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Place and recovery from alcohol dependence: A journey through photovoice

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ABSTRACT

It has been suggested that place, and interaction with the environment, may play a role in recovery from alcohol dependence. In this paper we report findings from a project that used an adapted photovoice methodology to better understand individuals' experience and perceptions of the role of place in recovery from alcohol dependence. Individuals attending a recovery café in central Scotland documented their environment and, in focus group settings, the individuals discussed and analysed their photographs. Here we report aspects of the environment, both therapeutic and risky, experienced by individuals negotiating the journey of dependence recovery. Elements of the natural environment were largely referred to as supportive and therapeutic, as were other more quotidian spaces, such as the home and café. The largest place-based risk faced by participants was the persistent availability and marketing of alcohol. The results demonstrate that the journey of recovery from alcohol dependence is contextually shaped, with place both supporting and hindering this journey.

1. Background

The role that place plays in recovery from alcohol dependence may be both risky and therapeutic. Places can be restorative in that they can moderate the negative effects of dependence, facilitate social reconnection and minimise exposure to risk. At the same time places can also be risky, can trigger relapse and be barriers to effective change. Those who negotiate the journey of recovery move through everyday spaces that may both challenge their recovery and support it. Despite this, within the geographies of alcohol and drinking few have explored the role that the environment may play in dependence recovery and the lived experience of place, both positive and negative. In this paper we use an adapted photovoice methodology to better understand individuals' experience and perceptions of the role of place in recovery.

The role of place has been a focus in the broader exploration of the geographies of alcohol consumption; ranging from more social and cultural understandings of alcohol consumption and gender (Nayak, 2003), identity (Peace, 2002) and ethnicity (Cochrane and Bal, 1990), to that exploring the association between alcohol outlet density and health related harm (Richardson et al., 2015), consumption (Author, under review reference removed for reviewing) and crime (Livingston, 2008). Further research has explored cross-national drinking habits (Smart and Ogborne, 2000) and the night-time economy has served as a focus for research exploring youth transitions (Engineer et al., 2003), consumer culture (Hollands, 2002) and alcohol fuelled violence (Hobbs et al., 2005). Wilton and DeVerteuil have suggested that although there has been much focus on spatial variations in alcohol consumption and related harm *'similar attention has not been given to geographies of alcohol treatment and recovery'* (Wilton and DeVerteuil, 2006, p.649), despite the clear public health burden it places on society and dependent individuals.

It has been estimated that globally, in 2010, alcohol dependence and the harmful use of alcohol affected an estimated 7.2% of men and 1.3% of all women (WHO, 2014). Alcohol dependence, often referred to as alcoholism, has been defined as "*a cluster of behavioural, cognitive, and physiological phenomena that develop after repeated alcohol use and that typically include a strong desire to consume alcohol, difficulties in controlling its use, persisting in its use despite harmful consequences, a higher priority given to alcohol use than to other activities and obligations, increased tolerance, and sometimes a physiological withdrawal state*" (WHO, 1992). Up until the late 1970s the narrower, medical term alcoholism was used, referring to a disease, or sickness believed to be caused by a pre-existing biological abnormality. In 1979 a WHO expert group replaced the term, instead referring to alcohol dependence syndrome as one problem within a wide range of alcohol related problems arising from heritable, genetic and environmental risk factors (Crabbe, 2002).

There are many different approaches to recovery from alcohol dependence, ranging from mutual aid groups, such as Alcoholics Anonymous (AA), to peer based recovery groups, such as recovery cafes, through to professional addiction treatment centres, including residential rehabilitation. What these approaches have in common is

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the aim to maximise 'recovery capital', referring to the resources needed to both initiate and sustain recovery, including social, physical, human and cultural (Cloud and Granfield, 2001). Whilst research has explored each of these four components of recovery, few have recognised that recovery is 'contextually shaped' (Best et al., 2015). The notion of treatment ecology however supports an exploration of the 'physical' environment, specifically Davis and Tunks' taxonomy of environmental effects on drug use and relapse, that emphasises the importance of various settings including living place and neighbourhood (Davis and Tunks, 1991). Jacobson (2004) argues that such places bear directly or indirectly on progress during and after treatment. Indeed Wilkinson et al. (2008) note that addiction treatment centres, particularly residential centres, do not fully address '*what happens before and after residential rehabilitation*' (p.404) with the solution lying *'not merely in pharmacotherapy and counselling but in engagement with the lived community'* (Best et al., 2015, p.200).

The idea that place shapes health outcomes is embedded within the geographies of health where place and space are viewed in relational terms (Cummins et al., 2007). Such a concept recognises that individuals are embedded in multiple health damaging and health-promoting environments *at the same time* and recognises the mutually reinforcing and reciprocal relationship between people and place. Places may therefore be made and remade and for those on the journey of recovery the connection with place can evolve. The role of place in recovery has been conceptualised using the frameworks of therapeutic environments (Gesler, 2005) and landscapes of risk (Heslin et al., 2013). Each acknowledging the role of the everyday built, natural, social and cultural environments.

In his seminal paper on therapeutic landscapes Gesler referred to the role of place in recovery from alcohol dependence stating that *'most alcoholics have low self-esteem, in part because they feel no identity with particular places. Often places represent failure, threats, or feelings of not being wanted. Therapy for alcoholics might usefully include establishment of refuges, places with positive images, where identity could be established'* (Gesler, 1992, p.738). Geographical research on therapeutic landscapes has evolved since Gesler's (1992) paper called for a cultural turn, and an expanded meaning of the concept of landscape in the then termed 'medical geography'. Gesler called on geographers to '*explore why certain places or situations are perceived to be therapeutic*' (p.735). The earliest explorations of therapeutic landscapes were restricted to traditional healing sites, for example Gesler's focus on sites such as the Marian Shrine at Lourdes, France (Gesler, 1996) and the Roman Baths at Bath, England (Gesler, 1998). The focus has since shifted away from these traditional sites of religiosity, healing and spiritual renewal to more natural landscapes and health promoting sites, such as forestry (Park et al., 2010) community gardens (Milligan et al., 2004), health care institutions (Kearns and Barnett, 2000) and respite centre (Conradson, 2005). Such sites of exploration however highlight the need for '*temporary movement away from an everyday, domestic location*' (Conradson, 2005, p. 341). Whilst the sites of therapeutic landscapes have evolved, Duff has continued to argue that the focus has remained on 'favourite' places, such as natural landscapes, meaning that 'quotidian' places, or everyday 'third' places, such as cafes and streets or even the home have been sidelined (Duff, 2011). Such critiques have extended the breadth of the therapeutic landscapes framework to one that now acknowledges that *'healing can take place in everyday, ordinary places, whether a residential backyard, a hospital room, or an imagined landscape'* (Williams, 2007, p.2).

Whilst risk is a fundamental feature of everyday life (Beck, 1992), within the literature of therapeutic landscapes it is rarely acknowledged (Williams, 2007). Therapeutic landscapes are seen as natural and, for many, risk free. At the same time risk environments are generally associated with built environments that are viewed as more dangerous and hostile. A relational view of place however would recognise a more complex framing, Duff (2011) suggests that therapeutic landscapes, particularly enabling places, are made rather than merely discovered and as such what may be risky for one may be therapeutic for another. Viewing place as relational enables us to recognise the influence of *'the physical environment, the human mind and material circumstances'* (Milligan and Bingley, 2007, p.800) and the interactions that occur between each. The frameworks of risk environments and therapeutic landscapes are therefore '*two sides of the same coin*' (Duff, 2009, p.203) with place comprising elements that can be both risky and more supportive of health. Furthermore, our connections with place can change through time. During recovery from drug or alcohol dependence, individuals can connect with the environment in ways that are different from when they were substance dependent, reflecting a temporal shift in the meaning of place.

Research exploring the role of risk and place in recovery has included close proximity to liquor and/or beer stores and reduced likelihood of attending outpatient treatment (Stahler et al., 2007), neighbourhood level disadvantage and increased drug activity during recovery (Jacobson, 2006) and auditory or visual stimuli and relapse (Rohsenow et al., 2001). In a review of relapse models Tucker et al. found that 'environmental triggers' are common in accounts of relapse, bound up in what he refers to as 'daily hassles' (Tucker et al., 1991). Such triggers may include advertising and marketing of alcohol products that can cue the desire for alcohol and be most problematic for vulnerable groups, such as those in recovery (Hovland, 2015). On the other hand aspects of place can also enable recovery with research emphasising the role of material resources, AA meeting locations and treatment attendance (Friedmann et al., 2001; Stahler et al., 2007), the presence of alternative activities (Cloud and Granfield, 2001), social capital and supportive communities (Whiteford et al., 2016). Focussing on three treatment programmes in Winnipeg, Canada, DeVerteuil et al. (2007) examined the impact of differential neighbourhood settings on the therapeutic potential of the programmes. They conclude that both social and built environments matter with environmental risks presented including ready access to drugs and alcohol and the strong links between social network and former spaces of drug and alcohol consumption. The public health literature on harm reduction and/or treatment has explored certain aspects of the environment, but provides little account of the lived experiences of these environments in recovery. DeVerteuil and Wilton (2009) however summarise how recent research, including that in health geography, demonstrates a shift towards a more embodied account of dependence, including explorations of stigma (Rhodes et al., 2007) and gendered experiences (Robertson, 2007), as well as a deeper understanding of place-sensitive experiences.

This paper employs a novel approach to explore the role that the environment plays in recovery for a group of individuals recovering from alcohol dependence. In this project we use photovoice, a participatory research method '*by which people can identify, represent, and enhance their community through a specific photographic technique*' (Wang and Burris, 1997, p.369). The method allows all those involved to be full stakeholders in the research process and enable reflexive discussion and co-produced knowledge. The express purpose of employing this method was empowerment, giving the participants a voice through which they could be '*fully involved in the public health conversation*' (Strack et al., 2004, p.49). Visual methods, such as photovoice, are recognised as being particularly useful for engaging vulnerable groups (Haines-Saah et al., 2013), in this case those recovering from alcohol dependence. The method allowed the participants to document the features of the environment that enable and/or hinder their journey of recovery, to reflect upon these features in a focus group setting and to bring their results to policy makers in the Scottish Parliament and other settings. Haines et al. have argued that there is a particular need for such visual methods in addiction research in order to provide *'compelling findings about the social contexts in which substance use occurs'* (Haines et al., 2010, p.207). Our focus in this article is with a group of individuals attending a 'Recovery Café' in central Scotland. The Café is one of many