EXPLORING THE GENDERED EFFICACY OF PHOTOVOICE METHODOLOGY

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MASTER OF SCIENCE

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ABSTRACT

This study set out to measure the gendered efficacy of the participatory action research method of photovoice. This study utilized secondary analysis, imagery analysis, and qualitative research methods to analyze both photographs and interview transcripts from a previous photovoice study that examined the lives of individuals who have been prescribed medication for a mental illness. This study sought to: 1) evaluate the independent relationship between the researcher and the participants' photographs; 2) unveil how effective photovoice is as a research method in terms of extracting rich data from mentally ill persons; and 3) assess photovoice's efficacy in regard to the gender of the participants within a given study. The findings of this study indicate that the high quality of data gathered from both male and female participants in the initial study indicates that photovoice is an effective methodology for examining mentally ill populations, regardless of the participant's gender.

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DEDICATION

I would like to dedicate this thesis to my partner, Casey Volness. You have selflessly supported every decision within my academic career. Your words of encouragement and high spirits have propelled me to complete this project.

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CHAPTER ONE: INTRODUCTION

Community based participant research (CBPR) – also referred to as participatory action research (PAR) – is largely used in qualitative studies seeking to engage their participants to become somewhat of co-researchers in the process (Duffy, 2011). One particular facet of CBPR, called photovoice, has been utilized as a hands-on method for members of a particular community to bring awareness or produce change within realms of disparity (Wang and Burris, 1997, Wang 1999). This methodology has been used to study and assess community health programs in the San Francisco Bay area (Wang & Pies, 2004), a male perspective of illness through prostate cancer victims (Oliffe & Bottorff, 2007), and several other realms of human well-being experiences (Graziano, 2004; Jurkowski and Paul-Ward, 2007; Wang and Burris, 1997). Overall, photovoice has proven to be affluent in the field of qualitative research in that it extracts rich data and detail, largely due to the fact that those who participate take on a sense of pride and empowerment in the journey that they are part of (Duffy, 2011).

Given the success of photovoice as a methodological means of obtaining rich qualitative data, a study was recently conducted utilizing this methodology to gain insight on the lives of individuals who are prescribed medications for a mental illness. This research will explore the effectiveness of photovoice in terms of its ability to extract rich data from individuals with mental illness. Although photovoice methodology has successfully been able to examine a number of marginalized populations, there is minimal research leveraging photovoice to explore the intricacies of mental health. Gaining access to the perspectives of individuals with a mental illness may be especially difficult considering the obstacles present in regard to seeking professional help for a mental illness. Such impediments will be more clearly addressed within the literature review.

Despite the growing body of literature examining photovoice studies, little research has been conducted regarding an assessment of the method itself. Of particular interest is a deeper understanding of the role of the photographs that are leveraged within the methodology. Although the images captured by the participants' cameras in photovoice seem to play an important role in accessing the lived experiences of those individuals, there is limited documentation addressing the potential value of the independent relationship between researchers and the photographs, excluding the perspectives of the participants.

Furthermore, although a number of studies have been conducted using photovoice since its development roughly twenty years ago, there is a void in the literature in terms of examining gendered implications regarding photovoice's effectiveness in drawing out the concerns of its participants. For example, do the procedures that occur throughout photovoice methodology extract richer data from male or female participants? A methodological evaluation centered on participant efficacy based on gender, beyond any other demographic, is likely to yield valuable results considering the methodology was birthed from feminist theory with an initial aim of providing women in marginalized cultures with a voice (Wang and Burris, 1997, Wang 1999). Understanding the strengths and weaknesses of this emerging methodology from a gendered perspective could enable qualitative researchers to work more effectively and efficiently in terms of research design, population sampling, and data collection and analysis.

Based on the information provided in light of past research, the following research questions will be examined within this study: Firstly, is there significance in an independent relationship between the researcher and the photographs in a photovoice study; a relationship that disregards the meanings of the images as described by the participants who took them? Secondly, how effective is photovoice methodology when used to extract data from individuals

who have or had a mental illness? Lastly, what role – if any – does the gender of participants play in photovoice research in terms of the effectiveness of the methodology?

In order to provide answers to these questions, we must first study the literature in the field of gender to gain an understanding as to how individuals constantly act out gender as a result of socialization. Comprehending the power of gender as an institution will provide a platform to conduct the research at hand. Beyond gender literature, a thorough investigation of the development of the methodology being examined is essential. Of particular interest is an examination of the theoretical developments that influenced the creation of photovoice and their potential influence on the populations that are studied with this methodology.

And, finally, taking into consideration the population of the study that is going to be examined in this research, a synopsis of the literature regarding gendered implications of mental health will also be germane for the project at hand. Being able to identify how men and women perceive, react to, and engage in treatment for mental illness will be crucial in terms of categorizing any gender similarities or differences that arise in the data. To better understand the significant role gender plays in mental health, it would be advantageous to first examine the history of mental illness in America, followed by a discussion of the evolving epidemiology of the field. Doing so will illuminate the sociological relevance of this particular topic, as mental illness is largely socially constructed.

CHAPTER 2: REVIEW OF LITERATURE

Mental Illness: An American History

The procedures and methods utilized to define and treat mental illness throughout American history have been largely shaped by the medical industry and society at large. In colonial times, early American perceptions of the mentally ill were influenced by other cultural beliefs presuming that mental illness was the result of demonic possession, religious injustice, or some other personal dilemma (Unite for Sight, 2013). As a result, severe stigmatization associated with the mentally ill led to degrading confinement and treatment of those deemed unstable in almshouses or madhouses (Weitz, 2013).

In the 1840s, activist Dorothea Dix began lobbying for higher quality treatment of the mentally ill (Public Broadcasting Service, 2002). Before the turn of the century, Dix helped to establish 32 government-funded state hospitals for the mentally ill. Initially, this institutionalization of mental illness provided those in need with humane, professional help. However, as the hospitals' occupancies continued to grow, funding and personnel for the institutions became insufficient. As a result, the quality of care for the mentally ill, again, entered a state of inadequacy (Unite for Sight, 2013). By the 1930s, mental healthcare in the United States resorted to performing inhumane – and often times disabling or lethal – practices such as electroshock therapy, lobotomies, and insulin therapy in an attempt to more efficiently maintain the nation's mentally ill population (Public Broadcasting Service, 2002).

With the intention of deinstitutionalizing mental illness in America, President Harry Truman signed the National Mental Health Act in 1946 (Public Broadcasting Service, 2002). The act led to the foundation of the National Institute of Mental Health, whose primary mission was to research the brain in an attempt to better treat mental illness. Within the next decade,

antipsychotic drugs that helped treat schizophrenia were developed. As the development and implementation of pharmaceuticals for mental illnesses continued throughout the 60s and 70s, growing numbers of individuals were removed from mental institutions. Although many were able to function independently thanks to their new medications, some were not equipped for survival, even with their prescriptions, and ended up homeless (Public Broadcasting Service, 2002).

This reality can be explained in light of research that has recognized that mental illness is caused by a combination of genetic and environmental factors (National Institutes of Health, 2013). Therefore, treating a mental illness solely for the biological imbalances that occur within an individual and disregarding the social realm of treatment – which better enables individuals to learn how to live with their illness – provides only partial treatment for the mentally ill. Despite the deficiency to this approach, the increasingly accepted concept of viewing medicine as an institution of social control has largely shaped our society's current view of mental illness as an individualistic condition that can be maintained through medication.

Throughout American history, considerably less attention has been paid to the social and therapeutic components of treatment for mental illness (Weitz, 2013). Although there were stints throughout history wherein psycho-social realms of mental illness were examined – socioeconomic conditions in relation to mental illness in the early twentieth century (Horwitz and Grobs, 2011), Freud's development of psychoanalysis (1925), and environmental influences on mental status focusing on PTSD experienced by WWII veterans (Horwitz and Grobs, 2011) – the majority of treatment has focused on medicine. To better understand the implications of treatment options as well as other facets of mental health – including gendered applications – it would be advantageous to examine the social nature of the conceptualization of mental illness.

The Evolving Nosology and Epidemiology of Mental Illness

The somewhat grotesque establishments used by early Americans to house the mentally ill and the psychiatrists who ran them conducted procedures largely as a means of collecting statistical data to provide evidence of the benefits of institutional care, rather than to establish an epidemiology of mental illness (Horwitz and Grob, 2011). One of the first attempts to classify mental illness came about during the 1880 census wherein the statistics collected regarding those who were diagnosed to be insane were categorized into seven groups. However, this system proved to be insufficient. To provide further clarification, in 1918, the Committee on Statistics of the American Medico-Psychological Association (which became the American Psychiatric Association in 1921) in collaboration with the National Commission for Mental Hygiene created the first nomenclature for mental illness intending it to be implemented by all mental institutions to create a uniform reporting system (American Psychiatric Association, 2012 and Horwitz and Grob, 2011).

The development of conflicting classification systems continued to confound to the point that the scientific dialogue regarding mental illnesses along with their symptoms and diagnoses become muddled and often varied across sources (Moon, 2004 and Pomeroy and Parrish, 2012). It wasn't until the first edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-I) was published in 1952 that a truly universal classification system manifested. The DSM-I contained 108 descriptions of mental disorders, a significant improvement from the seven vague categories identified in the late 1800s.

However, the DSM-I and the following DSM-II – published nearly twenty years later – faced criticism due to the fact that they were largely constructed based off of the perspectives of a small percentage of the APA's membership rather than being rooted in and supported

empirically-based evidence (Moon, 2004). The third edition of the DSM strived to change that. The DSM-III published in 1980 was developed by psychiatrist Robert Spitzer and largely focused on classifying mental disorders in accordance with their symptoms (knowledge gained through research-based criteria and supported by structured interviews) rather than etiological assumptions (Horwitz and Grob, 2011 and Moon, 2004). Established on this symptom-based perspective of defining mental illness, Spitzer and his colleagues constructed the Diagnostic Interview Schedule (DIS), a tool that enabled researchers to efficiently measure mental health statuses of communities on a national level. A revised version of the third edition, the DSM-III-R, was created in 1987 to address areas in need of correction and clarification (American Psychiatric Association, 2012).

Following a similar empirical approach to the previous edition, the DSM-IV was published in 1994 with the intent of simplifying and organizing the somewhat verbose DSM-III-R as well as updating findings in accordance with current research (Pomeroy and Parrish, 2012). The updated DSM-IV-TR of 2000 was published with little dissimilarity to the DSM-IV.

The most recent edition, DSM-5, was published in May of 2013. The Roman numeral system was aborted to make future revised editions easier to identify in chronological order; DSM-5.1, DSM-5.2 etc. (American Psychiatric Association, 2013). DSM-5 was updated with the intent of providing medical professionals with more detailed descriptions of symptoms and behaviors that are being presented by individuals to facilitate the diagnostic processes for emerging mental disorders (American Psychiatric Association, 2013).

Revisions made over the past sixty-plus years to the DSM have been a result of medical advancements, social influences, and political movements. Consider, for example, the history of homosexuality within the DSM. In its original edition, homosexuality was listed as a sociopathic

personality disturbance. However, the rise of the gay rights movement in the 1970s generated protests against the American Psychiatric Association to remove homosexuality from the DSM. As a result, in 1974, the DSM-II deleted homosexuality from subsequent printings. However, the disorder of "sexual orientation disturbance" and the revised DSM-III condition "ego-dystonic homosexuality" were created to diagnose homosexual individuals who wished to be heterosexual as mentally ill (Corcoran and Walsh, 2011, Pomeroy and Parrish, 2012).

Despite the advances that have been made regarding the classification of mental illnesses, the DSM and the overall epidemiology of the field still face criticism. In dismissing the need to agree upon a common etiology for mental illness while producing the DSM-III, its creators were able to focus on empirically supported research to establish a universal nosology of mental illness. However, choosing to build such a classification system without first establishing a sound and widely supported theoretical framework has left the DSM exposed to a constant battle of scrutiny.

The nosology of mental illness is further criticized due to its current diagnostic system, which identifies conditions due to the presence or absence of symptoms (Nesse and Jackson, 2006). Such a system leaves much room for comorbidity and heterogeneity across a number of conditions. For example, major depressive disorder is diagnosed when an individual claims to have experienced five out of nine diagnostic symptoms for more than two weeks (American Psychiatric Association, 2013). Two of the most easily identifiable of these symptoms are lack of motivation or pleasure and inability to concentrate. Although recognizing these symptoms in an individual could lead to the diagnosis of depression, it could also lead to the diagnosis of attention deficit hyperactivity disorder (ADHD), schizophrenia, or bipolar disorder, all of which share these common symptoms (Mayo Clinic, 2012).

There is also the issue of dimensionality regarding the identification of mental illness within an individual. For most biological conditions, the presence or absence of symptoms can unequivocally ascertain whether or not the condition is present. If an individual's pancreas no longer produces insulin, the individual has either type-two or type-one diabetes. If an individual experiences an extended period of time wherein he or she lacks motivation or is unable to concentrate, it is only possible, not guaranteed, that this individual is experiencing major depressive disorder. Such diagnostic ambiguity is common across mental illnesses, which makes it challenging to clearly classify the healthy from the pathological. The inability of the DSM to clearly define the domains of mental illness leaves the diagnoses for the conditions to be viewed merely as dimensional possibilities within the context of the individual at hand rather than categorical definitions with explicit boundaries (Nesse and Jackson, 2006).

Before moving forward, a crucial point of importance regarding the construction of mental illness in relevance to the research at hand should be reiterated. The continuous evolution of mental illness' nosology based on social and political factors largely demonstrates the sociological significance in this field of study. This will be important when considering how the participants of the study being examined interpret and react to the label of "mentally ill" through photovoice while simultaneously taking into account gendered affiliations.

Perhaps of even greater importance is highlighting the somewhat profound degree of ambiguity affiliated with mental illness itself. Through its socio-political underpinnings, the continuous evolution of mental illness's definition makes it difficult for individuals to identify with it. This is especially true across various demographics, such as gender, as – we shall soon see – mental illness is perceived differently by the sexes. With this in consideration, we may now

shift focus toward examining two other significant topics for this research: gender and photovoice.

An Evolution of Gender Theory

Early theories of gender and sexuality in Western civilization were rooted in religion and later in biology. It wasn't until a movement largely pioneered by Freud's application of psychoanalysis in *Three Essays on the Theory of Sexuality* (1953) that masculine and feminine traits were (although unintentionally) recognized to be products of social structures and institutions (Connell, 1987). From this discovery, an abundance of research ensued focused on identifying differences between the sexes. Of significant influence during this period was Talcott Parson's distinction between expressive and instrumental roles within the nuclear family (1956). Continuing research in the sociology of gender further refined the concept of sex roles and established social expectations for male and female behaviors and activities.

The development of sex role theory was sociologically appealing for a number of reasons. First of all, it established that men and women act differently in accordance to the social expectations of the environment in which they are involved (Connell, 1987). Identifying the role social influence played in determining human behavior empowered researchers to look beyond the primitive concept of biological factors being the primary driving force of gendered behaviors. Sex role theory is also appealing in the sense that it establishes a connection between social structures and individual personalities through agents of socialization (Connell, 1987). In being socialized into their "appropriate" gender roles, men construct an identity of masculinity and women construct an identity of femininity.

Similar in many ways to the ideology of role theory was that of Goffman's gender display. Goffman agreed that gender was a socially learned concept. His trademark to gender

theory was signifying the expressive nature of gender in agreement with one's sex. According to Goffman, men and women act out the rituals that society has constructed for them, saying "Gender expressions are by way of being a mere show; but a considerable amount of the substance of society is enrolled in the staging of it," (1979, p. 8). Goffman's publication *Gender Advertisements* examined hundreds of photographs used in advertisements to illuminate how individuals in these ads display their gender in accordance with society's expectations based on the actors' sex.

Although Goffman and other similar-minded role theories may be credited in shifting the origin of gender into the social sphere, theories of this nature have received much criticism for their suggestive voluntary-gender nature. As a result, one of the greatest faults of role theories addressed by many other contemporary gender theorists is that such theories credit individuals with too much agency in terms of "choosing" to act in accordance with their gender, (Lorber, 1994, Martin, 2004, West and Zimmerman, 1987).

As previously stated, referring to the responses towards an individual's gender as a "role" largely implies that gender is an act for which an individual may choose to occupy and abandon at any time. In response to the inadequacies of gender and sex role theories, significant research has come to support the concept of "doing gender" – considering its institutional affiliation and ever-permeating influence – as a more sociologically appropriate theory (Lorber, 1994; Martin, 2004; West and Zimmerman, 1987).

The perspective of "doing gender" supersedes previous ideas of gender – such as Goffman's theory of gender displays – in suggesting that gender is not an optional performance, but rather, a continuously ongoing activity present in every aspect of social interaction. Similar to role theories, the concept of doing gender agrees that gender is not biologically innate, but,

rather, it is socially constructed and learned through a process known as gender socialization (Lorber, 1994). During this process, individuals develop a gender identity, or a sense of gendered self.

In her book, *Gender Play*, Barrie Thorne shares her findings after researching the gender relations among children while they attend school. Thorne largely aligns with the doing gender perspective, recognizing the masculine and feminine behaviors of children, the gender divisions on the playground, and the willingness to establish friendships with others are all social constructions that are supported through the children's gender identities (1993). Thorne's research further supports one of the core concepts of doing gender: that gender is not something we passively have, but something we actively do.

In adopting and supporting this omnipresent concept of "doing gender," academia has begun to recognize gender as a social institution in that it is a social phenomenon that holds the qualities of endurance, internalization, and constraint (Lorber, 1994 and Martin, 2004). Placing a higher level of societal pressure in the practice of living in accordance to one's gender than did the concept of gender roles, the term gender norm refers to the conceptualization of a socially expected, inscribed and lived appropriate masculine or feminine behavior (Lorber, 1994).

Another flaw of sex role theory was that it drastically simplified the complexities of gender into a dichotomous split: either masculine, or feminine. A desire to establish a scale that better measured the dimensionality of gender led to the development of the Bem Sex Role Inventory (BSRI) (Bem, 1974). Creator Sandra Bem developed the BSRI to serve as a widely-accepted instrument to measure gender perceptions (Bem, 1974; Bem, 1993 and Holt and Ellis,

1998). The BSRI measures gender through assessing an individual's self-identification with stereotypical masculine, feminine, and androgynous adjectives.

The adjectives on the inventory were characterized as masculine if they were measured to be more desirable in American society by a man than by a woman (Bem, 1974). Similarly, the adjectives were characterized as feminine if they were measured to be more desirable in American society by a woman than by a man. In sum, one could describe the BSRI as a measure of how strongly one identifies oneself with gender norms. Comprehension of the workings of the BSRI was instrumental to this study, as its descriptive adjectives were utilized as a standardized measure for comparative analysis in this research.

The BSRI was contemporary in that it measured an individual's level of masculinity and femininity on two independent scales. Rather than limiting individuals to a single point on a continuum scale of feminine to masculine, individuals who complete the BSRI receive a rating on a masculine scale as well as a feminine scale. Providing individuals with the opportunity of scoring high or low in both categories exposed the previously dichotomous world of gender to the elusive realm of androgyny. The BSRI was further unique in that its inventory also included a list of adjectives that were viewed to be androgynous themselves, enabling BSRI completers to independently measure their level of androgyny, as well.

The inclusion of androgyny into the discourse on gender is germane considering that, until recently, the vast majority of discourse regarding gender had focused on the dichotomous divide between male masculinity and female femininity. Such a lucid – and largely socially unchallenged divide – left much room for questioning what lay within the gap between the two categories.

Judith Butler is among the theorists who seek to better explore this unexplored realm of gender. According to Butler – in alignment with a number of other academics who represent the ideology of queer theory – we must break free from the notion that gender identities are a dichotomous split and, rather, accept the idea that gender and sex are fluid entities. Judith Butler's theory of performativity suggests that, similar to gender, sex is also socially created. Butler suggests that the discursiveness of society establishes norms that are constantly reiterated which result in the materialization of sex (Butler, 1990 and 1993).

Butler's concept of performativity proposes that the being of a man or woman is not an internal reality, but rather a phenomenon that is constantly being produced and reproduced (1990, 2011). Humans engage in a series of effects that amalgamate an impression of being a man or woman. Butler acknowledges that there are both formal, institutional powers and informal, social practices that try to keep us in the gender boxes society establishes (2011). Butler is a supporter of the idea that, in order to disable the negative – and sometimes violent – effects of gender and sex incongruence, social beings should explore opportunities to challenge gender norms that constrain individual expression to normalized behaviors, appearances, and attitudes that are affiliated with one's sex. For many of these reasons, Butler's work has also become a profound component in the development of queer theory.

In generating this argument, Butler's performativity varies from Goffman's gender performance in that Butler limits individual subjectivity of social agents to that which is created and permitted by the social worlds in which the agents live. In other words, individuals may only "choose" to subjectively act out their genders within the discursive parameters that have already been established by their social worlds (Butler, 2004). Butler would further disagree with Goffman in that where Goffman would suggest individuals socially construct and perform their

gender roles in accordance with their sex, Butler would suggest that gender and sex are materialized through a discursive matrix of sex relations, not by individual subjects.

Other social theorists have aligned with Butler in mindset of pushing the envelope within gender discourse beyond the ideologies created by previous theories of gender. A current critique of the doing gender perspective has identified that, within this train of thought, sex and gender are treated as a congruent pair rather than treated as individual entities (Messerschmidt, 2009). Research has indicated that men and women act and behave in ways that do not always align with what is expected of their sex. For example, men may act feminine and women may act masculine. However, when individuals break the sex-gender congruency, they are often stigmatized or punished by society (Messerschmidt, 2009).

Following expected gender behavior is of particular importance to men considering our society's profound establishment of heteronormative masculine behaviors. The term hegemonic masculinity, as used by Connell and Messerschmidt, "embodied the currently most honored way of being a man, it required all other men to position themselves in relation to it, and it ideologically legitimated the global subordination of women to men," (2005, p. 832). Not only does hegemonic masculinity legitimize the subordination of women, but it also subordinates men who fall into the categories of "inferior" masculinities as well. Although hegemonic masculinity may be the dominant portrayal of ascendant men in society, the majority of men only strive, but do not completely capture, the power associated with the classification (Connell, 1987, Connell and Messerschmidt, 2005).

In many ways, the hegemonic masculine pressures enforced in our society set the majority of men up for a lifetime of internalized inadequacy. Understanding the unrealistic attainability of hegemonic masculinity is of great importance when considering the current

research being conducted regarding medication experience for the mentally ill. In the following section, I will expand on the sociological components of mental illness. More specifically, the following discussion will seek to explain how masculine stereotypes and gender norms in American culture are likely having a negative impact on the well-being of mentally ill men in the United States.

Mental Health: A Gendered Perspective

Society has attached a stigma to persons with mental illnesses, categorizing them as unstable and degrading them to be somewhat less of human beings (Arboleda-Flórez and Stuart, 2012 and Corrigan and Deepa, 2012). The stigma is largely portrayed through media, considering the number of books, movies, and newspaper headlines that depict violent or criminal acts in association with mental illness (Anderson, 2003). This negative association tied to mental illness largely deters social beings – especially men – from wanting to be diagnosed with a mental disorder, despite knowing that doing so could open doors to treatment opportunities. Research suggests that, for most men, accepting that one has a mental illness is a blow to his masculinity (Ryle, 2012). In a society where men are socialized to be tough, self-reliant beings, the process of surrendering oneself to the vulnerable, dependent status of mentally ill is proving to deter a number of men from seeking the treatment they require (Addis and Mahalik, 2003).

Continuing this exploration through a gendered lens, a significant amount of research has been conducted to illuminate similarities and differences of mental illnesses by sex. It has been consistently found that women are more likely to be diagnosed for internalized conditions such as depression and anxiety disorders, whereas men reliably account for higher rates of externalized disorders including substance abuse and antisocial maladies (Klose and Jacobi,

2004; Schwartz, Lent, and Geihsler, 2011; Seedhat et al, 2009). According to the 2010 United States Department of Health and Human Services survey, adult American women were more likely than adult American men to have a mental illness (23 percent vs. 16.8 percent). This statistic, however, may not be completely accurate due to gender differences in how various mental illnesses are defined and measured. Furthermore, it is expected that a large number of men with mental illnesses are not accounted for and remain untreated due to the masculinized approach towards help-seeking behaviors (Kilmartin, 2010, p. 309).

Not only does research suggest that women are more likely to validate psychosocial conceptualizations of mental illness than are men (Holzinger, 2012 and Kessler, Brown and Broman, 1981), but, also, studies have found that men are less likely to seek diagnoses for internalized mental illnesses such as depression for a number of reasons. Firstly, men experience depression differently than women. Common male symptoms of depression – including headaches and seeking distractions – aren't brought into awareness via the media nearly as much as common female symptoms such as feeling sad or excessively emotional (Mayo Clinic, 2010). Secondly, even if men recognize that something may be wrong, many may face a masculinity crisis in accepting the possibility of having a mental illness. As a result, men may be more likely to downplay the severity of their symptoms; they may be more reluctant in expressing their concerns with others; and they may be less likely to seek professional help (Kessler et al, 1981, Kilmartin, 2010 and Mayo Clinic, 2010).

Being that this is a sociological study, the majority of discussion in this literature review has revolved around the social underpinnings of mental illness, namely, exploring how social forces and structures affect gendered perceptions of mental illness. That said, it is also important

to acknowledge the biological affiliations of mental illness, particularly how an individual's sex may affect his or her response towards or likelihood of acquiring a mental illness.

Although the research is not conclusive, there is a body of literature that explores the biological basis for mental illness. In terms of diagnosis, it has been previously mentioned in this section that women are more likely than men to be diagnosed with depression and anxiety disorders ((Klose and Jacobi, 2004; Schwartz, Lent, and Geihsler, 2011; Seedhat et al, 2009). This may be partially explained by biological traits that are unique to women. For example, studies over the past few decades have typically reported anywhere between ten to 20 percent of women experience depression at some time during pregnancy or postpartum (Bowen, Bowen, Butt, Rahman, and Muhajarine, 2012; Gotlib, Whiffen, Mount, Milne, and Cordy, 1989; and Josefsson, Berg, Nordin, and Sydsjo, 2001). Another study has found that women with no history of depression are two and half times more likely to experience depression when entering menopause than when in premenopausal status (Freeman, Sammel, Lin, Nelson, 2006). Such findings suggest that the hormonal composition of women during these life events predispose them to depression.

Research has also indicated sex-based differences in the treatment of mental illness. As Smith (2010) explains, men and women absorb and metabolize medications differently. Women absorb antipsychotic drugs slower than men do as a result of slower gastric emptying (Bennick, Peeters, Van den Maegdenbergh, Geypens, Rutgeerts, De Roo, and Mortelmans, 1998). However, the lipophilic nature of antipsychotic medications typically results in a greater distribution of the medications in women than in men since women's bodies average about 15 percent more body fat than men's (Smith, 2010). Findings such as these further support the presence of biological gendered differences in mental illness.

It should be addressed, however, that biological components of mental illness are often intertwined with the social. For example, another study investigating depression in pregnant women reported that impoverished pregnant women were almost twice as likely to experience depression as middle-class pregnant women (Hobfoll, Ritter, Lavin, Hulsizer, and Cameron, 1995). A number of studies also link the social factors of economic inequality and female oppression to the higher rates of mental illness among women (Chesler, 1971, Piccinelli and Wilkinson, 2000, World Health Organization, 2014).

This discussion on gendered perceptions of mental health was valuable to this study as it identified a number of areas that needed to be considered while analyzing the data. For example, given the disparity across gender for self-identification of mental illness, it was expected that the majority of the participants in the initial study were to be female. Furthermore, considering that men who accept that they have a mental illness and seek treatment (such as participants of the initial study) fall prey to breaking the masculinized norm of avoiding help-seeking behavior may indicate that such men are likely to break other gender norms as well. A further analysis of such implications will be provided in later chapters. Having discussed the gendered implications as they pertain to the participants of this study, we can now begin to examine the methodology under review within this research.

Understanding the Intentions of Photovoice

The concept of photovoice methodology was developed by doctors Caroline Wang and Mary Ann Burris. The intentions of photovoice are clearly stated in its seminal article:

> Photovoice has three main goals: (1) to enable people to record and reflect their community's strengths and concerns, (2) to promote critical dialogue and knowledge about important community issues through large and small group discussion of photographs, and (3) to reach policy makers. (Wang and Burris, 1997, p. 370)

Photovoice has proven to be an effective tool in qualitative research in a number of ways. It enables communities to shed light on issues of importance that may be overlooked by researchers not actively involved in the environments being studied; it provides a voice to marginalized or overlooked communities; it utilizes the power of imagery to stir emotion and serve as a catalyst to promote policy change; and, it provides a valid means for conducting qualitative research through triangulating data collection and analysis, utilizing interviews, focus groups and imagery analysis, (Duffy, 2011; Jurkowski and Paul-Ward, 2007; Oliffe and Bottorff, 2007; Wang, 1999; Wang and Burris, 1997).

For these reasons, photovoice is leveraged as a form of participatory action research in that it extricates the reflexive realities of individuals in a marginalized community so that their knowledge may be used as a tool to enact social reform (McIntyre, 2008 and Reason and Bradbury, 2001). Photovoice differentiates itself from other forms of PAR in that participant taken photographs play a significant role in the research process. The photographs provide the participants and researchers with a physical document that serves a number of purposes.

First, the tangible act of taking the photographs engrosses the participants in the research process, granting participants of photovoice a large degree of autonomy in that they have creative control in selecting the images they wish to capture. This practice is unique to photovoice in that it engages the participants both physically and cognitively. Whereas traditional interviews in qualitative research are typically led and structured by the principle investigator (PI), photovoice interviews grant a much higher degree of agency to the participants in shaping the content and direction of the interview, and therefore, of the marginalized knowledge that is to be exposed.

The creation of photovoice was drawn from a collaboration of influences including education for critical consciousness, documentary photography and feminist theory (Wang and Burris, 1997, Wang, 1999). Brazilian activist Paola Freire's theory on education for critical consciousness refers to a concept aimed at increasing an individual's understanding of her or his environment taking into consideration cultural and political factors in addition to fighting oppression (Freire, 1977). Freire used drawings or photographs to engage community members to think critically about the societal issues they encounter.

Documentary photography is somewhat of an umbrella term used to describe a variety of photographic representations of social realities (Wang and Burris, 1997). Photovoice is distinguished from most documentary photography in the aspect that those who are typically being documented are given the cameras and the opportunity to conduct the documenting themselves.

These brief descriptions of critical consciousness and documentary photography are sufficient for this literature review, for the theoretical underpinning that is of particular consideration for this study – as it largely pertains to the second research question – is that of feminism. In their seminal photovoice article, Wang and Burris address that "feminist theory and practice has shed light on the male bias that has influenced participatory research," (1997, p. 370). The creators respond to this perspective in stating that one of their core motivators to create the methodology was to address socio-political issues faced by women, specifically the rural village women of China's Yunnan province (Wang and Burris, 1997). Considering that this methodology was conceived by women with the initial intent for it to be used by women leaves room for concern that its proficiency in producing valid data may be skewed towards one sex. This potential shortcoming of the methodology is largely reiterated in a recent study which

reviewed the literature on photovoice and indicated that 78 percent of the observed cases engaged primarily female samples (Catalani and Minkler, 2009).

Taking that into consideration, it is also important to recognize the strengths of photovoice research that has been conducted examining male populations. Rhodes and Hergenrather (2007) leveraged photovoice as a means to access the perspective of monolingual (Spanish-speaking) Latino immigrant men in North Carolina in regards to HIV prevention in their communities. The study was able to extract valuable information from its participants regarding methods and locations that would be most effective for distributing HIV prevention information to the Latino community.

Another photovoice study that solely engaged with male participants was Oliffe and Bottorff's examination of the experience of living with prostate cancer (2007). Their findings suggest that photovoice is a proficient tool for extracting complexities in social research, particularly for men. The support for this claim was largely bolstered in the reality that the participants of this study relied heavily on the images they captured to enter into dialogues that often challenged societal norms. For example, a number of the photographs in this study represented personal deviations from patriarchal masculine gender norms, such as experiencing the inability to complete day-to-day tasks or admitting feeling the emotions of fear and dependency. Oliffe and Bottorff suggest that "photovoice offers a new form of witness and terrain that can facilitate unique dialogue and a proactive way forward, detailing how some men will, rather than will not, talk," (2007, p. 856).

Both of these examples demonstrate the competency of photovoice when examining male populations. However, despite the advantages of photovoice, research regarding any critical evaluation of the methodology itself remains largely unreported. With the exception of

addressing potential methodological limitations to photovoice (Newman, 2010 and Nykiforuk, Vallianatos, and Nieuwendyk, 2011) there is a large gap in the literature in terms of addressing any variance of effectiveness among participants within the studies. The demographic of gender is of utmost relevance considering that the initial intent upon conceptualizing photovoice was to provide women with a means of expression to address areas of social, political, and institutional concern (Wang, 1999, Wang and Burris, 1997).

Although the methodology is not unequivocally quarantined for the examination of female populations – as the studies described above indicate – there are still a number of unanswered questions pertaining to the gendered efficacy of photovoice research. For example, neither of the previously mentioned studies that examined male populations greatly discussed the limitations of photovoice when used to explore men's experiences. Furthermore, in photovoice studies that leveraged both men and women in their samples, there is little documentation regarding similarities and differences in the quality and types of information participants provide regarding their gender. In the following research, I set out to better understand these unexplored areas of photovoice through the lens of individuals experiencing mental illness. Should an assessment of photovoice find that it is leveraged differently by men and women, the methodology could be adjusted in the future to provide researchers with the best tools available to extract rich data in qualitative research.

CHAPTER THREE: METHODOLOGY

Overview

The research being conducted employed secondary analysis of data that was collected during a study entitled "Living with My Medication." Throughout the following description, two studies will be frequently mentioned: the initial study and the current study. The initial study refers to the research that was conducted for the study "Living with My Medication", whereas the current study refers to the secondary analysis being conducted in this research. Before describing the methods and measures that will be utilized in the study at hand, it is necessary to explain the procedures of the initial study.

Initial Study and Design

The initial study developed entitled "Living with My Medication" was conducted by North Dakota State University faculty within the Pharmacy Practice and Sociology and Anthropology departments. Approval of the study was granted by NDSU IRB (See Appendix A, page 74) and the health care providers of Study Recruitment in Fargo, North Dakota. The research used a qualitative approach utilizing photovoice methodology to collect data. A total of 24 patients were recruited in the first three cohorts. Cohort one consisted of five participants; cohort two consisted of 12, and cohort three consisted of seven. To protect the confidentiality of the participants, the researchers of the initial study assigned a number to each of the participants to be used in place of their names. As such, the participants were labeled either C1, C2, or C3 – for cohorts one, two, and three, respectively – followed by a chronological participant number, one through 17 for cohorts one and two combined and one through seven for cohort three. In turn, participants from cohort one were labeled C1-1 through C1-5, participants from cohort two were labeled as C2-6 through C2-17, and participants from cohort three were labeled as C3-1 through C3-7.

Participants were recruited from the Sanford Behavioral Health, Fargo ND outpatient clinic and the partial hospitalization program for cohort one. In addition to Sanford Behavioral Health, cohort two participants were recruited by means of flyers and healthcare professional referrals at community-based health centers, such as Prairie St. John's and Southeast Human Services Center of Fargo, North Dakota. To be considered for the study, the individuals must have been at least 18 years of age at the time of informed consent, and they must have been prescribed at least one prescription medication for their medically diagnosed mental illness.

Participants in the study took part in four separate meetings throughout the process. The first meeting was an introduction to the study and acquired informed consent from the participants. The second meeting consisted of individual interviews between the researchers and participants. The third meeting was a focus group wherein multiple participants met together and engaged in a dialogue discussing some of their photographs and implications of the photovoice process. The fourth and final meeting consisted of participants and health care providers.

During the first meeting, participants received a 24 exposure disposable camera and were assigned the task of documenting their experience of living with their medication. Participants were told to imagine that they are being paid to create an exhibit entitled, "Being on My Medication." Participants were given ten days to take their photographs and were asked to record their feelings, reasoning behind the photos they took, or any other personal reflections about the process in the journal that was provided at the beginning of the study.

Upon completing the photo-taking process, the participants' cameras were mailed to researchers for development in preaddressed and postage-paid provided envelops. The researchers then set up individual interviews with the participants (meeting two) where they were able to share the meanings behind the photos they took using the SHOWED technique (See

Apendix B, page 75). The usage of the SHOWED technique in this photovoice study largely ties it into the field of participatory action research. More specifically, the final two questions of the SHOWED technique directly speak towards how the photographs taken by the participants in the initial study can educate people about the issues being addressed. This call to action takes the findings of this particular photovoice study beyond the individual responses provided by the participants and extends the findings into the community.

Participants in the initial study could also reflect in their journals to discuss the photos if they chose to. The interviews were audio recorded and, later, transcribed. Participants were then asked to select no more than five photos they wished to share with other participants during the upcoming focus group (meeting three). At the focus group, the researchers initiated and facilitated the discussion and encouraged the participants to engage in a dialogue with each other, explain the reasoning behind their photographs, and share the discoveries they made throughout the process while displaying their chosen photographs on a PowerPoint presentation that the researchers created. The focus groups were also recorded and transcribed.

During the final stage of the research project, a meeting was to be held between the participants of cohort one and mental health care providers at Sanford Behavioral Health Center to provide a platform for the participants to voice their discoveries throughout the process. However, no healthcare providers attended the final meeting for cohort one. In response to the absence of health care providers attending the final meeting and the subsequent disappointment expressed by cohort one participants, the researchers decided to hold the final meetings for cohorts two and three during continuing education sessions held at two different health care organizations in the community. Upon completion of the study, participants were asked to turn in their journals; however, not all participants did so.

Present Study: Design, Theory, and Methods

The first trajectory of this research was to assess the significance of an isolated relationship between photovoice researchers and the photographs leveraged within a particular study. The second intent of this research was to determine if photovoice proves to be a valuable methodology for examining mentally ill populations. Finally, the current research also strived to ascertain what role participant gender plays in leveraging photovoice methodology.

The current study utilized secondary analysis and focused on qualitatively examining the data collected from eight participants of the initial study. Both the photographs taken by the participants and the interviews held during the second meeting of the initial study were analyzed. The participants in the current study were selected by one of the principal investigators from the initial study because, during the first two stages of the study, I did not know the gender of the participants. By keeping the gender of the participants concealed at these stages, I was better able to evaluate the data without inflecting my personal gendered biases. Since I did not initially know the gender of the participants, it was essential that the principal investigator from the initial study selected the participants for the current study to ensure that a combination of both male and female participants would be represented in the data sample. For demographic information regarding the participants of the current study, see Appendix C on page 76.

To answer the research questions at hand, the research was conducted in three stages. The first stage focused on analyzing and conceptualizing the photographs taken by the participants in the initial study. This stage was completed to address the first research question regarding the researcher-photograph relationship. The method used to conceptualize the photographs will be described in the following section.

The second stage qualitatively examined the transcribed interviews of the participants. This stage was conducted to respond to the second research question assessing photovoice's capability in working with mentally ill populations. This stage of analysis incorporated a number of techniques and procedures of Glaser and Strauss' grounded theory (1967). Although the intent of this research is not to generate new theory, strategies generated by the development of grounded theory including line-by-line coding, focused coding, conceptualization, and comparative analysis were implemented to complete this study. Conceptualization of these strategies as they pertained to this study will be described throughout the remainder of this chapter.

The final stage of analysis sought to answer the final research question regarding the role of participants' genders in photovoice research. This stage involved unveiling the gender of the participants and analyzing the data collected through a gendered lens, comparing the gender of participants to the conceptualized themes and codes that arose, and applying various social theories to explain the phenomena that occurred. The following is a descriptive explanation of the methods that were practiced within each stage of the study.

Stage One: Photograph Analysis Methods

The first stage of research involved an analysis and interpretation of selected photographs taken by participants from the initial study. The photographs that were analyzed were those that were chosen by participants to share during the third meeting of the initial study. As a result, no more than five photographs were analyzed for any given participant. Each participant was labeled utilizing the numbers assigned to them by the researchers of the initial study (C1-1…C2-17) and each participant's photographs were labeled in accordance with their identified number (C-1.1, C-1.2…C2-17.1, C2-17.2 etc.) The photographs were described

utilizing the visual methodology of compositional interpretation (Rose, 2012, p. 51-79). Compositional interpretation is the process of describing and expressing the appearance of an image based on its content and expressive content. An image's content refers to what is actually shown in the image whereas expressive content illuminates the mood or feeling given off by the image.

The descriptions I generated for each photograph based on their content and expressive content were then conceptualized. Concepts refer to labeled phenomena (Strauss and Corbin, 1998). Identifying concepts was of critical importance as they became units of analysis for this study. The derived concepts were then assessed using external comparative analysis (Glaser and Strauss, 1967) wherein the concepts were compared to the largely accepted gendered vernacular generated through the BSRI (Bem, 1974). After identifying which group of descriptive words best aligned with the concept at hand, each concept was labeled as masculine, feminine, or androgynous. Once all of the photos had been labeled, I tallied the number of masculine, feminine, and androgynous labels each participant had received. Based on the highest reoccurring label for each participant, I assigned the expected gender to each participant. Step-by-step examples of this process will be provided in the following chapter.

Stage Two: Interview Analysis Methods

Upon completing an independent analysis of the photographs, the following stage involved coding and analyzing the interviews conducted with the participants that corresponded with the photographs previously examined. A researcher from the initial study labeled the interviews with their identifiers (C1-1…C2-17) for the current study. The interviews were transcribed by the researchers from the initial study sent to me via e-mail. Once received, I

uploaded the documents into the data analysis software Atlas TI, and saved the data on a password-locked computer as to protect the confidentiality of the participants of the initial study.

The procedures associated with the development of grounded theory including line-by-line coding and focused coding were utilized to extract concepts from the data. Line-by-line coding refers to the microanalysis technique used in the initial stages of a study wherein a code or description is ascribed to every line or phrase of the data (Charmaz, 2006 and Straus and Corbin, 1998). The initial codes were predominantly written as gerunds to attempt to capture the action being described in each line of the transcripts. Next, I implemented the strategy of focused coding wherein the most significant or frequently occurring initial codes were saturated to conceptualize the main themes of the data (Charmaz, 2006, Glaser, 1978).

Stage Three: Gender Reveal and Comparative Analysis Methods

Once I had completed the processes of hypothesizing the gender of the participants based upon their photographs and coding their corresponding interviews, a researcher from the initial study revealed the actual gender of each of the participants in the current study. The participants' actual genders were then compared with their hypothesized genders and the implications of gender's effect on photovoice participants' efficacy was evaluated.

CHAPTER FOUR: FINDINGS

Overview

The findings presented in the following section will be divided into three sections, Stage One, Stage Two, and Stage Three. The findings presented in Stage One will explicate on the independent researcher analysis of the photographs observed in this study, and address the shortcomings that resulted upon the methodology that was implemented within this stage of research. The findings described in Stage Two pertain to those derived from the interviews that were analyzed in this study. The write-up of Stage Two will begin with the conceptualization of the categories and subcategories that emerged within the data and proceed to expand upon the development of these themes explaining the lives in individuals who have experienced mental illness. The chapter will conclude with the findings from Stage Three, discussing the impact of gender within the current study by elucidating some of the gender variances that occurred among participants in this study.

Stage One

My primary intention in completing this stage of analysis was to determine if there is significance within photovoice methodology for the researcher to independently assess the photographs taken by the participants, without knowing the participants intent behind each of the photographs. I wanted to see if reflexively interpreting the photographs' meanings in isolation without also analyzing the participants' interpretations of the photographs would be of value in assessing the effectiveness of photovoice methodology. Since the role of the participants' genders was to be analyzed in a later stage in this study, I decided to conceptualize a comparative analysis based on this demographic to explore the relationship between the researcher (me) and the photographs being analyzed within the current study.

As a result, my purposes for analyzing the photographs in isolation were twofold. Firstly, I wanted to determine if the participants' genders aligned with the gender labels I interpreted and assigned to their photographs leveraging the tools of compositional analysis and the BSRI. Secondly, in this stage of analysis, I also wanted to see if reflexively interpreting the photographs meaning in isolation without also analyzing the participants' interpretations of the photographs would be of value in assessing the effectiveness of photovoice methodology.

A total of 38 photographs collected from eight participants were analyzed in this study. The Content, Expressive Content, BSRI Adjectives that Best Describe the Photograph's Concept(s), and the corresponding BSRI Label that were generated and assigned for each photograph are provided in Table 1.

The following process of analysis was conducted for each of the 38 photographs observed in this study to generate the data in Table 1. Consider the following image, Figure 1. The content description of this image was recorded as "awards, medals, baseball" (See Table 1) as that is what physically appears in this photograph. The expressive content description of this image was recorded as "accomplished, hard-working," because, following the conceptualization of expressive content as it is outlined in the practice of compositional interpretation (Rose, 2008), those words best described the mood of the image, in my perspective.

For the purposes of this study, I found that the expressive content deduced for each photograph proved to be more meaningful than the actual content. As a result, the concepts I generated for each photograph were the words I used to describe each photograph's expressive content. For the image above, the concepts that were used for analysis were "accomplished" and "hard-working."

Table 1

Photograph Analysis

Participant/ Photo Numbers	Content	Expressive Content	BSRI Adjectives that Best Describe Photograph's Concept(s)	BSRI Labels
C1-1				
C1-1.1	frowning girl	sad, dark, depressed	Androgynous	Solemn
C1-1.2	narrow stairwell, window at end	challenging, hope	Masculine	Ambitious, Willing to take risks
C1-1.3	bag of medication	sick, complex	Androgynous	Unpredictable, Unsystematic
C1-1.4	empty chairs	void, emptiness	Androgynous	Solemn
C1-1.5	smiling girl	cheerful, happiness	Feminine, Androgynous	Cheerful, Happy
C1-2				
C1-2.1	counter full of meds, diabetes supplies	sickly, complex	Androgynous	Unpredictable, Unsystematic
C1-2.2	diplomas	educated, hard-working	Masculine	Ambitious, Self-sufficient
C1-2.3	crosses hanging on wall	religious, spiritual, faithful	Feminine	Loyal, Sensitive to the needs of others
C1-2.4	missing a leg	incapability, defeat	Androgynous	Inefficient
C1-2.5	medical tube in chest	sick, medically dependent	Androgynous	Inefficient

(continues)

Table 1. *Photograph Analysis (continued)*

Participant/ Photo Numbers	Content	Expressive Content	BSRI Adjectives that Best Describe Photograph's Concept(s)	BSRI Labels
C1-3				
C1-3.1	dripping sink	broken, worn down	Androgynous	Inefficient
C1-3.2	made bed	clean, inviting	Feminine	Warm, Affectionate
C1-3.3	tree, backyard	nature, bright, warm	Feminine	Warm, Cheerful
C1-3.4	can of beer	sociable; escape	Masculine	Willing to take risks
C1-3.5	awards, medals, baseball	accomplished, hard-working	Masculine	Ambitious, Self-sufficient
C1-5				
C1-5.1	scattered money and pills	chaos, messy	Androgynous	Unpredictable, Unsystematic
C1-5.2	flowing river, rapids	nature, variegated	Androgynous	Unpredictable, Unsystematic
C1-5.3	tombstone	loneliness, sadness	Androgynous	Moody, Solemn
C1-5.4	crucifix	religious, spiritual, faithful	Feminine	Loyal, Sensitive to the needs of others
C1-5.5	piles of pill bottles	sickly, complex	Androgynous	Unpredictable, Unsystematic

(continues)

Table 1. *Photograph Analysis (continued)*

Participant/ Photo Numbers	Content	Expressive Content	BSRI Adjectives that Best Describe Photograph's Concept(s)	BSRI Labels
C2-10				
C2-10.1	cat, messy bed, cosmetics	dark, relaxed	Feminine	Feminine, Warm
C2-10.2	wheel of wheelchair	mechanical, structured	Masculine	Analytical
C2-10.3	empty workout bike	desire, absense, unattainable	Androgynous	Inefficient
C2-10.4	empty factory, vastness	dark, vacant, isolated	Masculine	Masculine, Self-sufficient
C2-12				
C2-12.1	Vivarin, empty store checkouts	cold, sick	Androgynous	Secretive, Moody
C2-12.2	Bills, paperwork, mess	Unmotivated, incapable, dependent	Androgynous	Inefficient, Unsystematic
C2-12.3	Messy bed, closed blinds	messy	Androgynous	Inefficient, Unsystematic
C2-12.4	store, person stocking shelves, working	routine	Androgynous	Helpful, Reliable
C2-12.5	smiling children	happy	Feminine	Cheerful, Loves Children, Affectionate

(continues)

Table 1. *Photograph Analysis(continued)*

Participant/ Photo Numbers	Content	Expressive Content	BSRI Adjectives that Best Describe Photograph's Concept(s)	BSRI Labels
C3-6				
3-6.1	Calendar with days crossed off	contained, shallow	Androgynous	Conceited
3-6.2	Bird tattoo on arm	bright, fiery, fierce	Masculine	Assertive, Aggressive
3-6.3	Alcohol and coffee	mood-altering, sporadic	Androgynous	Moody, Unpredictable
3-6.4	Tree-lined street	calm, peaceful, warm	Feminine	Warm, Tender
3-6.5	Pill bottles stacked in window frame	accumulating, blocking	Androgynous	Inefficient
C3-7				
3-7.1	Money and pills in sink	Wasteful, lost	Androgynous	Inefficient
3-7.2	Table w/ empty ice cream bucket	Empty	Androgynous	Moody, Solemn
3-7.3	Papers scatterd on table	Messy, Unorganized	Androgynous	Unsystematic, Inefficient
3-7.4	Dying plant	Sickly, Malnourished	Androgynous	Solemn, Inefficient

Figure 1. Photograph C1-3.5.

For the next step in the process, I then compared the concepts of each photograph to the descriptive adjectives in each category (male, female, and neutral) on the BSRI. To continue the current example, the concepts of "accomplishment" and "hard-working" derived from the image above most closely aligned with the adjectives "ambitious," "competitive," and "self-sufficient," all of which are found in the masculine list on the BSRI. As such, the photograph pictured above was labeled as masculine for that participant. For a full list of the masculine, feminine, and androgynous adjectives listed in the BSRI, see Appendix D on page 77. Here is another example of the photo analysis process using Figure 2.

Figure 2. Photograph C3-6.4.

The content of this photo was recorded as "tree-lined street." The expressive content – and therefore the concepts – generated for this image were "calm, peaceful, warm." The adjectives on the BSRI that most closely aligned in meaning with these concepts were "warm" and "tender," both of which are in the feminine list on the BSRI. As a result, photograph C3.6-4 was labeled as "feminine."

Once all 38 photographs were labeled as either masculine, feminine, or androgynous, I tallied these BSRI photograph labels for each participant. Based upon the highest frequency of the BSRI labels used to describe the expressive content of their photos, the participants were labeled accordingly, as displayed in Table Two. For example, participant C1-1's photographs generated four androgynous labels, one masculine label, and one feminine label. As a result, participant C1-1 was labeled "androgynous."

Table 2

Participant Gender Labels vs. Actual Gender

Participant	Pseudonym	Highest Occurring BSRI Gender Label	Participant Gender
C1-1	Anne	Androgynous	Female
C1-2	Betty	Androgynous	Female
C1-3	Claire	Androgynous	Female
C1-5	Ethan	Androgynous	Male
C2-10	Joey	Masculine	Male
C2-12	Linda	Androgynous	Female
C3-6	Fred	Androgynous	Male
C3-7	Gloria	Androgynous	Female

In sum, 23 of the photos were labeled as androgynous, seven photos were labeled as feminine, seven photos were labeled as masculine, and one photo was labeled as both androgynous and feminine. As shown, seven of the eight participants whose photographs were analyzed were labeled as androgynous and one was labeled as masculine. It should be noted that one of the androgynous-labeled participants yielded an equal number of masculine and feminine labeled photographs, but was labeled androgynous overall due to the equilibrium. While this particular method of labeling provided me with a manner in which I could utilize and incorporate a widely accepted instrument into my data analysis (the BSRI), I found this portion of my analysis to be largely flawed for a number of reasons.

Issues with Stage One Analysis in Current Study

Although the BSRI contains 60 adjectives to assess gender (20 masculine, 20 feminine, and 20 androgynous), the list did not prove to be expansive enough to match the diversity of the concepts that were drawn from the data in the current research study. For example, the theme of isolation was extracted from one of the participant's photos (See Figure 3).

The adjective on the BSRI that most closely matched "isolated" in meaning was the masculine-labeled adjective "self-sufficient". Although the words may mean similar things in certain contexts, the two terms are hardly synonymous and may be interpreted or defined in vastly different connotations, depending on the individual's experiences. As a result, the majority of concepts identified in this study were assigned an adjective – and therefor, a gender category – of "best fit," even though those adjectives did not always clearly align with the concepts that were assigned to each photograph.

Figure 3. Photograph C2-10.4.

As it is shown in Table 2, the gender labels produced from the BSRI indeed proved to be inadequate in terms of predicting the actual gender of the participants in the study. The ascribed gender label generated from the photographs of only one of the eight participants coincided with that participant's gender, as participant C2-10 was male and the majority of his photographs were labeled as masculine. Coincidentally, this lone participant was the only one of the eight who was labeled either feminine or masculine. This large display of inaccuracy, again, speaks to the inefficiency of the BSRI when used as a tool for comparative gender analysis within this research. Furthermore, this reality may also speak towards the large degree of androgyny present in men in women in today's society, indicating that clearly defined male and female gender norms and stereotypes may be disintegrating.

Even if every concept from the study perfectly aligned itself with an adjective on the BSRI, the issues affiliated with gender role theory are still present. If one were to fully apply the concepts of gender role/display theory to this study, one would be suggesting that the gendered behaviors demonstrated by the participants in this study are conscious acts (Goffman, 1979). Clearly, there are issues with this. One would be hard-pressed to claim that an individual who enters into a state of isolation as a result of his/her mental illness does so as a conscious gendered performance. Rather, it seems more likely that years of gender socialization have deeply penetrated into their identities to the degree that their physical and emotional responses to their mental illness are reflexively done without elaborate gender consideration.

For these reasons, I found the gender labeling of participants based upon the expressive content of their photographs to hold little value in this research. However, the process was valuable in the sense that it verified my concern that the BSRI and sex role theory in general may not be the best tools to evaluate the intersectional relationship between gender and mental illness,

as these tools were not able to adequately speak towards the subjective conceptualizations that occur at such a juncture.

Upon reflecting upon the completion of stage one in my analysis, I drew the conclusion that placing meaning upon a photograph without understanding the participant's intent and meaning for taking the photograph seemed to carry little merit in this study. Such a finding highlights the significance of photovoice research, wherein the participants are strongly connected to their photographs and use their photos to drive their discussion and participation in the study. This realization can be elaborated upon utilizing concepts of text-based and experiential territories from Dorothy Smith's practice of institutional ethnography (2005). Documents – in this case, photographs – are concrete in the sense that their appearance remains physically unaltered regardless of whoever interacts with them. However, although the image may remain constant, the manner in which individuals interpret the image may be vastly different, as was my experience in this study. An individual's interpretation of a singular document may even change over time. It is for these reasons that the language, the descriptive words, provided by the participants in this study are essential to access that territory of knowledge. Without accessing the experiential meaning the images hold in the everyday lives of the participants, photovoice as a methodology would be insignificant.

This claim is largely supported in critique of the methodology I utilized in Stage One of the current study. By independently analyzing and labeling the photographs, I displayed my own personal gendered socialization more than the genders of the photo takers. This is clear when seeing that my analysis only correctly hypothesized the gender of one participant based on the photographs he took. If nothing else, this stage of analysis reiterates the strength of photovoice in that it grants a large degree of autonomy to its participants. Rather than being constrained to rigid

theoretical frameworks or research designs, participants in photovoice studies are presented with a topic in which their perspective is considered valuable; and – through their own words and images – the participants are able to express the actual realities of their lived experiences. The importance of the autonomous quality of photovoice will be discussed throughout the remainder of this research. Having shared these observations pertaining to Stage One, I will now discuss my findings from Stage Two of my study.

Stage Two

In the following section, I will expound upon the major findings that occurred as a result of coding the interviews of the eight participants selected by a researcher from the initial study. First, I will disclose the core concepts that arose from the coding process. In this stage of analysis, I will start to refer to the participants by the pseudonyms I assigned them which can be found in Table 2. The usage of pseudonyms will be leveraged in order to more closely align with the ideals of photovoice, in that the individuals examined in this study were knowledgeable people, not just numbers or labeled phenomena. It was the stories and experiences provided by these people that allowed for this research to happen. Pseudonyms will be used rather than the individuals' actual names to protect their confidentiality.

Categories and Subcategories

Three significant categories emerged among the codes extracted from the participants' interviews. These categories were motivation for seeking help, personal effects of mental illness, and challenges with treating mental illness. Each category was broken into three subcategories to further organize the codes, as indicated in Table 3.

Table 3

Categories and Subcategories

Categories:	**Motivation for Seeking Help**	**Personal Effects of Mental Illness**	**Challenges with Treating Mental Illness**
Subcategories:	1) Social Support	1) Physical Manifestations	1) Issues with Medications
	2) Having a Positive Outlook	2) Taking Ownership of Mental Illness	2) Personal Obstacles
	3) Benefits of Seeking Professional Help	3) Wanting to Enact Change	3) Lack of Understanding / Uncertainty

Motivation for Seeking Help

The most prominent theme that emerged as a result of the qualitative analysis of the interviews was that of describing motivational factors that led the participants of the study to seek help for their mental illnesses. More specifically, the participants largely identified the importance of having social support, maintaining a positive outlook, and recognizing the benefits of attaining professional help. Every participant examined in the current study mentioned the significance of having some sort of support system. A number of participants spoke directly towards the benefits of having family, friends, mentors, pets and spiritual beliefs to connect with when coping with their mental illnesses.

> Betty: These crosses are very special to me (see Figure 4.) They represent my journey and have been given to me by my family, friends and church. I look up at them when I am lying in bed and depressed and they remind me of all the people in my life and in my journey. Faith is a big thing in my life, it is what I have to hold onto. I don't like all the health issues that just keep snow balling but I think back if I didn't have all these health problems, I wouldn't have all these crosses which represent the people in my life if I didn't have this illness. Each cross has its story of who I got it from and what they say when they give it to me.

Figure 4. Photograph C1.2-3.

The same participant reiterated how crucial it can be to have a support system when battling a mental illness.

> Betty: I'm here today because I'm living for my friends and my family and for others. And if it wasn't for them I would have given up a long time ago but if it is for them and the impact of what is going on for me on this journey to take the meds and take care of myself.

Whether directly or indirectly, every participant examined in the current study spoke towards the significance of having some sort of social support mechanism. For many individuals, livelihood was also found when seeking professional help. A number of participants identified an appreciation for the medical and social support systems that were provided when partaking in a partial hospitalization program (PHP), despite continuous challenges with medications.

> PI: Are you still glad that you've gotten help, even though the meds aren't helping you function the way you want to?

Anne: Yes, I'm so glad. But once you're discharged from PHP, it's so hard to do it alone—it almost feels like it's impossible.

PI: What do you do to get through?

Anne: Some days it's just like every hour I'm struggling to get through. Other days, it seems like I have something to look forward to, but I'm still at that low point.

Despite the multiple challenges associated with adhering to medication regimes that many participants identified arose as a result of seeking professional help, it appears as the benefits of attaining that help far exceeded the detriments. A number of participants recognized that seeking professional help provided them with the ability to concentrate on the positive experiences in their lives to overcome their mental illnesses.

Ethan: You see little glimmers of hope, even if for just a split second. That little glimmer is what you hang onto. And that next day, the glimmer is three seconds and it is gone and then five seconds. And then, the depression lessons and you can see the good stuff more often.

Another individual shared a similar perspective.

Joey: I had heard a story about a man who got treatment for heroin addiction. Every thought in his head was "where am I going to get my next fix?" a constant refrain in his head. But after treatment, it become ever fifth, eighth, tenth thought. But there became enough breathing space through the use of tools and medication and that is like what treatment did for me. Once you get treatment, the medication almost slows down your thinking and positive thinking and you can use the tools that you learned in treatment to manage those thoughts.

Although the specificities of their exact reasoning may differ, every participant in the current study shared the common thread of seeking help. Many were influenced by friends, family, or other social support systems; some grew tired of living their lives in a negative mindset and sought to attain the positivity they once possessed; and others required recommendations from healthcare professionals and continuous strains of treatment to start to find the glimmers of what life can potentially become when mental illnesses are suppressed.

Whatever their motivations for seeking help were, these individuals chose to do so because they noticed changes in themselves, which leads to the next category that emerged.

Personal Effects of Mental Illness

The category of Personal Effects of Mental Illness was the most difficult to explain. Naturally, being part of a study examining the complexities of mental illness, the participants in the initial study largely discussed the many ways in which their mental illnesses have negatively impacted their lives. More specifically, the participants predominantly identified a decline in mental health to coincide with a decline in physical health. Furthermore, the majority of participants seemed to struggle with understanding the source of their mental illness, and as a result, took to blaming themselves for their maladies.

These negative, self-aimed comments were directly mentioned by most of the participants. However, the experience of living with a mental illness also seemed to – although inadvertently – bring about a positive personal effect in terms of the participants' desires to enact social reform to both disabuse the negative perceptions of mental illness as well as providing other mentally ill individuals with the tools they need to facilitate their situations. Although none of the participants directly said: "Having a mental illness made me a better person," the desirability expressed to assist a marginalized population would unlikely be matched in magnitude by these particular individuals had they, first, not personally experienced a mental illness, and subsequently, had they not participated in this participatory action research endeavor.

The complexities of these statements referring to the personal benefits experienced by the participants in this study will be explored in greater detail soon. First, I would like to exemplify the negative personal effects the participants described throughout their interviews.

Negative Personal Effects

The majority of negative comments pertaining to having a mental illness addressed the physical manifestations that occurred as a result. Many individuals addressed how their mental illnesses brought about changes in their energy levels and inconsistencies in their temperaments which often led to changes in their physical appearances.

> Fred: I went to France for a summer and my routine was interrupted, and that is not good with bipolar. When I came back and the stress of coming back with the time change I lost ten pounds and my family thought I looked sick. It is hard to be told that you look like a skeleton and you look sick.

> Linda: I lost like 15 pounds because my stomach was hurting so bad.

Another participant acknowledged how the symptoms of her mental illness largely affected her abilities to function physically.

> Anne: For me, those stairs are like a journey and it takes all my energy to get up those stairs to the bedroom (See Figure 5.) If I make a trip up those stairs, I'm done for like 20 minutes until I can get energy back…I've only been out of high school for two years, and I was so active in high school, and I used to never have this pain, 'cuz I have fibromyalgia and extreme chronic pain. And I've been trying to figure out for two years why this is happening and no one's been able to give me an answer.

> PI: What do you think about why it's happening?

> Anne: To me, it's really scary when I'm only 19 and can't make it up the stairs. What's gonna happen when I'm older? I feel like a 60-year-old already.

This relationship between physical and mental health was thoroughly established by a number of participants. Based upon the information provided by the participants in this study, there seems to be a positive correlation between physical and mental health; namely, as one deteriorates, so does the other. Although it was not always clear which realm – the physical or the mental health – declined first, all participants who spoke towards the connection between these two sectors experienced the same correlation. As indicated above, the deterioration that

Figure 5. Photograph C1.1-2.

occurred typically made accomplishing mundane tasks such as walking up the stairs and completing paperwork excessively challenging.

These physical changes many participants noticed and spoke to largely seemed to exacerbate the negative self-perception that was catalyzed by mental illness. The changes in appearance that manifested for many of these participants seemed to reaffirm them that something beyond their individual control was affecting their lives. However, the complexities of mental illness disabled most of the participants from accepting the fact that their conditions were not completely self-induced.

The majority of participants blamed themselves for allowing their mental illnesses to take control of their lives. Although some addressed the importance of taking an individual responsibility towards getting better, others were hyper-critical upon themselves which seemed to worsen their symptoms.

Betty: I think I resent myself not them (her family), because I wouldn't be in this position because if I would have taken care of myself back when I was in college because I wanted to be like everyone else. (I) never looked at the consequences down the road, wanted to live in the now and put my health on the back burner, thinking I was invincible. I made my bed and now I'm lying in it. It took me a long time to admit it.

Although accepting that one has a mental illness is an important step in process towards seeking treatment, establishing the individually conceptualized identity of being mentally ill seemed to belittle some participants to such a degree that interfered with their desire to seek help. When participants largely internalized mental illness as an individualized issue, it made it difficult for them to want to feel better.

Anne: …it's just a constant daily struggle, not only just with my mental illness, but to get myself to want to be better… I just think that so many more people deal with, I don't know, maybe…I feel like so many people deal with some sort of struggle in their life that they need help with but don't get help…I don't know, it's hard.

This personal effect of mental illness can be at least partially explained by the high levels of isolation many participants acknowledged suffering from when their conditions were at their worst.

Anne: …with my depression I'm an isolator, I don't like to go out and do things.

Linda: I have become more of a recluse. I just don't hang out with people any more.

Joey: …you feel empty and isolated in this big area but at the same time in your life there should be things in life, hobbies, but they just sit around and you don't do them. They are just there.

These severe feelings of separation from society lead into the irony present in these findings, in that the loss of autonomy in one realm of consciousness resulted in the formation of an autonomous mindset within another. As a number of participants in this study began to lose a

sense of self-sufficiency in governing their everyday lives, many of them took it upon themselves to independently take responsibility for their mental illnesses.

> Anne: …so that's another thing that you have to make sure that YOU are taking care of YOURSELF. You have to make sure that you're taking your meds, no one's gonna do it for you and that's also a lot of pressure because sometimes your medications are going to make you feel sick and may not bring you out of the funk you're in and it's like, why take them in the first place?

Although an individual sense of responsibility is unequivocally a crucial element in terms of seeking and sustaining an effective treatment regimen for mental illness, the harshness with which a number of participants identified mental illness as an individualized issue appears to be a significant area of concern. What's further fascinating is the fact that, although many individuals in this study conceptualized mental illness as an individualized problem, every participant, in some capacity, discussed the social implications that either positively or negatively have contributed to their mental illness. This profound contradiction between conscious individualized and unconscious socialized attributes of mental illness is an area I will elaborate upon in greater detail in the following pages.

Positive Personal Effects

As discussed above, the participants in this study were relatively direct in addressing how mental illness has negatively affected their lives, mainly in terms of the accompaniment of declining physical health and overwhelming feelings of self-angst and isolation. However, although the individuals in this study did not directly address it, there did appear to be a positive outcome collectively experienced as a result of living with a mental illness. The philanthropic attitudes harbored by the participants in this study were empowering. It was a common desire

among the individuals in this study to promote awareness regarding mental illness to help others in the future.

> Anne: I really want people to recognize that it's not depression and things like that are not a crazy person's disease, 'cuz that's what I thought growing up. It can affect anyone and when it does it can be one of the most challenging things in your life ... I really think that mental illness awareness is way understated, especially in high schools. I really wish that we'd gone through this, like well, we did talk about what depression is and what it might be like, but we didn't talk about who gets it and that you don't need to go through something really traumatic to have it happen, nor that it's part of who you are.

Being a form of participatory action research, it is likely that the hands-on application of photovoice methodology led many participants to express an aspiration to help others. More specifically, two of the questions participants were exposed to when describing their photographs using the SHOWED technique were: "How could this image educate people?" and "What can I do about it?" These active questions extracted a common sense of attenuating the severity of mental illness experienced by others.

> Linda: That is why I wanted to be a part of this study. Because I feel if I can help you help someone else then I want to do it; whatever I can do (to) help you help you someone else.

The reasons participants mentioned to want to help others were also largely driven from the frustrations many experienced due to the inabilities of outsiders to understand the complexities of living with a mental illness.

> Anne: One thing that I've heard from a lot of different people, especially in PHP and other people dealing with depression is that people will think you're lazy; you don't care about anything, and that's not how it is for a lot of people. We do care! We're not lazy; it's that something is taking an extreme toll on us and it's hard to function at a proper level.

Many participants also voiced similar opinions about the lack of awareness made available to the general public regarding mental illness.

Anne: For me, personally, one of my goals, even like a career goal, is to get mental illness more awareness like in schools and stuff. I want to be a social worker, so that's one of my career goals.

Claire: Oh god, there should be manuals mailed to everyone's house: through the schools, going home to parents, newsletters.

As one can see by reading the quotes above, not only did the participants agree that there is a sufficient need for greater mental illness awareness to the general public, but participants were also prone to suggesting methods to disseminate such information. This access to the lived and experienced knowledge of the individuals that participated in this study is significant and unique to participatory action research methods. The recursive process Alice McIntyre (2008) describes when explaining the structure of PAR was largely displayed by the participants in this study. The participants were asked to consider a particular issue, how their lives have been affected taking medication for a mental illness. The participants then reflected on the presented issue, and captured photographs of symbolic relevance. The images and their corresponding quotes from the participants displayed throughout this chapter all demonstrate this process.

Whereas other forms of methodological inquiry may yield at this point of analysis to generate theory or expound upon where to direct future researcher endeavors in that realm, PAR goes further. In this study, while describing the photographs they took, the participants also developed plans of action addressing what can be done in the future to tend to some of the challenges they had experienced. Furthermore, the participants in this study were given the opportunity to share their experiences and everyday knowledge with local medical providers and other individuals, so they too may engage in the recursive process of understanding life with a mental illness.

Although the process described above my seem like an efficient and straightforward means for expanding the knowledgeable discourse of mental illness, to simplify the complexities

of mental illness awareness to such a degree would be naïve. Understanding how individuals with a mental illness feel they are perceived by others may help to explain a number of the social challenges members of this study deal with in terms of treating their mental illnesses. Despite photovoice's ability to illuminate the potential improvements that could occur within the realm of increasing mental illness awareness, the predominant voice of the interviews in this study was not one of benevolence. The final category I am going to explicate pertains to the challenges the individuals in this study faced and continue to face, even after seeking professional help.

Challenges with Treating Mental Illness

Unlike a number of physical injuries or bacterial infections, there is not a "one size fits all" medication or treatment regime for mental illness. The ambiguity of mental illness is likely to be partially responsible for the general public ignorance towards the issue. Beyond public ignorance, even individuals with a mental illness are often left with feelings of confusion and uncertainty, as was the case for a number of participants in this study.

> Anne: Well, let's see, this is my morning medication and that is six pills in the morning. Six pills every morning for 365 days and then three pills in the afternoon in the same day and three pills at night in the same day. That's a lot of medication you're putting into your body, and sometimes people don't even know what these meds are doing and with mental illness that's scary.

Many of the participants in this study consistently identified a core source of this vagueness to be the lack of communication between patients and professionals. Throughout the interviews, the participants consistently made comments that indicated their desire to be a collaborative part of the treatment process. For example, individuals often expressed frustration or disappointment when professionals who prescribed them medications did not explain why that particular medication was selected over others or what potential side effects those medications could generate.

Anne: I think when you're talking to your doctor, considering what meds you should be on, I think a patient should have plenty of options. I often get told, "Well, we should try this because the last thing didn't work for you so this might work for you…"

PI: So, what would you want the healthcare provider to do?

Anne: Maybe go over options. Like, when I got put on Cymbalta, I would like to have been told what Lyrica could do. Well, what if it doesn't do that? I don't know. It would (be) nice to not be prescribed a pill that makes you sick.

Discussions such as these pertaining to issues individuals experienced with medication were common, as exploring life while being prescribed a medication for mental illness was a core trajectory of the initial study. The side effects experienced by some participants while taking medications hindered their adherence. For others, the fear of waiting extended periods of time to find a medication regiment that successfully treats the symptoms of mental illness proved to be equally challenging.

Ethan: I think about the meds for a lot of people. The first two or three meds don't work. I thank God that the ones that I tried the first time worked because waiting the two weeks alone is tough to work, but if you had to wait two to three months would be bad.

Overall, the message from the participants was quite clear. The individualized processes of diagnosing and treating mental illness are diverse, unpredictable, and very challenging to deal with. Their primary voice within this study was one that wanted to be informed. Existing in the potentially debilitating, often stigmatized, and largely ambiguous realm of mental illness, the individuals in this study strongly emphasized their desire to develop not only their own knowledge and understanding of the complexities of mental illness, but also to promote this awareness to others.

It should be addressed that the clearly emerged themes that developed as a result of the research process strongly support the capability of photovoice methodology to extract rich data

from its participants. This finding speaks directly to the first research question of this study. The detailed qualitative data that manifested as a result of the initial study indicate that photovoice is indeed an efficient methodology in terms of extracting knowledge generated from the actual experiences of individuals who have or have had a mental illness. More specifically, this study gave a voice to a number of individuals who felt isolated in a socially deviated and institutionally operated realm of mental health. Participatory action research – particularly, photovoice – is further unique in its ability to give its participants a sense of agency in their own lives, validating their knowledge and personal experience as significant and beneficial to the discursive expansion of the topic being explored.

Although the findings presented above are significant in contributing to the enigmatic social sphere of mental illness, they only partially address the research questions at hand within this study. In the following section, I will shift my focus towards answering the final research question as I examine the impact the genders of the participants in this study played.

Stage Three

The findings presented in this section will address the role that participants' gender played in terms of evaluating photovoice's ability to extract rich data. The findings of Stage Three will further address the manners in which gender appeared to affect the data provided by participants in the initial study.

Impact of Gender on Data Quality

Findings of previous research report that men may be less likely than women to seek professional help for mental illnesses (Addis and Mahalik, 2003 and Kilmartin, 2010). Although the sample size of participants in the initial study who advanced beyond the first stage was relatively small (n=20) such findings were consistent with this research, wherein only three of

the 20 participants were male. This low representation of male participants may be partially explained by Connell (1987) and Messerschmidt's (2005) theory of hegemonic masculinity, in which the epitome of the masculine man is one who is viewed as superior to subordinate masculinities and femininities. Application of hegemonic masculinity would likely propose that men who strive to attain such dominant status in society would be hesitant to expose vulnerability, especially within the sensitive domain of mental health. One male participant spoke directly towards this, explaining how his gender socialization process led him to understand that his diagnosis of a mental illness was a sign of weakness or contradicted his upbringing as a man:

> Joey: I guess, one thing that is hard (to) admit that you should go in for something like this. Especially in this part of the country, at least that is how I felt and how I was raised was that you should be self-sufficient.

Despite these predisposed gender obstacles, the men who chose to participate in the initial study appeared to disclose any information that was relevant in terms of explaining the motivations for taking the photographs they did as part of the study. In fact, one of the male participants shared some of the most intimate data in the entire study when discussing how his family serves as motivation for treating his mental illness.

> Ethan: When I see them they keep me from doing that.
>
> PI: What is that?
>
> Ethan: Ending my life. She (his wife) keeps me on my meds. The little guy (his son), especially because he is such a sweet heart. It is my way of staying alive. I hope if other people who are thinking of ending their life, would think about who it will effect, who they are leaving behind.

Although statements of similar emotional power were common among a number of the participants, the fact that they did not transpire in isolation among female participants suggests that photovoice is an effective tool in terms of extracting rich, detailed data from all participants,

despite their gender. Butler's theory of performativity may be leveraged to help explain this phenomenon. It is possible that, within the domain of this photovoice study, male participants did not feel the social pressures to perform in accordance with their gender expectations. Perhaps, in the temporary, confidential vacuum created by the study, male participants were able to disregard the socially imposed and discursively reiterated institutional and informal practices that exist in everyday life. It is further probable that the professional treatment the men in this study had previously received enabled them to address and deal with their emotions in ways that mentally ill men who have not received such treatment may not be able to do.

These findings speak largely to the third research question in this study pertaining to the impact of gender when evaluating the efficacy of photovoice. For the reasons described above, as it is indicated by the richness of information disclosed by the male participants in this study, gender does not seem to affect the quality of data that is gathered in photovoice research. However, based upon the low number of male representatives in the initial study, it is likely that gender may play a significant role in terms of willingness to participate in a photovoice study discussing mental illness or some other stigmatized domain. Having now assessed the impact of gender on the quality of data in photovoice studies, I will explicate some of the intricacies that were observed between male and female participants within the current study to better establish the role gender plays in this research.

Data Variances by Gender

Although gender did not appear to be a substantial factor in terms of the depth of information attained, male and female participants did demonstrate some variances in terms of the data they provided. One such difference was the way in which male and female participants identified the cause or catalyst of their mental illness. While the majority of female participants

identified people and relationships to be the facilitator of their mental illnesses, the male participants more strongly identified institutions as the causal factor. This distinction became particularly fascinating upon further analysis as the self-identified causes of mental illness that were directly provided by the male participants appeared to have other unrecognized sources:

> Ethan: I have had four episodes of major depression and all of them have been related to jobs. The first was when I lost my first job and my wife was pregnant and I got really worried and anxious about house, bills, baby. Second, for six years, I worked with a man that reminded me of my dad and every day I went into his office and shook his hand, and one day I got mad at him and didn't shake his hands. That day, he had a heart attack and died. I felt guilty and bad and went into depression. Third was on Zolaf for ten, fifteen years, and my mind was playing a lot of tricks on me and kept thinking that I was going to get fired and the boss had a closed door meeting and I thought I was going to get fired; sent me into a tailspin.

Although the male participant was clear to explain how each of his major episodes of depression was, in some way, tied to a work-related incident, the participant did not acknowledge the strife occurring within the interpersonal relationships that also existed in each of the occurrences. For example, the participant mentioned the anxiety he experienced as a result of the pressure he felt to provide for his wife and unborn child. The participant also felt the need to describe the guilt he felt when his boss, whom he identified as a father figure, passed away.

While male participants were more prone to – whether consciously or subconsciously – identify structural or institutional factors as the source of their mental illness, female participants were more likely to directly acknowledge the issues within their personal relationships with others as a core cause of their mental illness.

> Claire: My daughter, which is another stressor. I wish I could go back to a few years ago when she was doing her dance and everything was perfect, and we were like best friends. Because she is now 17, and so much has to do with my husband. Since he has been gone for about six years, I've been the one to discipline...
>
> PI: What kind of stress with your daughter?

Claire: She is siding with my husband and not really speaking with me. It is what put me in PHP, what got me taking medication.

Another gender difference among the individuals in the study was the manner in which they viewed mental illness. While female participants were more likely to focus on how life can be better in the future, male participants were prone towards belittling themselves in the present for having a mental illness:

Ethan: When I'm feeling down I don't want people to see me because depression is sign of weakness. I don't want people to see me weak. I don't (want) people to cheer me up.

Here, again, we are reminded of just how deeply the "tough it out" concept of hegemonic masculinity is engraved into male culture. The isolation desired by this participant was matched by another male in the current study. Whereas the above statement was made in referral towards informal social relations, this individual discussed his reasoning as to why he did not want to seek formal means of support:

Fred: I just didn't want to go and group therapy. But to have a support who knew what I was going through was very good. I think that is something that should be encouraged is to see others are experiencing. It is nice to unload on someone. But you feel guilty after going on and on complaining with your counselor.

This particular piece of data was highly fascinating to me. The participant, here, is able to recognize the benefits of seeking social support, referring to it as "very good" and "nice" in his interview. However, he is quick to counteract his accolades of the practice by acknowledging the guilt he experienced giving into such forms of treatment. I interpreted this conflicting dialogue to be representative of the power gender holds over this particular individual. This analysis brings me back to the significance of Butler's gender performativity and Connell's hegemonic masculinity within this study.

In the middle of his statement, this participant seemed to be challenging preconceived gender norms in expressing his opinion that group therapy should be encouraged to everyone. In this moment, the participant provides an example as to how gender is discursively produced and reproduced within the shared experiences of individuals. While admitting that, as a man, he benefited from the organization of group therapy, the participant engaged in the performative act of establishing his gender within the context of this situation.

However, after admitting to the benefits of relinquishing personal feelings and information to others, he is quick to criticize the reality he has just exposed. For whatever reason, some formal or informal power reminded him at that moment that confessing to being dependent on others for his well-being did not adhere with the masculine code he had been socialized into. As a result, he is quick to belittle the statement he previously made, perhaps in attempt to mitigate the perceived significance of that statement to others in order to reestablish his presence as a self-sufficient, masculine being.

In some ways, these self-checking occurrences that manifested throughout the interviews of male participants may be viewed as a gender deficiency within this methodology. However, such a claim may be disregarded considering that female participants also engaged in similar self-regulated speech. Therefore, rather than labeling this phenomenon as a gender-related issue, I would argue that extracting clearer understanding of participants' inconsistencies in opinion falls on the responsibility of the interviewers within the study to inquire further clarification when such discrepancies occur.

CHAPTER FIVE: DISCUSSION AND CONCLUSION

In this, the concluding section, I will speak towards the overall outcomes of this study. Furthermore, I will expand on my reflexivity throughout and at the end of this research process. This will include my recommendations for future research within the areas I have explored. Finally, I will address the limitations my current research encountered and reflect on how those limitations could have affected my findings.

Reflexivity and Future Research

In summary and in regard to the research questions of this study, photovoice methodology was a very efficient method in terms of extracting information from individuals who have or had a mental illness. The participants examined in this study provided detailed – and oftentimes personal – accounts when describing the photographs they took as a part of the initial study. I would speculate with some certainty that had the participants in this study simply been interviewed without having taking the photographs, the information obtained by the initial researchers in this study would not be as rich, descriptive, and powerful as it ended up being.

My justification for this claim lies within the prescription of photovoice to give the participants a large degree of autonomy in terms of initiating discussion in the areas their photographs relate to. In typical formal interview experiences, participants may hold little power in the direction or content of the interview. However, in photovoice, the participants are allocated a certain degree of power in that they get to decide what images they want to capture with their cameras.

Furthermore, these photographs provided by the participants largely distinguish photovoice from other forms of qualitative research. The photographs were significant in terms of data collection for the initial study in that they largely served as visual entryways into the

lived experiences of the participants. For example, consider the following image, Figure 6, and its corresponding description.

> Fred: What I see this week is not going to be like what is going to be. Most people cross off the dates on that day and as they go, but I would cross off dates in the future, because I planned to not be there. Again I always felt like I was living the last days of my life. Depression is every day, and if you think about it like that, then it is bizarre to see the days or weeks in the calendar that are not crossed off.

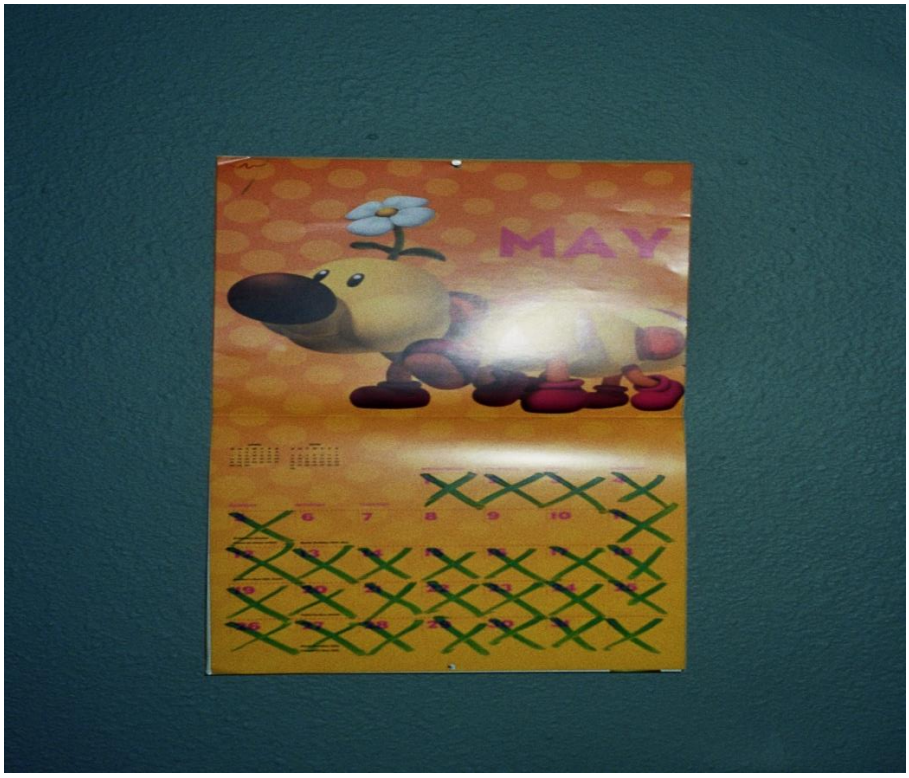

Figure 6. Photograph C3-6.1.

This photograph and the meaning behind it exemplify how powerful the combination of narrative and imagery can be in terms of attaining rich qualitative data. The photographs seemed to consistently serve as visual reminders to the participants, accessing deeply-rooted emotions and personal knowledge that have developed throughout their lived experiences with mental

illness. As a researcher, it would be difficult to access these personal sentiments while still taking into consideration the participants' rights and well-being. For example, it could be considered unethical for a researcher to bluntly ask a participant to discuss his or her suicidal thoughts. Furthermore, as my reflection of photograph C3-6.1 provided in Table 1 indicates, an exterior analysis of this image without also having access to the interior knowledge behind it proved to be largely inconsistent and unbeneficial for the purposes of this study. Photovoice, however, puts the ball in the participant's court. The participants get to decide what they are willing to disclose by choosing the images they wish to photograph. They then have the opportunity to invite the researchers into their experiences through the mutually shared images.

This perception of mine would not have been formulated had I not taken the time to continuously reflect on my own observations throughout the research process. Nearing the end of this research process, I can conclude that the reflexivity I engaged in while conducting this research was invaluable. The constant questioning I posed enabled me to connect what was displayed in the data I analyzed to preconceived theories of gender. Although these theoretical connections were significant in justifying my findings, I also found the questions I could not immediately answer equally appreciated as they illuminate topics worth exploration for future research projects.

One such area for investigation is that of male help-seeking behaviors in this particular geographic region. As noted earlier, only three of 20 participants who took photographs in the initial study were men. This disproportionately low number coupled with the research elucidating male help-seeking behaviors leads me to believe that a number of mentally ill men in this area are not receiving professional treatment. This claim can be further supported by the graph displayed in Appendix E, which shows that, over the past 20 years, women living in North

Dakota have been approximately 50 percent more likely than men to self-report experiencing 14 or more mentally unhealthy days per month (North Dakota Compass, 2013). Although the male participants in the current study touched on a number of factors that could begin to explain why men may be less likely than women to explore the possibility of having a mental illness, a thorough inquiry relating solely to this topic would be a beneficial to the discourse on masculinity and mental health.

The omniscience of this perspective regarding un-masculine nature of identifying as mentally ill leads me to believe that the answer to why this perception is so widely held lies within social structures. To identify these structures, I would suggest an implementation of Dorothy Smith's institutional ethnography (2005) to investigate the standpoint of mentally-ill men living in the Midwest. Such a research endeavor would strive to understand the institutional powers that influenced those men to either seek treatment or live in the shadows. Findings to a study of this nature could possibly be able to identify particular ruling relations that deter men from receiving potentially life-saving treatment for mental health issues. Knowing specifically what structures are responsible for maintaining this ideology of mental illness could result in policy change and restructuration to see that more men in this area feel comfortable to seek the help they require.

In further reflection regarding the findings of this study, I am confident in stating that photovoice is an effective methodology regardless of the gender of the participants. My initial concern upon building this study was that, since photovoice was created by women to be used for women, its methods may not translate as effectively to male populations. However, as indicated in the findings above, male participants in this study were just as expressive as female participants in terms of unveiling high-quality data. Despite this finding, it is still a reality that

the majority of photovoice studies that are conducted in contemporary research investigate predominantly female populations (Catalani and Minkler, 2009). This may be because photovoice was designed to provide a voice to marginalized populations, and women have historically experienced marginalization in much larger frequencies than men.

That said, upon completing this research, I am confident that photovoice is an excellent tool for exploring male populations. The hands-on, active nature of photovoice would likely appeal to male populations, and may even provide an incentive to participate in a study that many would otherwise disregard. Furthermore, the partial relinquishment of control to the participants to mediate the discussion based upon the photographs they take may also largely serve as a magnet to men who have been socialized into the masculine mindset of being in control.

Limitations

Despite the desirability of the findings generated in this study, there are a number of limitations that must be addressed. First, the low sample size of eight in this study makes it challenging to determine if these findings are generalizable to larger populations. Furthermore, the majority of discussion pertained specifically towards the male participants in this study, of which there were only three. It is further relevant to address that the three male participants in examined in this study were the only three male participants in the entire initial research project up to this point to complete the photograph-taking stage. Such a reality may suggest that the three men I examined in my study represent a very specific male perspective in that they were the only male participants that had the drive and determination to complete that stage in the study.

This phenomenon may have largely skewed my findings. For example, had other males in the study not dropped out, it is possible that the quality of their interviews would not match that of the three participants I examined. Experiencing such a disparity would likely have altered my findings in regard to the assessment of photovoice based on the gender of participants. I think such a reality would have been likely, as the five female interviews I examined displayed greater variance in quality. Therefore, to further stabilize the findings presented in this research, a follow-up study extending the number of both male and female participants would be advantageous.

Despite this potential limitation, the information derived from the eight participants examined in this study proved to be enough to extract solid, saturated themes in the coding process. It is not my intention to discredit the results presented in the previous section. Rather, I am making the recommendation that further research be conducted to continue the discourse and theoretical development on mental health and gender, particular exploring the intersection of mental illness and masculinity.

Another limitation to the study at hand was the inability to seek clarification on topics discussed by the participants. In completing a secondary analysis, I was not present at any of the interviews in which the transcripts I analyzed for this study were generated. In turn, there arose a number of occasions when reading the transcripts that I sought further explanation from a participant that I was unable to receive. As a result, when faced with such instances, I had to decipher the data to the best of my abilities, not knowing if I truly grasped the intentions of the participant.

On a similar note, since I was not present at the actual interviews, I missed a significant portion of unspoken data. For example, I was not able to observe the participants' body language

while they explained there photographs or take note of the tone or speed of their voice. Although this nonverbal data may seem insignificant, it would have been beneficial when interpreting passages where I was uncertain of the participants' intent.

That said, not attending the interviews was conscious choice, as I did not want to know the genders of the participants in my study until after I completed the coding process. Although the actual genders of the participants were not revealed to me until I had finished coding the interviews, I felt as though I was able to predict the genders of most of the participants based on their use of language. For example, some participants spoke of husbands or wives. Considering the predominantly heteronormative nature of the geographic area in which the study was conducted, I was relatively certain of the gender of those participants.

Furthermore, adopting Lorber's concept of constantly doing gender (1994), I was not able to turn off my gender lens when viewing the photographs and reading the prose provided by the participants. Whether or not I knew the participants' genders for sure, I would be naïve to claim that the assumptions I had made in my head as to what I thought their genders were had no effect on my coding process. Consequently, it is likely that I applied – or in some instances, intentionally challenged – stereotypical feminine and masculine descriptions when applying codes to the data I analyzed so they would provide clearer findings.

Conclusion

The findings of this research largely support the efficacy of photovoice methodology to extract high-quality, rich data from marginalized populations. This claim is bolstered by the development of three substantial themes that arose during this secondary analysis which emulate the perspectives of individuals with a mental illness who have been prescribed medication. Furthermore, the findings of this research also propound that the quality of data generated from

photovoice is not dependent on the gender of the participants being examined. This finding was driven by the detailed, personal data that was provided by both male and female participants in this study. The perspectives of the male participants in this study were consistent with the findings of previous research in that men living with mental illness experience personal obstacles in justifying help-seeking (Kessler et al, 1981, Kilmartin, 2010 and Mayo Clinic, 2010). These findings provided potential grounds for future research to better understand what institutional practices and structures are preventing such treatment opportunities from being sought by the male population.

Finally, this study also found that collaboration among the participants, their photographs, and the researchers is crucial to the success of photovoice as a qualitative research method. The photographs taken by the participants within a photovoice study serve as access points for the researchers into the lived experiences and knowledge of the populations being studied. However, the participants' description and intent behind the images captured are essential for the researchers to ascertain the meanings of the photographs themselves. It appears as though having the researcher reflect upon the photographs without also hearing from the participants who took them holds little value in photovoice research, except that doing so may better enable the researcher to understand just how important the triangulation among researchers, participants, and photos truly is in this methodology.

Although it may have been made by women with the intent for it to be used by women, photovoice is, by no means, solely beneficial to one sex. This research has demonstrated that, despite the sex or gender of the participants, photovoice serves as an excellent tool for providing a voice to marginalized populations. The continued implementation and development of this methodology would be an unequivocal asset to the social sciences.

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APPENDIX A: IRB APPROVAL OF PROTOCOL

NDSU NORTH DAKOTA STATE UNIVERSITY

Institutional Review Board
Office of the Vice President for Research, Creative Activities and Technology Transfer
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Federalwide Assurance #FWA00002439

September 27, 2011

Amy Werremeyer
Department of Pharmacy Practice
Sudro Hall

IRB Approval of Protocol **#PH12049**, **"The Use of Photovoice to Qualitatively Assess Medication Experience in the Lives of Mental Health Patients"**
Co-investigator(s) and research team: **Elizabeth Skoy and Gina Aalgaard Kelly**

Approval period: 9/26/2011 to 9/25/2012 **Continuing Review Report Due: 8/1/2012**

Research site(s): **Sanford Health** Funding agency: **n/a**
Review Type: ☒ Expedited category # 7 ☐ Full Board
IRB approval is based on original submission (received 9/16/2011).

Additional approval is required:

- prior to implementation of any proposed changes to the protocol (*Protocol Amendment Request Form*).
- for continuation of the project beyond the approval period (*Continuing Review/Completion Report Form).* A reminder is typically sent two months prior to the expiration date; timely submission of the report is your responsibility. To avoid a lapse in approval, suspension of recruitment, and/or data collection, a report must be received, and the protocol reviewed and approved prior to the expiration date.

A report is required for:

- any research-related injuries, adverse events, or other unanticipated problems involving risks to participants or others within 72 hours of known occurrence (*Report of Unanticipated Problem or Serious Adverse Event Form*).
- any significant new findings that may affect risks to participants.
- closure of the project (*Continuing Review/Completion Report Form*).

Research records are subject to random or directed audits at any time to verify compliance with IRB regulations and NDSU policies.

Thank you for cooperating with NDSU IRB procedures, and best wishes for a successful study.

Sincerely,
Kristy Shirley
Kristy Shirley, CIP
Research Compliance Administrator

Last printed 9/27/2011 12:24:00 PM

APPENDIX B: SHOWED TECHNIQUE

SHOWED

Name of Photographer _____

Title of Picture _____ Date_____

S	"What is Seen here?" (Describe what the eye sees)
H	"What is really Happening?" (The unseen "story" behind the image)
O	"How does this relate to Our lives?" (Or MY life personally)
W	"Why are things this way?"
E	"How could this image Educate people?"
D	"What can I Do about it?" (What WILL I or WE do about it?)

APPENDIX C: PARTICIPANT DEMOGRAPHIC TABLE

Pseudonym & Participant Number	Age	Gender	Ethnicity	Education	Annual Income (in thousands)	Marital Status
Anne: C1-1	19	Female	White	Some College	<10,000	N/A
Betty: C1-2	33	Female	White	College Degree	<10,000	Never Married
Claire: C1-3	47	Female	N/A	College Degree	>150,000	Separated
Ethan: C1-5	48	Male	White	College Degree	30,000-39,000	Married
Joey: C2-10	26	Male	White	College Degree	20,000-29,000	Never Married
Linda: C2-12	55	Female	White	Some College	<10,000	Divorced
Fred: C3-6	22	Male	White	Some College	10,000-19,000	Never married
Gloria: C3-7	55	Female	White	College Degree	10,000-19,000	Never Married

APPENDIX D: ITEMS ON THE BEM SEX ROLE INVENTORY

ITEMS ON THE MASCULINITY, FEMININITY, AND SOCIAL DESIRABILITY SCALES OF THE BSRI

Masculine items	Feminine items	Neutral items
49. Acts as a leader	11. Affectionate	51. Adaptable
46. Aggressive	5. Cheerful	36. Conceited
58. Ambitious	50. Childlike	9. Conscientious
22. Analytical	32. Compassionate	60. Conventional
13. Assertive	53. Does not use harsh language	45. Friendly
10. Athletic	35. Eager to soothe hurt feelings	15. Happy
55. Competitive	20. Feminine	3. Helpful
4. Defends own beliefs	14. Flatterable	48. Inefficient
37. Dominant	59. Gentle	24. Jealous
19. Forceful	47. Gullible	39. Likable
25. Has leadership abilities	56. Loves children	6. Moody
7. Independent	17. Loyal	21. Reliable
52. Individualistic	26. Sensitive to the needs of others	30. Secretive
31. Makes decisions easily	8. Shy	33. Sincere
40. Masculine	38. Soft spoken	42. Solemn
1. Self-reliant	23. Sympathetic	57. Tactful
34. Self-sufficient	44. Tender	12. Theatrical
16. Strong personality	29. Understanding	27. Truthful
43. Willing to take a stand	41. Warm	18. Unpredictable
28. Willing to take risks	2. Yielding	54. Unsystematim

Note. The number preceding each item reflects the position of each adjective as it actually appears on the Inventory.

APPENDIX E: SELF-REPORTED MENTAL HEALTH ASSESSMENT BY GENDER IN NORTH DAKOTA