"Recovery Speaks": A Photovoice Intervention to Reduce Stigma Among Primary Care Providers

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Objective: Preliminary findings are reported from a photovoice intervention, "Recovery Speaks," to reduce primary care provider stigma in regard to people with mental illness and addiction.

Methods: Twenty-seven primary care providers were recruited through a practice-based research network. Participants were randomly assigned to the intervention—attending a one-hour performance followed by discussion—or to no intervention. Provider stigma was evaluated by using established measures of stigma and recovery and qualitative responses. Linear mixed models controlling for baseline differences compared changes in provider stigma across time and groups.

Results: Providers who attended Recovery Speaks demonstrated significantly decreased negative stereotypes, attribution of dangerousness, fear, desire to coerce people into treatment, desire to segregate people from the community, and desire for avoidance. More desire to help and more hope for recovery were also found.

Conclusions: Witnessing people's unique recovery stories and how they contribute to their communities may reduce provider stigma.

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Stigma in regard to mental illness has been implicated as a primary factor behind health care disparities for people with mental illness (1,2). People with serious mental illness die, on average, 25 years earlier than people in the general population (2), and mortality rates appear to be increasing over time (3). Primary causes for early mortality and morbidity are treatable medical conditions, such as cardiovascular, pulmonary, and infectious diseases (2), and modifiable risk factors, such as smoking, obesity, and substance abuse.

People with mental illness consistently report being treated with a lack of dignity and caring and with outright contempt by staff in general medical settings (4). Reviews of providers have found negative attitudes among multiple provider groups toward people with mental illness and toward psychiatry in general; fear, blame, and hostility are the primary negative attitudes, and avoidance is the primary behavior (4). Provider attitudes have been found to affect provider beliefs about treatment adherence, specialist referrals, and willingness to refill a prescription (5).

The purpose of this randomized controlled study was to investigate the effects of "Recovery Speaks" in reducing stigma among primary care providers in regard to individuals with mental illness, addiction, or both. "Recovery Speaks" is a photovoice (6) intervention in which people with mental illness and addiction show pictures and tell stories of their recovery and describe their strengths, interests, and contributions to their communities. Photovoice has been used as a medium for communicating illness narratives and for advocacy (6). The hypothesized mechanism for this intervention is that provider stigma will be reduced by evoking the common humanity that providers share with people with mental illness and addiction.

METHODS

The Recovery Speaks performances were the result of a research project that involved an intervention focused on persons in recovery from mental illness or addiction or both. Participants attended a ten-week peer-led group in which they learned the photovoice method of taking pictures and developing accompanying narratives describing their strengths, interests, and contributions to their families and communities and what was helpful in their recovery, including clinical care. At each performance, eight to ten participants showed pictures, told their recovery stories, and described how they contribute to their communities. After each performance, the peer leader of the ten-week group led a discussion.

This study, which was conducted from April to June 2011 and approved by the Yale University Human Investigation Committee, focused on providers. All providers gave written informed consent. Participants were primary care providers who were recruited through the NetHaven Practice-Based

Research Network and by the medical director of a local federally qualified community health center. A total of 27 primary care providers participated. Fourteen providers were randomly assigned to attend a one-hour performance followed by a discussion. Thirteen providers were randomly assigned to the control group, which did not attend a performance.

Of the 27 providers, 25 (93%) were women, and two (7%) were men. The mean±SD age was 49.3±10.5. Twenty-four (88%) were white, two (8%) were Asian, and one (4%) was black; one (4% identified as Hispanic. The most common degree was A.P.R.N. (N=10, 37%); eight (29%) had a doctoral-level degree (Ph.D., D.N.P., or Pharm.D.), five (19%) had an M.D., three (11%) had a master's-level degree, and one (4%) reported a degree categorized as other. The most common specialty was primary care—child (N=11, 40%), adult (N=4, 15%), and family (N=4, 15%). Four (15%) were in the mental health field, two (7%) were in obstetrics and gynecology, one (4%) was in pharmacy, and one (4%) was categorized as other. Providers had an average of 4.4±1.9 years of experience. Providers had 22.5±11.7 patients with a mental illness or a substance abuse problem on their caseload, and they rated the intensity of services needed by these individuals as 4.8±1.4 on a 7-point scale, with 7 indicating the highest intensity of services needed.

Providers were assessed by using Link and Phelan's (7) and Corrigan's (8) definitions of stigma. Those who attended a performance were asked qualitative questions about it. All measures had documented high reliability and validity: the Characteristics Scale and Affective Reaction Scale (9), Social Distance Scale (10), Attribution Questionnaire (11), Recovery Knowledge Inventory (12,13), and Competence Assessment Instrument (14). Providers who attended a performance completed the online questionnaire before attending and within one week of attending the performance. Those in the control group completed the questionnaires twice, with a two-week interval. All providers received $100 for participation. Those who attended a performance received an additional $50.

Linear mixed models in SPSS 21.0 were conducted for all variables examined in the study, controlling for baseline scores.

TABLE 1. Measures of stigma and recovery among primary care providers who attended Recovery Speaks (intervention) or who received no intervention (control)

	Intervention (N=14)				Control (N=13)				Group × time interaction		
	Pre		Post		Baseline		2 weeks later				
Measure	M	SE	M	SE	M	SE	M	SE	F	df	p
Negative stereotypes[a]	4.0	.1	3.6	.1	3.9	.1	4.0	.1	8.9	1, 49	.004
Negative emotions[a]	3.5	.1	3.0	.1	3.4	.1	3.3	.1	1.4	1, 49	.25
Social distance[b]	4.0	.1	3.5	.2	4.0	.2	4.0	.2	3.9	1, 49	.06
Responsibility[c]	1.9	.2	2.1	.2	1.9	.2	2.5	.2	1.3	1, 49	.27
Dangerousness[c]	3.0	.2	2.3	.2	3.0	.2	3.2	.3	5.3	1, 49	.03
Pity[c]	7.1	.2	7.2	.3	7.0	.3	6.7	.3	.2	1, 49	.66
Anger[c]	2.5	.2	2.1	.2	2.5	.2	2.2	.2	.1	1, 49	.77
Fear[c]	2.6	.1	1.8	.1	2.4	.1	2.8	.1	18.9	1, 49	<.001
Help[c]	7.5	.2	7.8	.2	7.6	.2	6.8	.2	6.3	1, 49	.02
Coercion[c]	3.6	.2	2.9	.2	3.4	.2	3.9	.2	6.1	1, 47	.02
Segregation[c]	1.8	.1	1.4	.1	1.7	.1	2.0	.1	9.0	1, 48	.004
Avoidance[c]	4.9	.2	4.1	.2	4.8	.2	5.4	.2	8.5	1, 49	.005
Competence Assessment Instrument total[d]	3.2	.0	3.4	.0	3.2	.0	3.2	.0	10.7	1, 48	.002
Recovery Knowledge Inventory total[e]	3.3	.1	3.4	.1	3.3	.1	3.5	.1	.1	1, 49	.77

[a] Measured with the Characteristics Scale and Affective Reaction Scale. Possible scores range from 1 to 7, with higher scores indicating more negative stereotypes or negative emotions (respectively).
[b] Measured with the Social Distance Scale. Possible scores range from 1 to 7, with higher scores indicating a desire for greater social distance.
[c] Measured with the Attribution Questionnaire. Possible scores range from 1 to 9, with higher scores indicating more of the construct.
[d] Possible scores range from 1 to 4, with higher scores indicating more recovery orientation.
[e] Possible scores range from 1 to 5, with higher scores indicating more recovery knowledge.

RESULTS

The intervention as conducted appeared to be acceptable to providers. On a 7-point scale on which 7 was the highest rating, providers reported that they liked the performance (mean=6.5±.7) and that the performance moderately changed their understanding of people with mental illness (mean=4.4±.9) and moderately changed their practice as primary care providers (mean=4.3±1.0). When asked what they liked about the performance, one provider said, "I was impressed that people stood up and shared their stories. I found it very moving. I learned a lot about how people feel about stigma and how they are perceived and how that affects how they perceive themselves." When asked what they had learned from the performance, another provider said, "[This was] an excellent reminder of the complexity of all people's lives—the depth of experience that tries to be squeezed into a 15-minute office visit."

Table 1 summarizes the results of the linear mixed-models analysis of the interaction between group (intervention and control) and time (pretest and posttest); the models controlled for preintervention scores. At posttest, compared with providers in the control group, those who attended a Recovery Speaks performance had significantly lower scores on negative stereotypes of people with mental illness and addiction (p=.004), less perception of dangerousness (p=.03), less fear of them (p<.001), more desire to help them (p=.02), less desire to coerce them into treatment

(p=.02), less desire to segregate them from the rest of the community (p=.004), less desire to avoid them (p=.005), and more hope for their recovery (p=.002). A nonsignificant trend was noted toward decreased social distance (p=.06).

DISCUSSION

This report summarizes preliminary findings about a novel intervention designed to decrease primary care provider stigma in regard to people with mental illness. Our findings indicate that the intervention was acceptable to providers. Primary care providers who attended a Recovery Speaks performance reported lower negative stereotypes, less attribution of dangerousness, less fear, more desire to help, less desire to coerce people into treatment, less desire to segregate people from the community, less desire for avoidance, and more hope for recovery for people with mental illness and addiction.

Our intervention coincides with recent research investigating antistigma interventions for health care providers that found that the most successful interventions involve personal testimony from trained speakers with lived experience, multiple speakers, and an enthusiastic facilitator who models a person-centered approach; successful interventions also teach skills that help providers know what to say and do; engage in myth busting; use a person-first (rather than pathology-first) perspective; demonstrate that recovery is real and probable; and demonstrate competence and successful living of people with serious mental illness (15). Interventions that had these elements resulted in the most positive attitudes of health care providers toward people with mental illness (15). Our study found that the intervention reduced many more aspects of stigma than were measured in the analysis by Knaak and colleagues (13) (for example, stereotypes, negative emotions, coercion, and segregation from society). Thus it is possible that our intervention affects an even wider range of elements involved in health care provider stigma than heretofore addressed in antistigma interventions.

Contact-based antistigma interventions have also been found to be helpful for students in health care professions (for example, medical students and pharmacy students) (15). Such interventions decreased students' stigma and increased their confidence and interest in working with people with mental illness. But stigmatizing attitudes and beliefs remained stronger in regard to mental illness than to type II diabetes, despite the contact-based education provided in the intervention.

A significant barrier to the feasibility of the intervention was recruiting primary care providers. Recruitment was extremely difficult, even with the large monetary incentives offered for participation. Despite intense recruitment efforts by using local electronic mailing lists and by asking members of the practice-based research network to contact providers through their local networks, only 27 providers agreed to participate. At some performances, only one provider was present. The best participation was obtained from a local federally qualified health center where a provider was on the board of the practice-based research network that funded the study. Thus support at the institutional level was essential for providers to participate in the intervention. Offering continuing medical education credits may have increased provider participation.

Limitations of this study included the small sample (of which few were physicians and 40% were primarily treating children), which limited the validity of the statistical analyses, and the brief follow-up period—a follow-up at a minimum of one month is warranted, along with some questions about whether any behavior change occurred. In addition, no fidelity measures were used. The difficulties of recruiting primary care providers could have had a substantial impact on the results.

CONCLUSIONS

Results showed that the storytelling and photovoice intervention Recovery Speaks reduced many aspects of primary care provider stigma in regard to people with mental illness, most importantly fear and desire to avoid them. Future research should address the efficacy of this photovoice antistigma intervention for health care providers from a variety of professions, compare the results of this intervention with those from other antistigma interventions, and investigate the effect of reducing provider stigma on health outcomes (that is, mental health symptoms, substance abuse, health status, and provision of preventive treatments and screenings).

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