Article

Sensitive Inquiry in Mental Health: A Tripartite Approach

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Abstract

This article presents an innovative tripartite approach for conducting safe and ethical 'sensitive inquiry' in the field of mental health recovery. The tripartite approach brings together the principles of recovery with trauma-informed practice and collective impact strategies. Together, these provide a framework for embedding and embodying recovery principles in research design and practice that empowers participants and 'takes care' of participants *and* researchers. The approach was effectively deployed in a 1-year qualitative arts–based study conducted with people living with severe and persistent mental illness. Its success was evident in the high retention rate of participants, despite their ongoing vulnerabilities, and in the elicitation of findings that expand current understandings of mental health recovery from the point of view of people with lived experience. In this article, we discuss the tripartite approach, how this was applied in the study, and what the design achieved in research outcomes and participant experience.

What Is Already Known

(1) Research in the field of mental health is challenging for participants and often the researchers, especially when the research is concerned with the lived experiences of participants, (2) policy is best informed by the people directly involved, yet historical beliefs about people's competence to be 'research subjects' combined with the potential risk to vulnerable populations have meant that researchers avoided interviewing people with lived experience or focused on other voices (e.g., service providers), and (3) there is a growing interest in creative methodologies to overcome such difficulties.

What This Paper Adds

(1) A research design uniquely informed by three important mental health frameworks (i.e., recovery, trauma-informed practice, and collect impact), (2) a way to use creative methods (photovoice and written narrative) to facilitate research directly with people living with complex mental illness, so that their voice and experience is central, and (3) a combination of design and methods that minimizes risk of harm to participants and researchers and challenges the usual power relations between researcher and researched, so that participants are empowered.

Introduction

There has been a growing interest in the qualitative research literature about the particularities involved in what we here refer to as 'sensitive inquiry.' These are research encounters that are both substantively and methodologically sensitive. Often conducted with vulnerable people, they involve not only deeply personal themes, topics, or data but also require correspondingly sensitive methods and procedures for achieving research objectives. The intimate character of sensitive inquiry embodies potential risk not only for participants but also researchers who may be impacted by what they hear or see (Bahn & Weatherill, 2012). The personal interaction and interviewing associated with qualitative research in this context is "emotion work" (Dickson-Swift, James, Kippen, & Liamputtong, 2009, p. 62) that echoes the environment of therapeutic

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work (Tee & Lathlean, 2004). These exchanges can require an "ethics-of-care" approach by researchers, which foregrounds the well-being of participants over research imperatives (Hewitt, 2007, p. 1156). These challenges highlight the multi-faceted ethical and methodological considerations of sensitive inquiry (Bahn & Weatherill, 2012; Hewitt, 2007; Mitchell & Irvine, 2008).

The complexities of sensitive inquiry are especially acute in the field of mental health where research design requires attention to the often emotionally sensitive and trauma-based character of individual histories and circumstances. Furthermore, people living with severe and persistent mental illness live within a web of social disadvantage and stigmatization (Henderson, Evans-Lacko, & Thornicroft, 2013). They are among the most vulnerable members of society in terms of poor physical health, comorbidity, and decreased life expectancy (Harker & Cheeseman, 2016). They are more likely to experience suicide, social isolation, discrimination, homelessness, and unemployment (Lee, Crowther, Keating, & Kulkarni, 2013). Research in this context has historically been circumvented "because of beliefs of ipso facto incompetence and nonautonomy" (Hewitt, 2007, p. 1151). There can be difficulties with recruitment and retention of participants (Harris & Roberts, 2003) and tensions between 'care' of participants and the "generation of credible data" (Chan, Teram, & Shaw, 2015, p. 261).

In this context, the purpose of this article is to present an innovative tripartite approach for conducting safe and ethical sensitive inquiry that was effective in generating new data about mental health recovery. The study for which the research design was developed stemmed from a research partnership between Western Sydney University and The Benevolent Society, a nonprofit community-based organization providing services to disadvantaged and marginalized Australians. In designing the study—*Stories of Recovery From the Bush: Unravelling the Experience of Mental Illness, Self and Place*—the researchers took it as axiomatic that recovery principles would guide and shape the project, simultaneously honoring the priorities of emancipatory research in terms of "reciprocity, gain, empowerment and broader social change" (Phillips, 2006, p. 176). Furthermore, that the research design would 'give back' to and empower participants while at the same time, 'taking care' of both participants and researchers.

Despite the potential challenges of research in this sensitive area, the design worked to enable people who have a lived experience of mental illness to share their knowledge about recovery. The overall methodological approach reflects a unique combination of three crucial frameworks relevant to mental health and social change: consumer-led recovery, trauma-informed practice, and principles of collective impact. Together, these provided an ethical and coherent basis for design and implementation of the research. They ensured consistency between the methodological approach and the substantive investigation of mental health recovery, facilitating 'sensitivity' in the conduct of research involving, at times, acutely sensitive material. In the following sections, we discuss the three elements of the tripartite approach informing and 'holding' the research design, how the research was conducted (methods and procedures), and what the design achieved in research outcomes and participant experience.

Developing the Tripartite Approach

The *Stories of Recovery* project had two specific aims. First, to further develop knowledge and understanding of mental health recovery in regional and remote areas from the perspective of those with lived experience of severe and persistent mental illness. Second, to generate insights that would contribute to capacity building in the partner organization including their efforts to combat stigmatization and inform policy for people with lived experience of mental illness in regional New South Wales (NSW). Policy changes are "more meaningful" when informed by the people directly impacted (Parke, Hunter, & Marck, 2015). The research design problematic therefore centered on how we give "preference, voice and visibility" (Horsfall, Carrington, & Paton, 2016, p. 10) to people with lived experience of severe and persistent mental illness and how we make it as safe as possible to do so. Collaborating with the research partner, we drew on the principles of mental health recovery, trauma-informed practice, and collective impact strategies to develop a research design that factored in safety and sufficient flexibility for "consumer participation and involvement" including input as the project progressed (Phillips, 2006, p. 171).

Our methodological perspective aimed to "help empower individuals to share their stories and enact meaningful social change" (Babchuk & Badiee, 2010, p. 27). Furthering the understanding of recovery from participant's point of view meant giving them epistemic privilege, working with participants as co-subjects, and acknowledging "each individual is an expert on their own life [and] working in partnership with" them (Commonwealth of Australia [CoA], 2010, p. 42) as co-producers of knowledge. Our methods needed to facilitate participant control and also support researcher sensitivity. Discussing emotional or painful experiences can feel exposing to vulnerable participants, and in such circumstances, the use of creative research methods is gaining prominence (Horsfall & Welsby, 2007). We therefore utilized photovoice (Wang & Burris, 1997) partnered with written narrative (Yardley, 2008). Photovoice is traditionally a form of participatory action research that can give voice to marginalized people(s). It uses photography for collective purposes, involving "community members in generating practical knowledge . . . and through this promoting personal and social change" (Schneider, 2012, p. 153).

The genesis of the research design stemmed from our belief that qualitative research in the mental health recovery field should be practiced from recovery-oriented principles that respect and foster human rights (Forrest, 2014). Further, that the research experience should empower and benefit participants by emphasizing their "liberty, social inclusion and self-determination" (Forrest, 2014, p. 30). This philosophical orientation drawn from recovery principles provides

consistency across the whole research design and implementation process, encompassing the substantive area of research, the creative methods used, the conduct of the research, and the impact of the research. In this way, the tripartite approach underpins a 'recovery-oriented research practice' that mirrors the principles of recovery-oriented mental health practice, as defined by the National Standards for Mental Health Services (CoA, 2010) and discussed below.

Principles of Recovery

Recovery is a consumer-generated, person-centered paradigm supporting people with lived experience of mental illness to pursue a meaningful life and positive sense of identity, with or without symptoms. It holds that people living with persistent and severe mental illness are the experts in their own recovery. The principal elements of recovery identified by people with lived experience include "connectedness; discovery; hope; active sense of self; and ability to respond/take control" (Glover, 2012, p. 8). However, these elements are contingent upon interactions with others in familial, social, and clinical networks which can aid or impede the recovering person's capacity for hope, agency, self-determination, and "meaning and purpose in life pursuits" (Onken, Craig, Ridgway, Ralph, & Cook, 2007, p. 3). Recovery-oriented services aim to: support these abilities; enable the development of a holistic and positive sense of self; and support people's self-narratives beyond illness identities and the stigma and discrimination associated with them. Our recovery-oriented methodologies were designed to uphold the principles of recovery and to support participant's journey of positive self-authoring.

We placed participants at the center of knowledge generation and designed the research to be as flexible and responsive as possible. This meant conducting the research in partnership with the participants (CoA, 2010; Phillips, 2006; Schneider, 2012; Tee & Lathlean, 2004) and ensuring they had genuine choices in their participation to safeguard people's dignity. We practiced a strengths-based approach to recovery, amplifying the contributions participants could make to the research and to positive social change (Tse et al., 2016). However, this required a delicate balance between honoring participant's strengths and providing supports that enabled their participation. The research design had to negotiate a tension between research that needed to speak powerfully, yet at the same time needed to take care of research participants. Thus, in considering how to operationalize recovery-oriented research, we had to be mindful that consumers who engage with mental health services are often "trauma survivors" (Mental Health Coordinating Council [MHCC], 2013). This required us to also draw on the principles of trauma-informed practice to shape the research design.

Trauma-Informed Practice

Trauma survivors often have a history of being silenced and abused and can experience "periods of intense anxiety" (Ferencik & Ramirez-Hammond, 2011, p. 38). The impacts of trauma can disrupt memory and capacities for information processing, emotional regulation, and interpersonal relationships (MHCC, 2010). Trauma has its own trajectory of recovery, needing time to build the trust necessary for relationships and the skills necessary for affect regulation. Principles of trauma-informed practice recognize that people's behavior and responses are often "directly related to traumatic experiences" rather than innate personality attributes (Ferencik & Ramirez-Hammond, 2011, p. 5). Such practice therefore emphasizes safety and positive relationship connections (Bath, 2008), where trauma survivors are "respected, informed, connected and hopeful" (MHCC, 2010). We used this understanding of trauma to design research that was supportive of "participant control, choice and autonomy" and which also enabled "opportunities for power sharing and collaborative decision-making" in the process of conducting the research (Horsfall, Carrington, & Paton, 2016, p. 10).

In creating a space for participants to take part in a journey of self-authoring focused on strength and resilience, we emphasized and modeled "safety, trustworthiness, choice, collaboration and empowerment" (MHCC, 2013). We provided a safe physical and emotional environment for participants, as well as support workers and researchers, ensuring appropriate safety measures were in place across the research phases. Facilitating 'stories' about people's experiences is "a critical element in the trauma recovery process" (Bath, 2008, p. 20). We therefore constructed the research methods around creative experiences that gave voice to participants and contributed to relationship building and social integration. Success of the project also depended on a complex fabric of organizational and interpersonal relationships. We therefore also had to consider the network of associated parties that would be involved in supporting the participant's engagement in the research. This included carers, supports, and staff from the partner and affiliated organizations. Here, we turned to the principle of collective impact guiding recovery-oriented services to further inform the research design.

Collective Impact

Collective impact initiatives are developed to address social problems with a view to bringing about (usually large-scale) social change. They involve trust-building and coordination between different organizations in different sectors (public, private, and nonprofit) that come together around a common agenda to generate collective social impact (Kania & Kramer, 2011). Echoing a social ecological perspective, collective impact focuses on the interactions and "cycles of mutual influence" (Stokols, 1996, p. 286) between "the individual and the environment" (Onken et al., 2007, p. 1). It recognizes that the complexity of social problems requires systematic, multifaceted, and coordinated solutions involving a range of stakeholders working together. Collective impact projects depend on a shared vision among stakeholders. They usually comprise a "centralized infrastructure, a dedicated staff, and a structured

process that leads to a common agenda, shared measurement, continuous communication, and mutually reinforcing activities among all participants" (Kania & Kramer, 2011, p. 38). The Partners in Recovery (PIR) initiative is an example of collective impact in the mental health field.

Maintaining the veracity of the PIR commitment, we deployed collective impact principles on a smaller dimension. This recognized the diverse network of familial, community, and social relationships within which the recovering self-authored person is embedded. The partner organization served as the centralized infrastructure, coordinating activities and facilitating the engagement of staff who 'believed in' the research objectives. The common goals and clear communication between the partner and affiliate organizations, researchers, staff, and participant supports enabled a robust and united commitment to the research participants and their continuation in the project. All those involved directly or indirectly in the project were able to cooperate in delivering the research findings in a way that was both respectful of and safe for the research participants. Bringing collective impact to bear on a project embedded in the principles of recovery and trauma-informed practice provided a successful methodological approach to underpin the research design and methods used to conduct the study.

Applying the Tripartite Approach

Informed by the tripartite approach described in the previous section—principles of recovery, trauma-informed practice, and collective impact—*Stories of Recovery* used creative methods to provide people with a space to talk about personal and sensitive issues in ways that were comfortable for them. This enabled us to understand what was important to participants and why this was the case. Arts-based methods such as photography can help people see familiar everyday things with 'new eyes' (Diamond & Van Halen-Faber, 2002). This is significant because some elements of the recovery journey—relationships and places, for example—are often not discussed because they are thought to be common or ordinary aspects of life. Photographs also provide a form of detachment that facilitates critical reflection on people's lives (Freire, 2003) or areas of their lived experience that they have not yet examined or contemplated (McIntyre, 2003). Using photovoice also gave us a means to document the subjective experiences of research participants in a sensitive way. Consistent with recovery principles, the photovoice method locates each person "as the expert in analysis of their own life" by giving them control over the cameras and the photographs they take for discussing later at interview (Horsfall, Carrington, & Paton, 2016, p. 11).

The research was conducted in six phases over a one-year period: recruitment, photovoice workshops, telephone interviews, one-to-one interviews, data analysis/narrative development, and exhibition. The staged design meant participants could integrate each step in the research process within a comfortable time frame. Following attendance at a photovoice workshop, participants had a two to three-week period for

taking photographs. Interviews were held approximately two to three weeks later, after the photographs had been developed. Following the interviews, there was a two to three-month period for data analysis, construction of the recovery narratives, and planning for the exhibition, which aimed to break down stigmatization. During this time, the partner organization, support staff, and research staff were in contact with and/or available to participants. The research process was also flexible with workshops and interviews scheduled in various locations and interviews renegotiated to accommodate participant's needs. The timing of the interviews was also conducted with consideration for the "self-care" of researchers who could be exposed to stories of trauma and loss (Dickson-Swift et al., 2009, p. 74). We therefore allowed time for post-interview debriefs as well as supervision throughout the duration of the research.

Phase 1: Recruitment and Participants

We began the research process by conducting pre-recruitment meetings with staff from the partner and affiliated organizations. Members of the PIR consumer reference group also attended. We held a two-hour face-to-face information and training session with PIR staff and staff from the Personal Helpers and Mentors service (PHaMs), introducing them to the main photovoice method. This enabled support staff and other interested parties to understand what was involved in the research and how potential participants could best be supported. It also began the important process of building relationships with the organizational staff who would be key to participant recruitment and ongoing participation in the project. Invitations to volunteer for participation in the research were open to people registered with the PIR program in Western NSW and members of the PIR consumer reference group. A total of 26 people with complex needs experiencing persistent and severe mental illness attended one of three photovoice workshops. Of these, 24 attended interviews and continued through to completion of the project.

The retention rate of participants was exceptional at >92%. However, this was even more significant, given the 'everyday' problems they faced over the duration of the project. Many had complex issues including multiple diagnoses while living with poverty, homelessness, and/or difficulties with literacy and numeracy. Some had to manage their engagement in the research around traumatic experiences, hospital admissions or the effects of medications, and other treatments like Electro-convulsive Therapy (ECT). We facilitated people's involvement in the research by ensuring appropriate supports, as determined in ongoing phone and text conversation with participants, thereby enabling them to successfully complete the research in their home settings at times convenient for them. This often involved them bringing a support person or carer to the interviews. We held the photovoice workshops and individual interviews in community venues that were convenient for participants such as community centers or local church halls. We also provided refreshments to support and nurture people.

Transport was organised where needed. Utilizing the principles of collective impact to create a helpful environment for the participants, as well as their families and support people, was key to the retention and engagement of participants who were themselves motivated to successfully complete the research.

Phase 2: Workshops for Photovoice

The purpose of the photovoice workshops was to provide details of the research project to enable informed consent and to demonstrate and practice the photovoice method. These processes were also important for us as researchers in starting to build relationships with the potential participants, an especially important facet of trauma-informed research. We held four workshops in all with a maximum of 12 people attending each workshop including support staff. One of the sessions was held for PIR consumer reference group members. The three-hour workshops were held in safe, familiar places for the participants and light refreshments were available for participants as well as their carers, and the PIR and PHaMs support staff who attended to aid participants and researchers where necessary. Each of the 26 participants attended one small group workshop where they were given a copy of the research documents (such as the research questions, a flowchart of the research process, questions for follow-up interviews, and participant information sheets) along with a disposable camera which could take up to 28 photographs. We showed participants how to use the cameras and asked them to take photographs over the subsequent two weeks of what was helpful to them in recovery.

At the workshops, participants were fully informed about the research in line with ethics approvals from Western Sydney University (H11225) and The Benevolent Society. All of the participants had the opportunity to read (or have read to them) a plain language information sheet and to sign consent forms that provided details about the project, the use of photography, and what would be done with the data that were collected (see Horsfall, Carrington, & Paton, 2016, p. 28). The informed consent process was carried out with the assistance of carers and support staff where needed. Additionally, the information sheets and consent forms were made available in audio form to *all* participants and could also be retrieved via smartphones. The researchers also made sure they spent time with each participant over the course of the workshop and/or during the breaks. This helped to build rapport and trust. Throughout the research, we supplied as much information as possible through various formats and renegotiated consent at each research encounter. In particular, we reminded participants that they were taking part in a research project, important to foreground as the data collection took place over a period of weeks.

Phase 3: Interviews by Telephone

During the period in which participants were taking their photographs, researchers made two or three follow-up telephone calls. The purpose of these conversations was to offer support and encouragement to the participants and to help problem-solve where necessary. We simply asked people how they were going, what sort of photos they had taken or were planning to take, and if there was anything they would like to talk about in terms of the research. Field notes were also taken. This process was a crucial step in the period between the initial workshops and subsequent personal interviews where participants would reflect on and discuss their photographs. In the immediate sense, these calls were an important element in participant retention by reassuring participants and providing clarifications where needed. However, and perhaps more importantly, this process helped to maintain and further build relationships of trust between the participants and the researchers. At the end of the photo-taking period, participants returned their cameras for development and the photographs were subsequently discussed by participants with a researcher in individual interviews.

Phase 4: Interviews in Person

The individual interviews provided participants with the opportunity to talk about their photographs and choose the images they wanted to exhibit. The interviews also provided the basis for distilling the one-page written narratives that would be exhibited alongside participant photographs. Signed consent was sought for the use of participant photographs in the exhibition, catalogue, and project report. This process included written permissions from any people who were identifiable in photographs. The semistructured one-to-one interviews were held for up to two hours. They were audio recorded and later transcribed. Consent to write field notes in lieu of audio recording was given by one of the participants. The interviews took place at the offices of the partner organization and affiliated organizations or centers. These locations were familiar to the participants and safe spaces for both the participants and researchers. If needed, PIR and PHaMs support staff were accessible from outside the interview room while the interviews were being conducted. Two participants had a support person remain in the interview for part (one) or all (one) of the time.

The photographs were used as the stimulus for interview discussion. As with other visual arts, photography can serve as a mechanism to communicate that which is difficult to speak about (Booth & Booth, 2003). At the beginning of the interview, we spread the photographs out on a large table so that participants could look at them, discuss those they felt were of most significance, and discard any they wanted to. Many took up this opportunity, often choosing to throw away blurry images or ones that did not work artistically for them: *These ones didn't turn out right. No, I'll just take these ones. Saves being put up. Those ones can go. They have no good photo of me blue cattle dog* (P5).[1]

In these discussions, we focused on stories of recovery prompted by the photographs and guided by a series of questions previously given to the participants (see Horsfall, Carrington, & Paton, 2016, p. 34), which helped to allay anxiety about the interview process. We simply asked participants questions such as: tell me about your photos; do any mean more to you than

Figure 1. Participant photograph (P12).

others; can you tell me the story of this photo; and what do they say about what is helpful for you? We followed participants lead reflecting back to people and asking further questions about photos they focused on: can you say a bit more about it?

Substituting for 'probing questions' that are the core of traditional qualitative interviews, a focus on the photographs provided a sense of safety for participants. Attention was deflected from them yet, at the same time, the photographs provided a doorway into the intimate space of participant's lives. This process enabled us to understand what was helpful and supportive in terms of the participant's recovery journey from their point of view. The following examples show how the photos provided an entry to participant's inner worlds:

P10:   It's about being depressed. So this is 'sick', this is 'well'. This is 'sick'. Can't get in there—"No not today Josephine" is what I want that [photograph of the bathroom] called—"No, not today Josephine. I'm not going in there." And of course, that's when I'm better and you have a nice bath.

P12:   When I took the photo of the fence (Figure 1) I said, "I remember most of my life was spent behind a fence." You don't get to go outside. That's it. That's all you see all day every day. Trees outside, birds and that flying around. Then you've got the windows. People will say, "What does that mean?" "Well that's how he lived life: looking out the window." It's a photo that's opening the fence—where I can walk out and be free.

Conducting sensitive inquiry in these one-to-one interviews required care of participants in a safe environment that drew on the trust established through the workshops and further built in telephone interviews. Holding a safe space for participants while guiding them back to the research task as needed was a complex process requiring both interpersonal and research skills. People's stories of stigma, loss, and grief were compelling but outside the 'recovery' data being collected. It was therefore important that we exercised compassion and modeled "respect, honesty, [and] empathy" in affording participants dignity in their interactions with us (Ferencik & Ramirez-Hammond, 2011, p. 44). Our capacity to do so was aided by our academic backgrounds with one researcher specializing in qualitative research with vulnerable communities and the other being an art therapy researcher and practitioner.

Experience working in these contexts meant we understood the importance of our own self-care as much as we understood the importance of care and safety for participants (Bahn & Weatherill, 2012). This necessitated allocating sufficient time and resources in the research design to set in place appropriate measures for debriefing and supervision, including with the partner investigator, on a regular basis. In practice, this meant we scheduled at least thirty minutes between each interview; that we conducted interviews concurrently so that we could talk to each other between sessions; and that we conducted no more than three interviews each day and did no more than two days consecutive interviewing. We also scheduled debriefings with

the manager of the partner organization after each set of interview schedules.

Phase 5: Analyzing the Data and Developing the Narratives

Following Braun and Clarke (2006), we conducted a thematic analysis of the deidentified interview transcripts. This was an interpretative and data-driven process that focused on emergent themes as well as the specific research questions (Braun & Clarke, 2006; Crowe, Inder, & Porter, 2015). All three authors—both researchers and the manager of the partner organization—were involved in the data analysis. To ensure validity, we first interrogated the data individually, looking for central narratives about recovery and identifying key recovery ideas and concepts in an initial round of coding. We also identified what people thought was important and the overall story they were telling us. We subsequently had two data-analysis days where we developed the themes and subthemes collaboratively, checking the raw data as we went. Concurrently, we looked to see how the data answered the research questions or provided alternative stories to the dominant discourses in recovery. This was read against the research literature and expert knowledge of the partner investigator (Manager, Child and Family Services, The Benevolent Society).

We also developed one-page draft narratives based on the interview transcripts and in collaboration with the participants. The narratives provided a summary reflection on the photographs taken by each participant and served as an 'artist statement' in the exhibition. The process of distilling up to eighty pages of transcript into a one-page story required us to look for the 'poetry' of the person, the rhythm of their voice, and what it was they wanted to be heard. In challenging stigma, we needed to be mindful of what was included and how participants were portrayed. The narratives comprised only participants words, capturing their voice in content and form. Draft narratives were returned to participants for comment and/or changes via support staff who discussed the narratives with participants. This process ensured the insights we had identified from the interview transcripts had meaning for participants (Hewitt, 2007) and was also another opportunity for us to give participants epistemic privilege. Most made minor changes to their narratives while three participants made more substantial changes. This demonstrated that participants felt able to negotiate from a position of agency and trusted that we would respect their input.

Phase 6: Public Launch and Exhibition

The aim of this stage of the project was to challenge community assumptions about mental illness and to hopefully provide an empowering experience for participants. An alias was chosen by each participant and used in the exhibition catalogue reproducing their narratives and selected photographs (see Paton, Carrington, & Horsfall, 2016). The exhibition was co-curated by the research participants and held in a regional gallery (Fairview Artspace, Mudgee, NSW) over a three-week period. With around 100 people in attendance, the opening address was given by a deputy commissioner from the NSW Mental Health Commission. Most importantly, there was a good turnout rate from participants. Some contributed to the organization of the opening, such as making decisions about who to invite or where to hang the artworks, and also had active roles in the proceedings, being speakers or providing musical entertainment. The embrace of the exhibition by participants demonstrated the extent to which they felt empowered to challenge the stigma and discrimination that so often surrounds mental illness. It provided them with a very real opportunity to make a significant, powerful, and public statement about their lived experience of mental illness and recovery.

Outcomes of the Tripartite Approach

The tripartite approach underpinning the *Stories of Recovery* project aimed to further the understanding of mental health recovery by providing opportunities for people with lived experience of severe and persistent mental illness to convey their knowledge. Producing new insights about recovery stemmed from centering the participants themselves as experts; in this, the research design itself was enabling. The recovery-oriented, trauma-informed, and collective impact approach, together with the creative methods used, facilitated participants to express their stories, knowledge, and experience in ways that would not have been possible with traditional interviewing techniques alone. Participants were given the tools to have their own voice and, trusting that we might actually listen, they spoke differently.

As a result, we elicited findings that enlarge the recovery concept of social connection to include nature, animals, and family history (no matter how troubled that history may be). Indeed, nature, be that wild places, community parks, or domestic gardens, was almost universally significant to participant's sense of connection and belonging: *It's really a magic area* (Figure 2), *getting outdoors and being in the environment and being just present with the environment and that helps with my mental wellbeing. It's an energizer—it tops me up, it fills me up* (P11).

An important subtheme of connection and belonging highlighted by the findings was history and its importance to identity. This is a crucial finding because service providers often tend to avoid family history, especially if it is troubled or traumatic. Yet to participants, such a history is part of who they are. It is therefore vital that service providers follow the lead of service users about personal history, being mindful of the potential for retraumatization, but at the same time, not avoiding something important to the recovering person's identity.

Our findings support the recovery emphasis on social inclusion and the shift away from deficit approaches to people experiencing mental illness (Tse et al., 2016). The data demonstrated that people living with mental health issues contribute to social capital in communities and families through the cycles

Figure 2. Participant photograph (P11).

of their wellness and unwellness. Highlighting this is important and has the potential to significantly contribute to the reduction of stigmatization and discrimination often experienced by people with mental illness living in the community. As can be seen in the following quotation, people demonstrated their need to care for and contribute to the social capital of communities. This emerged, we argue, due to the recovery orientation of the research method and that people were given opportunities to speak about what they contributed rather than being asked 'what do you need.' For example:

> P23: No matter what you've gone through or done the next person listening to you can get through what they're going through. I had so many people commit suicide and it's too confronting and to tell the story it'd save somebody else. Just talking on the phone, doing the shopping at Coles I come across someone. Someone wants to talk and I've had people saying, "Oh it's been a pleasure talking to you" and "Thank you very much for talking to me" So, it makes a difference in their world. And that's a lot for me.

Similarly, asking participants 'what is helpful' provoked powerful examples of resilience and renewal amid moving stories of trauma, loss, and grief. In many cases, the struggles provided motivation for making change in their lives, for example: *I'm trying to get into things, all the services I need, all the courses I need, all the other medical things I need. I'll do anything to get them boys back* (Figure 3; P6).

Our research methodology also enabled participants to verbalize their concerns about service provision, highlighting what is important and what is unhelpful. The findings showed the significance of compassionate person–centered service provision in both clinical and nonclinical settings and highlighted the presence of a culture clash between different services. Clinical services especially, have not yet fully embraced the implications of recovery's conception of people as self-determined choice makers in control of their lives.

The findings generated by the *Stories of Recovery* research provided unique perspectives offering innovative possibilities for policy development and service provision (see Horsfall, Carrington, & Paton, 2016 and Horsfall, Paton, & Carrington, 2017, for details of the research findings and recommendations). While participants contributed much to the research, our tripartite approach also served to give back to participants in terms of empowerment, growing positive identity, and social inclusion. Simply knowing that people had the opportunity to contribute to improving service provision and to challenge stigmatization was a positive influence on their well-being. However, the research methodology was also enabling. It gave participants the opportunity to speak about mental health service providers and to say what was necessary, important, or unhelpful in service provision: *The mental health system ruined my life and its worse than my original problems. Attitudes of service providers can be very discouraging and not helpful at all when they focus on the clinical side all they think about is*

Figure 3. Participant photograph (P6).

medication. *Don't like it. Not holistic at all. Numbs the pain with drugs that don't help* (P7).

Relatedly, the opportunity to tell their stories and be heard was a very powerful dimension of the research as many participants had histories and experiences of not being listened to: *Everywhere else I go even if I go the police station or something they just keep on telling me to get out the door* (P14); *thank you for letting me tell my story* (P6); and *I'm just pleased that my story, it's all been recorded and said* (P24). The positive impact of this self-authoring process on their well-being, notwithstanding complexity of illness, cannot be overstated (Onken et al., 2007).

Important to the success of the methodology was the collaboration between the research team, partner organization staff, and participant supports (carers and families) that enabled opportunities for participant leadership and co-design, especially in the exhibition phase. With supports in place, a group of participants took the lead on organizing aspects of the opening event including guest speakers and entertainment. Furthermore, participants themselves were involved in speaking at the opening and providing entertainment. They also had very clear ideas about what story their exhibition narratives should convey to viewers and felt sufficiently empowered by our methodology that some made substantial changes. For example, one participant renamed and rewrote parts of her narrative to reflect what she wanted readers to know about the nature of mental illness: *The heads and tails of depression/anxiety* (P10); while another

renamed the narrative in a way that reflected her growing positive identity: *The real story about me* (P20). One participant even wrote their own narrative before they were interviewed.

However, being empowered by the tripartite model, participants also contributed to the evolution of the research methodology throughout the course of the research. For example, during interview, one of the participants redesigned our strategy for giving people back their photographs. Initially, we intended to return these to participants by post after the process of printing photographic enlargements for the exhibition was complete:

P6:	So, do I get to take these home?
Researcher:	No! Sorry! Well actually—no because why I need to keep them is that I need to cross-reference them with the CD so that I know what numbers and then can we post them to you? You want to take them now don't you?
P6:	What if we [here P6 takes the researcher's pen and writes numbers on each of the mini-photo identifiers that accompanied the CD so the chosen images could be cross-referenced for printing without the need to keep the photographic prints.]
Researcher:	Ah, so let's number them. So here, you can do it. I'm glad you can take them. That's a really good idea 'cos there's people I spoke to yesterday and I said, "No you can't take them home" and I hadn't thought to do that!
P6:	I'm smart!

Researcher: You are smart! I'll remember that for the next people! Thank you.

Three months after the research project was completed, we contacted as many participants as possible to follow up on the impacts of their participation in the research process, to elicit feedback on their experience, and to convey our thanks personally (after having written to each participant at the close of the research project). This process revealed that the opportunity to reflect more holistically on their lives through visual form and to articulate their stories publicly was empowering for participants and had a positive impact on their level of social engagement. The following examples show some of the changes experienced by participants since being involved in the project:

P20: I'm not scared of meeting people now; I was wary before, not happy to meet people; but now I have some new friends. I'm singing more and have a regular gig on Friday nights.

P4: I've continued to work with photos in this way after the project; using them to 'heal', they help me connect to feelings and memories; helping me to confront people I didn't want to look at; I'm now 'touching' and 'looking' at the photos—the process is healing and soothing.

P2: I've now got awareness of how many people are struggling with mental health issues from all walks of life; I've got more empathy; and I'm more confident in relationships with others. I'm moving forward with my music and have another gig, too.

Concluding Comments

The *Stories of Recovery* research approach utilized consumer-led recovery principles to inform the overall design and conduct of the research. On a macrolevel, we also used the lens of collective impact to elicit a shared vision across the net of support necessary for participant engagement in the research. At the microlevel, we integrated trauma-informed 'care' into a best practice research model using strategies that supported participants in the research. The research findings showed that deploying creative methods within a research design informed by the tripartite approach was key to eliciting the research outcomes. The design enabled participants to express their stories, knowledge, and experience in a context of safety for both participants and researchers. The research also contributed to participant empowerment and enjoyed an exceptionally high retention rate despite people's ongoing vulnerabilities and challenges.

In its capacity to generate insightful data while at the same time maintaining safety for all involved, the tripartite approach provided a comprehensive basis for successfully implementing sensitive inquiry in the context of this study. We therefore recommend using the tripartite methodology when doing research with people with lived experience of mental illness. Further research is implied to test whether and how this methodology would be useful across groups of vulnerable participants outside of the mental health field. Additionally, the successful use of photovoice in this context suggests that it is a useful method for enabling participants to tell their own stories in their own words and to 'speak truth to power.'

Note

1. Participants are referred to as P1, P2, and so on to protect their confidentiality. The numbers refer to the order in which they were interviewed. Data quotes are in italics, unless indented.

References

Babchuk, W. A., & Badiee, M. (2010, September 26–28). Realizing the potential of qualitative methodologies: A conceptual guide for research and practice. In J. Dirkx (Ed.), *Proceedings of the 28th Annual Midwest Research-to-Practice Conference in Adult, Continuing, and Community Education* (pp. 25–31). East Lansing: Michigan State University. Retrieved from https://msu.edu/~mwr2p/Babchuk%26Badiee-MR2P-2010.pdf

Bahn, S., & Weatherill, P. (2012). Qualitative social research: A risky business when it comes to collecting "sensitive" data. *Qualitative Research*, *13*, 19–35.

Bath, H. (2008). The three pillars of trauma-informed care. *Reclaiming Children and Youth*, *17*, 17–21.

Booth, T., & Booth, W. (2003). In the frame: Photovoice and mothers with learning difficulties. *Disability and Society*, *18*, 431–442.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*, 77–101.

Chan, T. M. S., Teram, E., & Shaw, I. (2015). Balancing methodological rigor and the needs of research participants: A debate on alternative approaches to sensitive research. *Qualitative Health Research*, *27*, 260–270.

Commonwealth of Australia. (2010). *National standards for mental health services*. Canberra, Australia: National Mental Health Strategy, Australian Government. Retrieved from http://www.health.gov.au/internet/main/publishing.nsf/Content/CFA833CB8C1AA178CA257BF0001E7520/$File/servst10v2.pdf

Crowe, M., Inder, M., & Porter, R. (2015). Conducting qualitative research in mental health: Thematic and content analyses. *Australian and New Zealand Journal of Psychiatry*, *49*, 616–623. doi:10.1177/0004867415582053

Diamond, C., & Van Halen-Faber, C. (2002). Searching ways: Art proustifies science. *Curriculum*, *32*, 121–130.

Dickson-Swift, V., James, E., Kippen, S., & Liamputtong, P. (2009). Researching sensitive topics: Qualitative research as emotion work. *Qualitative Research*, *9*, 61–79.

Ferencik, S., & Ramirez-Hammond, R. (2011). *Trauma-informed care: Best practices and protocols for Ohio's domestic violence programs*. Columbus: Ohio Domestic Violence Network.

Forrest, R. (2014). The implications of adopting a human rights approach to recovery in practice. *Mental Health Practice*, *17*, 29–33.

Freire, P. (2003). *Pedagogy of the oppressed* (M. B. Ramos, Trans., 30th Anniversary ed.). London, England: Continuum International.

Glover, H. (2012). Recovery, lifelong learning, empowerment & social inclusion: Is a new paradigm emerging? In P. Ryan, S. Ramon, & S. Greacen (Eds.), *Empowerment, lifelong learning and recovery in mental health: Towards a new paradigm*. London, England: Palgrave Macmillan, 15–35.

Harker, K., & Cheeseman, H. (2016). *The stolen years: Mental health and smoking action report, ASH*. Retrieved from http://www.ash.org.uk/stolenyears

Harris, J., & Roberts, K. (2003). Challenging barriers to participation in qualitative research: Involving disabled refuges. *International Journal of Qualitative Methods*, *2*, 14–22.

Henderson, C., Evans-Lacko, S., & Thornicroft, G. (2013). Mental illness stigma, helpseeking, and public health programs. *American Journal of Public Health*, *103*, 777–780.

Hewitt, J. (2007). Ethical components of researcher-researched relationships in qualitative interviewing. *Qualitative Health Research*, *17*, 1149–1159.

Horsfall, D., Carrington, A., & Paton, J. (2016). *Stories of recovery from the bush: Unravelling mental illness, self and place* (Research Report). Western Sydney University. Retrieved from http://handle.uws.edu.au:8081/1959.7/uws:35379

Horsfall, D., Paton, J., & Carrington, A. (2017). Experiencing recovery: Findings from a qualitative study into mental illness, self and place. *Journal of Mental Health*. doi:10.1080/09638237.2017.1385736

Horsfall, D., & Welsby, J. (2007). If someone actually asked us, you'd find we have a lot to say: Arts based with women who have an intellectual disability. In J. Higgs, A. Titchen, D. Horsfall, & H. Armstrong (Eds.), *Being critical and creative in qualitative research*. Sydney, Australia: Hampden Press, 260–271.

Kania, J., & Kramer, M. (2011). Collective impact. *Stanford Social Innovation Review*, *9*, 36–41.

Lee, S., Crowther, E., Keating, C., & Kulkarni, J. (2013). What is needed to deliver collaborative care to address comorbidity more effectively for adults with severe mental illness? *Australian & New Zealand Journal of Psychiatry*, *47*, 333–336.

McIntyre, A. (2003). Through the eyes of women: Photovoice and participatory research as tools for reimagining place. *Gender, Place and Culture: A Journal of Feminist Geography*, *10*, 47–66.

Mental Health Coordinating Council. (2010). *Trauma informed care in mental health services*. Consultation Paper, National Strategy for Trauma-Informed Care. Retrieved from http://www.blueknot.org.au/Portals/2/NS-TIC%20Lit%20Rev%20190510_F_.pdf

Mental Health Coordinating Council. (2013). Trauma-Informed Care and Practice: Towards a cultural shift in policy reform across mental health and human services in Australia, A National Strategic Direction. Authors J. Bateman, C. Henderson (MHCC), & C. Kezelman Adults Surviving Child Abuse (ASCA), *Position paper and recommendations of the National Trauma-Informed Care and Practice Advisory Working Group*. Rozelle, Australia: MHCC.

Mitchell, W., & Irvine, A. (2008). I'm okay, you're okay? Reflections on the well-being and ethical requirements of researchers and research participants in conducting qualitative fieldwork interviews. *International Journal of Qualitative Methods*, *7*, 31–44.

Onken, S., Craig, C., Ridgway, P., Ralph, R., & Cook, J. (2007). An analysis of the definitions and elements of recovery: A review of the literature. *Psychiatric Rehabilitation Journal*, *31*, 9–22.

Parke, B., Hunter, K., & Marck, P. (2015). A novel visual method for studying complex health transitions for older people living with dementia. *International Journal of Qualitative Methods*, 1–11. doi: 10.1177/1609406915614150

Paton, J., Carrington, A., & Horsfall, D. (2016). *Stories of recovery from the bush: Images and narrative unraveling mental illness, self and place*. Exhibition Catalogue, Western Sydney University. Retrieved from http://handle.uws.edu.au:8081/1959.7/uws:35492

Phillips, R. (2006). Consumer participation in mental health research. *Social Policy Journal of New Zealand*, *27*, 171–182.

Schneider, B. (2012). Participatory action research, mental health service user research, and the hearing (our) voices projects. *International Journal of Qualitative Methods*, *11*, 152–165.

Stokols, D. (1996). Translating social ecological theory into guidelines for community health promotion. *American Journal of Health Promotion*, *10*, 282–298.

Tee, S. R., & Lathlean, J. A. (2004). The ethics of conducting a co-operative with vulnerable people. *Journal of Advanced Nursing*, *47*, 536–543.

Tse, S., Tsoi, E., Hamilton, B., O'Hagan, M., Shepherd, G., Slade, M., . . . Petrakis, M. (2016). Uses of strength-based interventions for people with serious mental illness: A critical review. *International Journal of Social Psychiatry*, *62*, 281–291.

Wang, C., & Burris, M. A. (1997). Photovoice: Concept, methodology, and use for participatory needs assessment. *Health Education & Behavior*, *24*, 369–387.

Yardley, A. (2008, September). Living stories: The role of the researcher in the narration of life. *Forum: Qualitative Social Research*, *9*. Retrieved from http://www.qualitativeresearch.net/index.php/fqs/article/view/990/2154