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Exploring social support and identity in recovery: a photovoice study

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Institutional details

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Acknowledgements

The authors also want to acknowledge the excellent support that the Serenity Café (recovery café) for many years provided in Edinburgh. The café, which also engaged in earlier stages of this work, closed suddenly during the time this project ran and the vibrant community has lost an important hub for people in recovery.

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Executive summary

Key findings

- Recovery is embraced and sustained by embedding the tools used in early recovery into an ongoing lifestyle to support an emerging recovery identity.

- Over time, strategies such as structuring time, being positively occupied, going to meetings and connecting with others become a stable base from which people can reach out for new experiences.

- Embedding these tools in an ongoing lifestyle provides individuals with the safety and security to try new things beyond the recovery community.

- Visible recovery networks and role models encourage access to recovery and help individuals to develop and sustain their own identity in recovery.

- Supportive social spaces to build networks and share experiences are central to enduring recovery.

Background and aims

Recovery from addiction can be a challenging and fluctuating journey and individual support needs vary throughout. Services for people in recovery have changed significantly in recent years, with emphasis placed on solutions and service-user experiences rather than traditional treatment approaches. However, the 'key ingredients' that help people to sustain recovery are not yet fully understood. This project aimed to explore what helps people to achieve and sustain recovery, in relation to social support, and both social and individual identity changes.

Methods

This study adopted a qualitative approach, using the participatory research method developed in the 1990s called photovoice. Photovoice uses photography as a way to tell the stories of people whose voices are often not heard and enables engagement and empowerment through a participatory approach. Eight people who self-defined as being in recovery were recruited and were given a camera, if they wished to use one, to keep for eight months. Over the study period, participants were asked to take photographs that represented their recovery journey, their experiences of social spaces where support can be provided and obtained, and their reflections on identity. The photographs and participants' experiences were discussed at three different time points; i) in individual interviews, ii) in a focus group mid-way through data collection, and iii) two focus groups at the end of the data collection period.

Data were analysed iteratively using thematic analysis, with input from a peer researcher who is in recovery and could provide insights into the identified themes. Identified themes were discussed within the team at several time points to contextualise their importance and meaning. Narratives were chosen to correspond with the participant who took the photo, to give the most accurate possible representation of their experience and photo.

Findings

The results showed that overall the participants rebutted the idea of different or novel active ingredients in recovery. They argued that the same set of ingredients exist for all people but may be used in varying degrees. All participants embraced recovery and incorporated it into their personal identity, using the tools or 'ingredients' in different ways to sustain themselves and this developing recovery identity. Participants agreed that core activities such as going to meetings, being positively occupied, and connecting with others were key to early recovery. Consistent use of these tools provided confidence in recovery and allowed participants to develop a strong base from which to reach out for new experiences. By embedding these tools in their lifestyle, participants experienced a sense of security which in turn allowed them to explore new experiences, developing relationships and a sense of identity beyond the recovery community.

Recurring themes were feelings of gratitude for having the opportunity of another chance at life and to be in a place where they felt they fit in. This was something that they had not felt when they were actively using alcohol and was, in many cases, one of the reasons that they had turned to alcohol. Several participants noted that recovery is for many people invisible, something participants believed inhibited access to recovery. Ensuring that recovery is visible and portrayed as the desirable and positive outcome the participants believed it to be, was considered essential to support recovery. Role models were seen as a positive influence for people at various stages of recovery highlighting the importance of visibility in supporting access to and sustenance of recovery.

The photographs taken by participants, to a large extent, involved exploration of their surroundings, wherever they felt most 'at home'; for some nature was a place where they found positive energy whereas others labelled themselves as being more connected to city life. Photographs centred around places they felt at ease, sometimes in places where they had felt sadness or misery during their period of active substance use. The positive narrative around life in recovery was contrasted with the notion that even after many years in recovery, it can be a challenging process requiring energy and work. For this reason, some participants strongly disagreed with the expression of being 'better than well', which they saw as almost an unobtainable state. To some extent this phrase, which had been used by previous research participants, induced false hope for people in early recovery and did not promote appreciation of the plateaus that some people in long-term recovery identified were features of several stages of their recovery.

Implications

Our findings from this study resonate with previous work around recovery and key resources and processes that enable people to access and sustain recovery. The findings do not suggest any novel 'ingredients' in recovery that can inform future service development. Conversely, our conclusion is that investing in services and support mechanisms that provide the basic recovery tools is the most useful utilisation of resources. Socially supportive environments and spaces where

recovery is visible allows participants an opportunity to meet role models, see a positive future in recovery and model behaviour which shapes an emerging recovery identity. We hope that the findings from this project can contribute to the evidence base by emphasising the crucial role social support plays in recovery, to underpin future decisions about funding and support to community-based services.

Abbreviations
AA Alcoholics Anonymous
AAD alcohol-attributable death
ADP alcohol and drug partnership
AOD alcohol and other drugs
APC alcohol per capita
ARD alcohol-related death
PAR participatory action research

Background and aims

Alcohol is a major contributing factor to the global burden of disease; 5.3% of deaths globally in 2016 were caused by harmful alcohol use, which was highest in the European Region (10.1%) (WHO, 2018b). The significant level of mortality due to alcohol in Europe is unsurprising, considering the high levels of consumption – in 2016 the total alcohol per capita (APC) was 9.8 litres of pure alcohol (WHO, 2018b). However, the average APC for the region declined by 11% from 1990 to 2014. Despite these changes in the overall level of consumption, increasing levels of alcohol consumption in parts of the region resulted in a 4% increase in alcohol-related harm in the same time period (Shield et al., 2016).

Alcohol consumption in the United Kingdom (UK) has reduced over time; APC in 2016 was 9.8 litres, compared to 10.2 litres in 2010 (WHO, 2018a). The prevalence of alcohol use disorders (AUDs) is similar to the European Region average (8.7% and 8.8%, respectively), whilst the prevalence of alcohol dependence is lower than the regional average (1.4% and 3.7%, respectively) (WHO, 2018b). Within the UK, alcohol consumption and harm differs between the four nations. In Scotland, the average weekly intake of alcohol has declined by around 20% since 2003; from 16.1 units to 12.8 units. The average weekly intake of men in 2016 was double that of women (16.9 and 8.8 units, respectively) and the age group with the highest average weekly intake was 55–64-year-olds (15.7 units) (McLean et al., 2016). Compared to England, the average weekly intake among Scottish drinkers[1] is slightly higher. In 2015, the average weekly intake was 11.9 units in England and 12.9 units in Scotland (HSCIC, 2016, McLean et al., 2016).

Mortality due to alcohol in Scotland is higher than in England and Wales, as would be expected with higher overall levels of consumption. In 2017, there were 1235 alcohol-related deaths (ARDs) and 3705 alcohol-attributable deaths (AADs), with significantly higher likelihood of dying as a cause of alcohol for men as well as for people living in the most deprived areas of society. Whilst both ARDs and AADs have reduced over time, as well as a reduced inequalities across the socioeconomic gradient, the statistics indicate a great need for intervention as 60% of ARDs are due to liver disease and 22% to mental and behavioural disorders (SHAAP, 2018).

Addressing alcohol and drugs in Scotland

Alcohol and drug services in Scotland are organized and managed across the nation in 30 Alcohol and Drug Partnerships (ADPs) which have the responsibility to "commission evidence-based, person-centred and recovery-focused treatment services to meet the needs of their resident populations" (Scottish Government, 2018). These local partnerships are guided by the Framework for Local Partnerships on Alcohol and Drugs, launched in 2009 (Scottish Government, 2009). The document specifies principles on which the work is set out, which includes multi-agency cooperation (to be based within existing structures), accountability and governance structured according to existing arrangements between Scottish Government and local partners, and for the government to support partnerships a the local level in order to achieve set goals.

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[1] Those who had consumed alcohol in the past year

The treatment system in Scotland is structured according to a four-tiered approach, outlined in Table 1. Recommendations within the Quality Alcohol Treatment and Support (QATS) report stipulates that treatment and recovery service users are represented within the APDs to ensure that services are appropriate. Furthermore, the document is clear on the specific focus on recovery that the ADPs should address in the design and delivery of services, specifically that: "services should be underpinned by a recovery ethos which supports and builds on the strengths and assets within individuals" (The Scottish Government, 2011). The 2018 strategy for preventing and reducing harm caused by alcohol and drugs has a public health focus and explicitly states that the vision for Scotland is that "individuals, families and communities are fully supported within communities to in their own type of recovery" (p.04). Furthermore, the importance of mutual aid and peer support is included as an additional recovery resource to structured treatment (Scottish Government, 2018). However, recent years have seen significant cuts to funding of alcohol and drug services (Scottish Conservatives, 2017).

Tier 1: services for the whole community
Tier 2: local services that identify and respond to people with alcohol problems
Tier 3: services for people with more complex needs
Tier 4: services for people with highly specialised needs
Source: The Scottish Government (2011), p. 11

Table 1. Four-tier structure of alcohol treatment and support in Scotland

Recovery and identity

Recovery as a concept lacks consensus in its definition (Lancaster et al., 2015), however there is an acknowledgment that 'recovery capital' (Cloud and Granfield, 2008) may offer a paradigm shift, allowing an asset-based approach to flourish (White et al., 2012). The Betty Ford Institute Consensus Panel paper on recovery outlines three common elements to recovery: well-being, sobriety and citizenship. The consensus paper was not developed based on the available evidence but rather professional and personal experiences of substance use disorders and recovery (The Betty Ford Institute Consensus Panel, 2007). Similarly, in a study including service providers, recovery was described as encompassing more than simply abstinence from alcohol or other drugs (Neale et al., 2014).

Importantly, recovery has been described not as an end or a goal but rather a process that people who have experienced addiction go through (Best & Laudet, 2010). Best et al. (2008) found that initial stages of recovery were related to health factors, but sustained recovery related to social aspects – having a higher number of non-using people in social network reduces relapse rate. In addition, those who had been in recovery the longest reported the highest levels of quality of life. Best et al. (2012) found that having more people within the social network who also were in recovery was related to engaging in meaningful activities and higher quality of life. Longer time in recovery was associated to having more non-users and people in

recovery within their social networks, along with higher quality of life. The dynamic of social groupings and social support therefore appears to be a key factor in long-term recovery.

The literature is vast on factors that promote recovery, known as 'recovery capital'; human capital, physical capital, cultural capital, and social capital (Best & Laudet, 2010). Granfield and Cloud (2001) argued that people with greater social capital –family, friends, and community– are likely to need less intense treatment services, even if their substance use is at a rather high level. Recovery capital, in its broad sense, has been found to be important both inside and outside of treatment, to help individuals be successful with their recovery process (Best & Laudet, 2010). Whilst sustaining recovery is supported through internal and external resources (White & Cloud, 2008), community capital, such as social groups and housing support, appear particularly important (Best & Laudet, 2010). Support from a social perspective, therefore, is an important component of not only seeking recovery but to sustain it long-term.

In the context of social support, social identity theory provides insights into factors and processes of long-term recovery and social support that may be of particular importance. Best et al. (2017) noted that "as a person becomes part of the group, so too does the group become part of the person", which is relevant for people entering into, and desiring to be part of, a recovery community. Social identity theory has its roots in social psychology, originating from the work by Tejfel in the late 1970s who argued that social identity is created through values or worth by defining oneself in relation to in-groups (a group that the individual is part of) and out-groups (that the individual is not part of and is different to the in-group). In other words, social identity relates to how people define themselves in what they are, or what group they belong to, in relation to what they are not (Spears, 2011). Developing social identities can have an impact on self-efficacy as well as health related behaviours, and identifying with a recovery identity, rather than addiction (or 'being an addict'), can therefore help form new behaviours. Best et al. (2017) showed that differences in how people define their recovery, which is strongly related to what sort of fellowship (e.g. Alcoholics Anonymous (AA) or Therapeutic Communities) they access. In their study, Best and colleagues found that people who defined themselves as 'recovered' had the highest self-rated physical and psychological health, compared to those who defined themselves as 'in recovery' or 'in medically assisted recovery'. However, in terms of social identity, those who were 'in recovery' had the highest proportion around them who were also in recovery (82.8% compared to 63.1% and 39.1%, p<0.001).

The processes and social strategies involved in changing recovery from being the all-encompassing work of an individual's every waking moment to recovery being a more integrated part of personal identity is also under-researched. White et al. (2012) highlighted the importance of moving from a culture of addiction to a culture of recovery, and the importance of shedding one identity while developing another, new, personal identity. Identity stability is often considered important in enhancing well-being (Haslam et al., 2008, Haslam et al., 2009). However, Dingle et al. (2015) specifically examined the benefit to recovery of identity transition and found identity change to be a significant indicator of successful recovery. Social networks and groups that incorporated a recovery focused social identity were found to be

beneficial to physical health measures, not just subjective well-being (Dingle et al., 2015). Dingle and colleagues pointed to the need for more nuanced understanding of social identity development within a recovery community, an objective addressed by this research.

Aim and research questions

The aim of this project was to explore the experience of sustaining recovery within the context of a supportive social environment. The proposed work addresses three research questions:

1   What are the 'key ingredients' that make supportive social environments, such as Serenity Café (recovery café), important in sustaining recovery both individually and as a group of peers?

2   How do people incorporate recovery into their personal identity and their lives over time?

3   What role do supportive social spaces have in the process of identity transition?

Methods

This study adopted a qualitative approach, using photovoice to facilitate exploration on the topic of recovery, identity and social support. Participants were recruited through a local recovery support service, which the peer researcher has a close connection. Participants were individuals linked with the service, using it to varying degrees depending on their stage of recovery. Participants were invited to take part if they defined themselves as being in recovery from alcohol problems, regardless if it was alcohol alone or as part of a wider substance misuse problem. Participants had to be at least 18 years of age and the target population were people with at least 1.5–2 years in recovery. Only one participant fell outside the target group and was included because they self-identified as being in sustained recovery, having been in recovery from drug addiction for many years but with only a five-month period in recovery from alcohol problems. The following sections will provide an overview of the method and procedures.

Photovoice

Photovoice is a qualitative, participatory action research (PAR) method in which participants use photography as a way of engaging in the research process and express their views of a specified topic (Tinkler, 2013). Evans-Agnew and Rosemberg (2016) note that three distinct uses of the method are evident. The first is as a photo elicitation approach within phenomenological and grounded theory research, focusing on describing participants' lived experiences. The second is using the photovoice method to develop theories around experiences. The final use is as a PAR method for social change, in which stories or captions that participants use for photos they have taken are used.

Photovoice originates from the work of Wang and Burris, first named 'photo novella'. The initial photo novella study focused on women's reproductive health in rural China and was underpinned by empowerment education, feminist theory and documentary photography (Wang and Burris, 1994). In later work, Wang and Burris progressed photo novella to 'photovoice' (voice: "Voicing Our Individual and Collective Experience", p. 381). Three main goals of photovoice were described: "(1) to enable people to record and reflect their community's strengths and concerns, (2) to promote critical dialog and knowledge about important issues through large and small group discussion of photographs, and (3) to reach policy-makers" (p. 184) (Wang and Burris, 1997). A search on PubMed using the terms 'photovoice' OR 'photo novella' show an increase in the last five years, indicating its increased popularity as a qualitative research method (see figure 1).
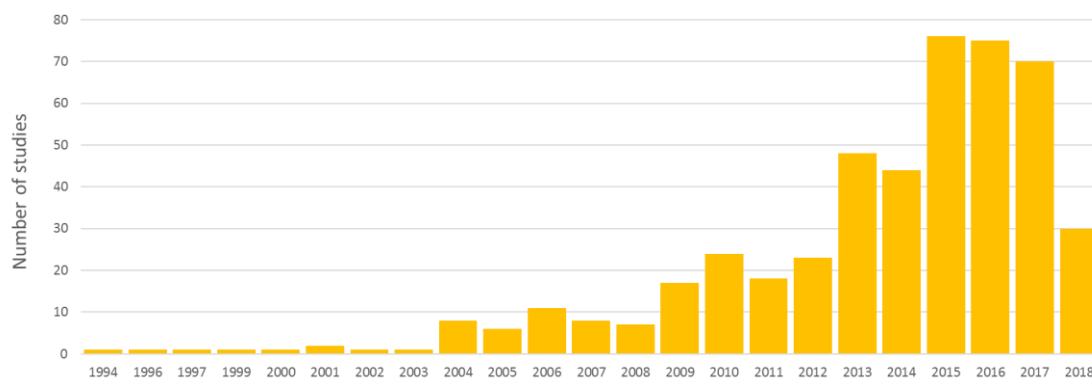
Figure 1. Studies published including 'photo novella' or 'photovoice', 1994–2018

Since the emergence of photovoice, as it is now known and conceptualised, it has been used to explore topics in a range of fields. A common trait is to use the method to explore perceptions among marginalised groups as the method benefits from not requiring literacy; the use of visual stimuli as a facilitator for dialogue and conversation is a key component of photovoice (Plunkett et al., 2013). In fact the dialogue, rather than the pictures themselves, is what enables participants and researchers to interpret the phenomenon of study (Plunkett et al., 2013).

Hergenrather et al. (2009) identified steps in the photovoice method, from the initiation to the final stage of the research:

1   Identification of community issue

2   Participant recruitment

3   Photovoice training

4   Camera distribution and instruction

5   Identification of photo assignments

6   Photo assignment discussion

7   Data analysis

8   Identification of influential advocates

9   Presentation of photovoice findings

10 Creation of plans of action for change

We used these ten steps to plan and guide the current study, with the aim to contribute to the existing body of photovoice literature by adopting an as comprehensive as possible approach.

Recruitment and data collection

Phase 1

The first phase of the project started in December 2017 and ran until late March 2018. A photovoice workshop was organised (step 3 of photovoice) to introduce participants to the project, project staff (three researchers, two peer researchers and one photography artist), and go over ground rules of the method (Appendix 1). Seven individuals attended the initial photovoice workshop, and three joined after the workshop. Two individuals later withdrew their participation, before contributing any data. At the workshop, participants were provided with written information (Appendix 2) of the study as well as being informed verbally, and written consent was obtained for all phases of the study.

The workshop included discussion about the photography task, which was loosely described as focusing around recovery and the active ingredients in recovery, with particular attention to the Christmas holiday period, which was coming up. During the next two months, participants took photos either with a camera they had been given during the workshop, or with their own phones. Several participants stopped using cameras as they felt that they wanted to take photos 'in the moment', rather than going out with a particular idea in mind. The larger cameras were seen as unsuitable for that purpose as they felt that they were too large to carry out.

Table 2 shows the characteristics of the eight participants who took part, including their participation in the various stages of the project. Pseudonyms were chosen by the research team, unless participants had their own suggestion. Two participants chose their own pseudonyms.

Pseudonym	Years in recovery	Workshop	Interview	Focus group 1	Focus group 2/3
Haley	3.5	Yes	Yes	Yes	Yes (2)
Craig	4.5	Yes	Yes	Yes	Yes (2)
Stuart	9	Yes	Yes	Yes	Yes (3)
Amanda	0.5	Yes	Yes	Yes	Yes (3)
Jean	4.5	No	Yes	Yes	Yes (2)
Sean	5	Yes	Yes	Yes	No
Lesley	2.5	Yes	Yes	No	No
Dode	>20	Yes	Yes	No	Yes (2)

Table 2. Study participants

After approximately two months, participants were invited to take part in individual interviews (conducted by LS). The interviews focused on discussing the photos taken to date, experiences of the Christmas period, and feelings about recovery identity and the 'active ingredients' in recovery. Between February and March, LS

interviewed seven participants on six separate occasions (one interview was conducted as a paired interview upon request of the participants).

Phase 2[2]

One focus group was conducted mid-way through the project and one was conducted at the end of the project. The first focus group was conducted on 26 March, and was attended by six participants, two researchers (LS and SR), the photographic artist, the peer researcher, and a PhD student. In preparation for the focus group, mind maps of key themes were produced. The intention with these mind maps was to discuss common themes from the interviews and develop these further in a collaborative fashion. However, the mind maps did not stimulate discussion as participants agreed with each theme without initiating further discussion. The focus group reverted, therefore, to a more traditional format using open questions and the mind maps were put aside.

The second focus group was organised as two separate groups, due to issues with getting all participants to attend the same day. Due to a late participant cancellation, one group only comprised of two participants. These final focus groups were intended to further reflect on the entire project and to allow the participants to choose the photos they felt best represented them in recovery, in relation to identity and social support. In this final discussion, participants were asked to select 5–10 photos they felt represented their recovery journey and in particular their identity. These were also the photographs from which a selection for a public exhibition were chosen. Appendix 3 shows how discussion was facilitated, using notes and scribbles by both researchers and participants to note specific ideas relating to individual photographs. The final focus groups were attended by two researchers (SR and LS), the photographic artist, the peer researcher, and a master's student.

The process which followed the final focus group was to take a selection of photos from the sample discussed (two from each participant) to create a public exhibition that would tell the participants' stories of their recovery journey and the impact on their identity. Suitable quotes from the interviews or focus groups were paired with photos from the same participant, apart from in one occasion where the participant (Amanda) wrote a poem to go with her photograph. The focus of the exhibition was not to focus on the specific research questions but to communicate key co-produced messages that were identified throughout the process in collaboration with the peer researcher. The aim of the exhibition, therefore, was to communicate positive messages of recovery to the public to educate and inspire. The first public exhibition was held on 16 January at a local arts venue for two weeks, a few months behind schedule due to unforeseen circumstances (see Implications). The photos were displayed for another 3 weeks in a local community centre (South Edinburgh) followed by a month in another local arts centre (North Edinburgh). The exhibitions reached a range of people from different localities, some of whom deliberately set out to see the exhibition, many more of whom came across the photos while visiting

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[2] The second phase originally included another round of interviews to discuss a selection of up to 40 photos, but the first round of interviews and the subsequent focus group generated very similar data and participants also had limited availability to meet on several occasions. This data collection phase was therefore omitted, but did not impact answering the overall research question

a local venue. The display products have also been used in education of student nurses within the University. The exhibited photos are now awaiting permanent homes in venues across Edinburgh and the Lothians with interest having been expressed by residential units for those in recovery, day centres, community services and outreach projects. The exhibitions and photos for permanent display provide a lasting legacy from this project, sharing participants' messages with a wide audience and are an important source of impact from participatory research of this kind.

Data analysis

All interviews and focus groups were transcribed verbatim by a transcription company. Personal information such as names, professions, and locations were removed from the transcripts by LS to ensure confidentiality. Data were analysed using thematic analysis (Braun and Clarke, 2006), following guidance on ensuring trustworthiness – the qualitative research quality measure. Trustworthiness, which is a way to strengthen the rigour of a qualitative study, includes credibility, transferability, dependability and confirmability (Nowell et al., 2017).

All data were read several times by LS, who used inductive (data-driven) coding for initial coding of the dataset, following the guidance of Saldaña (2016). The coding and identified categories which were discussed in team meetings with two (LS and SR) or three of the researchers (LS, SR, and FC) on multiple occasions. Discussions were held throughout, particularly shortly following the focus groups to debrief the discussion as well as further progress of the coding. Three meetings were held with the peer researcher (BW) to discuss the developed themes and gain his perspective on specific aspects of the research based on his personal experience of being in recovery. This did not change the coding framework of the developed themes, but resulted in exploring topics in more detail, changing the emphasis of understandings and moving data between themes. The insight of a peer researcher was invaluable at this stage allowing researchers to ask deep and probing questions of the data. There were times during the meetings with the peer researcher that the research team tested analytic ideas and sought explanation and reflection in order to explore the meaning in participants' data. This process has been refined over the course of this project and there continues to be learning about how best to work with peer researchers which could be explored further in future work.

All data were coded using Nvivo version 11 (QSR International Pty Ltd, 2012) to organise codes and categories. All codes and categories were summarised in an Excel spreadsheet with explanatory notes (see Appendix 4) to facilitate collaborative discussions on the analysis. A second meeting was held to discuss specific codes and categories developed from ongoing refining of the coding framework (see Appendix 5).

Ethical considerations

Ethical approval for this study was obtained from the Nursing Studies Ethics Research Panel within The School of Health in Social Science (Ref: STAFF097). As photovoice has the potential to raise a number of ethical issues, the initial workshop with participants focused on specific safety and ethics aspects that they needed to

consider before agreeing to take part in the study. These safety guidelines have been developed over the course of a number of photovoice projects within Nursing Studies, University of Edinburgh (Appendix 1). Primarily, it was emphasised that health and safety needed to be considered at all times and participants were explicitly informed not to take photographs in any situations that may put them at risk or that depicted any illegal activities. Despite this, one participant had a number of photos taken from inside their car, which appeared to be whilst driving, showed during the interview. The researcher (LS), who conducted the interview, reinforced the need to adhere to health and safety procedures, which was also reiterated during the first focus group to ensure that other participants did not engage in taking photographs in situations that put them or others at risk.

Another key ethical aspect covered was that of personal identification. It was made clear that any faces that appeared in photographs needed signed consent from the individuals appearing in the photograph. Whilst photographs with faces were not an issue in the discussions to facilitate the interviews or focus groups, photographs that were to be used for the exhibition or for future publications could not feature individuals without consent. As no consent forms were returned, photos that were selected by the participant but contained faces were reviewed by the research team and were replaced with another photo that would help tell the story. One clear example was Craig's photograph of himself and two of his children, who he expressed great pride over, which was replaced with a photograph of woodlands that appeared to have been taken in the same place (see page 17).

Results

The narratives from this study contained a number of overarching ideas around recovery and identity. While this project set out to identify 'active ingredients' of sustained recovery, participants refuted the existence of such ingredients, explaining the importance of embedding tools and strategies from early recovery in an ongoing lifestyle. Personal identity was shaped by the consistent use of these tools and the growing confidence that came from their use. In simple terms, the ingredients are skills, knowledge and resources that participants emphasised they had gained and started to develop in early recovery. Recovery is facilitated by social support, connections to other people through Fellowships or support groups, finding role models and learning that recovery is a positive way to live. Strategies such as structuring time, planning the day, being positively occupied, supporting and connecting with others were all central to early recovery and served as a backdrop to the evolution of personal identity in longer-term recovery. Skills and knowledge flourish alongside confidence in the new recovery identity allowing individuals to rely on these tools and develop a new sense of personal identity.

In this group, recovery was by no means easy and whilst participants spoke predominantly about positive aspects of their recovery it was evident that sustained recovery is ongoing, sometimes hard, work. We found that the tools participants used early on in their recovery, they also used further on in their recovery. Their reliance on these tools gave them a deeper sense of anchoring and a confidence in themselves which allowed them to develop personal identities within new social groups beyond the recovery community. Their strength to branch out came from a confidence in their ability to reach back to the tools which sustain them should they feel insecure. This confidence also allowed the participants to either shake off their old life and shape who they wanted to be, or to embrace that addiction had once formed part of their life. Of note is, however, that all participants identified with the concept of being 'in recovery' or a 'recovering alcoholic/addict', which links strongly with the 12-step programmes which they all accessed.

The next sections outlines the four key themes developed from the seven categories and 14 sub-categories (see Appendix 5) identified in the data.

Actions to promote stability

Stable recovery

In order for recovery to be established and remain stable, a set of behaviours or actions were acknowledged. A higher power was mentioned frequently, which was not necessarily a religious or spiritual being. In general, higher power meant feeling connected to, as Jean noted, *"something bigger than me".* Jean represented this in her photo, which she had staged to represent the things that are important for her to feel that connection; yoga and meditation (Photo 1). For Jean, yoga helped her in her recovery journey but later became her big passion, leading her to train as an instructor. Several other participants took up yoga, including Dode who also trained to become an instructor and had visited other countries to practice.

"Being at [place name] doing a yoga class and thinking how the fuck did I get here, how's this even possible, and it's all possible through recovery. It's all happened. And I can absolutely guarantee that none of that would have happened. I wouldn't have been in [place name]. I couldn't go on holiday because every penny went to drink and drugs. Everything that I ever had. I wouldn't buy a pair of socks because that would interfere with the drink money or whatever."

Dode

For me recovery really is about feeling connected to something bigger than me, and that involves being connected to people as well which I never had a sense of before.

Photo 1. Higher power and connectedness, by Jean

Beside a higher power, participants discussed aspects of recovery that were immensely important to encourage people to seek out help to get into recovery. This included authenticity, hope and an awareness that recovery is achievable and possible. When asked, several participants noted that before getting into recovery they did not know anyone in recovery. In one of the final focus groups, the peer researcher noted that: *"Anonymous organisations, it's a comfort to me that you don't have to be known or you can actually keep it a secret if you want, but then it means it's difficult to demonstrate"*. This related to the key issue of having role models, which was identified in the theme 'Social environment'.

Gratitude and pride

Gratitude was a recurring theme throughout the interviews and focus groups – an essential emotion to move on in life and to develop a recovery identity. Participants expressed gratitude towards people who have supported them, but also a more abstract feeling of being grateful for life.

> *"Honesty and gratitude, those two things, are definitely hugely, hugely important to me. Being grateful and never taking anything for granted and to be honest at all times, you know"*

Jean

As part of recovery being an ongoing process (see 'Recovery as a process'), Dode noted that gratitude is a key component to staying 'on track' and emphasised that it is gratitude in everyday life that is hard work, not on special occasions.

> *"You know, that gratitude, you have to cultivate it. And you have to cultivate it, especially on days when you feel like shit […] It's dead easy to feel gratitude when you're sitting on the edge of the Grand Canyon, or you know, surrounded by bloody sharks underwater, and just feeling...that's easy. It's on a daily basis, that it takes the discipline."*

Dode

Whilst the theme of gratitude came through strongly, none of the participants used the word pride. In the first of the final two focus groups, we specifically asked why gratitude, but not pride, featured so clearly. Several participants strongly objected to the idea of being proud of their achievement to being in recovery, as participants kept reinforcing that recovery was not something they had achieved on their own.

> *"But we've not done it ourselves, we've had a lot of help along the way. We couldn't have done it without the help that we've had. So it's not like yeah, I've done really well at this, it's thank god I got help and I'm very grateful for it."*

Craig

> *"It's a good point because within the culture, within the programme, and it is a programme, so you're reprogramming yourself when you come into recovery, especially through using the 12 step route, but almost every route you'll have to do certain things and you'll have to not do other things, and one of the things you don't do is heap pride on or start to develop that pride because without all the other help that you're getting you're not going to be there."*

Dode

In the second of the final focus groups the same topic was discussed, where Amanda and Stuart reflected on that pride is a potential risk of becoming complacent.

> *"Pride can be quite dangerous. For me. I'm not saying it is for everyone else. But that's why I start the steps on 2nd January just to stop myself."*

Stuart

"It is really interesting actually because I've kind of had that conversation before. Like before I relapsed I had a boyfriend who was saying to me I just think it's really crap that you can't take any credit…because in the rooms [at meetings] people often talk about none of this is my doing, it's all down to AA, this is all down to my higher power, I haven't done anything, I couldn't have got out of this mess by myself. There's a lot of talk, don't trust any of your thoughts kind of thing. Because our heads have been telling us to do bad things for a long time and we've been believing them."

Amanda

Hayley spoke about her identity and how she does not hide that she is in recovery, but at times does not actively disclose it from the outset in certain situations. She mentioned the word 'proud', but in relation to being a 'recovering alcoholic', not her achievements in achieving recovery per se.

"If it came up in conversation I'd be quite happy to say yeah, because I was ashamed of my addiction. But in recovery I'm a proud recovering addict, and I've got to show that for the people who may be behind me, I've got that shame and guilt. It's nothing to be ashamed of. It's choices we've made and look this is where my life's at now and it's getting better."

Hayley

Whilst not feeling pride about their recovery, Craig spoke about his children several times, who featured in a number of photographs[3] and how proud he was of them as well as grateful that they were still part of his life despite having been in and out of their lives a lot (Photo 2).
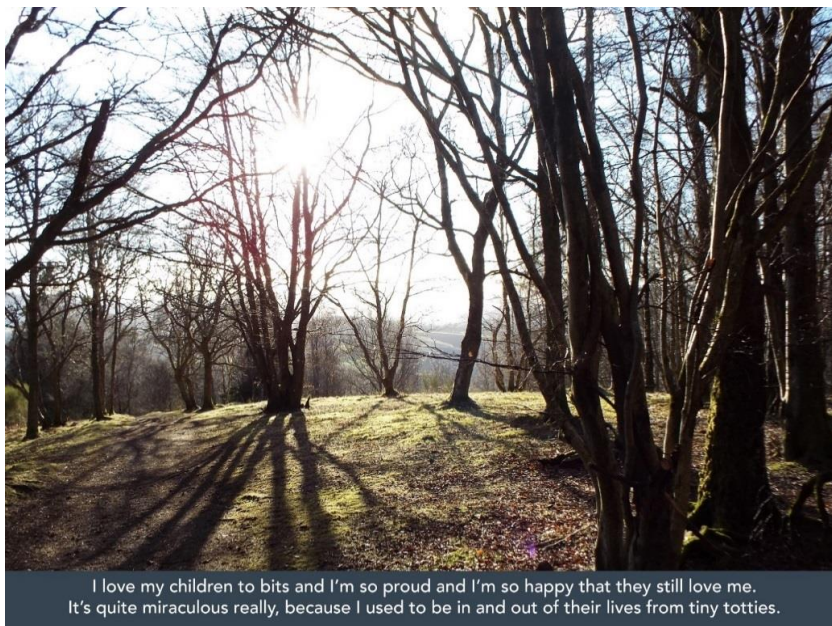
I love my children to bits and I'm so proud and I'm so happy that they still love me. It's quite miraculous really, because I used to be in and out of their lives from tiny totties.

Photo 2. Pride of children, by Craig

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[3] As we did not have consent for these photographs, we opted for one that were similar to those that featured Craig's children

Social environment

Recovery tools

One of the key research questions for the study was what the 'active ingredients' in recovery are. This was discussed throughout and it became clear that participants felt that there are a number of principles, tools and strategies that helped individuals to get into, and sustain, recovery. It was not specific 'active ingredients' that make recovery, but rather a mix of factors. Hayley used the analogy of baking a cake; the ingredients are more or less the same for everyone but the quantities might differ.

> *"I've always been one that says my recovery was like a cake mixture; as long as you've got all the ingredients, mix them together, you're going to get recovery. If you try and deviate any way at all it can get a bit messy, especially at early recovery. A bit further on into your recovery you can put an elaborate icing on it. It's just all about what you make it."*

> Hayley

Fellowships and attending meetings were, unsurprisingly, a core activity along with developing routines and structure in life. This was particularly pertinent in early recovery, when this focused on keeping busy and managing responsibilities, which reflects the literature which has shown that along with peers in recovery meaningful activities is a strong predictor for successful recovery (Best 2012). The positive and purposeful filling of each day, structuring each week, provided a structure on which to build ongoing recovery. This was particularly important and took a great deal of energy in early recovery but became a norm, embedded in a lifestyle as recovery was sustained. The stable routine provided an anchor from which it became possible to branch out as time passed. This allowed people to step outside the routine to try new opportunities, always with the certainty that the familiar routines and tools of early recovery would give enduring security if new ventures became too challenging.

Volunteering at the local recovery café, was something several participants had done and that had helped them at the early stages of recovery. Sean expressed this, and noted that whilst the recovery café offered social support, his social anxiety made him seek out volunteering to help ease the anxiety.

> *"I needed stuff to do. Because they were offering and it was like I know how to do this stuff and there's only so long you can sit about. I experienced social anxiety and I still do sometimes but at the time it was really ripping it out of me, a lot of social anxiety. And sitting in a coffee shop talking to people over endless cups of tea or coffee or whatever was not doing me any good to just be doing that. To be offered the opportunity to then go in the kitchen and do whatever, wash dishes or prepare vegetables for a soup or bake a cake or something like that was massively helpful."*

> Sean

The volunteering was also part of the process of helping others and providing support to those earlier on in their recovery journey. Lesley noted that her recovery was focused on really appreciating and taking care of herself, and part of that process was to contribute to different services.

> *"I learned a lot of assets and positive things about myself as well. And I started doing bits of service at meetings, so helping others, you know, just people that had been through similar things. I volunteered as well, so I did a bit of volunteering at the [café] and a few other organisations that were, like, drug and alcohol services"*
>
> Lesley

The idea of both providing and receiving support was key to developing a strong recovery identity. Amanda described this as *"There's no recovery without being around other addicts, and addicts who have a lot of clean time and life experience and who can pass it on"*. For Amanda, who had been in recovery from a heroin addiction for several years but relapsed with alcohol, engagement with the recovery community was a significant reason to her current optimism about herself. She noted that when she first got into recovery several years ago, her engagement with services were poor, as she then felt she had been "sentenced to it". Whereas now she freely and willingly accessed recovery services and displayed a strong optimism about her future. Craig, in the initial interview noted that accessing recovery services can help with grounding yourself: *"You can go and be interested in what's happening to somebody else; you realise other people have a lot harder a time than you have"*. Being genuinely interested in, and showing compassion for others (see 'Compassion and personal discovery') was generally mentioned by all participants as a key aspect of recovery. For many, this was a shift in their identity as some noted that they previously had been more focused on themselves than caring about other people. The act of volunteering and the positioning of oneself as someone who could offer assistance and support to others was an important part of the recovery journey, allowing individuals to see value in their contribution and develop their personal identity.

As already mentioned, connections with higher powers, spiritual growth and connections with the recovery community at large were seen as essential to successful recovery. The need for role models was highlighted as important and had really shaped the individual journeys of many of the participants. Yet role models were not always easy to find, partly due to the anonymity around Fellowships but also, in part, due to lack of disclosure in the later stages of recovery. This seemed particularly true when new relationships were forged outside of the recovery community, when those in stable, long term recovery did not feel the need to disclose. As several participants described recovery as different to 'the real world', we noted that there seemed to be a discord or gap between people who are in recovery, and identifying as being in recovery, and those who are in long-term recovery but may not be actively disclosing it. The peer researcher highlighted this in one of the final focus groups, and recalled the moment where he felt that he understood what recovery was.

"My tipping point was my first day in treatment when the doctor assessed me and said I'm in recovery […] that's when I realised it wasn't a guilty secret. It was a problem that was manageable and it was something that people went through, not something that was your fault that you just had to swallow and suffer with."

Peer researcher

The challenge of making recovery visible is real for the recovery community and those developing and designing services. The need for anonymity to promote easy access, coupled with the need to promote the positivity of recovery as a lifestyle choice produces a dichotomy which was, in part, addressed by the recovery café and supportive social environments.

Supportive places

We were particularly interested in exploring the impact of the local recovery café and the services it offered to people in recovery. Overall, one of the key features of the café was an accessible and visible service. The visibility, actually blending in with people from outside the recovery community, was seen as a strength making recovery a visible and desirable goal. Amanda mentioned a particular area where she accesses a lot of recovery support, which has *"Strong women and men who are living great lives sober"*.

Many noted that services or support need to be inclusive and feel safe, which was something that seemed pertinent particularly in early recovery. Those who had been in recovery for a long time noted that they would socialise in environments that serve alcohol but one of the benefits of the café is that it provides a safe space for people who may not want to socialise in the 'real world'. Safe spaces were also discussed in relation to places that participants accessed or had taken photographs of that represented calm or peace. Amanda had taken a photograph from a place that had great significance for her, relating to her childhood; a place that she was soon moving back to.

"Whenever I'm down there I just feel this peace. I just feel like it's a safe place and… I mean, I've no idea what it's going to be like to actually live there because I'm sure it's going to be really quiet."

Amanda

In relation to this move, Amanda was not sure what her access to meetings would be like and she worried that it may be a challenge. Craig also reflected on living in a smaller locality in early recovery, where the small size of the community meant having to sneak to AA meetings in order to avoid running into someone he knew. He noted that later on, he had found out that someone he knew also was in recovery and he reflected upon the fact that people are trying hard to hide their activities and their recovery when in fact many people are in the same situation.

Compassion and personal discovery

Caring for and understanding self and others

One recurring topic was that of underlying problems that participants noted they had needed to deal with as part of their recovery. This included depression, ADHD, or general anxiety, for which alcohol and/or drugs had been a coping mechanism for many of the participants. Dode, who had been in recovery for over 20 years, described how undiagnosed ADHD, which he found out he had in adulthood, and childhood trauma were underlying causes to his long trajectory of drug and alcohol misuse

> *"So what happened was that, I had no idea I had ADHD, I had no idea I had an attachment disorder. And so, I came into recovery, and I was still acting, in many ways, as I was when I was drinking […] in my mind, but just absolutely addicted to getting wasted, you know. And it was that, it was an underlying pain, it was the trauma of childhood experiences that were just, they wreaked havoc on my mind."*
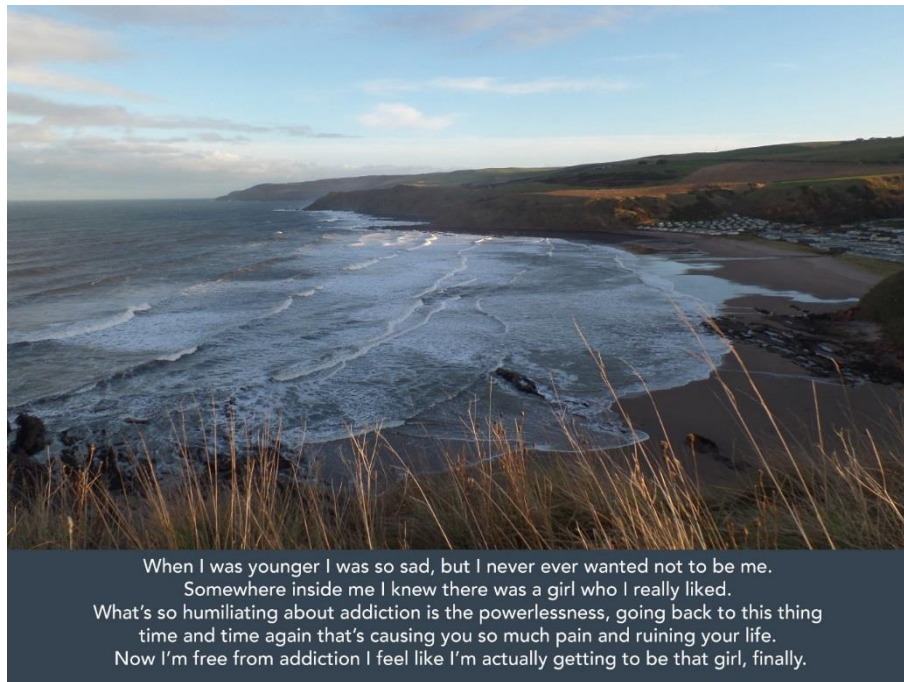
> Dode

Jean described how her long experience of chronic depression was an underlying cause to her alcohol misuse: *"I self-medicated… I have a mental health problem, I suffer from chronic depression and have done since I was in my 20s. That's really where my drinking really got hold of me".* The need for, and ability to, dealing with previous experiences came through in many interview. Lesley had gone through several different counselling and CBT treatments to address her anxiety, which related to experiences of childhood bereavement and domestic violence which, according to herself, she had not dealt with and were key for her to deal with in order to stop drinking.

> *"So there was a lot of underlying stuff that I realised now kept cropping back up, and I was just pushing it down and pushing it down, just not with alcohol but eventually that was always going to take me back to alcohol."*

> Lesley

Lesley spoke in detail about how caring for herself was a key change in her recovery, which included making sure she was getting appropriate nutrition. One of her photographs was of a breakfast table, set up with a pot of coffee and a cooked breakfast. She noted that it did not look special, but in her days of alcohol and drug use she rarely ate proper food. Dode also spoke about the poor nutrition he had during his days of using, particularly after coming off drugs, which was a thought-through process of not eating, to only eating liquid foods, to eating solid food. In general, most participants explicitly noted that they had a newfound appreciation for themselves and taking care of themselves was part of that. Being tuned into their own emotions and behaviour was key, in order to be aware of changes that could potentially put them at risk of relapse.

With recovery came a new sense of self-acceptance and self-worth, and that process lead to identity change for some. Whilst some participants talked about discovering themselves, others emphasised that they re-discovered who they really are. Amanda described how she had never strived to be someone else, but rather that there were things in her life, including addiction, which prevented her from being herself. In recovery, however, Amanda felt that she finally gets to be who she really is (Photo 3).

When I was younger I was so sad, but I never ever wanted not to be me.
Somewhere inside me I knew there was a girl who I really liked.
What's so humiliating about addiction is the powerlessness, going back to this thing time and time again that's causing you so much pain and ruining your life.
Now I'm free from addiction I feel like I'm actually getting to be that girl, finally.

Photo 3. Being true self, by Amanda

Similarly, Lesley had taken a photograph of a snowdrop which she said represented who she is as her experiences had led her to being 'droopy and wilting', but put it into a different context by reflecting on that it can be a good thing, if you are a snowdrop (Photo 4).

A couple of friends described me as a snowdrop.
I had been in a place where I was all droopy and wilting;
people think it's a bad thing normally, but actually for the snowdrop that's a good sign,
and that sometimes in me it was just hidden.
I looked droopy and wilting but actually I was starting to blossom.
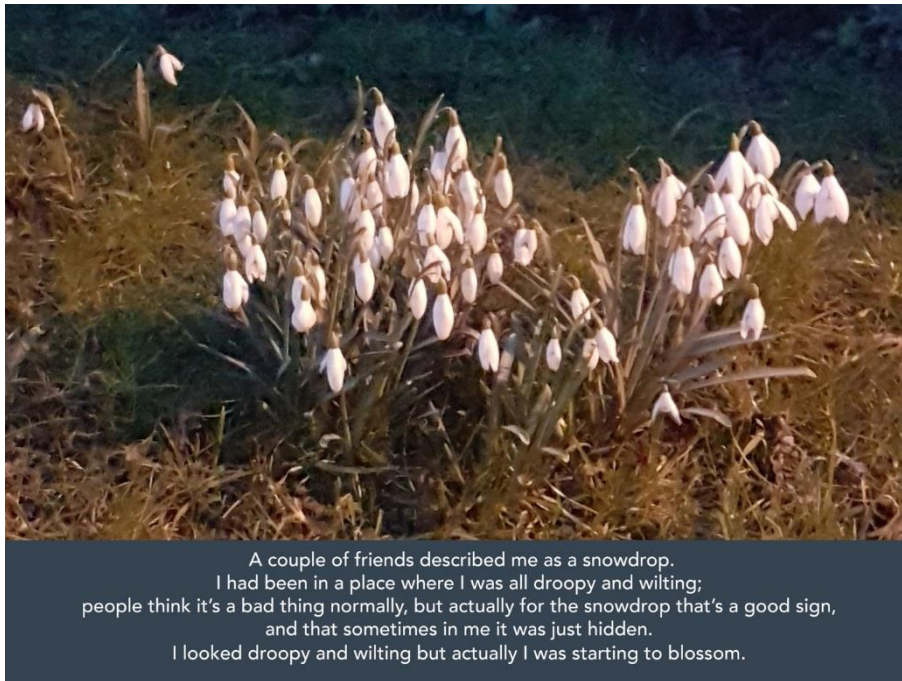
Photo 4. Droopy like a snowdrop, by Lesley

Key to the participants' identity was that most of them defined themselves relatively strongly as being in recovery, recovering addict, or just as 'addict'. However, as the discussion progressed in one of the final two focus groups progressed, Dode went on to say that he did not strongly identify as being in recovery anymore, even though it is a significant part of his life.

> *"I hadn't really thought about it, but that notion of identity and that change in identity is really important isn't it? Not until you said it there did it come back to me that it's been a process as well. I was constantly defining myself as somebody in recovery, and I don't do that as much these days. I don't do it nearly as much. Even in groups I don't identify as an addict or an alcoholic anymore, I identify as someone who's been in recovery for a long time, and amongst many other things I'm a human being […] So I've found that I've been struggling with that more and more in recent years, and I think I've just come to accept it now that in actual fact I'm all right with that. It was a period in my life where I was addicted to drugs and drink and other things, and now I'm not. I don't want to ever go back to that, but I'm not going to brand myself that for the rest of my life. It's like it was a period of your life, it was an important part, and it's led me on to where I am now. And I still go to meetings, but it's not what defines me."*

> Dode

Dode's response highlights the importance of the recovery identity as it develops in early recovery and is then sustained in the subsequent years. After more than 20 years in recovery, Dode's identity had continued to evolve, sustaining his recovery but moving him beyond a period where he felt the recovery identity any longer fully defined him. This changing identity had not been realised or articulated by other participants but demonstrates the constant evolution of personal identity which takes place over a lifetime and of which recovery identity is a part.

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Recovery as a process

Challenges

Overall, the message that the participants wanted to communicate and spread was that of a positive experience of recovery. However, following on from the previous project where the term 'better than well' had featured, we were interested in exploring what made participants feel better than well. Several participants objected to there being such a thing as being better than well, arguing that it gives false sense of achieving better state of mind than the average person. Craig reflected on a memory from early recovery: *"I can remember in treatment getting told oh, "give it two years, your neural pathways and that will have grown back, you'll feel a lot better in two years", and then you get to two years: "well, maybe five years""*. Similarly, Sean described how he, at an early stage, had been presented with a graph of how wellbeing progresses in recovery, suggesting that after five years it will be higher than the average person. This image stuck with Sean, who experienced some challenging times a couple of years into his recovery and with the feeling of what he was 'supposed to be', it was not necessarily helpful.

> *"I remember seeing that and hearing that lecture and for a moment getting a bit excited and I thought great, because I was three or six months clean or something, oh, great, that's fantastic. But I don't think that's been the reality for me. I feel like I've done a lot of walking in circles, maybe getting well in certain ways but there's other ways that I would like to have more personal growth, like in education and things like that"*
>
> Sean

Plateaus in recovery was common, which was described by Dode who had the longest period in recovery and could reflect on the ups and downs. Several participants noted that especially in early recovery, after a bit of a 'honeymoon period', they experienced a period in which they struggled and lived through quite a challenging time. Overcoming challenges related back to sticking to basic principles (see 'Actions to promote stable recovery'), self-care and understanding their own needs. Jean noted how she had to cut down on work: *"I really admire people who go back to work full time […] I just don't know how they do it and manage to maintain their recovery"*. Similarly, Lesley described how she relapsed 14 months after she initially got into recovery, primarily because of not listening enough to what she needed and pushing herself too hard.

> *"I did give up work and I had to get, like, disability benefit, which was difficult, coming from a background of having money and working, and managing – I'd say, in inverted commas – but having to kind of knock that pride out and just say, right, now I'm not fit to work; and it was a doctor that made that decision, it was kind of out of my hands. So that freed me up quite a lot, and rather than trying to cover things up all the time I could just be myself and just do what I needed to do for me."*
>
> Lesley

These excerpts further reinforced the general perception of a heightened self-awareness among the participants that help them navigate challenging times and ensure that they stay on the path of recovery. These difficult periods also offered participants opportunity to return to the principles and strategies learned in early recovery, learning that by returning to those tools, recovery could be sustained. While challenges were often seen as negative, the learning from those periods of difficulty is what helped individuals to develop confidence in their tools and to know that they could rely on their own ability to stay well by using the strategies learned in early recovery. This process of growth permitted the development of resilience in recovery.

Whilst times that were challenging were related to many different events that went on in life, one area that came up for discussion several times was relationships and friendships. In her interview, Amanda reflected upon how an ex-boyfriend was the reason she started using heroin.

> *"It was a boy and he was clean from heroin, and I didn't understand all that kind of thing because I was too young, so I didn't know there was a high chance that he would start using again. Then when he did I was like I just did it as well."*

> Amanda

However, later on she felt that she had in the past had a tendency to seek out damaging relationships which had dampened her self-worth, but now felt able to appreciate her self-worth. Hayley and Jean both had children who had experienced their active addiction, but did not explicitly talk in detail about the impact. Jean mentioned being close to losing her children at one point, which was averted due to intervention by her ex-husband. She spoke about how recovery for her also meant healing, and recovery, for the family as a unit, demonstrating her connection and placing connectedness at the centre of her recovery.

Recovery is ongoing work

A common category that came up several times was the notion that recovery is to some extent different to 'the real world', and participants emphasised how people who don't have experience of recovery cannot fully understand their situation. This may have been a necessary distinction to make for the participants, in order to embrace their recovery identity. Participants had a dual experience of the world, including experiences before they got into recovery and after they got into recovery. Many photographs featured situations that the participants noted were an experience of a situation or a place in a new state of mind. One of the clearest and most poignant examples was a photograph taken by Sean, from a major music festival. The panorama photo had Sean in the middle, surrounded by blurry individuals moving through the photo. He described how he previously had attended the music festival to take drugs, whereas after a couple of years in recovery he went and worked as a volunteer. He noted a dual experience in terms of feeling like the situation challenged him and that he found it rewarding to volunteer, but also that he

did not particularly enjoy the new state of mind experience of a festival he had been to many times during his alcohol and drug using days.

> *"I went to [place] music festival last year, which is like somewhere that I went to three or four times, and it was always very chaotic. And I'm still not sure why I decided to go. It was maybe some kind of challenge. Maybe it wasn't, I don't know why I'm saying that […] it's an amazing place, and if you're into performing arts in any way then you're going to find something you like at [place]. But it is a risky situation. But it is in a way, to put yourself in that situation if you're recovering, because you're surrounded. You're literally sounded by drugs everywhere you look. And I didn't really enjoy it. But I think I was experiencing mild exhaustion at the time prior to going, but I didn't really enjoy it that much."*

> Sean

This sort of potentially risky experiences was mentioned by others too, some indicated that they no longer avoided venues where alcohol is served but had adapted their social life to be able to do things they had done before, but without alcohol.

All participants identified as being 'in recovery', as opposed to being 'recovered, and this aligns clearly with the 12-step programme. However, in one of the final focus groups Stuart mentioned being 'recovered' a point followed up by the researcher;

> *I: Just as you were chatting there you used the phrase being recovered.*
> *Stuart: Being recovered, yeah. That was a slip of the tongue actually. [Name], my friend, uses that all the time, being recovered for the day.*

> *I2: Okay.*

> *Stuart: He'd say it in AA meetings and people would go you can't be recovered.*

> *Peer researcher: It's contentious isn't it?*

> *Stuart: Yeah. And in a way I don't think I'm recovered. I might be recovered for a day. I wouldn't normally say that. I don't know why I said it. I'm in recovery. But I'm only in recovery every ten minutes really. I'm only that far away from a pint, I'm only that far away from knocking on my dealer's door.*

> *I: Does it still feel like that's the distance to it after all this time?*

> *Stuart: No, it doesn't. I can go in pubs and most pubs now serve coffee and stuff and do food and whatever. First couple of years I didn't go in a pub. First thing I went to where there was booze was actually my brother's wedding in [place name]. And I was okay with it.*

Stuart's fluctuating conversation about the term 'recovered' resonated with discussions of visiting particular venues or events which had been familiar during periods of addiction. The fragility of recovery was juxtaposed with the certainty that participants could feel in their own ability to sustain recovery at any given time. The narrative of the Fellowships which encourage an enduring identity of recovering and promote vigilance by suggesting that there is always potential for relapse, sits alongside the participants' own self awareness and ability to assess what they themselves feel able to face. This very internal decision making is often implicit and forms part of the internalised struggle to develop and grow within a recovery identity.

Discussion

This study has shown that to people in recovery, there are a number of key factors that play part in accessing and sustaining recovery over time. These factors appear not to be new 'active ingredients' but rather are principles, strategies and tools developed in early recovery and are embedded in a lifestyle over time. Similar to most people, their use of resources vary in intensity as time goes on, but the ability to use time effectively, structure the day, attend support groups and meetings and to connect with peers, family and themselves were all central to sustaining recovery. These tools were learned in early recovery, modelled by role models and were drawn upon throughout the recovery journey, helping participants to develop a recovery identity. Tools such as these provided security and an anchor from which participants could go on to try new experiences, extending their own development.

Among participants in this study, recovery was embraced and incorporated into their identity. Though as time went on, the intensity to which they defined themselves as in recovery diminished as they introduced new activities or features into their lives that formed part of how they defined themselves. In summary, participants included in this study had a wide range of tools, within the larger concept of recovery capital (Cloud and Granfield, 2008), that included knowledge, skills and resources (including people) that were used throughout recovery but helped participants anchor their identity. We interpreted these as the strategies and tools that helped participants absorb their new identity into their lives.

Having peers in recovery and spending time on meaningful activities are strong predictors for recovery (Best, Gow, Taylor, Knox, & White, 2011), which resonates with more general evidence relating to that higher number of social connections and is associated with better health (Sani, 2015). Whilst participants did not speak specifically about the number of non-users in their current social network it was clear from their narratives that they had, at least at one point in their recovery, a significant proportion of their social context defined by other people in recovery. This is congruent with Bathish et al. (2017) who found an increase in people in recovery, compared to active addiction in respondents' social networks. Furthermore, in recovery, people reported an increase in number of important people in their network and multiple group memberships compared to in active addiction.

A clear finding from our study was the need for social support in connecting with others with similar experience and to have role models. These findings reflect Moos (2007), who identified that the key ingredients of mutual aid groups that were associated with long-term stable recovery were bonding and support, obtaining an abstinence-focused role model, and doing service work within the group. As we have shown, there were many strategies employed by participants that helped them establishing new identities and integrate into the in-group of recovery as well as other groups, but the social support was a key factor. The social environment, therefore, seems to be an important key factor in supporting recovery at all stages of recovery.

One particular question of interest in relation to social identity is identification with alcohol or drug (AOD) users. Dingle et al. (2015) showed that identification with AOD users decreased over time following treatment, whereas identifying with people in

recovery increased. At follow-up, transitioning into a recovery identity and disassociate from user identity was associated with reduced substance use and well-being. Bathish et al. (2017) found that those who had attended 12-step groups to greater extent identified with AOD users, which aligns with the principles of AA. Furthermore, participants whose social groups were diverse indicated higher level of wellbeing. This resonates with our findings that people transition through recovery and with time spread their network into wider spheres that extend beyond the recovery community and may have had an impact on their success in sustaining recovery.

One reflection our team had on the research process was the group dynamic and the vast experience the participants had in sharing their story. Frings et al. (2019) noted that sharing of stories is a way to understand link between self, addiction and (lack of) self-control. Stories that illustrate consequences of relapse can be a "protective active ingredient of AA membership" (p.206). As stories were shared extensively, and freely, data collection was somewhat different to groups who are not necessarily used to talking about themselves, their feelings and their lives in detail and in that manner. This was in some ways a challenge, as the multiple data collection points meant that individual stories were shared multiple times, rather than eliciting new reflections, which was the intention. Whilst this reflects on the participants' experience of 12-step programmes and telling their story, it is also a reflection on the research team and reflection that could be useful for others working with similar groups in similar projects. Thought needs to go into interview and focus group questions to ensure they elicit further discussion and reflection from the participants, rather than repeat an original story.

Critical reflection on repeat use of photovoice

Whilst our previous experience of photovoice has been positive and proven to be a useful research method to explore topics which in many ways are linked to stigmatisation and exclusion, our experience in the current project was different to previous work in a number of ways. Firstly, many of the participants who took part in the research were part of the previous project or had significant insight into it, due to the amount of attention it was received not only at a local level in the recovery café but also at a wider national level. The participants therefore came with some pre-existing ideas of the method. This, we believe, may have diminished the impact of the method, as participants did not come 'fresh' to it. Secondly, the previous project explored the role of the environment, which was a tangible topic to explore using photography. The team discussed early on, due to the length of data collection, whether it should have been divided into distinct tasks within that period to provide direction for the photo task. However, it was decided that providing instructions might have limited the creativity of the participants, as the objective was to ascertain their experiences without prescribing in details what that would mean. As the topic was social support and identity in recovery, the ambiguity of the topic may have hindered full engagement with the topic. This was particularly clear as fewer new topics came up in the focus groups in contrast to the interviews, despite having different questions for each data collection. More nebulous topics such as identity are perhaps more difficult to grasp and photograph and participants may also have tried to replicate photographs which had been well received in previous projects.

Our conclusion to the reflections we have made upon the use of the method, in this particular instance, is not that the use of photovoice was inappropriate, but rather that more consideration needs to go into the study design when faced with able individuals, who may have previous experience of the method. Further, consideration as to how to instruct the participants and how to develop the research questions in order to appropriately respond to them with the chosen method should be integrated into early planning stages. Whilst we are confident that similar data could have been generated using more traditional methods of interviews and focus groups, without the element of photography the engagement of participants would have been more difficult. Participants enjoyed addressing specific aspects of their experience of recovery through the photographs they took and have responded positively to the exhibition process.

Implications

Our findings from this study resonates with previous work around recovery and key resources and processes that enable people to access and sustain recovery. However, our findings do not suggest any novel 'ingredients' in recovery that can inform future service development. Conversely, our conclusion is that investing in services and support mechanisms that provide the basic recovery tools potentially is the most useful utilisation of resources. Despite this, we see increasing cuts to treatment and recovery services under austerity which may have severe implications for people who need them the most. Roy and Buchanan (2016) noted that increased cuts to services, the conditions in which the operate in and viewing alcohol and drug users as 'undeserving' through political measures such as ability to claim benefits, further enhances stigmatization against people with alcohol and drug problems. This is what recovery services such as Serenity Café successfully, to some extent, overcome. With limited resource, they have provided a range of support services for people in recovery, but importantly the basic service of a safe space which is also open to the general public and therefore strives to reduce stigma. However, our project took an unexpected turn towards the end, when the governing charity running the local Serenity Café (recovery café) we were working with, and had been working with for several years, unexpectedly went into administration. Through our peer researcher and participants we had already developed an understanding that the Café provided many of the basic tools they identified as key to their recovery. As the Café was a well-known resource in east Scotland and beyond, the loss of such an accessible peer support service was tangible. We hope that the findings from this project can contribute to the evidence base by emphasising the crucial role social support plays in recovery, to underpin future decisions about funding and support to community-based services.

References

Bathish, R. , Best, D. , Savic, M. , Beckwith, M. , Mackenzie, J. and Lubman, D. I. (2017), "Is it me or should my friends take the credit?" The role of social networks and social identity in recovery from addiction. J Appl Soc Psychol, 47: 35-46. DOI: 10.1111/jasp.12420

Best, D., Gow, J., Taylor, A., Knox, A., & White, W. (2011). Recovery From Heroin Or Alcohol Dependence: A Qualitative Account of the Recovery Experience in Glasgow. Journal of Drug Issues, 41(3), 359–377. DOI: 10.1177/002204261104100303

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

Cloud, W., Granfield, R. (2008). Conceptualizing Recovery Capital: Expansion of a Theoretical Construct. Substance Use & Misuse, 43, 1971-1986.

Dingle, G. A., Stark, C., Cruwys, T., Best, D. (2015). Breaking good: breaking ties with social groups may be good for recovery from substance misuse. Br J Soc Psychol, 54, 236-54.

Evans-agnew, R. A., Rosemberg, M.A. S. (2016). Questioning Photovoice Research. Qualitative Health Research, 26, 1019-1030.

Frings, D., Wood, K. V., Lionetti, N., Albery, I. P. (2019). Tales of hope: Social identity and learning lessons from others in Alcoholics Anonymous: A test of the Social Identity Model of Cessation Maintenance. Addictive Behaviours, 93: 204-211. DOI: 10.1016/j.addbeh.2019.02.004

Haslam, C., Holme, A., Haslam, S. A., Iyer, A., Jetten, J., Williams, W. H. (2008). Maintaining group memberships: social identity continuity predicts well-being after stroke. Neuropsychol Rehabil, 18, 671-91.

Haslam, S. A. J., J. , Postmes, T., Haslam, C. 2009. Social Identity, Health and Well-Being: An Emerging Agenda for Applied Psychology. Applied Psychology, 58, 1-23.

Hergenrather, K., Rhodes, S., Cowan, C., Bardhoshi, G., Pula, S. (2009). Photovoice as Community-Based Participatory Research: A Qualitative Review. American Journal of Health Behavior, 33, 686-698.

HSCIC 2016. Health Survey for England 2015 Adult alcohol consumption Health Survey for England 2015: Adult alcohol consumption. Health and Social Care Information Centre.

Lancaster, K., Duke, K., Ritter, A. (2015). Producing the 'problem of drugs': A cross national-comparison of 'recovery' discourse in two Australian and British reports. International Journal of Drug Policy, 26, 617-625.

Laudet, A. B., Humphreys, K. (2013). Promoting recovery in an evolving policy context: What do we know and what do we need to know about recovery support services? Journal of Substance Abuse Treatment, 45, 126-133.

McLean, J., Christie, S., Gray, L., Authors, P., Bardsley, D., Calder, A., Currie, E., Hill, S., Leyland, A. H., Montagu, I., Rooney, K. & Terje, A. (2016). The Scottish Health Survey.

Neale, J., Finch, E., Marsden, J., Mitcheson, L., Rose, D., Strang, J., Tompkins, C., Wheeler, C., Wykes, T. (2014). How should we measure addiction recovery? Analysis of service

provider perspectives using online Delphi groups. Drugs: Education, Prevention and Policy, 21**,** 310-323.

Neale, J., Tompkins, C., Wheeler, C., Finch, E., Marsden, J., Mitcheson, L., Rose, D., Wykes, T., Strang, J. (2015). "You're all going to hate the word 'recovery' by the end of this": Service users' views of measuring addiction recovery. Drugs: Education, Prevention and Policy, 22**,** 26-34.

Nowell, L. S., Norris, J. M., White, D. E., Moules, N. J. (2017). Thematic Analysis: Striving to Meet the Trustworthiness Criteria. International Journal of Qualitative Methods, 16**,** 1609406917733847.

Plunkett, R., Leipert, B. D., Ray, S. L. 2013. Unspoken phenomena: using the photovoice method to enrich phenomenological inquiry. Nursing Inquiry, 20**,** 156-164.

QSR International PTY LTD (2012). NVivo qualitative data analysis software.

Roy, A., Buchanan, J. (2016) The Paradoxes of Recovery Policy: Exploring the Impact of Austerity and Responsibilisation for the Citizenship Claims of People with Drug Problems. Social Policy & Administration, 50: 398–413. DOI: 10.1111/spol.12139.

Saldaña, J. (2016). The Coding Manual for Qualitative Researchers, London, SAGE Publications Ltd.

Sani, F. , Madhok, V. , Norbury, M. , Dugard, P. and Wakefield, J. R. (2015), Greater number of group identifications is associated with healthier behaviour: Evidence from a Scottish community sample. Br J Health Psychol, 20: 466-481. DOI:10.1111/bjhp.12119

Scottish Conservatives. (2017). Funding to tackle Scotland's alcohol and drug crisis slashed. [Website]. http://www.scottishconservatives.com/2017/04/funding-to-tackle-scotlands-alcohol-and-drug-crisis-slashed/ [Accessed 12 March 2019].

Scottish Government (2009). A new framework for local partnerships on alcohol and drugs. Edinburgh: Scottish Government.

Scottish Government (2011). Scottish Ministerial Advisory Committee on Alcohol Problems (SMACAP) Essential Services Working Group: Quality Alcohol Treatment and Support (QATS).

Scottish Government (2018). Treatment and Services [Online]. Available: https://www2.gov.scot/Topics/Health/Services/Alcohol/treatment [Accessed 16 November 2018].

SHAAP (2018). Dying for a drink - Circumstances of, and contributory factors to, alcohol, deaths in Scotland: results of a rapid literature review and qualitative research study. Edinburgh: Scottish Health Action on Alcohol Problems.

Shield, K., Rylett, M., Rehm, J. (2016). Public health successes and missed opportunities - Trends in alcohol consumption and attributable mortality in the WHO European Region, 1990–2014. Copenhagen.

Shortt, N. K., Rhynas, S. J., Holloway, A. (2017). Place and recovery from alcohol dependence: A journey through photovoice. Health & Place, 47**,** 147-155.

The Betty Ford Institute Consensus Panel. (2007). What is recovery? A working definition from the Betty Ford Institute. Journal of Substance Abuse Treatment, 33(3): 221-228. DOI: 10.1016/j.jsat.2007.06.001

Tinkler, P. (2013). Using Photographs in Social and Historical Research, Thousand Oaks, SAGE.

Wang, C., Burris, M. A. (1994). Empowerment through Photo Novella: Portraits of Participation. Health Education Quarterly, 21, 171-186.

Wang, C., Burris, M. A. (1997). Photovoice: Concept, Methodology, and Use for Participatory Needs Assessment. Health Education & Behavior, 24, 369-387.

White, W. L., Kelly, J. F., Roth, J. D. (2012). New Addiction-Recovery Support Institutions: Mobilizing Support Beyond Professional Addiction Treatment and Recovery Mutual Aid. Journal of Groups in Addiction & Recovery, 7, 297-317.

WHO (2018a). Global Information System on Alcohol and Health (GISAH). https://www.who.int/substance_abuse/activities/gisah/en/ [Accessed 12 March 2019]

WHO (2018b). Global status report on alcohol and health 2018. Geneva: World Health Organization. https://www.who.int/substance_abuse/publications/global_alcohol_report/gsr_2018/en/ [Accessed 12 March 2019]

Appendices

Appendix 1 – Photovoice groundrules

Photovoice Methodology Groundrules Checklist for Participants

Thank you for agreeing to take part in the study.
Below are a few things to think about in relation to the photovoice methods used in the study. These are designed to help you feel confident when you go out with your camera and when you tell people about the study. It is helpful to have these 'groundrules' in place from the beginning as they help to keep everyone safe when photographing.

This research explores aspects of your life. There are **no wrong answers**, we really want to understand your experience, the motivations and understandings that you have. You are the expert in all of these things! You can tell us whatever you choose and should feel no obligation to share things which you would rather keep private.

You can take **as many or as few** photos as you choose. Feel free to take photos of things which are important to you or which shape your experience. The photos that you take are yours and we hope that you might share them with us for the study but there may be some which you choose not to share and that is fine.

Please do not take photos of the following:

- **Children** – No photos of children will be stored in this research
    - We can't be sure that children consent to the photo being taken.
    - Parental consent can be complicated.
    - Think about photos of your own childhood – would you want them used?
- **People's faces**
    - We need written consent from anyone in your photos so better not to include people, especially those you don't know.
        - Photos of an anonymous crowd are fine
        - Photos of yourself are fine
        - Disguised and unrecognisable faces are fine
    - Think about any photos of yourself – are you happy for these to be shown? Feel free to tell your researcher if you want to discuss the photo but not to have it displayed.
- **Identifiable places, names and addresses**
    - Try not to explicitly photograph places which identify yourself – eg your street name or primary school
    - Don't photograph your passport, utility bill, appointment card, name and address!
        - We can blur the number of your door or the name of a shop
        - Landmarks are fine
        - Public places are fine
- **No photographs of things your know are illegal**
    - No photographs of underage alcohol sales, illicit transactions etc.

- We will need to report anything illegal.
  - Showing the research team a photo of something illegal would mean that authorities would be informed.
- DO not put yourself at risk to take a photograph
  - You are more important than any shot! Think of your own welfare!
    - Please do not take photos when driving, or out of car windows
    - Always look for traffic or hazards and remember that things can move around you as you stop to take a shot.
    - Think of your own wellbeing when you decide where to go to photograph and make sure you feel up to making any trips or visiting particular locations.
    - Ensure someone knows where you are going and when you will be coming back.

- The photos that you take will be **stored securely**

- **The photos that you take will not be linked to your name**
  - We won't say … this is Sarah's corner shop, this is Sarah's wardrobe …

- Photos help people to understand your experience
  - Are you happy for people to see your photos in future?
  - These are your photos so you are in control of what you photograph and what happens to the shots.
  - You can talk to your researcher about a photo but decline to have it stored.
  - You can help to construct the words which go alongside your photo. This is something which you can work with your researcher on and which it is important that you feel comfortable with.

- **We will come back to ask you if we want to display your photo anywhere other than in a report or academic journal publication.**
  - Photos won't be on a billboard or on the back of a bus unless you have given your explicit consent!

- At the beginning of the study you received an information sheet which explains the project in more detail. If you have any problems at all or any concerns about the project or the photography, please feel free to use the contact details on that information sheet to get in touch. We are very grateful that you have agreed to participate in this photovoice methodology project and we are keen to make your experience a positive one so please do keep in touch with us and alert us to any problems, however small.

Appendix 2 – Participant Information Sheet

Capturing the 'active ingredients' in recovery: a photovoice project
A project where you can share your experience of recovery, identity and social environment

If you want to get involved in the project, please contact:
Lisa Schölin, Research Fellow at Edinburgh University
Email: lisa.scholin@ed.ac.uk

You are invited to take part in a research project, looking at understanding how social environment (family, friends, support groups etc.) impacts recovery from alcohol dependence. We will give people cameras to document these experiences and ask them to take part in two individual interviews and two group discussions to discuss the photos. This information leaflet explains what the study is about and where you can how you can get more information. Please take time to read this before you decide if you want to take part.

What is Photovoice?

Photovoice is a method where people take photos that represent their experiences, which are discussed with the researchers and other participants. This method gives people an opportunity to show the world as they see it and highlight problems or needs within local communities.

What is the study about?

The aim of the study is to explore how the social environment impacts recovery and personal identity. In this study we are interested in understanding:

- the 'key ingredients' in people's social environment and how it impacts recovery for the individual and also as part of a social group;
- how people include recovery into their personal identity and affects their lives over time; and
- the role social spaces have for the personal identity for people in recovery.

Who can take part?

We want stories from people who are in recovery from alcohol dependence. You can take part if you are in recovery from alcohol dependence or if alcohol was part of a wider substance misuse problem. We want to hear from men and women who have been in recovery for at least around 1.5 to 2 years. You have to be at least 18 years old to take part in the project.

What do I have to do?

If you decide to take part, you will be invited to a workshop where a trained photographer will show you how to use a digital camera and different photo techniques. You will then get a camera and take photos over a 5-month period. During this time, you will be able to come into Serenity Café to upload photos and get any help with the camera. The project also includes two interviews and two focus groups (group discussions) around your photos and experiences. Discussions will be audio recorded with your permission. This is standard research procedure and helps the researcher to focus on the discussion.

Do I have to take part?

No. It is up to you to decide if you want to take part in the project. If you decide to take part, you will be asked to sign a consent form to confirm your participation. If

you don't want to take part or decide to withdraw at any stage, you do not have to give a reason for doing so. If you choose to withdraw from the study, this will not affect the support you may receive from Serenity Café or any other service. If you are a staff member or volunteer, your employment will not be affected.

What are the possible disadvantages or risks of taking part?

Taking photos of your life and your experience of alcohol problems and recovery might upset you. Please remember that you do not have to share any experiences unless you want to. If you at any point feel uncomfortable, embarrassed or upset you can stop and continue at a later time if you want to. If this happens to you, you are encouraged to talk to someone at the Serenity Café, your GP or people from your existing support network (for example a supporter or sponsor).

What are the possible benefits of taking part?

There is no payment for taking part in the study. The photography workshop is free of charge and the skills you develop might be useful at other times in your life. All the photos you take during the project are yours to keep and as a thank you for taking part you will get some photos printed. If you need support or transport to the workshop, interviews or group discussions we will arrange for this without any cost. Free refreshments and food will be provided on these occasions.

Will my taking part in this study be kept confidential?

Yes. If you choose to take part in the study, your personal information will be kept confidential. We will not inform anyone outside the research team that you are taking part in the study. Photos and stories will be included in different publications (journal articles, reports and conference papers). Your name will never appear in any of these and any identifiable information will be changed. If any people appear in published photos, they will need to agree (sign a consent form) to use that photo. Digital data (photo files and recordings) will be stored on password protected university computers. Printed photographs, notes, and signed consent forms will be stored in locked filing cabinets at the university. All data will be stored for a minimum of three years after completion of the project.

What will happen to the photographs and the stories I share?

At the end of the project you will get your own personal record of your photographs. With your permission we will organise a photo exhibition with photos taken by participants. The information collected in the project will be presented in journal articles, reports and at research conferences. It is important that you understand that your name and personal details will always be kept confidential.

Who is organising and funding the research?

The research is conducted by a team at University of Edinburgh and staff from the National Galleries, who have previous research experiences using photovoice with the Serenity Café. This project is funded by Alcohol Research UK (http://alcoholresearchuk.org/).

Ethical approval

Ethical approval for this project has been given by the School of Health in Social Sciences Ethics Committee, University of Edinburgh.

Where can I get more information?

If you would like further information about taking part in this project, please contact Lisa or Sarah.

Dr Lisa Schölin (Research Assistant) School of Health in Social Sciences University of Edinburgh **Email:** lscholin@ed.ac.uk	**Dr Sarah Rhynas** (lead researcher) School of Health in Social Sciences Edinburgh University **Telephone:** 0131 650 3882 **E-mail:** sarah.rhynas@ed.ac.uk

Complaints

If you wish to make a complaint, you may also contact Professor Charlotte Clark, Head of School - Health in Social Science, The University of Edinburgh at Charlotte.Clark@ed.ac.uk

Appendix 3– Focus Group Facilitation Notes
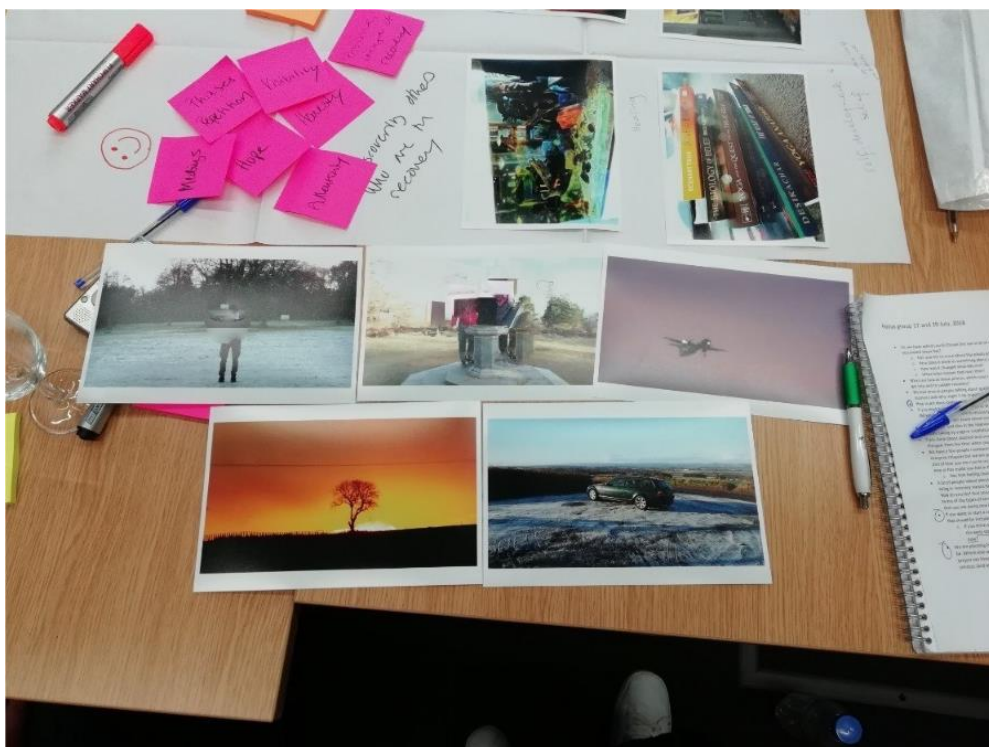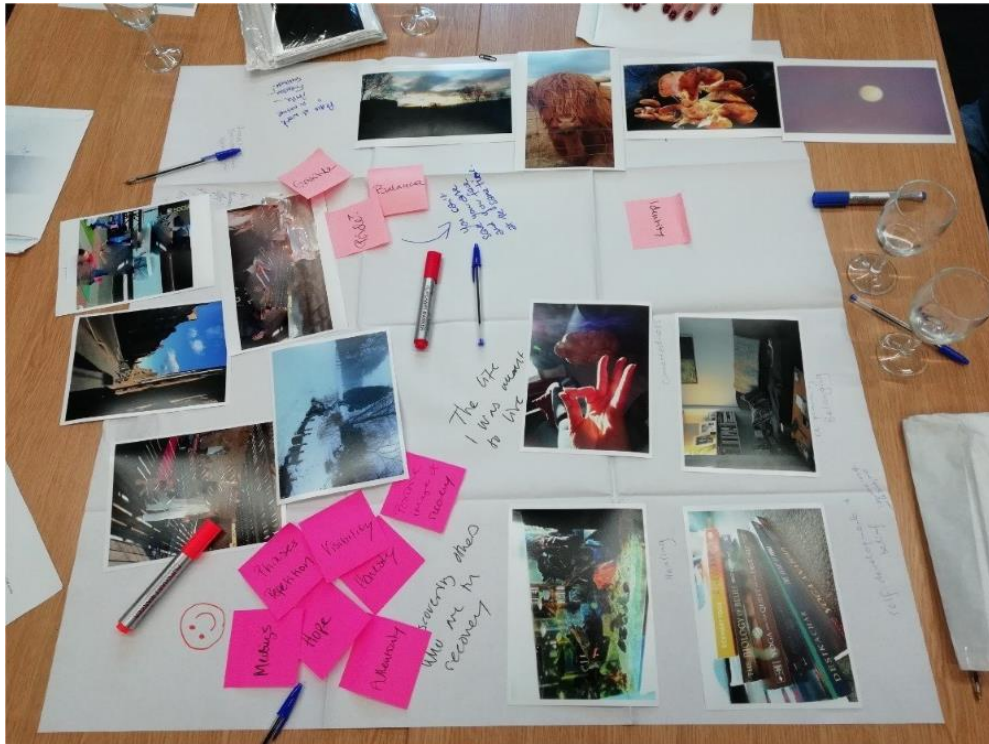
Appendix 4– Coding hierarchy for developed themes

1. **Actions to promote stability**
   a. **Stable recovery**
      i. Recovery is possible
         1. Recovery as an option
      ii. Need something that gives meaning and hope
         1. Higher power
         2. Hope
   b. **Gratitude and pride**
      i. Being grateful helps you heal
         1. Forgiveness and patience
         2. Freedom
         3. Gratitude
         4. Giving back
      ii. Pride for others but not for self
         1. Pride
2. **Social environment**
   a. **Recovery tools**
      i. Basic principles to getting into and staying in recovery
         1. Volunteering
         2. Attending meetings
         3. Routines and structure
            a. Keeping busy
            b. Managing responsibilities
         4. Meaningful activities
         5. Basic things
      ii. Recovery is giving and taking support
         1. Access
         2. Role models
         3. Support
         4. Supporting others
         5. Connecting
   b. **Supportive places**
      i. Recovery support/services need to be inclusive and safe
         1. Fitting in
         2. Safe space
         3. Inclusive
      ii. No 'no size fits all'
         1. Trying different recovery services
3. **Compassion and personal discovery**
   a. **Caring for and understanding self and others**
      i. Dealing with underlying problems alcohol/drugs were used to cope with
         1. Underlying problems
      ii. Self-discovery and self-definition
         1. Being true self
         2. Prioritising own needs
         3. What matters in life

4. Self-acceptance and appreciating self-worth
            iii. **Compassion**
                    1. Forgiveness and patience
                    2. Compassion and understanding
4. **Recovery as a process**
    a. **Recovery as ongoing work**
            i. Recovery is different to 'the real world'
                    1. New state of mind
                    2. 'Real world' vs recovery
            ii. Recovery is a constant process
                    1. 'Recovery' vs 'recovered'
                    2. (Potentially) risky places or situations
    b. **Challenges**
            i. Early recovery can be challenging
                    1. Plateaus
                    2. Struggling
            ii. Evaluating relationships
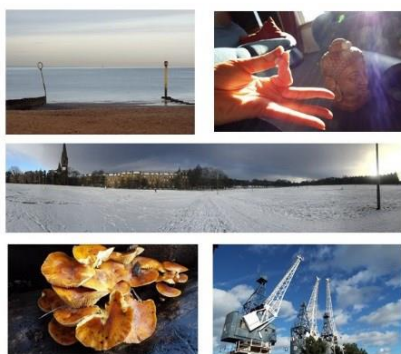   1. Relationships and friendships

Appendix 5– Detailed coding framework

Code (and subcodes)	Code description	Issues	Sub-category	Category	Theme	Theme description
Possibilities of recovery	Learning about people who successfully have gotten into recovery and	inspiration	1. Possibilities of recovery	Stable recovery	Actions to promote stability	Foundational behaviours, emotions, actions etc. that participants fe
Higher power	Having a higher power to help with feeling purpose and to be able to	motivation	2. Need something that gives meaning and hope			
Hope	Hope as an important ingredient for recovery	purpose				
Freedom	Participants' reflection of why they were and discovering, or re-		3. Being grateful helps you heal	Gratitude and pride		
Giving back	The feeling of giving something back to society for the 'bad' behaviour		4. Pride for others but not for self			
Healing	Importance of healing for participants as well as family					
Pride	Not feeling pride about recovery important to not become complacent					
Gratitude	Gratefulness to the life participants were living and opportunities					
Role models	Being able to see people further down the line is important. Also to	emotional support	5. Basic principles to getting into and staying in recovery	Recovery tools	Social environment	Things, places and activities that helped participants getting into, and that helps them sustain recovery
Support	Support participants receive and have received, from a number of	part of society/community	5. Recovery is giving and taking support			
Supporting others	The importance of giving back and giving support to others as a way	mindfulness				
Belonging	Feeling that you belong somewhere (e.g. recovery café), which might	appreciation				
Connecting	Being able to connect with people or with the world, in a way	fellowships				
Basic things	Reflection on how it is simple everyday things that make recovery, not	mindset				
Meningful activities	Hobbies, careers or passions participants pursue as part of their	worries				
Routines and structure	Developing a structure to keep to, which helped participants getting a					
Attending meetings	Attending fellowship meetings essential to the recovery process					
Volunteering	Participants talked about how volunteering helped them/helps them in					
Access	Being able to attend e.g. fellowship meetings when needed					
Fitting in		safety	6. Important with recovery support/activities that are inclusive and safe	Supportive places		
Safe space	Places where people in recovery can socialise without substances, also	community	7. No 'one size fits all'			
Inclusive	Support services, like the café, doesn't turn people away	hope				
Inclusive	Participants reflected on why some services worked or didn't work and	warmth				
Compassion and understanding	Descriptions about how participants developed compassion for others	ADHD	8. Dealing with underlying problems alcohol/drugs were used to cope with is part of recovery	Caring for and understanding self and others	Compassion and personal discovery	Getting into recovery meant figuring out how to care for oneself and to discover, or re-discover, ones true self, including learning how to care about other people and having compassion
Forgiveness and patience		depression	9. Self-discovery and self-definition			
Underlying problems	Underlying problems like depression or ADHD as an underlying	self-appreciation	10. Compassion			
Self-acceptance and self-worth	Participants described how they now prioritised their health, wellbeing	proper nutrition				
Prioritising own needs		self care				
What matters in life		compassion				
Self discovery						
Being true self	Being true seld					
(Potentially) risky places or situations	Reflections on being in spaces where alcohol or drugs are present and	temptations	11. Recovery is different to 'the real world'	Recovery as ongoing work	Recovery as a process	Participants' aacknowledgment of that recovery is aon goingoing process and an investment that takes work. Less so for those in longterm recovery but whilst recovery was described as positive, there was also the notion that there are setbacks and hurdles to overcome along the way
New state of mind	Seeing places or experiencing things sober that previously had been	challenges	12. Recovery is a constant process			
Recovered' vs recovery	The idea that you can't be recovered, recovery is a constant process	socialising				
Real world' vs recovery	Notion that people who are not in recovery think differently and that	appreciation				
Plateus	The notion that recovery sometimes hit plateus where it feels like	letting go	13. Early recovery can be challenging	Challenges		
Struggling	Early recovery often meaning struggling and expecting things to be	disengagement	14. Evaluating relationships and friendships is important			
Relationships and friendships	Reflections on which types of relationships were good or bad for the	confusion				

Appendix 6– Exhibition invitations
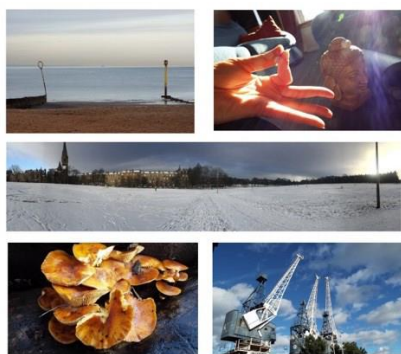

Recovery is real!

Launch of an exhibition of a photovoice project on recovery and identity

In 2015, the University of Edinburgh undertook a photovoice project together with Serenity Café to explore the role of environment in recovery. The project was presented in a photo exhibition, which was a great success and was shown in the Scottish Parliament. Through the photos, people in recovery were given a voice to share their experiences.

In 2017, a second project was initiated, with a focus on the role of identity in long-term recovery. For eight months, a number of people in recovery took photos that represented their lives and experiences in becoming who they are today.

We invite you to come along and take part in the launch the latest project, at Out of the Blue Drill Hall on 36 Dalmeny Street, at 18.00 on the 16th of January.

The exhibition will be displayed from the 14th to the 18th of January during daytime opening hours (10.00-17.00).

Photovoice Exhibition Launch

16 January 2019
18.00–20.00
Out of Blue Drill Hall
36 Dalmeny Street
Edinburgh
EH6 8RG

Recovery is real!

An exhibition of a photovoice project on recovery and identity

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In 2017, a second project was initiated, with a focus on the role of identity in long-term recovery. For eight months, a number of people in recovery took photos that represented their lives and experiences in becoming who they are today.

The exhibition will be displayed from the 14th of February to the 22nd March. Opening hours are Monday-Friday, 9am-4pm, Sat 10am-12noon

Photovoice Exhibition

North Edinburgh Arts
Café Gallery
15a Pennywell Court
Edinburgh
EH4 4TZ

https://northedinburgharts.co.uk/