	Yes	Not clear	Yes	Yes	No	Yes	No	Not clear	No	No	Exclude	The focus is not on the recovery from mental distress	Conference paper
Andalibi et al.	2017	Not clear	No	Yes	Not clear	Yes	Yes	Not clear	Yes	No	Not clear	No	No	Exclude	The focus is not on the recovery from mental distress	Conference paper
Anderson-Clarke & Warner	2016	Yes	Yes	Yes	Yes	Yes	Yes	No	No	No	No	No	No	Refer to full text	Include	
Anderson et al.	1997	Yes	No	No	Not clear	Not clear	Yes	No	Yes	Yes	Not clear	Not clear	No	Exclude	The focus is not on the recovery from mental distress	The design does not include an element of photography
Andonian	2010	Yes	Not clear	Yes	Yes	Not clear	Yes	No	Not clear	No	No	Not clear	No	Refer to full text		
Anthony	2008	Yes	Yes	Not clear	Yes	Yes	Yes	No	No	Not clear	No	No	No	Refer to full text		Clarify whether the design includes an element of photography
Aranda et al.	2015	No	No	Yes	No	Yes	Yes	No	Yes	No	Yes	No	No	Exclude	The focus is not on the recovery from mental distress	Participants are not people with mental health problems
Argentzell et al.	2012	Yes	No	Not clear	Yes	Yes	Yes	No	Not clear	Not clear	No	No	No	Exclude	The focus is not on the recovery from mental distress	
Argyle & Bolton	2005	Yes	Not clear	Not clear	Not clear	Yes	Yes	No	Not clear	Not clear	Not clear	No	No	Refer to full text		Clarify whether the design includes an element of photography
Armour et al.	2009	Yes	Yes	Not clear	Yes	Yes	Yes	No	No	Not clear	No	No	No	Refer to full text		Clarify whether the design includes an element of photography
Arvidsdotter et al.	2016	Yes	No	Not clear	Yes	Yes	Yes	No	Yes	Not clear	No	No	No	Exclude	The focus is not on the recovery from mental distress	
Asher et al.	2017	Yes	Not clear	No	Not clear	Not clear	Yes	No	Not clear	Yes	Not clear	Not clear	No	Exclude	The design does not include an element of photography	
Aston	2013	Yes	Yes	Not clear	Not clear	Not clear	Yes	No	No	Not clear	Not clear	Not clear	No	Refer to full text		Clarify whether the design includes an element of photography
Baker et al.	2009	Yes	Not clear	Not clear	Not clear	No	Yes	No	Not clear	Not clear	Not clear	Yes	No	Exclude	Quantitative study	
Balbale et al.	2016	Not clear	No	Yes	Not clear	Not clear	Yes	Not clear	Yes	No	Not clear	Not clear	No	Exclude	The focus is not on the recovery from mental distress	Methodological article

Appendix 7.2: Example of screening tool for full-text version of potentially relevant articles to be included in the systematic review

		Include						Exclude								
Author (s)	Y	People with mental health problems	Recovery from mental distress	Design includes an element of photography (including videograph	From the perspective of people recovering from mental distress	Qualitative or mixed-methods studies	Language - English/Romanian	People with physical health issues only or dual diagnoses	Other experiences than recovery from mental health issu	Design does not include photograph	From the perspective of mental health practitioners, family, carers, etc.	Quantitative studies	Language - non-English/non-Romanian	Include/exclude	Reason for exclusion	Notes
Abbotts & Spence	2013	Yes	Yes	No	Yes	Yes	Yes	No	No	Yes	No	No	No	Exclude	The design does not include an element of photography	Art = including drawing, painting, pastels, acrylic, papier mâché, glass painting, silk scarf painting, mosaic, clay modelling, and installation art
Adame & Knudson	2008	Yes	Yes	No	Yes	Yes	Yes	No	No	Yes	No	No	No	Exclude	The design does not include an element of photography	
Aitken et al.	2013	No	No	Yes	No	Yes	Yes	Yes	Yes	No	Yes	No	No	Exclude	Literature review	Review of the literature. Check references
Alexander et al.	2016	Yes	Yes	No	No	No	Yes	No	No	Yes	Yes	Yes	No	Exclude	Literature review	Review of the literature. Check references for photo diaries
Anderson-Clarke & Warner	2016	Yes	Yes	Yes	Yes	Yes	Yes	No	No	No	No	No	No	Include	n/a	Printed
Andonian	2010	Yes	No	Yes	Yes	Yes	Yes	No	Yes	No	No	No	No	Exclude?	The focus is not on the recovery from mental distress	
Anthony	2008	Yes	Yes	No	Yes	Yes	Yes	No	No	Yes	No	No	No	Exclude	The design does not include an element of photography	
Argyle & Bolton	2005	Yes	No	No	Yes	Yes	Yes	No	Yes	Yes	N0	No	No	Exclude	The focus is not on the recovery from mental distress	Full-text from LU Library
Armour et al.	2009	Yes	Yes	No	Yes	Yes	Yes	No	No	Yes	No	No	No	Exclude	The design does not include an element of photography	
Aston	2013	Yes	Yes	No	Yes	n/a	Yes	No	No	Yes	No	n/a	No	Exclude	The design does not include an element of photography	
Barley et al.	2012	Yes	Yes	No	Yes	Yes	Yes	No	No	Yes	No	No	No	Exclude	The design does not include an element of photography	Art = crafts; brief mention of one participant developing an interest in photography
Bone	2018	Yes	Yes	No	Yes	Yes	Yes	No	No	Yes	No	No	No	Exclude	The design does not include an element of photography	Arts = pottery; general desciption of art-making
Booth	2015	Yes	Yes	Yes	Not clear	Not clear	Yes	No	No	No	Not clear	Not clear	No	Exclude	Conference poster	Poster?
Bradshaw et al.	2007	Yes	Yes	No	Yes	Yes	Yes	No	No	Yes	No	No	No	Exclude	The design does not include an element of photography	
Bungay et al.	2010	Yes	Not clear	Not clear	Not clear	Not clear	Yes	No	Not clear	Not clear	Not clear	Not clear	No	Exclude	Literature review - check references	
Cabassa et al.	2013b	Yes	Yes	Yes	Yes	Yes	Yes	No	No	No	No	No	No	Include	n/a	Printed. Based on a recovery framework in mental health not substance abuse; some elements of recovery from substance abuse. Discuss in supervision
Cameron et al.	2013	Yes	Yes	No	No	n/a	Yes	No	No	Yes	Yes	n/a	No	Exclude	The design does not include an element of photography	
Carson	2012	Yes	Yes	Yes	Yes	Not clear	Yes	No	No	No	No	Not clear	No	Include		Movie available at: https://www.slam.nhs.uk/patie
Carvalho & Ximenes	2016	Yes	No	Yes	Yes	Yes	Yes	No	Yes	No	No	No	No	Exclude	The focus is not on the recovery from mental distress	
Casey & Webb	2018	Yes	Yes	No	Yes	Yes	Yes	No	No	Yes	No	No	No	Exclude	Although there is an element of photography this is not central (drawing is more prominent). Photography is used to document the art-project. Conclusions cannot be drawn how photography has contributed to exploring recovery; only a small number of participants have mental health issues	Participatory Visual Research Methodologies (PVRM) - use of the visual (photography, video, digital storytelling, drawings) as a participatory methodology.

Appendix 8: Tool for extracting relevant data from the articles included in the systematic review

Name of reviewer: Date:		
Author(s)		
Year		
Title		
Journal published/Source		
Sample characteristics	Number of participants	
	Age category	
	Gender	
	Type(s) of experiences of distress	
	Recruitment	
Context of study	What is the setting for the research? e.g. mental health hospital services	
	What is the geographical location?	
Aim/research question	Is the aim of the research clear? Is the research aim relevant for the review question?	
Theoretical perspective(s)	Is the theoretical background of the research clear?	
Photography-based method(s)	What type of photography-based methods have been employed?	
	What is the rationale for choosing photography in research?	
	Are they implemented on their own approach or combined with other approaches?	
	What are the functions/characteristics of the photography-based methods? e.g. data collection, knowledge production/dissemination etc.	

Appendix 8: Tool for extracting relevant data from the articles included in the systematic review (continued)

	Are there any strengths and weaknesses of photography-based methods revealed by the research?	
Perspective and implication of participants in photography-based activities	Does the research reflect the perspective of participants?	
	How are participants involved in photography-based research?	
	Are participants' pictures included in the study?	
Role of researcher/reflexivity	What is the researcher's role in implementing photography-based methods?	
Data collection	What data collection methods were used?	
	Was the data collection adequately described and rigorously conducted?	
Data analysis	How are the data analysed?	
	How adequate is the description of the data analysis?	
Main findings	What are the chief findings of the research?	
	What are the main outcomes of photography-based methods?	
Ethical considerations	Was ethical approval obtained? Was informed consent obtained?	
	Are there any ethical issues in relation to using photography in research?	
Limitations	What are the limitations of the research?	
Implications for practice and future research	What are the implications for practice?	
	Are there any future directions for research drawn from the study?	

Appendix 9: Quality appraisal of the studies included in the systematic review

	Clear statement of research aim(s) and/or question(s)	Clear description of the methodology	Mention of theoretical perspectives guiding the research	Clear description of the research design	Recruitment strategy is appropriately described	Clear description of data collection (including how photography was used)	Data analysis is sufficiently rigorous	Clear statement of research findings	Researcher's and participants' roles are clearly stated	Ethical issues have been considered	Research is overall valuable
Anderson Clarke & Warner (2016)	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Cabassa et al. (2013)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Clements (2012)	Yes	Yes	Yes	Yes	No	Yes	No	No	Yes	Yes	Yes
Duff (2012)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Greco et al. (2017)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Horsfall et al. (2018)	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Lal et al. (2014)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes
Larivière et al. (2015)	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes
Mizock et al. (2014)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Notley et al. (2012)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Piat et al. (2017)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes
Quaglietti (2018)	Yes	Yes	No	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes
Sitvast (2015)	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes
Trans Smith et al. (2015)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Yates et al. (2012)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

Appendix 10: Summary of the photography-based recovery studies included in the systematic literature review

Author/date/ country	Context/ Setting	Theoretical framework	Methodology/design/sample	Focus of study	Analytical themes of recovery identified through thematic synthesis
Anderson Clarke & Warner 2016, USA	Occupational therapy Community centre (Clubhouse)	Recovery framework (consumer-based definitions of recovery focused on personal growth, regaining autonomy, and establishing a meaningful life)	• Phenomenology • Photovoice / photography workshops, semi-structured interviews • 8 participants with various mental health problems	Lived experiences of mental illness and factors affecting recovery	• Meaningful exchanges • Situatedness • Coping while hoping
Cabassa et al., 2013, USA	Supported housing agencies	Whitley and Drake's (2010) recovery model (recovery consisting of five inter-related dimensions: clinical, existential, functional, physical, and social)	• Grounded theory • Photovoice / photography workshops, individual photo-elicitation interviews • 16 participants with various mental health problems	Recovery from the perspective of individuals with serious mental illness	• Self-discovery • Meaningful exchanges • Coping while hoping
Clements, 2012, USA	Community psychosocial rehabilitation centre (Clubhouse)	Empowerment recovery model in mental health (recovery understood as a manifestation of personal empowerment)	• Participatory action research • Photovoice & photo-elicitation interviews / group discussions • 6 participants with various mental health problems	Exploration of the concept of recovery; personal stories of recovery	• Self-discovery • Situatedness
Duff, 2012, Australia	Psychiatric disability and rehabilitation services	'Enabling places' (therapeutic landscapes and restorative environments; landscapes of care)	• Qualitative design (situational analysis) • Photovoice / photo-journals, individual interviews • 24 participants with various experiences of mental distress	Places and how they promote and support recovery in mental health ('enabling places')	• Meaningful exchanges • Situatedness
Greco et al., 2017, Canada	Day hospital program for severe behavioural disorders (for children)	Empowerment recovery model in mental health (shift from client-centred to client-driven care)	• Narrative-phenomenological / elements of ethnography • Photovoice / photographic life-books, interviews, and participant observations • 4 children with mental health related disorders	Recovery-oriented self-report measure for children with a mental health disorder	• Meaningful exchanges • Situatedness • Coping while hoping
Horsfall et al., 2018, Australia	Community centre	Recovery framework (development of a positive sense of identity and a meaningful and contributing life, with or without symptoms)	• Qualitative design • Photovoice & written narrative / group workshops, individual interviews, exhibition • 26 participants with severe and persistent mental illness	Exploration of what people find helpful and supportive in their recovery journeys; place-based recovery-oriented services	• Meaningful exchanges • Situatedness • Coping while hoping
Lal et al., 2014, Canada	Early Intervention Program for psychoses	Recovery model (recovery as a transformative, individualized process leading to a fulfilling and meaningful life, as well as a clinical outcome)	• Constructivist grounded theory • Individual interviews & photography-elicited focus groups • 17 participants with various experiences of psychosis	Meanings of well-being from the perspectives of youth mental health service users diagnosed with psychosis	• Self-discovery • Situatedness • Coping while hoping

Larivière et al., 2015, Canada	Occupational therapy / Program for people with borderline personality disorder	Person-Environment-Occupation model Recovery framework	• Qualitative design (narrative approach, life stories) • Picture collages (from magazines), individual interviews • 12 female participants diagnosed with borderline personality disorder	Experience of recovery in women with borderline personality disorder	• Meaningful exchanges • Coping while hoping
Mizock et al., 2014, USA	Psychosocial rehabilitation and education centre	Theory of recovery (recovery as a developmental process of working toward life satisfaction, wellbeing, and autonomy)	• Qualitative (iconographic and narrative approach) • Photovoice & written narratives (Recovery Narrative Photovoice) • 20 participants with various mental health problems	Meaning of recovery for individuals with serious mental illness	• Self-discovery • Situatedness • Coping while hoping
Notley et al., 2012, UK	In-patient mental health rehabilitation unit	Recovery framework (recovery as a journey rather than episode of care)	• Qualitative design (interpretive approach) • Photo-elicitation / semi-structured individual interviews • 10 participants with various mental health experiences	Experience of in-patient rehabilitation from the perspective of service users	• Self-discovery • Meaningful exchanges • Situatedness • Coping while hoping
Piat et al., 2017, Canada	Supported housing projects	Recovery framework / Therapeutic landscapes (health geography)	• Qualitative design • Photo-elicitation interviews • 17 participants with severe mental illnesses	Impact of moving from supervised to supported housing on recovery; the role of place in recovery work	• Meaningful exchanges • Situatedness
Quaglietti, 2018, USA	Outpatient mental health clinic	Person-centred model of recovery (personal recovery narrative)	• Mixed-methods • Photography workshops • 31 participants (veterans) with various mental health problems	Creating photographs to explore the experience of recovery from mental health problems	• Self-discovery • Meaningful exchanges • Coping while hoping
Sitvast, 2015, The Netherlands	Long-stay wards (mental health care hospital)	Recovery model (strengths approach); CHIME personal recovery framework (Leamy et al., 2011)	• Hermeneutic photography; Appreciative Inquiry Cycle • Photo-sessions with participants (pictures taken of participants) • 15 participants with various mental health problems	Development and evaluation of an intervention in recovery-oriented care to promote recovery processes and goals	• Self-discovery • Meaningful exchanges • Coping while hoping
Trans Smith et al., 2015, USA	Residential setting for formerly homeless people	Recovery model (mental health recovery implies more than a reduction in symptoms and increased functioning)	• Qualitative design • Photo-elicitation individual interviews • 17 participants with co-occurring disorders	Exploration of the role of place in recovery (narrative identity reconstruction)	• Self-discovery • Meaningful exchanges • Situatedness • Coping while hoping
Yates et al., 2012, UK	Community mental health teams	Recovery model (recovery as a non-linear, dynamic process of transformation)	• Grounded theory with elements of ethnography • Photovoice, diaries / semi-structured one-to-one interviews • 8 participants with severe and enduring mental health problems	The relationship between recovery of people receiving community mental health services and the places in which they live	• Self-discovery • Meaningful exchanges • Situatedness

Appendix 11: Typical steps of a photo-elicitation study

1. The research participants are provided with photo cameras and trained to use them (photographic exercises); ethical issues around photography are explained along with health and safety rules.
2. The researcher ensures that the participants understand the topic that they are invited to represent visually (potentially through negotiation with the research participants).
3. Participants take a number of pictures, usually in their familiar environment or community, over a certain period of time.
4. The photographs taken are selected by the participants together with the researcher who may recommend a limited number of photos per participant (to ensure depth of data, but also representativeness of the topic, along with the economical use of the allocated time).
5. The selected images are critically and reflexively discussed in a photo-elicitation interview (up to 90 minutes), photography workshop or focus group (1-2 hours), or a combination of those, as prompted by the researcher and other participants. Group activities, known to facilitate the social construction and negotiation of meanings, are normally facilitated by the researcher and ideally involve 6-8 participants.
6. Participants' interpretation of their images informs data analysis, which allows the researcher to stay close to the meanings attributed by informants to their photographic work and therefore reduce interpretation bias.
7. The researcher may decide to label and organise photographs in different formats such as tabulation, visual maps, or analysing them using specialised software (e.g. Atlas.ti, NVivo) that facilitates coding and thematic processing of the visual material, but also the researcher's comments and reflections that may be valuable for writing up the findings.
8. Member-checking groups could be set up (optionally) to give the research participants the opportunity to comment on the preliminary/final findings identified by the researcher throughout the process, and address any misunderstandings or misinterpretations.

Appendix 12.1: Recruitment poster for the research project (English)

You are invited to take part in photography workshops and interviews exploring recovery from mental distress

Why? • You may have an experience of recovery to share

How? • Through photography (no skills or camera required)

• Interactive group sessions and/or one-to-one discussions

When? • July-August 2019 (dates to be confirmed)

Where? • Your mental health community day centre

With whom? • Lucian Milasan, mental health adviser, former volunteer with your day centre, currently studying PhD in Mental Health at Lancaster University (United Kingdom), passionate about photography and exploring mental health issues through images

What's next? If you are interested and would like to receive more information, please contact me at L.Milasan@Lancaster.ac.uk, [telephone - exclusively for research purposes] or speak to a member of staff.

Refreshments provided!

Thank you

Appendix 12.2: Recruitment poster for the research project (Romanian)

Ești invitat să participi la ateliere de fotografie și interviuri care au drept scop explorarea recuperării sănătății mintale

De ce? • Pentru că ai o experiență de recuperare pe care vrei să o împărtășești

Cum? • Prin intermediul fotografiei (nu se cer cunoștințe de fotografie sau camera foto)

• Activități de grup interactive și/sau discuții de unu-la-unu

Când? • Iulie-August 2019 (datele urmează să fie confirmate)

Unde? • La centrul comunitar de zi

Cu cine? • Lucian Milasan, consultant pe probleme de sănătate mintală, fost voluntar la centrul de zi, doctorand la Universitatea din Lancaster (Marea Britanie), pasionat de fotografie și explorarea problemelor de sănătate mintală prin imagini

Ce urmează? Dacă ești interesat și dorești mai multe informații, te rog contactează-mă prin email la L.Milasan@Lancaster.ac.uk (telefon – exclusiv pentru proiectul de cercetare) sau cere detalii de la personalul centrului de zi.

Se asigura gustări și băuturi răcoritoare!

Mulțumesc

Appendix 13.1: Participant information sheet (English)

Participant Information Sheet

Research project: Exploring the experience and meaning of recovery from mental distress in Romanian mental health service users through photography

My name is Lucian Milasan and I am conducting this research as a Mental Health PhD student at Lancaster University, Lancaster, United Kingdom.

What is the study about?

This research project uses photography to explore people's experiences of recovery following mental distress. The aim is to use the understanding gained to inform the development of mental health services focused on the needs and perspectives of service users.

Why have I been approached?

You have been approached because the study is based on information from people who have an experience of living with mental health problems.

Do I have to take part?

No. Your participation in this study is voluntary. Your access to the services provided by the day centre will not be affected by your participation/non-participation in this study.

What will I be asked to do if I take part?

If you decide you would like to take part, you are invited to attend four weekly photography workshops (two hours each) and/or a one-to-one interview (60-90 minutes) with the researcher at the day centre (see the schedule attached). You will take pictures that reflect your experience of recovery and discuss this in the photography groups/interviews. You will be also invited to a feedback and reflection group at the end of the project to discuss the provisional conclusions of the research. Note that no photography training nor equipment are required as that will be provided at the start of the project.

Will my data be Identifiable?

The information you provide is confidential. However, there are some limits to confidentiality: if what is said during the workshops/in the interview makes me think that you, or someone else, is at significant risk of harm, I will have to break confidentiality and speak to a member of staff about this. If possible, I will tell you if I have to do this.

Although the project activities will be audio-recorded, your participation in this project will be anonymous, which means that only the researcher has access to any personal data recorded throughout the project.

The data collected for this study will be stored securely on an encrypted password-protected laptop to which only the researcher conducting this study will have access:

- Audio recordings will be destroyed and/or deleted once the project has been submitted for examination
- Hard copies of the interview/workshop transcriptions (with pseudonyms) will be kept in a locked cabinet throughout the project. They will be destroyed once the project has been submitted for examination
- The files on the laptop will be encrypted (no-one other than the researcher will be able to access them) and the laptop itself password protected.
- At the end of the study, electronic copies of the interview/workshop transcriptions (with

- pseudonyms) will be kept securely on a password-protected laptop for ten years. At the end of this period, they will be destroyed.
- The typed version of your interview/photography workshops will be made anonymous by removing any identifying information including your name. Anonymised direct quotations from your interview/photography workshops may be used in the reports or publications from the study, so your name will not be attached to them.
- All your personal data will be confidential and will be kept separately from your interview/photography workshops responses.

What will happen to the results?

The results will be included by the researcher in a thesis and may be discussed with other mental health professionals and policy-makers responsible with developing mental health services. The results may also be submitted for publication in academic journals, books, or conferences.

Are there any risks?

There are no risks anticipated with participating in this study. However, if you experience any distress following participation you are encouraged to inform the researcher and contact your social worker at the community centre (tel. 0753088673).

Are there any benefits to taking part?

Although you may find participating interesting, there are no direct benefits in taking part.

Who has reviewed the project?

This study has been reviewed and approved by the Faculty of Health and Medicine Research Ethics Committee at Lancaster University, England.

Where can I obtain further information about the study if I need it?

If you have any questions about the study, please contact:
Lucian Milasan (researcher)
Email: L.Milasan@Lancaster.ac.uk
Tel.: [mobile number – for research purposes only]

Complaints

If you wish to make a complaint or raise concerns about any aspect of this study and do not want to speak to the researcher, you can contact the research supervisors:
Dr. Naomi Fisher (supervisor): N.Fisher@Lancaster.ac.uk
Dr. Amanda Bingley (supervisor): – A.Bingley@Lancaster.ac.uk

If you wish to speak to someone outside of the Mental Health Doctorate Programme, you may also contact:
Professor Roger Pickup (Associate Dean for Research)
Tel: +44 (0)1524 593746 | Email: r.pickup@lancaster.ac.uk
Faculty of Health and Medicine | Division of Biomedical and Life Sciences
Lancaster University | Lancaster | LA1 4YG

Thank you for taking the time to read this information sheet!

Appendix 13.2: Participant information sheet (Romanian)

Informații proiect

Proiect de cercetare: Explorarea experiențelor de recuperare a sănătății mintale a beneficiarilor de servicii din Romania prin intermediul fotografiei

Mă numesc Lucian Milasan și coordonez acest proiect de cercetare ca doctorand în Sănătate Mintală la Universitatea din Lancaster, Marea Britanie.

Despre ce este vorba în acest proiect?

Acest proiect de cercetare se folosește de fotografie pentru a explora experiențele de recuperare a sănătății mintale. Scopul este de a folosi informațiile obținute pentru a dezvolta servicii de sănătate mintală bazate pe nevoile și perspectivele beneficiarilor de servicii.

De ce am fost abordat?

Ai fost abordat pentru că studiul se bazează pe informațiile obținute de la persoanele cu probleme de sănătate mintală.

Trebuie să particip?

Nu neapărat. Participarea ta în acest studiu este voluntară. Accesul tău la serviciile furnizate de centrul de zi nu va fi afectat de participarea sau neparticiparea ta în acest studiu.

Ce voi face dacă decid să particip?

Dacă decizi să participi, vei fi invitat să iei parte la patru ateliere de fotografie (două ore pe săptămână) și/sau discuții unu-la-unu (60-90 minute) cu cercetătorul la centrul de zi (vezi programul de activități atașat). Vei face poze care reflectă experiența de recuperare a sănătății mintale și vei discuta aspecte legate de această experiență în grupurile de fotografie și/sau interviuri. De asemenea, vei fi invitat să iei parte la un grup de discuții la sfârșitul proiectului pentru a discuta rezultatele preliminarii ale cercetării. Ține minte că nu ai nevoie de cunoștințe de fotografie sau echipament, întrucât acestea vor fi asigurate la începutul proiectului.

Vor fi datele mele identificate?

Informațiile furnizate în cadrul proiectului sunt confidențiale. Totuși, există anumite limite în ceea ce privește confidențialitatea: dacă ceea ce ai spus în timpul activităților de grup sau interviuri îmi dă de gândit că tu sau alte persoane sunt în pericol, voi fi nevoit să încalc confidențialitatea și voi raporta situația unui membru al centrului de zi. Dacă e posibil, te voi informa despre acest lucru.

Deși activitățile proiectului sunt înregistrate audio, participarea ta în acest proiect va fi anonimă, ceea ce înseamnă că doar cercetătorul are acces la date personale înregistrate în timpul proiectului.

Datele colectate în cadrul acestui studiu vor fi înmagazinate pe un laptop încriptat și protejat cu parolă la care doar cercetătorul are acces.

- Înregistrările audio vor fi distruse și/sau șterse odată cu înmânarea proiectului spre examinare
- Copii ale interviurilor/grupurilor de fotografie transcrise (cu pseudonim) vor fi păstrate într-un loc sigur, sub lacăt, pe tot parcursul proiectului. Transcrierile vor fi distruse odată ce proiectul a fost depus spre examinare
- Fișierele de pe laptop vor fi încriptate (nimeni cu excepția cercetătorului nu va avea acces la ele) și laptopul va fi protejat cu parolă

- La sfârșitul cercetării, copiile electronice ale transcrierilor interviurilor/grupurilor de fotografie (cu pseudonim) vor fi păstrate în siguranță pe un laptop protejat cu parole, pentru zece ani. La sfârșitul acestei perioade transcrierile vor fi distruse.

- Varianta tipărită a interviurilor/grupurilor de fotografie vor fi anonimizate prin înlăturarea oricărei informații personale, inclusiv numele tău. Citate anonimizate din timpul interviurilor/grupurilor de fotografie vor fi folosite în rapoarte ce ar putea fi publicate, fără să aibă atașat numele tău.
- Datele tale personale vor fi confidențiale și vor fi păstrate separat de răspunsurile tale din timpul interviurilor/grupurilor de fotografie.

Ce se va întâmpla cu rezultatele cercetării?

Rezultatele vor fi incluse de cercetător într-o lucrare de doctorat și cu posibilitatea de a le discuta cu alți profesioniști din domeniul sănătății mintale și legislatori responsabili cu dezvoltarea serviciilor de sănătate mintală. S-ar putea ca rezultatele să fie propuse spre publicare în publicații academice, cărți, conferințe, etc.

Ce riscuri există?

Nu există niciun risc anticipat în legătură cu participarea ta în acest studiu. Totuși, dacă vei fi afectat emoțional ca urmare a participării tale, ești rugat să faci acest lucru cunoscut cercetătorului și să contactezi asistentul social de la centrul comunitar (tel. 0753088673).

Ce beneficii există?

Deși s-ar putea să ai o experiență interesantă în cadrul proiectului, nu există beneficii directe în legătură cu participarea ta.

Cine a aprobat proiectul?

Studiul a fost aprobat de Comitetul de Etică în Cercetare a Facultății de Sănătate și Medicină, Universitatea din Lancaster, Anglia

De unde pot obține mai multe informații despre studiu?

Dacă ai întrebări legate de acest studiu, te rog adresează-te lui
Lucian Milasan (cercetător)
Email: L.Milasan@Lancaster.ac.uk
Tel.: [număr de telefon – folosit exclusiv pentru proiect]

Plângeri

Dacă vrei să depui o plângere sau să-ți exprimi nemulțumirea în legătură cu aspectele acestui studiu și nu vrei să vorbești cu cercetătorul, ai posibilitatea să contactezi îndrumătorii de proiect:
Dr. Naomi Fisher (îndrumător): N.Fisher@Lancaster.ac.uk
Dr. Amanda Bingley (îndrumător): – A.Bingley@Lancaster.ac.uk

Dacă vrei să vorbești cu cineva în afara programului de doctorat în sănătate mintală, contactează-l pe:
Prof. Roger Pickup (Associate Dean for Research)
Tel: +44 (0)1524 593746 | Email: r.pickup@lancaster.ac.uk
Faculty of Health and Medicine | Division of Biomedical and Life Sciences
Lancaster University | Lancaster | LA1 4YG

Mulțumesc pentru timpul acordat citirii fișei de informații proiect!

Appendix 14: Project activities (attachment to the Participant Information Sheet)

Project meeting • Presentation of the research project, tasks, and roles during the project	25.06.2019 (10am-12pm)
Workshop 1: Induction & working with imagery • Investigating potential life stories hidden in photographs • Bringing memories to life through photography	02.07.2019 (10am-12pm)
Take pictures relevant to your experience of recovery in between workshops	
Workshop 2 & 3: Pictures of recovery (I) • Finding meanings behind photographs illustrating experiences of recovery	09.07.2019 (10am-12pm) 16.07.2019 (10am-12pm)
Take pictures relevant to your experience of recovery in between workshops	
Workshop 4: Pictures of recovery (II) • Finding themes of recovery by engaging the research participants in creative and collaborative ways to make sense of their experiences of recovery	22.07.2019 (10am-12pm)
Qualitative interviews • One-to-one discussions to explore (or deepen understanding) of the lived experience of recovery, through photography	15.08-21.08.2019 Duration: 60-90min
Feedback and reflection group • Discussing the provisional research findings and investigating participants' perspective on the potential of photography to support and facilitate recovery	13.08.2019 (10am-11pm)

Appendix 15.1: Consent form (English)

Consent Form

Research project: Exploring the experience and meaning of recovery from mental distress in Romanian mental health service users through photography

You are invited to take part in a research project that aims to explore the experience of recovery from mental health problems from the perspective of Romanian mental health service users. This aim will be achieved by using photography activities i.e. photography workshops and one-to-one interviews. The findings of this project are intended to contribute to developing mental health services in Romania that are focused more on the needs and perspectives of service users.

Before you consent to participating in the study we ask that you read the participant information sheet and mark each box below with your initials if you agree. If you have any questions or queries before signing the consent form please speak to the principal researcher, Lucian Milasan, Mental Health PhD student at Lancaster University, UK.

	Please initial each statement
1. I confirm that I have read the information sheet and fully understand what is expected of me within this study.	
2. I confirm that I have had the opportunity to ask any questions and to have them answered.	
3. I understand that my participation in interview/photography workshops and feedback and reflection group will be audio-recorded and then made into a pseudonymised written transcript.	
4. I understand that audio recordings will be kept until the research project has been examined.	
5. I understand that my participation in this project is voluntary. Also, I understand that I am free to withdraw at any time without giving any reason and without my service provision or legal rights being affected.	
6. I understand that once my data have been anonymised and incorporated into themes it might not be possible for it to be withdrawn, though every attempt will be made to extract my data, up to the point of thesis submission.	
7. I understand that the information from my interview/photography workshops will be pooled with other participants' responses, anonymised and may be published.	
8. I understand that I will be able to take pictures of recognizable faces only if I have my subjects' agreement in the form of a model consent form (provided by the researcher). I also understand that all the recognizable faces in my	

pictures will be anonymised by the researcher through blurring when/if they are disseminated.	
9. I consent to information and quotations from my interview/ participation in the photography workshops being used anonymously in journal publications, reports, presentations, conferences, training events, discussion with policy-makers, and books.	
10. I consent to my photographs produced during the project, for which I will continue to own the copyright, being used anonymously in journal publications, reports, presentations, conferences, training events, discussion with policy-makers, and books. I understand that there is a risk that, once disseminated, my photographs can be copied and disseminated by others beyond the scope of the research project and researcher's control.	
11. I understand that the researcher will discuss anonymised data with their supervisor as needed.	
12. I understand that any information I give will remain confidential and anonymous unless it is thought that there is a risk of harm to myself or others, in which case the researcher may need to share this information with their supervisor or, depending on the gravity of the situation, with the staff members at the day centre.	
13. I consent to Lancaster University keeping written transcriptions of the interview/photography workshops (anonymised) for ten years after the study has been completed.	
14. I consent to take part in the above study.	

Name of Participant_____ Signature_____ Date _____

Name of Researcher _____Signature _____Date _____

Appendix 15.2: Consent form (Romanian)

Formular de consimțământ

Proiect de cercetare: ”Explorarea experiențelor de recuperare a sănătății mintale a beneficiarilor de servicii din Romania prin intermediul fotografiei”

Ești invitat să participi într-un proiect de cercetare care are drept scop explorarea experiențelor de recuperare a sănătății mintale din perspectiva beneficiarilor de servicii din Romania. Acest scop se dorește a fi atins prin intermediul fotografiei, adică ateliere de fotografie și interviuri unu-la-unu. Se speră ca rezultatele acestui proiect să contribuie la dezvoltarea serviciilor de sănătate mintală în România care au la bază nevoile și perspectiva beneficiarilor de servicii.

Înainte de a-ți da consimțământul de a participa în acest studiu, ești rugat să citești fișa de informații a proiectului și bifezi cu inițialele proprii dacă ești de acord. Dacă ai întrebări sau nelămuriri înainte de semnarea formularului, ești rugat să te adresezi cercetătorului principal, Lucian Milasan, doctorand în sănătate mintală la Universitatea din Lancaster, Marea Britanie.

	Ești rugat să semnezi cu inițialele tale
1. Confirm faptul că am citit fișa de informații a proiectului și am înțeles întrutotul ce se așteaptă de la mine în acest studiu.	
2. Confirm că mi s-a oferit ocazia să adresez întrebări legate de proiect și că mi s-a răspuns corespunzător.	
3. Înțeleg că participarea mea în interviu/atelierele de fotografie și grupul de feedback și reflecție va fi înregistrată audio și transcrisă folosind un pseudonim (în locul numelui meu real).	
4. Înțeleg că înregistrările audio vor fi păstrate până când proiectul va fi evaluat de examinatori.	
5. Înțeleg că participarea mea în acest proiect este voluntară. De asemenea, înțeleg că mă pot retrage oricând din proiect, fără să dau nicio explicație și fără să-mi fie afectate drepturile legale ca beneficiar de servicii.	
6. Înțeleg că odată ce datele proiectului au fost anonimizate și încorporate în categorii tematice, s-ar putea să nu fie posibil ca aceste date să fie șterse sau retrase, deși se va încerca tot posibilul, până în momentul în care teza de doctorat va fi înmânată spre verificare.	
7. Înțeleg că informațiile din interviu/atelierele de fotografie vor fi agregate cu răspunsurile celorlalți participanți, anonim, și s-ar putea să fie publicate.	
8. Înțeleg că am voie să fac fotografii cu persoane ale căror fețe sunt identificabile doar dacă mi s-a permis acest lucru de către subiecți sub forma unui consimțământ (furnizat de cercetător). De asemenea, înțeleg că fețele	

identificabile din fotografii vor fi anonimizate electronic când/dacă vor fi diseminate.	
9. Îmi dau consimțământul ca informații și citate din interviu/atelierele de fotografie să fie folosite, anonim, în publicații de specialitate, rapoarte, prezentări, conferințe, training-uri, discuții cu legislatori, și cărți.	
10. Îmi dau consimțământul ca fotografiile pe care le fac în cadrul proiectului, pentru care o să îmi păstrez drepturile de autor, să fie folosite anonim în publicații de specialitate, rapoarte, prezentări, conferințe, training-uri, discuții cu legislatori, și cărți. Înțeleg că există riscul ca odată diseminate, fotografiile mele să fie copiate și diseminate de alții dincolo de cadrul proiectului și fără controlul cercetătorului.	
11. Înțeleg că cercetătorul va discuta datele ce au fost anonimizate cu îndrumătorii de proiect dacă e necesar.	
12. Înțeleg că orice informație din cadrul proiectului va rămâne confidențială și anonimizată, cu excepția situațiilor în care există riscul de vătămare proprie sau a altor persoane, caz în care cercetătorul poate fi nevoit să dezvăluie această informație îndrumătorului de proiect sau, în funcție de gravitatea situației, membrilor personalului centrului de zi.	
13. Îmi dau consimțământul ca Universitatea din Lancaster să păstreze transcrierile interviului/atelierelor de fotografie (anonim) pe o perioadă de zece ani după finalizarea studiului.	
14. Îmi dau consimțământul să particip în acest studiu.	

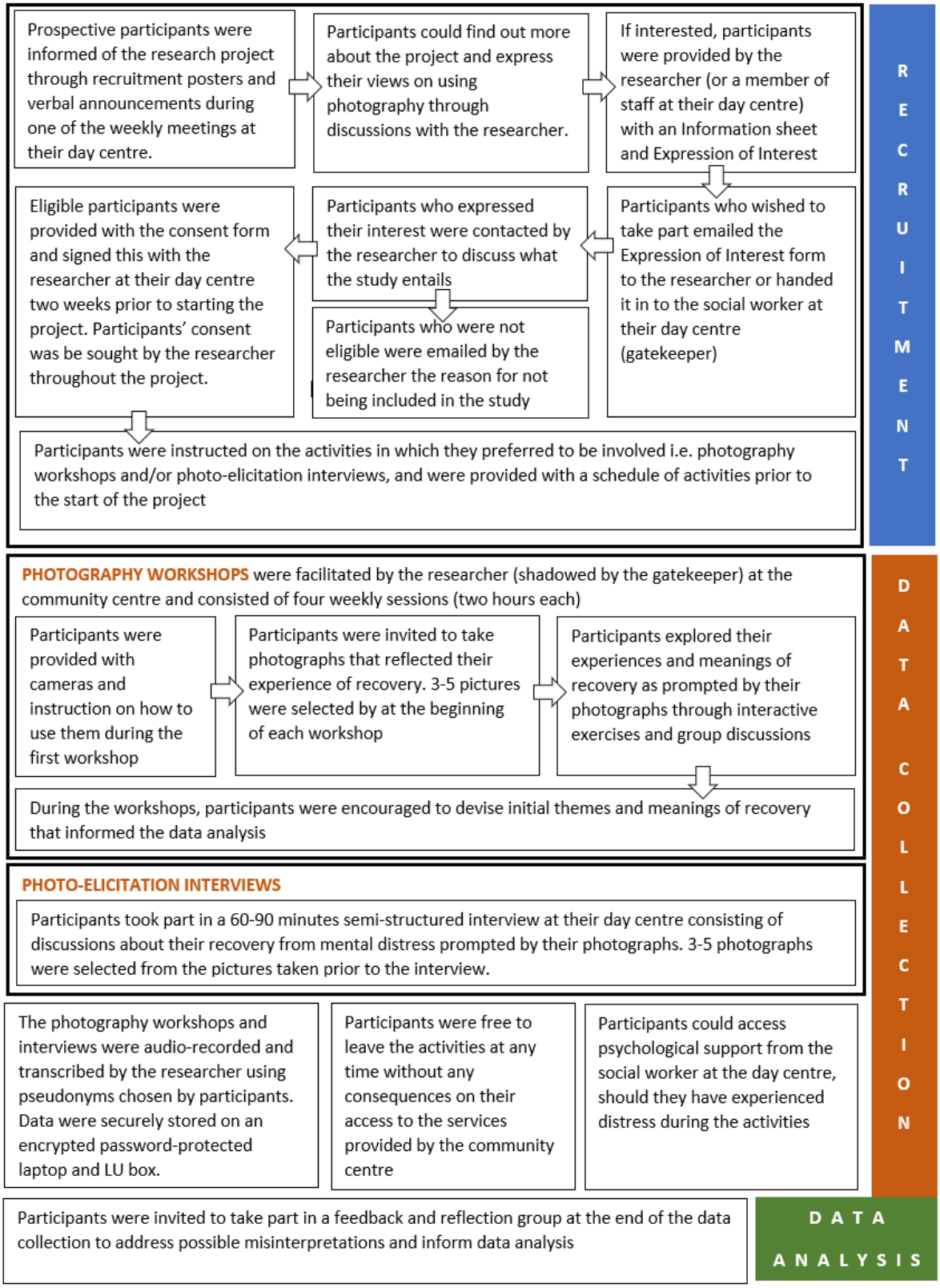
Numele participantului_____ Semnătura_____ Data _____

Numele cercetătorului_____ Semnătura_____ Data _____

Appendix 16: Research project inclusion/exclusion criteria

Included	Excluded
• male and female adults (aged 18+) [and] • service users of the targeted mental health community day centre in Romania [and] • people recovering from mental distress (regardless of "symptomatology" and "diagnosis") Mental distress is defined here as a "highly variable and heterogeneous set of experiences including: - Strong and overwhelming emotional states of various kinds, that disrupt everyday life and prevent people from functioning. - Habitual and repetitive patterns of acting – for example, in relation to personal hygiene, or to do with safety and security – that create anxiety if they are not carried out. - Experiences of seeing and hearing things that other people do not see or hear, or of holding beliefs that are considered by others to be unusual and extreme." (Cromby, Harper, & Reavey, 2013, p. 9). • people of different ethnicities, social and educational backgrounds • with or without photography skills/training or equipment • people who have the mental capacity to consent on their own behalf • speaking Romanian (or English)	• service users of the targeted day centre under the age of 18 • people experiencing other types of recovery that are more prominent than the recovery from mental health issues (e.g. mental distress is rather a consequence of issues such as substance abuse, physical illnesses, severe learning disabilities, autism, etc.) • people who do not have the mental capacity to consent • people not speaking Romanian (or English) fluently

Appendix 17: Research participants' experience throughout the research project



Appendix 18: Demographic characteristics of the research participants

Number of participants	15
Male	8 (53%)
Female	7 (47%)
Average age of participants	43
Minimum age	28
Maximum age	63
Ethnicity	
Romanian	12 (80%)
Hungarian	3 (20%)
Education	
Junior school	2 (13%)
Vocational school	3 (20%)
College	6 (40%)
University	4 (27%)
Employment status	
Unemployed (ill health pension)	14 (93%)
Employed	1 (7%)
Marital status	
Single	10 (66%)
Married	1 (7%)
Divorced	3 (20%)
In a relationship	1 (7%)
Mental health problems (diagnosis)	
Schizophrenia	13 (87%)
Depression & anxiety	2 (13%)
Average age when first experienced mental distress	27
Medical treatment	
Antipsychotics	13 (87%)
Antidepressants	2 (13%)
Non-medical treatment (counselling or psychotherapy)	
Accessing (or previously accessed) therapy/counselling	5 (33%)
Did not access therapy/counselling	10 (67%)
Average years of accessing mental health services at the community day centre	9
Minimum	1
Maximum	21

Appendix 19: Examples of questions asked to explore participant-produced photographs during the workshops and photo-elicitation interviews (adapted from Rose, 2016, p. 374-375)

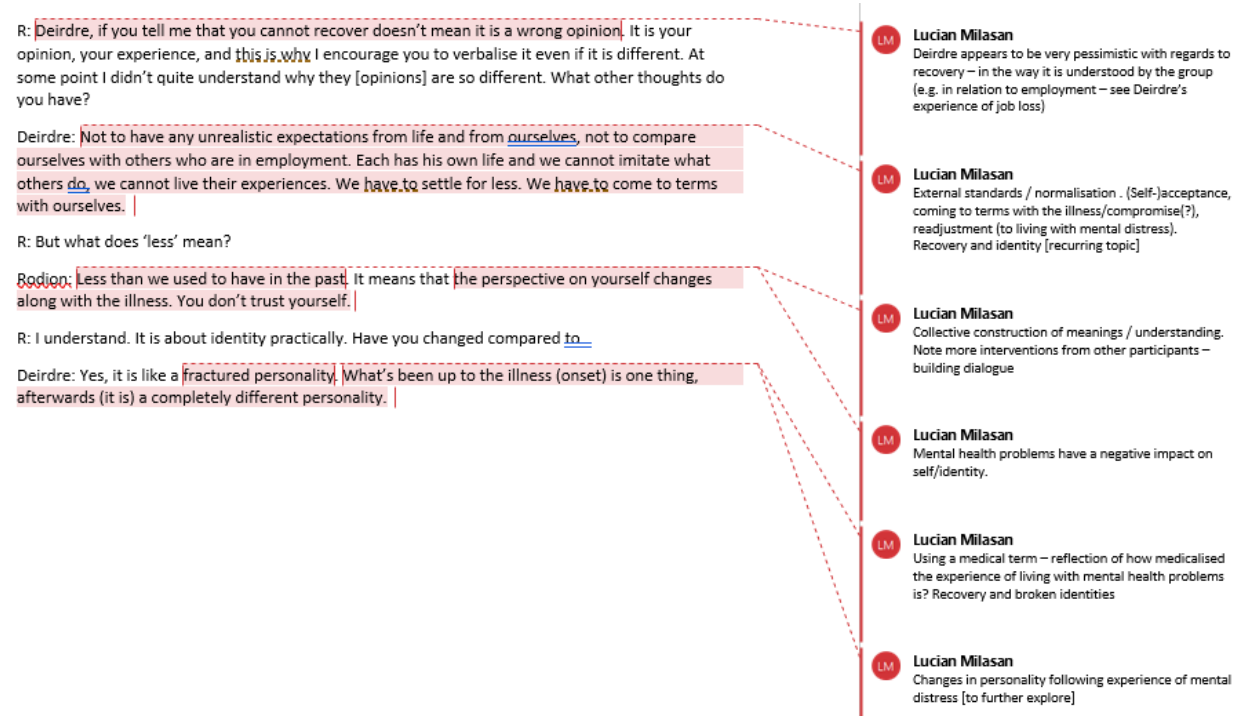
- Where and why was this picture taken?
- What were your thoughts and feelings when you took this picture?
- How is this photo relevant to your experience of recovery?
- What does the photo show? Where is the viewer's eye drawn in the image and why?
- What are the elements of the photograph?
- What is the link between the elements of the photograph and your experience of recovery? What do these elements mean in terms of recovery? What does this photograph say about your own story of recovery?
- What are the positive/negative aspects of recovery as illustrated in your photograph?
- Is the colour/contrast/light/angle/perspective/composition of your photograph relevant to illustrate your experience of recovery and, if so, why?
- Is there anything missing from this photograph? What else would you have photographed to illustrate your recovery?

Appendix 20: Step-by-step approach to analysing data (iteratively) using Interpretative Phenomenological Analysis (adapted from Smith et al., 2009)

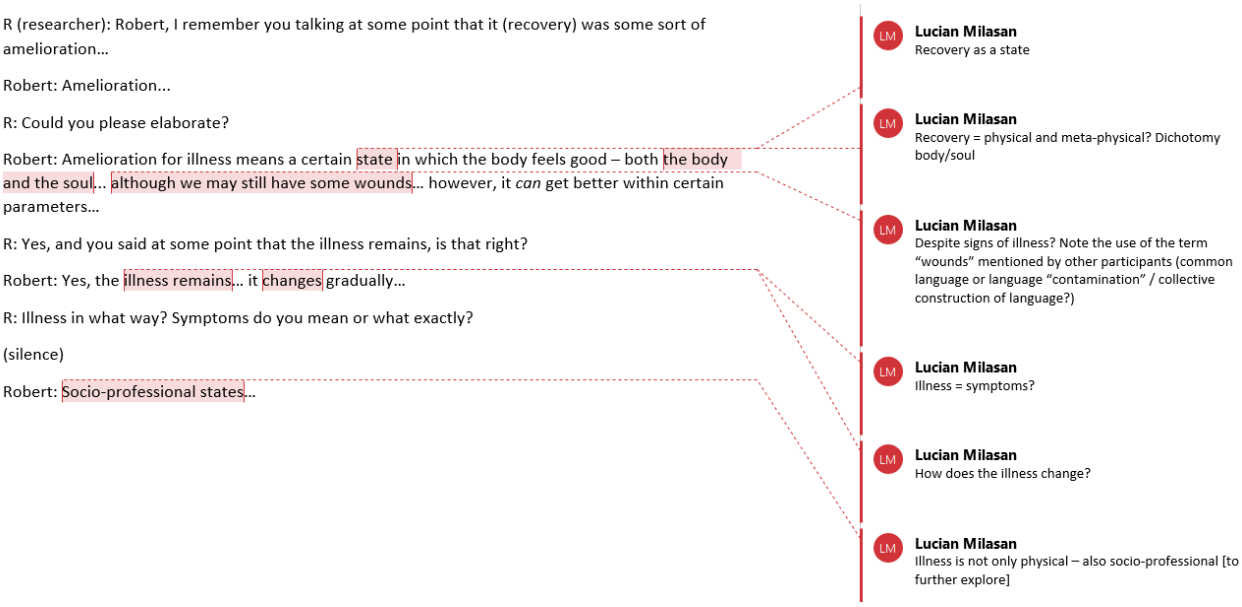
	Stage 1 **Photography workshops**	**Stage 2** **Photo-elicitation interviews**
I. Reading and re-reading	Each photography workshop was transcribed, translated into English, read, re-read, participants' photographs revisited and recordings listened to, before the start of the next workshop. Attention was paid to each participant's verbal and visual contributions separately, but also to the group as a whole (e.g. group dynamics, construction of meanings of recovery, particularities of communication for each participant, engagement with the photography element, etc.)	Each interview was transcribed, translated into English, read, re-read, participants' photographs revisited, and the recording listened to, before moving onto transcribing the next interview, in order to familiarise with the experiences shared by each participant. The interview guide included, but was not limited to, questions informed by the photography workshops.
II. Initial noting	Initial comments following from each photography workshop (interview) were noted by the researcher (exemplified in Appendices 21.1(a) and 21.1(b)), with emphasis on exploratory aspects of recovery that could have been potentially developed (or clarified) during the next workshop (interview). Recollections from each of the photography workshops (interviews) were also recorded by the researcher in the fieldwork diary (excerpts in Appendix 36) that triggered reflections and questions to be addressed to participants in the subsequent workshops (interviews). Aspects of recovery that were important to participants were highlighted with a view of making sense of them together with those involved (moving from descriptive comments to interpretation).	
III. Identify key themes	Areas of recovery identified by the researcher and participants during the workshops and the reflection group (Appendix 22) were further explored by the researcher based on participants' interpretations of their photographs and corresponding quotes. Researcher's initial exploratory comments were revisited. Quotes and images representative for the topic of recovery as understood by participants were attached initial codes grouped into provisional recovery themes aided by qualitative analysis software (Atlas.ti) (example in Appendices 21.2(a) & 21.2(b)) and MS Excel spreadsheets (Appendix 21.2(c)).	
IV. Searching for connections across identified key themes	Connections between recovery themes were explored while going through phases of data "messiness" (Appendix 23). Each theme was looked at and interpreted in connection to other themes (Appendix 35) in order to capture the "whole" of the research phenomenon while staying close to its "parts". Structure was sought at this stage by bringing together commonalities of the experience and meaning of recovery, but also particularities (at individual and group level). The aim was to move to higher levels of abstraction (Appendix 24) (i.e. simplified representation of the "whole" that allowed for further theoretical connections presented in *Chapter 5: Findings* and further interpreted in *Chapter 6: Discussion*).	
V. Moving to the next case	Each subsequent workshop (interview) transcript was analysed with a "fresh eye" by following steps I-IV, allowing the identification of new themes from one activity to the next.	
VI. Looking for patterns across cases	Connections across cases were explored by the researcher with input from the supervisory team. This stage involved restructuring and recoding the provisional thematic structure (IV) to reflect subordinate themes occurring in at least half of the participants' accounts (Appendix 34). Superordinate themes have been devised by grouping subordinate topics in thematic clusters (Appendix 33).	

Appendix 21.1(a): Example of initial transcript noting with reflective comments (workshops)

Workshop 2



Workshop 3



Appendix 21.1(a): Example of initial transcript noting with reflective comments (workshops) (continued)

Workshop 4

Deirdre: Since I stepped through the door that was open by the onset of my mental illness many years ago, my life took a different road. A road that I didn't expect and that I didn't believe it was possible, at least not for me, according to the principle that bad things always happen to others. When I was thinking about the future, I didn't project a road like this for myself, I considered myself exempt from many of the bad experiences I've been through.

These experiences are perceived by normal people, who are mentally healthy, like something from the SF (science-fiction), the same way I perceived them before the onset of the illness, when I was listening to them (experiences) as they were narrated by a teenager with mental health problems I knew at that time.

Lucian Milasan
Door as a metaphor for transition – from wellbeing to illness

Lucian Milasan
Road as a metaphor for a journey through mental distress

Lucian Milasan
Stage of denial? (see Kübler-Ross's stages of grief)

Lucian Milasan
Perception of illness

I chose the photograph depicting a gate on which is presented in a stylised bas-relief a crucified man, undoubtedly a reference to the Christ martyrdom, to suggest my entrance, without a way back, to the world of mental suffering.

As a symbol of pain, the cross is ramified in a real tree or a multitude of crosses indicating the self-torture imposed by the mental illness, my being overwhelmed by ideas of worthlessness that build numerous nests in the tangled forest of a tormented psyche. From the onset of the illness, also start the ideas from the micro-manic complex that have been controlling me up to today – the idea of inferiority, of incapacity. With the difference that during the initial stage I was seeing everything in dark colours, I couldn't see any ray of hope, I was captive in a thick swamp, the horizon was narrow and burdensome. Second picture...

Lucian Milasan
'cross to bear' – struggle / use of metaphors again

Lucian Milasan
Onset of illness as a sentence, imprisonment for life 'no way back'

Lucian Milasan
Multiplied suffering, more 'crosses to bear'

Lucian Milasan
Distress as negative feelings and thoughts

Lucian Milasan
Psychological nature of distress

Lucian Milasan
Idea of control – no choice?

Lucian Milasan
Self-esteem issues. Reinforced by being on an incapacity pension?

Lucian Milasan
No hope for recovery – link to Deirdre's overall pessimistic attitude toward recovery

Lucian Milasan
Use of metaphors / feeling stuck, trapped

Appendix 21.1(b): Example of initial transcript noting with reflective comments (interviews)

Interview (Loredana)

R: What did you have in mind when you took this photograph?

Loredana: It gave me a feeling of spring... leaves, butterflies, little flowers... and it helps me... well, not that it helps me... I like spring when trees are coming back to life, blossoming... and this gives me a feeling of happiness.... I like nature very much and I like flowers and the trees... It makes me feel good, healthy and hopeful...

R: And how is this related to recovery? What do you think?

Lucian Milasan
Renewal?

Lucian Milasan
Revitalisation / new beginnings?

Lucian Milasan
Natural landscapes – restorative, therapeutic (see similar comments from workshops)

Lucian Milasan
Hope was a recurring theme during the photography workshops – to further explore / identify nuances

Loredana: Spring is when we celebrate Easter and I go to church and I pray and God gives me courage... the same way nature comes back to life... God [Jesus] is rising for us, for people... and it charges me with hope. You know, it's not easy to live with this illness and the truth is that I like to go to church and say 'Our Father...'. I say it on the street as well wherever I walk. It makes me forget about this burden... about... how shall I call it... I have thoughts... I'm thinking that I'm not that useful (purposeful?) for society. I am retired on health grounds and I don't work and somehow I feel guilty, but...

Lucian Milasan
Resurrection of Christ / feeling alive again?

Lucian Milasan
Spiritual resources – to explore further

Lucian Milasan
Nature related metaphors – language of recovery and mental distress based on natural elements

Lucian Milasan
Religion as a source of hope

Lucian Milasan
Struggles / lived experience (recovery is not always related to positive aspects – recovery IN mental distress?)

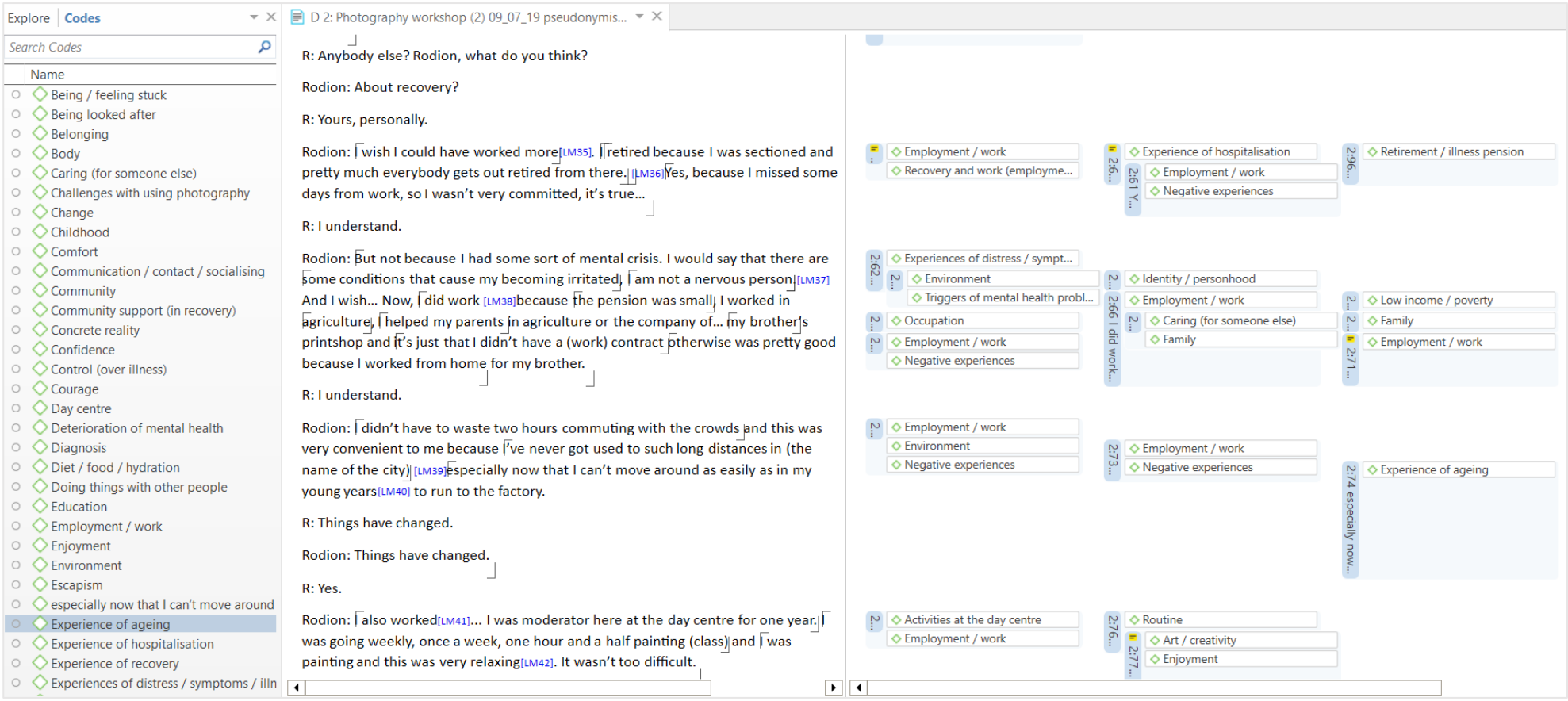
Lucian Milasan
Spirituality as a way to cope / distraction from negative thoughts?

Lucian Milasan
Internalised stigma – feelings of guilt / unproductiveness

Lucian Milasan
Explore link between being on benefits and stigma / impact on recovery

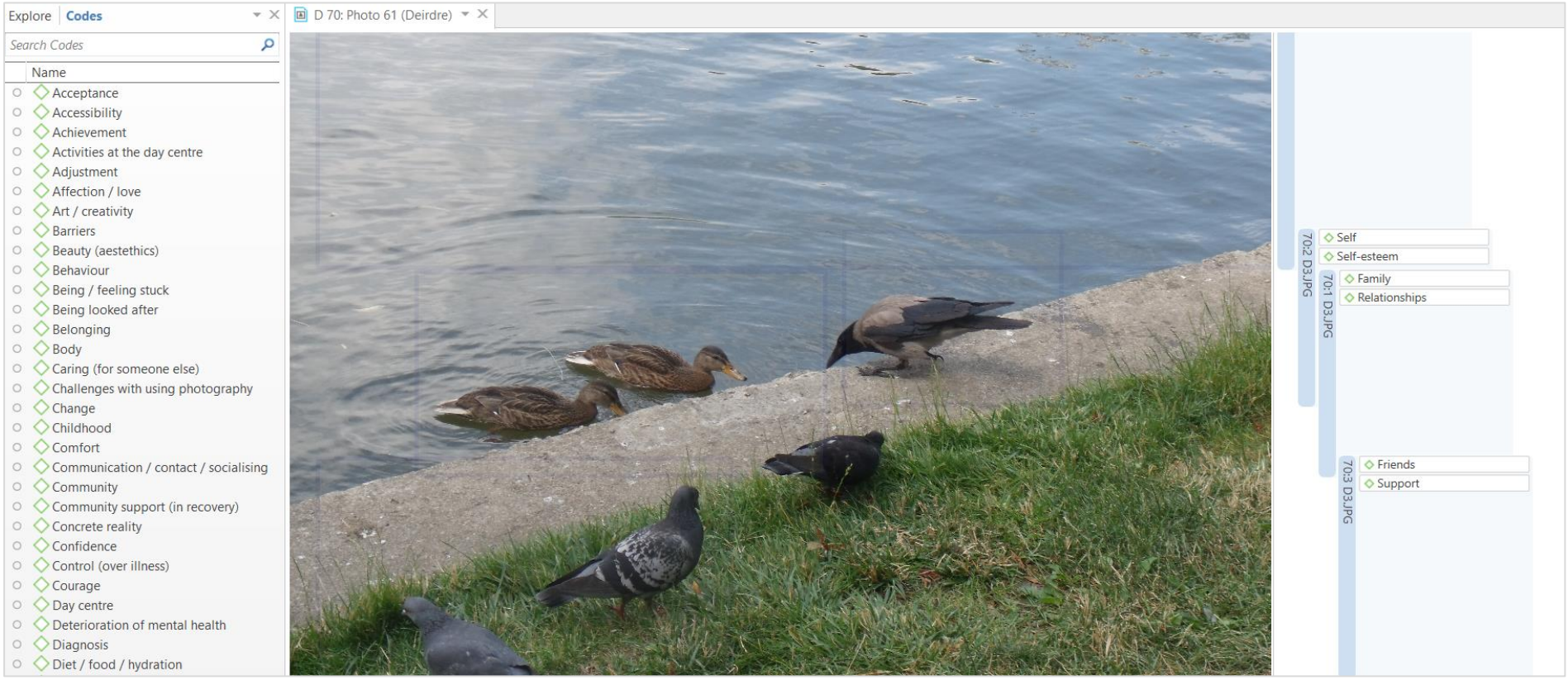
Appendix 21.2(a): Example of initial coding using the Atlas.ti qualitative software (textual data)

Workshop 2



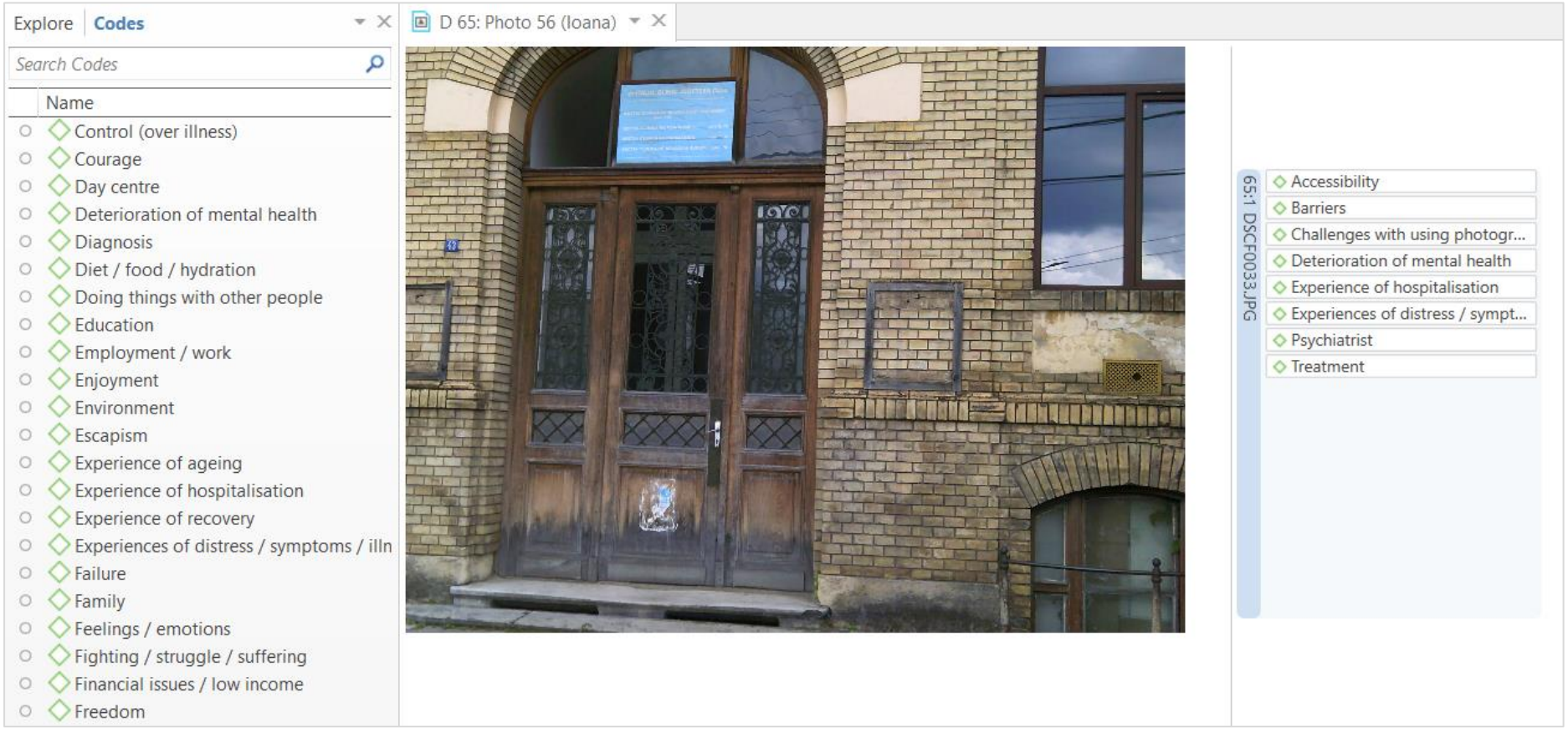
Appendix 21.2(b): Example of initial coding using the Atlas.ti qualitative software (visual data)

Workshop 4 (Deirdre)



Appendix 21.2(b): Example of initial coding using the Atlas.ti qualitative software (visual data) (continued)

Workshop 4 (Ioana)



Appendix 21.2(c): Example of processing data in Microsoft Excel® ("unpacking" themes - freedom as subtheme of awakening)

Freedom [related to citizenship]	[I] R: Why do you think that [**freedom**] is important for recovery? Emilian: That's how people in the Occident think… **think freely**… no one tells you how to think… you can **make choices** and **do things the way you want**… […] Yes, it's good to **think freely**… **without other people telling you how to think**… […] As I said, I change their [voices'] meaning… Sometimes I hear good voices but sometimes only mean voices… It's very difficult… Usually when I hear a voice in my head I have to listen to the good voice as well… **The decision is made in your head**. It's just that I don't always hear the good voice in my head…	Freedom of thinking; Contrast with the contrains of the home environment - link to relations of power e.g. with psychiatrists; freedom of thinking in relation to external factors e.g. other people telling him how to think or internal, in relation to hearing voices
	[I] Emilian: **I like people's ideas**, the things they do… I like the **light** [reference to the bulbs in his picture]… **I like to think freely…**	Emilian mentioned previously that the darkness makes him feel anxious
	Emilian: I'm a person searching for beauty… who can't get tired of beautiful things… [a person who] likes experimenting… [who] likes talking… [who] likes making contact… [who] likes interacting with other people… [who] likes being normal like everyone else… R: Normal… what does normal mean to you? Emilian: Normal like other people, not like me… **thinking slowly**… schizophrenic… **that's how I am… my mind is a little bit slow…** [laughs] Well… it affects me… **I should be faster in thinking**… They [doctors] explained to me that **our mind is split in many parts that we have to bring together**…	
	[I] R: And the fear [inscripted on his tattoo as 'fearless']? What are you afraid of? Emilian: **I am afraid that I cannot […] think freely… I am afraid that I am going to hear voices…**	
	[I] R: You took a picture of the Statue of Liberty here as well. Interesting… How is this related to recovery? What did you have in mind? Iaco: Well, liberty [freedom]. The name Americans gave to the Statue of Liberty is spot on […] **I feel free**, you know. But there are some things that depend on the **education** you receive at home. **You are free, but you have people around who you need to respect. Big, small [people], doesn't matter. You have to respect them so you become a model [for them].** So, you become [a model for them]. So that's what it [the photo] suggests. **Freedom**… but **freedom** now… the current generation… if you don't have people around and at school to guide people based on some elementary principles with an educational purpose… you have to learn to be… how do you call that? **Integrity**. To be **responsible**, otherwise… I don't know… it doesn't help.	Freedom while being respectful for others / social responsibility [in a society transitioning from communism to capitalism]
	[I] Iaco: The **freedom of treating myself**… with specialists' help, of course. [We discuss and she [the doctor] suggests me… 'Did you try this…?' or 'Do you want to try that…?' We discuss about all these… 'Doctor, I would like to try that medication'. So with my consent… And if I feel that [medication] helps, then I switch to that medication.] R: So, they give you the information, the choice and you are in a position to… Iaco: **I am the one who feels. I feel the effect of that [medication].** R: Has it always been like this?	

… | Recovery - occupations | Recovery - social support | Recovery - medical | **Recovery - life, existential** | Recovery - barriers | Overarching themes | Other themes | ⊕

Appendix 21.1c: Example of processing data in Microsoft Excel® ("unpacking" themes - freedom as subtheme of awakening)

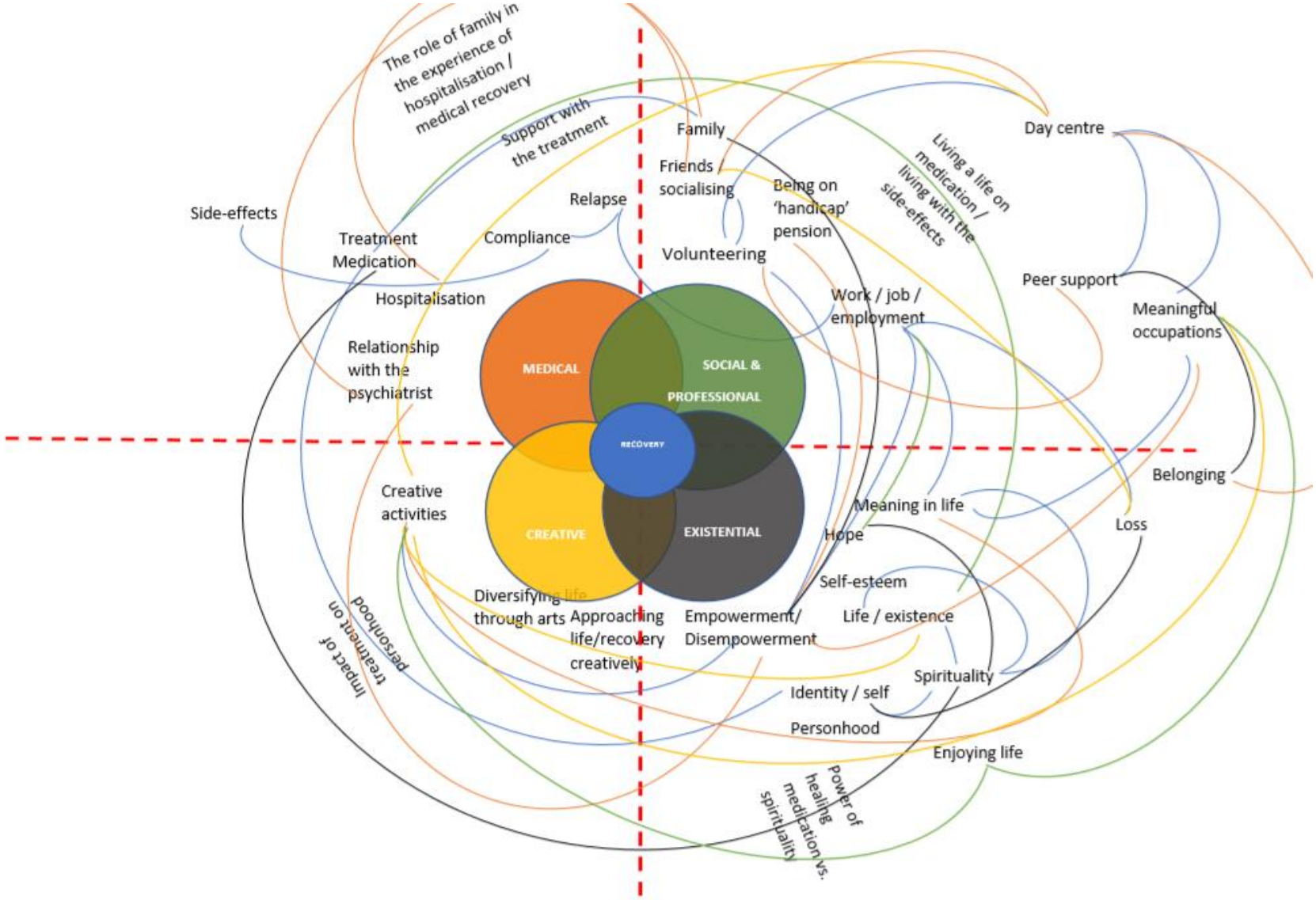
(continued)

	[I] Rodion: So, **during democracy you can say that I have one vote and can't change things**... There is no pressure like before when we were members [of the communist party] **to be committed and involved** in patriotic activities. There's nothing like that [now]. I can say that I have one vote and I can't change them [the corrupt government] even if I wanted. What can I say? **If you are threatened by the way Romania is ruled, well, vote for someone else who is more competent** in issuing laws... for example, [how is it possible that] serial killers are released from prison [referring to the new laws of justice that are controversial in Romania]. This is outrageous. I don't think God or the Bible would allow such stupid laws...	
	[I] Rodion: Well, some people maybe did feel that [patriotism?] and they were true patriots... I was so-so. **I didn't quite feel like doing my duty before the country.** For example, **I didn't enrol in the army**. I was in the Military Hospital for a few days and I said that if I am **exempt on medical grounds** from Mr. X [psychiatrist], then **I am not going to enrol**... It was **compulsory** at the time [during communism]. This [army] was a patriotic duty. So, I wasn't that... even now I am quite indecisive. I don't know who to vote for. **I usually vote but not with the current government because I am not pleased**... And I tell other people. Do you really want to vote for them? I can't change their opinion. Do you think is going to be well? No... It's not going to be well. But if they [other people] want to vote for them [current government], I can't change their opinion. So, I don't take too much responsibility, but I am active verbally [talking to people] to try to find a different way. [...] First of all, **it's somehow important to escape the society, to get to know yourself...** it's a little bit like what the monks were doing [laughs] when they were removing themselves [from the society?] to get to know God better.	*"it's somehow important to escape the society, to get to know yourself..."*
	[I] Rodion: And be impartial... just watching TV and **build your own opinion about what you see**. To **listen to other people's opinions without saying anything or changing them**... This **shapes you in a different way** than those horrendously boring speeches of **Ceausescu** [former communist dictator]. When I was born, Ceausescu was already president when I was one [year old]... This is the only thing I knew. I tried to remember... but I don't know... **I knew it was important when we studied socio-political sciences in college... but it's like trying to teach maths to someone who doesn't know anything except for writing poems**. [laughs] **That's how I was feeling.** [...] It just didn't get into my head... It was like learning something **mechanically** [automatically] but it didn't get into my head **automatically**.	
	[I] Rodion: Yes, **we have more freedom nowadays in the sense of doing something you like**. But... there must be a limit with regards to freedom. Because... as that guy said [the former Minister of Defence?] the current government cut down 60% of the jobs in the Ministry of Defence and many good employees were retired aged 45-47 and they were replaced with members of the [socialist] party without a great deal of qualifications based on nepotism. And these [new] people are not good at preventing this country and people being sold piece by piece. The borders are open, foreigners don't necessarily want us to do well. They see us as a country that doesn't know where it is... Well, I didn't go to England, but I was in Spain. [...] Rodion [laughs] **There is freedom if you know how to see it. But you have to go on the other side of the bars [in the photograph]. There are always bars... sometimes useful for protecting people, but they are useless when people search for something.**	Freedom nowadays compared to [lack of] freedom during the communism; limitations to freedom; perspectives on freedom

... | Recovery - occupations | Recovery - social support | Recovery - medical | **Recovery - life, existential** | Recovery - barriers | Overarching themes | Other themes | ⊕

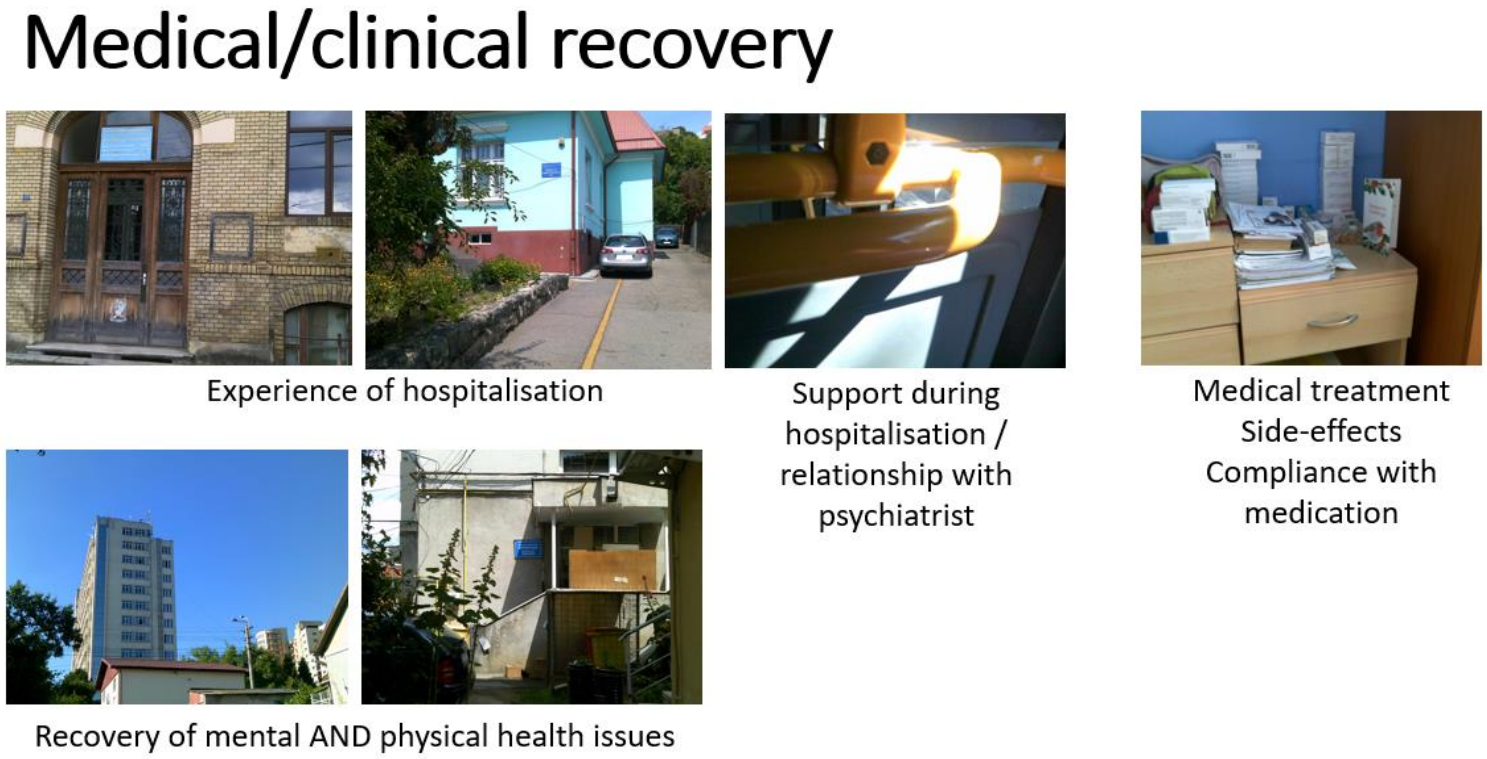
Appendix 22: Recovery themes and sub-themes identified together with the research participants during the photography workshops and feedback and reflection group

Appendix 23: Illustration of the data "mesiness" during the analytical stage

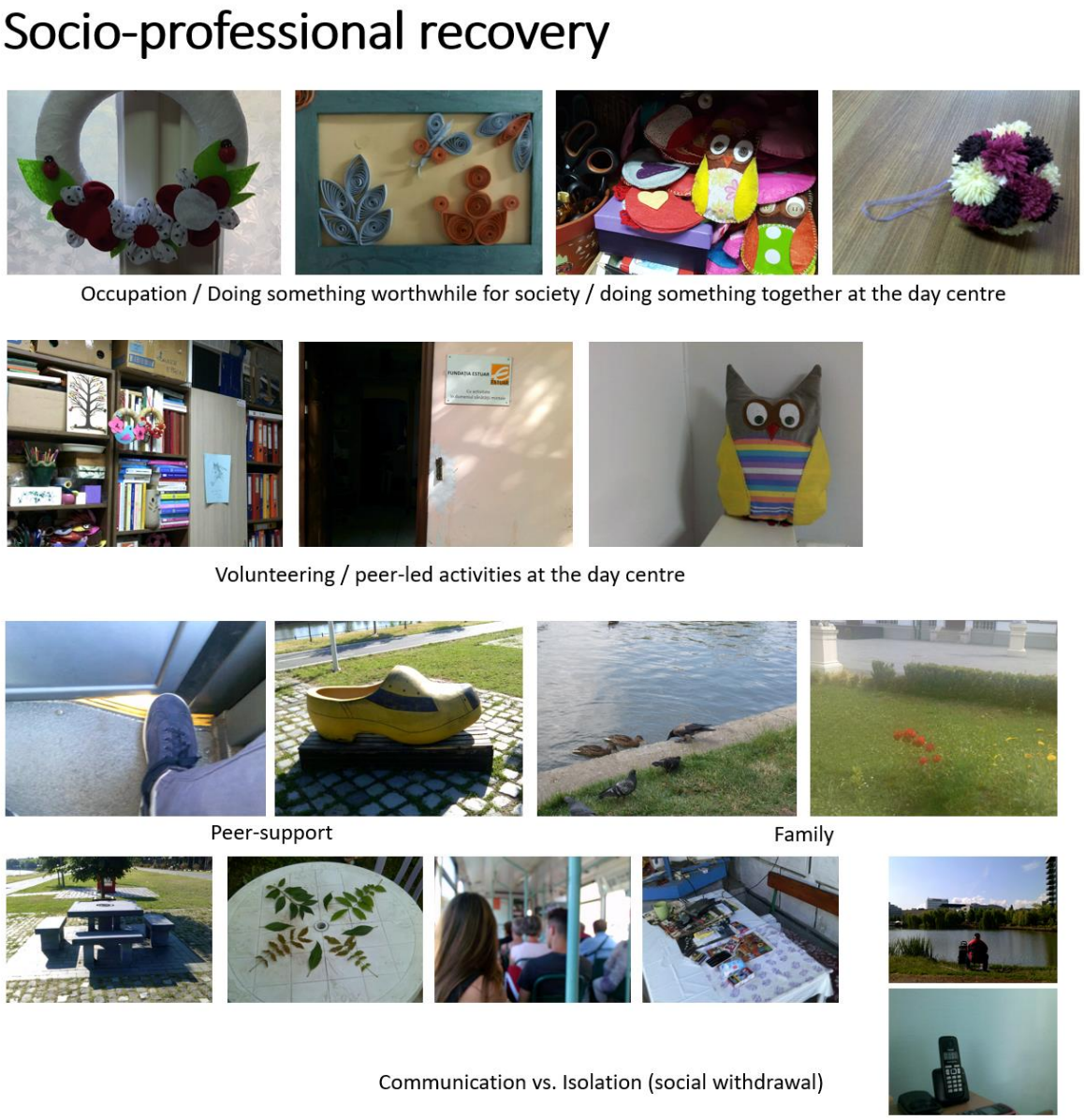


Appendix 24: Transition between the descriptive areas of recovery (Appendix 22) identified together with the research participants, and the analytical stage

Appendix 25: Collage of participant-generated pictures illustrating the clinical dimension of their experience of recovery



Appendix 26: Collage of participant-generated pictures illustrating the socio-professional dimension of their experience of recovery



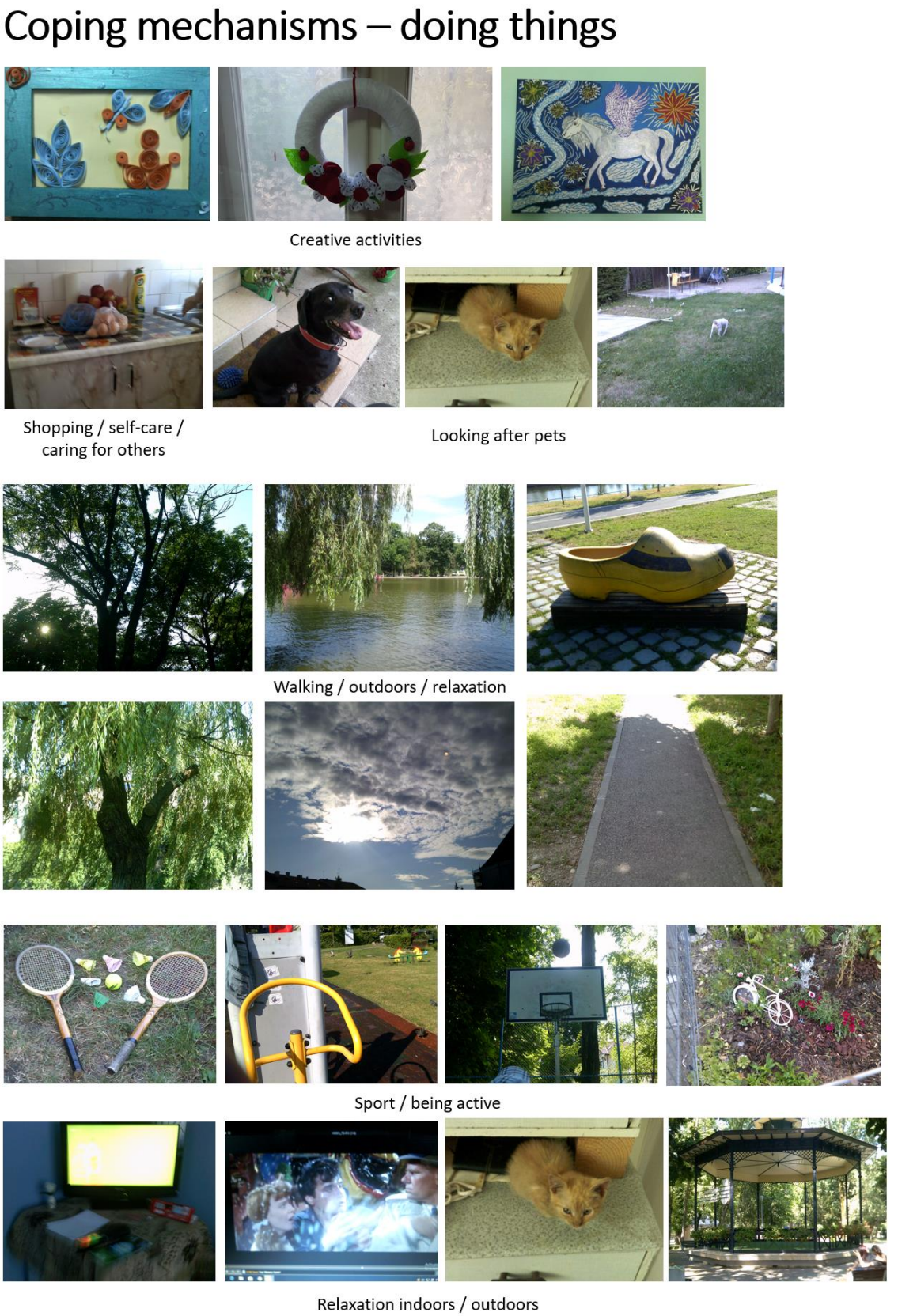
Appendix 27: Collage of participant-generated pictures illustrating the existential dimension of their experience of recovery

Appendix 28: Collage of participant-generated pictures illustrating the creative dimension of their experience of recovery

Appendix 29: Example of photographic metaphors used by participants to represent their experience of recovery

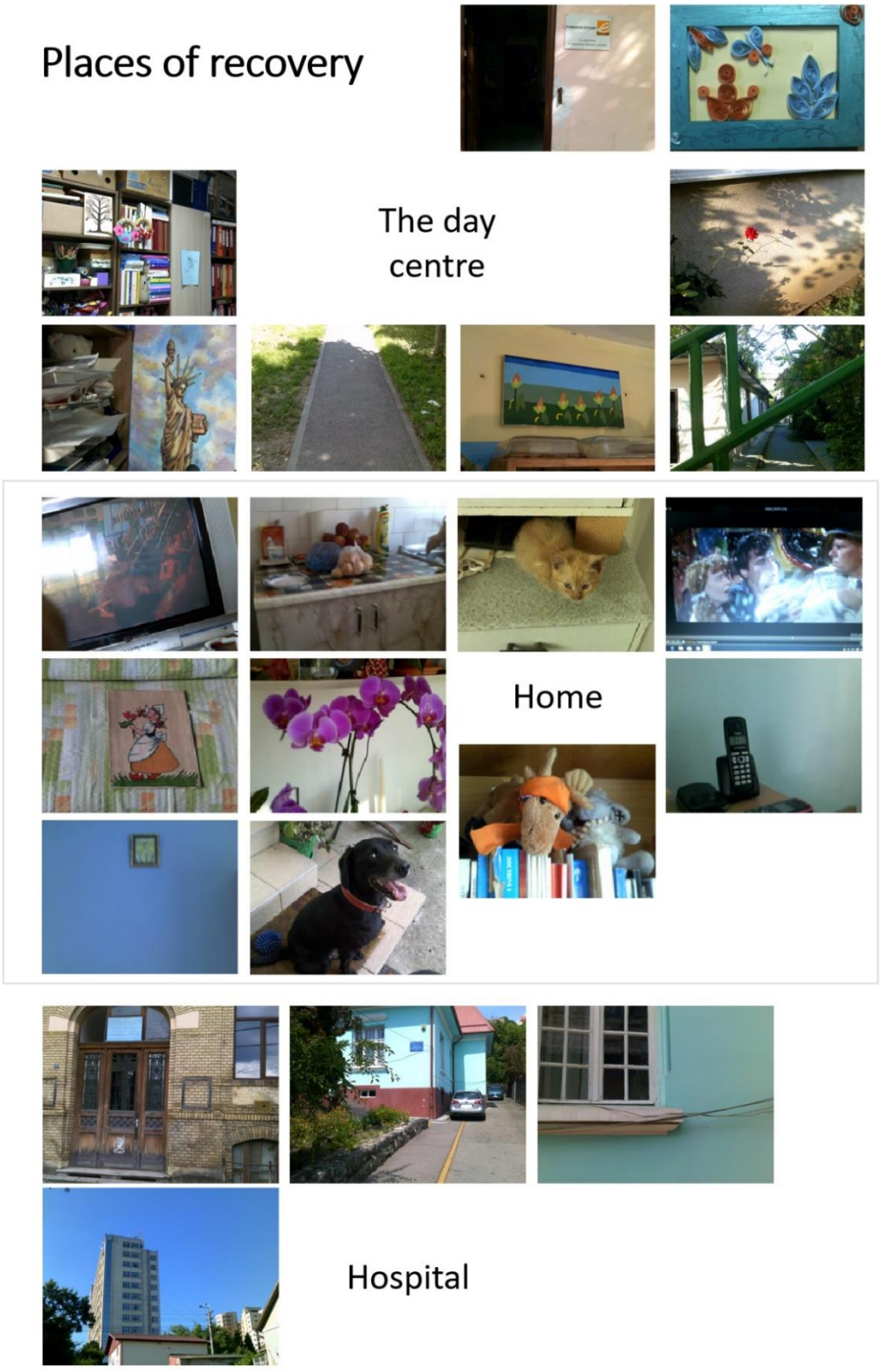
Appendix 30: Example of photographic metaphors used by participants to represent their experience of mental distress

Appendix 31.1: Collage of participant-generated pictures illustrating their various coping mechanisms (doing things)



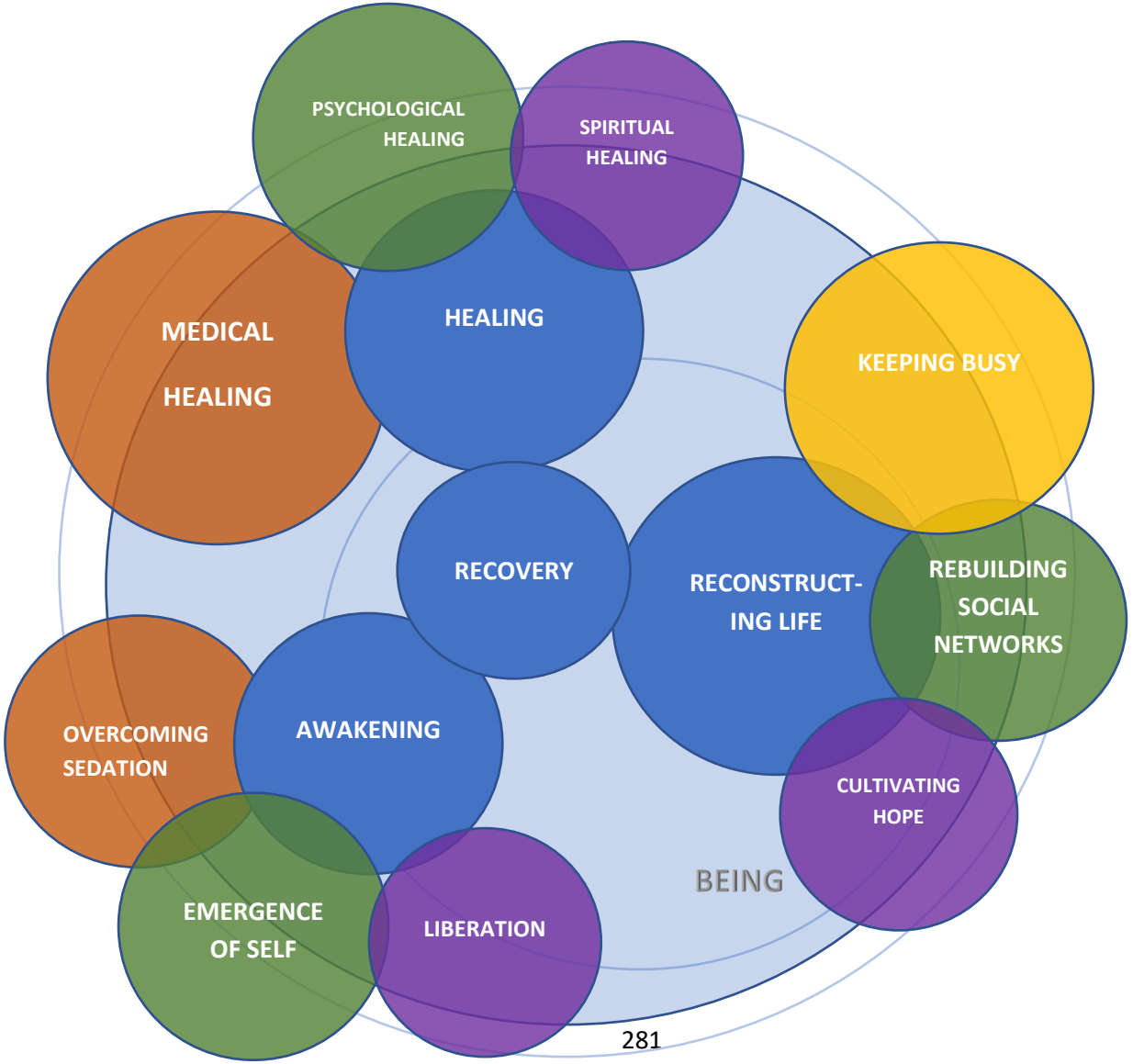
Appendix 31.2: Collage of participant-generated pictures illustrating their various coping mechanisms (support and escapism)

Appendix 32.1: Collage of participant-generated pictures illustrating various places of recovery (the day centre, home, and hospital)



Appendix 32.2: Collage of participant-generated pictures illustrating various places of recovery (nature and community)

Appendix 33.1: Diagram representing final recovery themes and subthemes identified through interpretation of the initial themes identified together with the research participants and transcript Interpretative Phenomenological Analysis



Appendix 33.2: Summary of the superordinate and related subordinate themes identified in participants' verbal and visual accounts of recovery

Awakening	**Recovery as a process of increased awareness of self and others, space and time, social and political contexts, which usually takes place gradually while individuals manage to reduce the debilitating effects of mental distress and sometimes psychiatric treatments.**
• Overcoming sedation	Psychiatric treatments and their side-effects can be as debilitating as mental illness by adding additional layers of distress and diminishing individuals' social, vocational, and psychological functioning. In light of this, recovery was understood by participants as a passage from a sedated self to one that that is able to fully experience the inner and outer world through sensorial and emotional experiences that are not blunted by high doses of medication.
• Emergence of self	Linked to the previous subtheme, emergence of self refers mainly to participants' realisation that they are not defined entirely by their illness identity, but also by human qualities, skills, and potential. Recovery is therefore described as a process of opening to self and restoring personal values lost to experiences of mental distress and psychiatric hospitalisation, which are reshaped and reconceptualised while in recovery (although a number of participants claimed that their identity has not changed as a result of illness).
• Liberation	Recovery as liberation is understood as an emerging sense of freedom awakened in participants in light of the knowledge that they acquired through lived experiences of oppression (particularly during the communist regime in Romania), and societal and political constraints in this country (including corruption, poverty, and stigma). Participants' recovery is seen in this thesis as part of a wider narrative of life, a life that participants hope to restore along with their ideals of freedom and awareness of civil rights and responsibilities. This subtheme also encompasses freedom from family constraints, the burden of symptoms, and also from psychiatric practices that hinder the recovery of some participants.
Healing	**The concept of recovery as healing is understood differently by participants in line with their lived experiences that were analysed along three main coordinates identified together with the research participants: medical, psychological, and spiritual. Healing is best explained as the process of alleviating the "wounds" left behind by mental illness through medical treatments, psychotherapy (or alternative therapies and self-help), and Christian religious practices.**
• Medical healing	Medical healing consists mainly of positive experiences of reducing symptomatology and the frequency of hospitalisations, seen as a way to "normalisation". Psychiatric treatments are central to this subtheme, but also positive encounters with mental health professionals who accompanied participants on their road to recovery. This aspect was nuanced through critical discussions around compliance with psychiatric treatments that created tensions in participants, but also new understandings of clinical recovery as not needing medical treatment one day.

Appendix 33.2: Summary of the superordinate and related subordinate themes identified in participants' verbal and visual accounts of recovery (continued)

• Psychological healing	Participants illustrated recovery as a journey to restoring positive thoughts and feelings as opposed to distressful emotional experiences. Therapy was exemplified as a route to recovery that was not always accessible and affordable to participants, hence their tendency to follow alternative routes (self-guided creative activities, self-help). The idea of cathartic "cleansing" was reiterated by participants (potentially in relation to "spoiled identities") through visual metaphors to emphasise recovery as a process of emotional purging leading to a state of mind that is constructive in nature.
• Spiritual healing	Religious practices and beliefs are key to the recovery of some participants who were guided and enlightened through spiritual resources (praying, going to church, Bible study) throughout their journey. They find refuge in spirituality that seems to compensate for areas of life that are problematic and hinder their recovery (e.g. abusive families). Culturally, they share a past of oppression and spiritual recovery with Christian-Orthodox practices that were restricted during the communist regime in Romania.
Reconstructing life	**Recovery is seen by participants as a restoration of a life affected by the loss of social roles and relationships, health, and plans for the future, caused by mental illness. This process of restoration takes place on three main levels: occupational (keeping busy), social (rebuilding social networks), and existential (cultivating hope).**
• Keeping busy	Data analysis revealed keeping busy as the most frequent subtheme in which participants conceptualised recovery mainly as securing employment or getting involved with different activities (creative, sportive, recreational) at the day centre, at home, and occasionally within their communities. Employment appears to be the main indicator for recovery as a source of income, sense of productivity, independence, personal and professional growth. Hence, the stigma around "idleness" and work "incapacitation" reinforced by current policies in Romania. Culturally, employment in the context of migration that is characteristic to Romania was explored in relation to recovery.
• Rebuilding social networks	The process of recovery does not happen in isolation, but through (re)connection with families, friends, peers, and the wider community. Hence, establishing meaningful and positive relationship was key to recovery for most of the participants (for some, relationships were a source of distress and trauma). Communication, togetherness, and a sense of belonging are key to this process to ensure that the social withdrawal, negative thinking, and emotional instability associated with mental distress are alleviated.
• Cultivating hope	Hope is the essential ingredient to reconstructing a life impacted by mental illness identified in relation to awakening (emerging hope) or healing (hope for "getting better"), but also concrete plans and aspirations for the future that guide participants on their journey to recovery. Sources of hope are multiple, mirroring what participants considered important for their recovery: spirituality, relationships, the day centre, natural environments, but also the psychiatric system (hope for better care).

Appendix 34: Frequency of superordinate and subordinate themes identified in the research participants' accounts

	Agnes	Cristi	Daniela	Deirdre	Emilian	Ioana	Iaco	Johnny	Loredana	Mariana	Mihai	Raul	Robert	Rodion	Tincuta
Awakening															
Overcoming sedation	✓		✓	✓		✓	✓					✓	✓	✓	
Emergence of self	✓			✓	✓	✓	✓		✓				✓	✓	✓
Liberation		✓	✓	✓	✓	✓	✓			✓				✓	
Healing															
Medical healing		✓	✓		✓	✓	✓	✓	✓	✓	✓	✓			✓
Psychological healing	✓		✓	✓	✓		✓					✓	✓	✓	
Spiritual healing		✓	✓		✓	✓			✓						✓
Reconstructing life															
Keeping busy	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Rebuilding social networks	✓		✓	✓	✓	✓	✓		✓	✓		✓	✓		✓
Cultivating hope	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓		✓	✓	

Appendix 35: Connections between themes and subthemes

		Awakening			Healing			Reconstructing life		
		Overcoming sedation	**Emergence of self**	**Liberation**	**Medical healing**	**Psychological healing**	**Spiritual healing**	**Keeping busy**	**Rebuilding social networks**	**Cultivating hope**
Awakening	**Overcoming sedation**		Impact of medication / side-effects on self / identity	Freedom restrained by medical treatments / Sedation as a form of constraint	Medication as "point of support" and barrier to recovery	Awareness of feelings and thoughts beyond the effects of medication	Alternative ways of healing linked to avoiding side-effects of medication	Sedation impact on ability to do things	Sedation impact on social skills/ communication	Hope to overcome side-effects of medication
	Emergence of self	Impact of medication / side-effects on self / identity		Self free of constraints e.g. political, psychiatric, social	Emergence of self through overcoming illness constraints through medical treatments	Emergence of renewed self through "cleansing" negative feelings and thoughts	Metaphysical self / connection of self to divinity	"You are what you do" / self defined through actions	Reshaping self as part of family, friends, community / being in society	Hope for an improved self beyond the constraints of illness
	Liberation	Freedom restrained by medical treatments / Sedation as a form of constraint	Self free of constraints e.g. political, psychiatric, social		Medical treatments as a way to overcome barriers caused by distress	Freedom of thinking and feeling	Freedom of practicing religion	Freedom of choice of activities	Freedom to exercise social and civic rights / participation within communities/ liberation from stigma	Hope for a life free of symptoms / hope for a better future
Healing	**Medical healing**	Medication as "point of support" and barrier to recovery	Emergence of self through overcoming illness constraints through medical treatments	Medical treatments as a way to overcome barriers caused by distress		Blurry boundaries between psychology and psychiatry	Faith leaders are occasionally first point of contact for addressing mental illness/ cultural ways	Medical recovery (certified by doctors) as premise for employment	Reduction of symptoms allow for social reengagement	Hope for a life without medication
	Psychological healing	Awareness of feelings and thoughts beyond the effects of medication	Emergence of renewed self through "cleansing" negative feelings and thoughts	Freedom of thinking and feeling	Blurry boundaries between psychology and psychiatry		Positive thinking developed through religious practices e.g. praying	Therapeutic activities e.g. art-therapy	(Re)connecting with people leads to positive thoughts and feelings	Positive thinking harbours hope for a better future

	Spiritual healing	Alternative healing linked to avoiding side-effects of medication	Metaphysical self / connection of self to divinity	Freedom of practicing religion	Priests are occasionally first point of contact for addressing mental illness/ cultural ways	Positive thinking developed through religious practices e.g. praying		Religious activities e.g. going to church, praying, Bible study	Church as an opportunity for socialising / belonging	Religion / spirituality is conducive to hope through prayer
		Awakening			**Healing**			**Reconstructing life**		
		Overcoming sedation	**Emergence of self**	**Liberation**	**Medical healing**	**Psychological healing**	**Spiritual healing**	**Keeping busy**	**Rebuilding social networks**	**Cultivating hope**
Reconstructing life	**Keeping busy**	Sedation impacts on ability to do things	"You are what you do" / self defined through actions	Freedom of choice of activities	Medical recovery (certified by doctors) as premise for employment	Therapeutic activities e.g. art-therapy	Religious activities e.g. going to church, praying, Bible study		Doing things together with others/ belonging / empowerment	Hope for regaining employment
	Rebuilding social networks	Sedation impacts on social skills/ communication	Reshaping self as part of family, friends, community / being in society	Freedom to exercise social and civic rights / participation within communities/ liberation from stigma	Reduction of symptoms allow for social reengagement	(Re)connecting with people leads to positive thoughts and feelings	Church as an opportunity for socialising / belonging	Doing things together with others/ belonging / empowerment		Hope for recovery while supported (and supporting) others
	Cultivating hope	Hope to overcome side-effects of medication	Hope for an improved self beyond the constraints of illness	Hope for a life free of symptoms / hope for a better future	Hope for a life without medication	Positive thinking harbours hope for a better future	Religion / spirituality is conducive to hope through prayer	Hope for regaining employment	Hope for recovery while supported (and supporting) others	

Appendix 36: Fieldwork diary (excerpts)

Wednesday 21.08.2019 [Interview Loredana] *Loredana chose to take pictures at the day centre as she was uncomfortable taking the camera with her at home. I didn't ask any further details and I respected her choice. However, I was aware of the limitations in terms of possible subjects to discuss in relation to recovery (apart from the day centre and how important this was to her recovery). I should have probably asked the participant what pictures she would have taken if she took the camera with her. However, she has portrayed her environment and the aspects relevant to her recovery starting from some apparently simple pictures of some crafts that were suggestive of spring, Easter, resurrection, renewal, which led to talking about her recovery and reconstructing her life (he power of metaphors). In this case spirituality/religion was probably the most important dimension of recovery (which reinforces one of the dimensions subtly revealed in the photography workshops). Family was central to Loredana's recovery although ambivalence was noted as family can also be a source of stress as well (experience of divorce, child abuse , etc.). I was tempted to interrupt the participant at times and redirect her to a discussion around her recovery as she tended to discuss in great detail about her family and some personal issues that she had with her parents and sister, but this led to relevant information about how family contributed (or hindered) her recovery. The lesson I've learned after this interview was 'just let people tell their story' and the things that are important to them rather than what I believe is relevant for the research topic.*
Monday 19.08.2019 [Interview Daniela] *One would argue that recovering from depression and anxiety is less complex than recovering from schizophrenia or other 'severe' mental health problems. However, Daniela described a series of challenges that culminated with suicidal episodes that she has managed to overcome in the end. Work, as indicated by the participants in the photography workshop, was an important dimension of recovery that has been confirmed by Daniela who is actually working as a nurse. Work is a source of meaning and hope e.g. future career plans. There were times when I was so impressed about this participant's story that I did not know what to ask. I just feel like I need time to digest these stories and sometimes the pace of the interview does not allow me to do that which may explain a slight feeling of physical and emotional exhaustion after the interview (aside from the heatwave in Romania and lack of air conditioning at the day centre). The participant has given me one of the briefest but nonetheless comprehensive definitions of recovery – 'reconstruction of life' while clearly describing all the important areas of life from work to social relationships and relationship with herself.*

Monday 19.08.2019 [The way I see the day centre]

There is no clear sign at the main gate that indicates that there is a day centre for people with mental health problems. It is a hidden place unless you go through the massive gate that guards the interior court and see the entrance to the day centre. There is a small sign by the door that reveals the location. If you arrive before 9am or after 12pm there are bars on the main door. The day centre is open only three hours a day, of which only 1-2 hours are allocated for activities for service users. There were better times, better places for the day centre a few years ago, before the activities have been scaled down due to cutting funds. There are bars on the windows as well, all the time, reminding me of some institution for people with mental health problems from the past. Or a prison. This is only when you see the day centre from the outside, guarded by small shops mixed with residential areas. Inside is usually quiet even when there are activities. Voices of service users are usually whispered, contained in a small space that serves for activities and office as well. The hallway welcomes you with materials for activities (fabrics, canvases, boardgames, books). The main activities room is not much different as it serves for storage as well. Twenty square meters is not a lot and it all looks like a Tetris game – boxes on the shelves with different labels on, books, artwork, folders, and chairs – many chairs around the table waiting for the service users who signed up for the next activity. Two cats (and a third who is very shy) are as quiet as the service users. They crunch on their food left by the staff or the service users at the back of the room. They eat and leave. Service users come to activities and leave. It makes me wonder what they leave with. All I can witness is a wide range of crafts and colourful things they left behind – their work for today.

Monday 19.08.2019 [Interview Emilian]

Emilian was punctual, and the interview started well but shortly after starting using the pictures to elicit discussions about his recovery, the participant seemed distracted by the images and his camera which affected the communication during the interview to a certain degree. I was reluctant to tell Emilian to leave the camera aside during the interview because he disclosed during the interview that he was extremely sensitive to people telling him what to do or how to behave (possibly in relation to criticism from family). This made me reflect on photographs working as a distraction in both a negative and positive way (distraction while taking photos was considered by the participant as the main way the photography as an occupation may help his recovery).

Despite distractions which made the semi-structured interview guide challenging to follow, some of the photographs that were not discussed in the group setting were revisited with some interesting interpretations in what concerns the personal experience of emilian's recovery – a dimension that he did not reveal during the photography workshops (e.g. free thinking, personal traits that helped his recovery, hope). Emilian clearly likes himself, the way he looks, the way he appears in pictures, which he disclosed candidly. At some

point he asked me to take a picture of him which he was very pleased with. I tried to relate to his preferences and asked him about his tattoo – a message in Chinese that he had tattooed on his right arm shortly after he migrated to England (where he became unwell). A different kind of visual material that worked well for eliciting more information about him – the message on his tattoo translated 'immortal, courageous, and fearless' which elicited interesting discussions around the importance of human qualities in the process of recovery.

Thursday 15.08.2019 [Interview Ioana]

Ioana attended all four photography workshops and contributed fully to each task. Therefore, there were not many questions left to ask from my point of view, therefore I approached the interview in a more unstructured way compared to the previous interviews. There were not any pictures left that were not discussed during the photography workshops and the participant did not take any new pictures prior to the interview. Therefore, I started the interview with the existing pictures in case there were more things to be elicited from the participant's perspective. The participant did not talk about any pictures possibly because the meanings were revealed in the photography workshops and she may have reached some saturation in terms of talking about recovery. However, she disclosed some more details about the onset of her mental health problems and things that aggravated her distress (including abusive relationship with her daughter) which helped me better understand the full picture of her recovery. Some things disclosed by the participant during the photography workshops have been reiterated which made some information redundant, without any additional depth. This made me reflect whether the interview added indeed any significant information compared to what has been said during the workshops for this particular participant.

Thursday 15.08.2019 [Interview Iaco]

This photo-elicitation interview revealed some valuable historical aspects about living with mental health problems during and post-communism. The photos prompted some deep discussions around mental health issues and recovery in relation to topics such as freedom, justice, politics, self. The semi-structured interview worked well and the participant made good use of the space I offered him to unfold his story which was fascinating as it contextualised his recovery in the historical background of the Romanian Revolution in 1989. The participant needed only a small number of prompts (to bring the interview closer to the topic of recovery) and my interventions were more summarising or paraphrasing than additional questions.

Wednesday 14.08.2019 [Interview Raul]

Raul was contacted by the gate keeper during the recruitment stage and accepted to take part in the interviews only. He was included in the study as he met the recruitment criteria. However, prior to the interview when I wanted to hand him a camera to take pictures that are representative for his recovery, Raul declined and told me that would like to take part without taking any pictures (he disclosed that he took part in a photography project in which pictures that didn't turn out the way he wanted, and this has made him feel very frustrated and distressed and eventually has decided that this activity was not for him). I wanted to cancel the interview as this participant would be the only one who did not use photography to illustrate his experience of recovery. However, after I discussed the situation with the supervisory team, I decided to include this participant in order to investigate the reasons why photography did not work for everyone. I suggested the use of photographs generated by other participants during the workshops, but the supervisory team argued that they would not reflect this participant's experience, therefore potentially irrelevant. On reflection, I should have probably asked: If you took a picture of something that is representative for your recovery, what would that be?

Tuesday 13.08.2019 [Feedback and Reflection Group]

The atmosphere during the group was relaxed and participants seemed to enjoy coming back to the group especially that on this occasion they had the chance to see their photos displayed on an electronic picture frame and also printed. I have noticed a sense of pride and enjoyment on their faces that culminated with their favourite picture being framed (some participants were hugging their frame when they left). Having a choice in terms of pictures to use in the collage, the way to display them, to write additional recovery messages or not, seemed to animate the group, including some participants who were not very vocal during the photography workshops. The task resulted in amplifying the collective voice of participants that was not particularly noticeable during the workshops. The feedback from participants with regards to their participation in the workshops was positive and they described a wide range of experiences and benefits to their mental health and recovery (from photography as a form of expression to technical skills that makes some of them privileged to have taken part in this project). Positive feedback after the group from the social worker at the day centre who has noticed the positive impact the activity had on the service users in terms of openness, communication, confidence. The social worker disclosed that in the meanwhile the participants expressed their regret that the activity has come to an end and that she is considering including photography in the weekly schedule (despite the day centre activity being scaled down due to lack of funding). We discussed the possibility that the group was peer-run. At the end of the group some participants exchanged some pictures which was interesting to observe (the act of sharing their photos and their stories as well).

Wednesday 24.07.2019 [Reflections on the photographic language]

On reflection, I inappropriately considered participants who managed to move from a concrete reality reflected in their pictures to symbolic meanings hidden in different elements in their photographs to be somehow more advanced compared to those who did not seem to grasp the hermeneutic interpretations of the pictures reflecting their experience of recovery. This is potentially because my own preference for discussions about what is 'behind' the picture or 'the background story' that I assumed to hold more depth or interpretative potential. For this reason, I constantly encouraged participants to seek 'hidden' elements, bring their subconscious into conscious through photography, although such tasks did not come naturally to some participants (which I inappropriately considered to not have made enough progress with developing their photographic "language").

I may have been influenced by the current literature (photovoice, photo-elicitation) included in the systematic review on using photography in exploring the experience and meaning of recovery, in which hermeneutics appear to be an important dimension. However, pictures depicting concrete aspects of life brought by the research participants in photography workshops seem to be as valuable to understanding the experience of recovery as the pictures charged with symbols and interpretations. For example, a simple picture of a road that leads to the day centre (which appears to be an important landmark in participants' recovery) has a powerful story behind as it is the weekly walk of a service user to a place where his recovery is supported by getting involved in various activities. Also, pictures from nature don't necessarily have to be abused interpretatively as they may reflect a simple activity that is supporting participants' recovery (escape to nature, relaxation, etc.). In conclusion, more consideration is needed to each participant's way to express things in photography which varies the same way their verbal expression does, in spite of photography being considered as 'universal' language (it may be 'universal' but there seem to be some particularities as well – what do these particularities depend on? So far, the level of education, ethnicity, gender, etc. do not seem to provide an explanation to this).

Tuesday 23.07.2019 [Photography workshop 4 – 2 hours]

Unlike the previous workshops, my anxiety levels were more manageable today despite my fears that I might not have explored the recovery topic in enough depth. Today's workshop was a confirmation that participants understood what the focus of the project was, and some elements of recovery they mentioned during the last two workshops were brought in a storied way (it was noted that two participants have written down their stories along with their pictures that reflected their story of recovery). Most of the participants took part actively. Three participants (out of nine present) were quiet and, as with the previous groups, they did not engage with the activities to a level that reflected their experience of recovery (despite being asked questions to help them open up – occasionally yes/no

questions that did not help). This contradicted my expectations that photography can help people who have problems with expressing themselves verbally, but it may be as well the group setting that inhibited them (despite their initial preference for taking part in groups). There is a chance to further reflect on this if some of the 'quieter' participants will take part in one-to-one interviews. Their lack of engagement made me feel slightly uneasy previously, but today I was focused on the rich stories that five-six participants prepared for the group to reflect their road to/through recovery.

Informal discussions with participants before the group made me think about their status as 'retired' on medical grounds (some of them retired in their 30s) which means that they can't legally undertake any paid work (renouncing their pensions is considered risky by participants because in case they cannot manage work will result in their being without an income – returning to the 'retired' status after proving that they can get a job proved to be difficult for some participants) – to explore this further in interviews in relation to recovery (also look up relevant legislation).

Tuesday 16.07.2019 [Photography workshop 3 – 2 hours]

Today's workshop started with a warm-up exercise – a roleplay in which the participants asked an imaginary character that they created questions to check whether he/she recovered from mental distress. Participants seemed to enjoy the switch from being asked questions to asking questions for a change. The exercise was initially simple in structure, but it evolved to complex questions that participants' psychiatrist or parents would have asked in relation to recovery, which revealed potential ways in which the participants constructed their meanings around recovery e.g. clinical (symptoms, treatment).

With regards to selecting the photographs, I have noticed that images from different participants were similar in some respects e.g. water was present in most of the participants' pictures despite their different photo-missions. […] It is uncertain whether there was an element of (conscious or subconscious) 'contamination' in the process of selecting and interpreting the photographs today. In spite of this, most of the participants showed significant progress with the transition from identifying concrete realities in pictures e.g. what objects the picture depicts, to symbols and stylised interpretations of great depth and insight. However, there are two-three participants who did not reach this stage (uncertain why? – education does not seem to be a factor as one of them has a university degree). Do they have to reach that stage or is the visual language of metaphors accessible only to some people?

Language continues to create some tensions. I started to use participants' terminology of "illness" in spite of my views that recovery shouldn't be a predominantly clinical concept (as opposed to mental distress, which does not translate coherently in Romanian, or

mental health problems). Recuperation (Rom. recuperare) was the term I suggested from the beginning as being the closest to the English term 'recovery'. Participants don't seem to use this term as they prefer 'amelioration' (Rom. ameliorare), 'getting well' or 'getting better' (Rom. 'a se face [mai] bine' = 'to make oneself well [better]'). I am feeling reluctant about using synonyms to ensure that the discussions don't divert to topics that do not necessarily capture the experiences and meanings of recovery (to be discussed with the supervisory team)

Tuesday 09.07.2019 [Photography workshop 2]

Some participants asked whether they can include negative aspects of their life along with the things that helped their mental health. This was not necessarily intended at the beginning but as with photographs that develop from the negatives, I encouraged them to consider negative aspects as well. This may be an opportunity to readjust the design of the activities to match participants' perspective. Their point of view challenged my own assumptions that recovery implies positive experiences.

The gate keeper was absent during the first half hour of the workshop (one of her colleagues was present but she was not familiar with the workshop so she did not intervene). I had some printing problems, so I wasn't able to use the worksheets that I prepared for this week, but I tried to process the questions verbally (sometimes unstructured activities seem to work better as they give participants more control over the task). I have noticed that the group seemed to lack energy today and did not engage in discussions as openly as last time. I tried to create a more positive atmosphere by praising them at the beginning of the activity for the group task from last time when they managed to identify important elements in photography (e.g. colour, contrast, luminosity, metaphors, emotions, etc.). I suspect that asking for clarifications for what recovery is (following my own tensions from the last group between whether recovery is possible or not from their perspective) did not help their mood as some of the participants seem to be uncertain whether recovery is actually possible. I tried to open a dialogue around recovery to ensure that I don't start the photography task looking at elements of recovery if it is not clear what recovery means to them (or would be these meanings reveal themselves through photographs?). I made a compromise and invited them to look at elements that may help their mental health rather than recovery per se (which some of them identified with 'feeling better' or 'ameliorating' but not necessarily 'getting well').

Tuesday 02.07.2019 [Photography workshop 1]

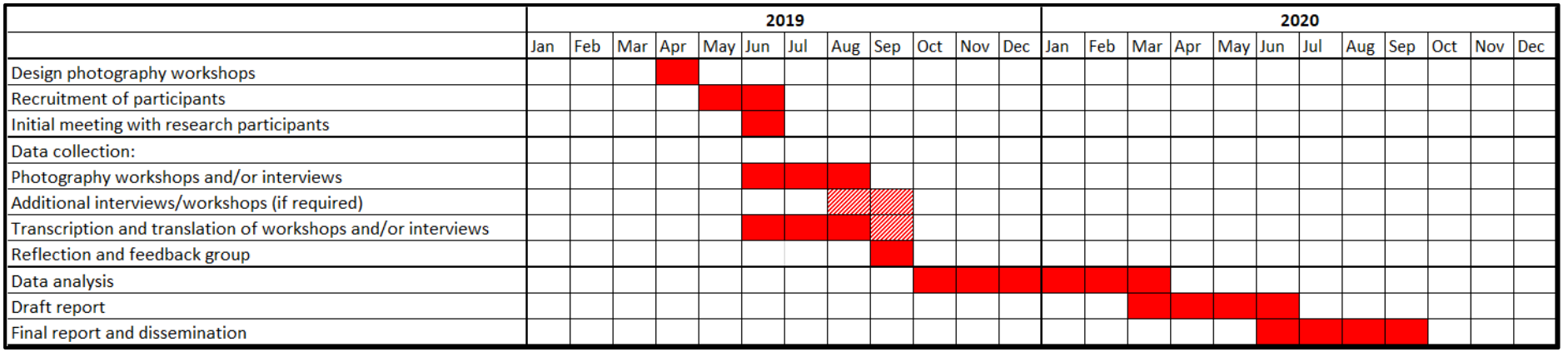
I was surprised that most of the participants picked on some photographic elements without any prompts that reflect advanced visual literacy skills (e.g. perspective, colours (association with feelings, state of mind, indicative of health or illness), luminosity (light as

optimism), contrast (both chromatic and conceptual), details (including cultural cues) resulting from deconstructing the image. They started (with some prompts) to look into possible stories behind different photographs which is promising for outlining their own stories through photography. Participants have even identified some metaphors that are representative of their own lived experience of mental distress (e.g. bricks as feelings, cracks in the wall as 'wounded' feelings or mental health problems, walls as defensive mechanism, bridge "as strong as man's will", idea of the road or bridge to recovery, etc.).
Participants interacted well with their cameras and a series of technical, health and safety, and ethical aspects were reinforced (as some participants continue to take pictures of other people without asking for permission). I offered participants additional support the day before the workshop in case they require technical assistance to avoid turning up for the group without any pictures. I also addressed some of their anxieties around using the cameras.

Tuesday 11.06.2019 [Phone call with the social worker at the day centre to prepare the data collection activities]

The social worker (gatekeeper) is reluctant about the ability of four service users willing to take part in the project to communicate verbally and has some reservations about involving them in the project ('they may not say too much'). I think this could be an opportunity to see if photography will help them express their thoughts and emotions (as reported in the literature)?
The gate keeper also suggested that more instructions should be given to participants who may struggle with making decisions (to further explore this aspect in the field to assess if it is a cultural aspect / echoes of a paternalistic approach / who is making decisions in their place and how much this helps/or not their recovery?). Again, involving people more actively (but not to the point that it becomes uncomfortable for them) is an opportunity to empower them and explore whether photography contributes to their empowerment/recovery as claimed in the literature.
There are no problems with participants' mental capacity in terms of signing the forms or looking after the cameras handed to them at the beginning of the project. The social worker suggested that outdoor activities should be organised to encourage people to take pictures (there are people who don't leave their houses for any reasons other than coming to the day centre). I partly agreed to her suggestion and I explained that may restrict participants to one location which may impact on their participation in the project (e.g. some people may find elements of recovery outside the suggested outdoors activities) and also on the data (in case all the participants will take very similar pictures of nature for example and how this helps their mental health – source of bias?). Therefore, it has been agreed that participants keep the cameras in between sessions to allow for a diversity of environments and potentially aspects of recovery to be explored.

Appendix 37: Project timeline



Appendix 38: Ethical approval from the Faculty of Health and Medicine Research Ethics Committee at Lancaster University

Lancaster University

Applicant: Lucian Milasan
Supervisor: Naomi Fisher and Amanda Bingley
Department: Health Research
FHMREC Reference: FHMREC18047

25 February 2019

Dear Lucian

Re: Exploring the experience and meaning of recovery from mental distress in Romanian mental health service users through photography

Thank you for submitting your research ethics application for the above project for review by the **Faculty of Health and Medicine Research Ethics Committee (FHMREC)**. The application was recommended for approval by FHMREC, and on behalf of the Chair of the Committee, I can confirm that approval has been granted for this research project.

As principal investigator your responsibilities include:

- ensuring that (where applicable) all the necessary legal and regulatory requirements in order to conduct the research are met, and the necessary licenses and approvals have been obtained;
- reporting any ethics-related issues that occur during the course of the research or arising from the research to the Research Ethics Officer at the email address below (e.g. unforeseen ethical issues, complaints about the conduct of the research, adverse reactions such as extreme distress);
- submitting details of proposed substantive amendments to the protocol to the Research Ethics Officer for approval.

Please contact me if you have any queries or require further information.

Tel:- 01542 593987
Email:- fhmresearchsupport@lancaster.ac.uk

Yours sincerely,

R·E·Case

Becky Case
Research Ethics Officer, Secretary to FHMREC.

Appendix 39: Ethical approval from the host organisation in Romania

ESTUAR

Estuar Foundation, Social Center Cluj

G.Baritiu street, no.22/13

Cluj-Napoca

Tel: 0040753088673

Email: office.cluj@estuar.org

www.estuar.org

16.01.2018

To whom it may concern,

With regards to the research project 'Exploring the experience and meaning of recovery from mental distress in Romanian mental health service users through photography' conducted by Lucian Milasan, PhD student at Lancaster University

I confirm that we discussed what the research entails with Lucian Milasan and agreed that he can conduct the photography workshops and interviews on our premises with participants selected from our service users.

I also confirm that the activities will be conducted during the working hours (9am-4pm) and at least one of the members of staff will be present during the activities should any of the participants or the researcher require practical or psychological support.

In what concerns the ethical issues, I have to mention that we do not have our own ethical approval process except a confidentiality form (attached). Therefore, an approval letter from Lancaster University confirming that the research proposed by Lucian Milasan is ethical will suffice.

Thank you for taking into consideration this information and we look forward to welcoming Lucian and his research at our mental health community centre.

Yours sincerely,

Amedeea-Viorica Enache

Executive Director, Estuar Foundation