

2-23-2019

## “Build a Bridge So You Can Cross It:” A Photo-Elicitation Study of Health and Wellness Among Homeless and Marginally Housed Veterans

Keri L. Rodriguez

*Center for Health Equity Research and Promotion, VA Pittsburgh Healthcare System, Pittsburgh, PA, USA; Division of General Internal Medicine, Department of Medicine, School of Medicine, University of Pittsburgh, PA, USA, keri.rodriguez@va.gov*

Lauren M. Broyles

*Center for Health Equity Research and Promotion, VA Pittsburgh Healthcare System, Pittsburgh, PA, USA, lbroyles@grantcentral.com*

Michael A. Mitchell

*Office of Data Analysis, Research, and Evaluation, Allegheny County Department of Human Services, Pittsburgh, PA, USA; Center for Health Equity Research and Promotion, VA Pittsburgh Healthcare System, Pittsburgh, PA, USA, mitchellm593@gmail.com*

Melissa E. Wieland

*Center for Health Equity Research and Promotion, VA Pittsburgh Healthcare System, Pittsburgh, PA, USA, Follow @melissawieland on Twitter at: <https://nsuworks.nova.edu/tqr>*



*Part of the Primary Care Commons, and the Quantitative, Qualitative, Comparative, and Historical Methods Center (Q3CH) at the South Central (VSN-16) Mental Illness Research, Education and Clinical Center, Southeast Louisiana Veterans Healthcare System, New Orleans, LA, USA; Community and Population Medicine, LSU School of Medicine, New Orleans, LA, USA, Jennifer.True2@va.gov*

### Recommended APA Citation

~~Recommended page for Bradley, M. A., Mitchell, M. A., Wieland, M. E., True, G., & Gordon, A. J. (2019). “Build a Bridge So You Can Cross It:” A Photo-Elicitation Study of Health and Wellness Among Homeless and Marginally Housed Veterans. *The Qualitative Report*, 24(2), 371-394. <https://doi.org/10.46743/2160-3715/2019.3498>~~

---



**THE QUALITATIVE REPORT**  
DISCOVER ONE OF OUR VIRTUAL  
QUALITATIVE RESEARCH WORKSHOPS  
WITH INDUSTRY EXPERTS.

JOIN US ONLINE. LIMITED SPOTS AVAILABLE. BOOK YOURS NOW!

**TQR**  
THE QUALITATIVE REPORT  
WHERE THE WORLD COMES TO LEARN  
QUALITATIVE RESEARCH

## “Build a Bridge So You Can Cross It:” A Photo-Elicitation Study of Health and Wellness Among Homeless and Marginally Housed Veterans

### Abstract

As part of a photo-elicitation interview study, we aimed to describe homeless and marginally housed Veterans’ experiences with health and wellness, health decisions, and health-related behaviors. Twenty Veterans receiving Veterans Affairs Homeless Patient-Aligned Care Team care took photographs depicting health and wellness, then used their photographs to discuss the same topics in 30-60 minute audio-recorded, semi-structured photo-elicitation interviews. Transcripts were analyzed using template analysis. Veterans described eight dimensions related to their health and wellness; physical, social, and environmental were most commonly discussed, followed by emotional, intellectual, spiritual, occupational, and financial wellness. Photographs contained literal and metaphorical depictions that were positively-oriented, comprehensive, and reflective. Of central importance was overcoming external and internal obstacles to wellness. Photo-narratives may be helpful in educating health care providers and advocating for the needs of homeless and marginally housed Veterans. Integrated primary care services should address the multi-faceted aspects of health and wellness for Veterans.

### Keywords

Veterans, Vulnerable Populations, Patient Experience, Primary Health Care, Qualitative Research, Photo-Elicitation

### Creative Commons License



This work is licensed under a [Creative Commons Attribution-Noncommercial-Share Alike 4.0 International License](https://creativecommons.org/licenses/by-nc-sa/4.0/).

### Acknowledgements

This work was supported by a pilot research grant from VISN 4 Mental Illness Research, Education, and Clinical Center, VA Pittsburgh Healthcare System (PIs: Michael A. Mitchell, Lauren M. Broyles). This work was also supported by Department of Veterans Affairs, Health Services Research & Development (HSR&D) Service, locally initiated research funding (PI: Michael A. Mitchell; 72-079). Finally, this work was supported by the Department of Veterans Affairs, Office of Academic Affiliations Advanced Fellowship Program in Addiction Treatment (Michael A. Mitchell), a Career Development Award (CDA 10-014) from the Department of Veterans Affairs, Health Services Research & Development service (Lauren M. Broyles) and with resources and facilities at the VA Pittsburgh Healthcare System, Pittsburgh, PA. The views expressed in this article are those of the authors and do not necessarily reflect the position or policy of the Department of Veterans Affairs or the U.S. Government.

---

**Authors**

Keri L. Rodriguez, Lauren M. Broyles, Michael A. Mitchell, Melissa E. Wieland, Gala True, and Adam J. Gordon

## **“Build a Bridge So You Can Cross It:” A Photo-Elicitation Study of Health and Wellness Among Homeless and Marginally Housed Veterans**

**Keri L. Rodriguez**

Center for Health Equity Research and Promotion, VA  
Pittsburgh Healthcare System, Pittsburgh PA, USA  
Division of General Internal Medicine, Department of Medicine, School of Medicine,  
University of Pittsburgh, PA, USA

**Lauren M. Broyles**

Center for Health Equity Research and Promotion, VA  
Pittsburgh Healthcare System, Pittsburgh, PA, USA

**Michael A. Mitchell**

Office of Data Analysis, Research, and Evaluation, Allegheny County Department of Human  
Services, Pittsburgh PA, USA  
Center for Health Equity Research and Promotion, VA Pittsburgh Healthcare System,  
Pittsburgh PA, USA

**Melissa E. Wieland**

Center for Health Equity Research and Promotion, VA  
Pittsburgh Healthcare System, Pittsburgh, PA, USA

**Gala True**

VA South Central (VISN 16) Mental Illness Research, Education and Clinical Center,  
Southeast Louisiana Veterans Healthcare System, New Orleans, LA, USA  
Community and Population Medicine, LSU School of Medicine, New Orleans, LA, USA

**Adam J. Gordon**

Department of Veterans Affairs Salt Lake City Health Care System, Salt Lake City, UT, USA  
University of Utah School of Medicine, Salt Lake City, UT, USA

---

*As part of a photo-elicitation interview study, we aimed to describe homeless and marginally housed Veterans' experiences with health and wellness, health decisions, and health-related behaviors. Twenty Veterans receiving Veterans Affairs Homeless Patient-Aligned Care Team care took photographs depicting health and wellness, then used their photographs to discuss the same topics in 30-60 minute audio-recorded, semi-structured photo-elicitation interviews. Transcripts were analyzed using template analysis. Veterans described eight dimensions related to their health and wellness; physical, social, and environmental were most commonly discussed, followed by emotional, intellectual, spiritual, occupational, and financial wellness. Photographs contained literal and metaphorical depictions that were positively-oriented, comprehensive, and reflective. Of central importance was overcoming external and internal obstacles to wellness. Photo-narratives may be helpful in educating health care providers and advocating for the needs of homeless and marginally housed Veterans. Integrated primary care services should address*

*the multi-faceted aspects of health and wellness for Veterans. Keywords: Veterans, Vulnerable Populations, Patient Experience, Primary Health Care, Qualitative Research, Photo-Elicitation*

---

In 2010, the Veterans Health Administration (VHA) embarked on a plan to implement patient-centered medical homes (Rosland et al., 2013). As the largest integrated healthcare system in the United States (U.S.), this meant that, in more than 900 primary-care clinics across the nation, the Patient Aligned Care Team (PACT) initiative would focus on enhancing continuity of care, patient access to care, care management and coordination, and patient partnership for primary care patients (Rosland et al., 2013). Also, in response to Veteran homelessness, the U.S. Department of Veterans Affairs (VA) established a homeless-focused primary care initiative starting in 2012 that included the development of an integrated medical home model known as the Homeless Patient-Aligned Care Team (H-PACT), which has now grown to include 60 active H-PACTs nationwide (Gabrielian et al., 2014; U.S. Department of Veterans Affairs, 2013). H-PACT facilities were designed to address homeless Veterans' complex, intersecting needs through the provision of comprehensive, integrated primary care, as well as psychiatric, substance use, housing, and other services (Gabrielian et al., 2014; U.S. Department of Veterans Affairs, 2013).

Evaluations of the H-PACT model have demonstrated the impact on homeless Veterans' healthcare service utilization and other outcomes (O'Toole et al., 2013). However, research into H-PACT patients' health and wellness from their perspective is lacking. To ensure that H-PACT services are designed and delivered in truly patient-centered ways, an understanding of the perspectives of Veterans served in H-PACT is warranted (LaVela & Gallan, 2014). The purpose of this analysis was to describe homeless and marginally housed Veterans' experiences with health and wellness, health decisions, and health-related behaviors. Photo-elicitation, a visual-based research (VBR) method that uses images to guide and enrich in-depth interviews, was deemed most appropriate to prompt H-PACT patients to reflect upon how their views and experiences shaped their perspectives on health and wellness, as well as their treatment-seeking behaviors (Bugos et al., 2014; True, Rigg, & Butler, 2015). VBR methods have been advantageous in gathering data from historically harder to reach groups (e.g., homeless and marginally housed) and improving the quality of qualitative data (Cox & Benson, 2017).

## **Participants and Methods**

### **Setting and Participants**

This analysis is part of a photo-elicitation interview (PEI) study that recruited participants from the H-PACT at the VA Pittsburgh Healthcare System (VAPHS), a 646-bed academic medical center in southwestern Pennsylvania. Homeless individuals were somewhat broadly operationalized as those who lacked fixed housing, as well as those who were at risk of housing loss in the near future (U.S. House, 2009; U.S. Code, 1987). Veterans were eligible for the study if they: (1) had at least one healthcare visit in the H-PACT between March and August 2015; (2) planned to remain in the Pittsburgh area for at least five months; and (3) were able to read and understand English. Veterans were not eligible if they: (1) were unwilling to have their interviews audio-recorded or (2) had sensory impairment that prevented communication with the interviewer.

We aimed to recruit, enroll, and complete the study with 15-20 Veterans based on established minimum standards in qualitative research for theoretical saturation (Creswell,

1998). Potential participants were approached by a clinical staff member prior to their scheduled H-PACT appointments. Those who expressed interest were referred to a research staff member for further information about the study and informed consent procedures. This research study was approved by the Institutional Review Board and the Research and Development Office at VAPHS. Further details on the methods, as well as results from other qualitative analyses (Sestito et al., 2018; Sestito et al., 2017), results from the exit survey (Rodriguez et al., 2018), and lessons from designing and executing this PEI study (Mitchell et al., 2016), can be found in our previously published work.

## Data Collection

During Research Visit 1 (RV-1), participants completed a sociodemographic survey, then participated in a photo-elicitation orientation session and received a digital camera and memory card. Orientation consisted of a brief explanation of the purpose and methods of photo-elicitation research, camera instructions, picture-taking strategies, ethical and safety considerations, instructions for the first photo journaling session focused on their experiences with health and wellness, facilitators and barriers to health, and the role of housing in maintaining their health. Veterans were asked to take photographs to help illustrate and reflect on the following questions: “How do you think about ‘health’?”; “What do you do to stay healthy?”; “What helps and what gets in the way?”; and “How does housing play a role in taking care of your health?” Veterans were asked to take approximately 15 to 20 photographs on these topics over the subsequent 2 weeks.

For Research Visit 2 (RV-2), staff printed all photos taken by the Veteran, who then participated in a 30-60 minute audio-recorded interview. Interviews followed a semi-structured interview guide focused on their experiences with health and wellness, facilitators and barriers to health, and the role of housing in maintaining their health. Afterwards, participants received prompts for Research Visit 3 (RV-3) involving the topics of healthcare quality and access. Veterans were asked to take photographs to help illustrate and reflect on the following questions: “What is good healthcare?”; “What has helped you get to your VA primary care appointments and any other healthcare services?”; “What kind of barriers do you face getting to your VA primary care appointments and any other healthcare services?”; and “What was your life like before and after you started receiving services from primary care?” Veterans were again asked to take approximately 15 to 20 photographs on these topics over the subsequent 2 weeks. For RV-3, staff again printed all photos taken by the Veteran, who then participated in a 30-60 minute audio-recorded interview focused on the topics of healthcare quality and access. At the end of RV-3, participants also completed an exit survey on their attitudes about the study.

The interview guides for RV-2 and RV-3 were initially written by the principal investigator based on a review of relevant literature and finalized based on feedback from the study team and an H-PACT peer support specialist. The interviewers were a PhD medical sociologist, a PhD in public health, and a master’s-trained VA Interdisciplinary Addiction Program for Education and Research (VIPER) fellow. One of the interviewers was also in charge of recruitment for the study. The interviewers had no preexisting relationships with study participants. Interviews were conducted in private rooms in the VAPHS Research Office Building. Only the interviewer and participant were present during the interview, except for one instance in which a participant brought his significant other, who remained silent throughout the interview.

## **Data Analysis**

We used REDCap (Vanderbilt University, Nashville, TN) to manage sociodemographic and health characteristic data (Harris et al., 2009). We transcribed the qualitative data from all 20 RV-2 audio-recorded interviews verbatim using Microsoft Word 2016 (Microsoft Corp., Redmond, WA), which was also used during the coding process. After the codebook was developed and finalized by two team members, both separately coded all 20 RV-2 transcripts (Strauss, 1987). The coders used template analysis, which consists of using both deductive and inductive strategies (King, 1998, 2004). First, Substance Abuse and Mental Health Services Administration's (SAMHSA's) Eight Dimensions of Wellness Model guided the deductive thematic analysis with a-priori categories of health and wellness (Substance Abuse and Mental Health Services Administration, 2015; Swarbrick, 2006). This model is comprised of eight integrated aspects of health, including physical, spiritual, emotional, environmental, social, occupational, intellectual, and financial, which represent overall well-being (Substance Abuse and Mental Health Services Administration, 2015; Swarbrick, 2006). We started the coding with this model because it is congruent with H-PACT's mission to provide comprehensive, individualized care through the integration of medical, substance use, and mental health care, with access to housing and other supportive services (Gabrielian et al., 2014; U.S. Department of Veterans Affairs, 2013). Second, inductive thematic analysis was conducted across and within interview transcripts using the grounded theory approach of constant comparison to identify additional emergent themes within the data (Strauss & Corbin, 1998). Any coding discrepancies were resolved through negotiated consensus between the two coders (Bradley, Curry, & Devers, 2007).

## **Results**

### **Sample Characteristics**

Of the 30 Veterans who provided written consented to participate in the study, 20 completed RV-2 and constituted the analytic sample. Most of the participants were male (95%), African American (60%), single (45%), had at least some college or vocational school education (60%), were staying with friends or family (30%) or lived in rented or owned property (30%) at the time of consent, and self-classified their health status as "fair" (50%) (Table 1). The mean age was 55.2 years, with a standard deviation of 8.70 years. The mean number of months as an H-PACT patient at the time of consent was 16.3, with a standard deviation of 9.53 months. The participants took a total of 355 photographs for RV-2. The mean number of photographs was 18, with a standard deviation of 16 photographs. The largest number of pictures taken by a participant for RV-2 was 75 and the smallest number was 7. The audio-recorded RV-2 interviews included a total of 734 minutes of audio, with a mean length of 36 minutes, 43 seconds and a standard deviation of 11 minutes, 9 seconds. The longest RV-2 interview was one hour, eight minutes, 25 seconds and the shortest was 23 minutes, 30 seconds.

*Table 1. Sociodemographic and Health Characteristics of the 20 Study Participants For Which Data Was Analyzed*

| <b>Characteristic</b>  |              |
|--|--------------|
| <b>Age in years, mean (SD)</b>   | 55.2 (8.70)  |
| <b>Number of Months as an H-PACT Patient at Time of Consent, mean (SD)</b> | 16.3 (9.53)  |
|  | <b>n (%)</b> |
| <b>Sex</b>   |              |
| Male   | 19 (95)      |
| Female   | 1 (5)        |
| <b>Race</b>  |              |
| White  | 7 (35)       |
| African American   | 12 (60)      |
| Native American/Pacific Islander   | 1 (5)        |
| <b>Education</b>   |              |
| Less than high school diploma  | 2 (10)       |
| Graduated from high school or received a high school equivalency degree    | 6 (30)       |
| Some college/vocational-technical school                                   | 10 (50)      |
| Associate's degree   | 2 (10)       |
| <b>Marital Status</b>  |              |
| Single   | 9 (45)       |
| Separated  | 3 (15)       |
| Cohabiting   | 3 (15)       |
| Divorced   | 2 (10)       |
| Married  | 2 (10)       |
| Widowed  | 1 (5)        |
| <b>Housing at Time of Study Consent</b>                                    |              |
| Transitional housing   | 5 (25)       |
| Staying with friends or family   | 6 (30)       |
| Rented/owned property  | 6 (30)       |
| Residential treatment  | 2 (10)       |
| Unsheltered/street   | 1 (5)        |
| <b>Self-Assessed Health Status</b>   |              |
| Excellent  | 0 (0)        |
| Very Good  | 2 (10)       |
| Good   | 8 (40)       |
| Fair   | 10 (50)      |
| Poor   | 0 (0)        |

### **Dimensions of Health and Wellness**

All eight of SAMHSA's dimensions of health and wellness emerged as topics of discussion across the RV-2 interviews, including environmental, physical, emotional, social, spiritual, occupational, financial, and intellectual wellness. The median number of dimensions discussed by participants was 6, with a range of 3 to 8. Most commonly, participants discussed physical (n=20), social (n=19), and environmental (n=19) dimensions. Somewhat less commonly, emotional (n=15), intellectual (n=11), spiritual (n=10), occupational (n=10), and financial (n=8) dimensions were discussed. Consistent with SAMHSA's conceptual model of dimensions of health and wellness (Substance Abuse and Mental Health Services



Administration, 2015), these eight dimensions were not discussed by the participants in a mutually exclusive manner. For example, one person stated that VA care addresses a variety of these dimensions of his health and wellness:

Going through Coatesville [VA facility], I would get out and disregard my health, things like that, and then I kept refocusing on some help I was getting, and it makes you think...it would be nice to take full the plunge and decide to get healthy, mentally, physically, spiritually, socially and also financial. All the benefits that the VA has as a Veteran, utilizing my benefits. So, I been dealing with them, going through the VA system since about 2000.

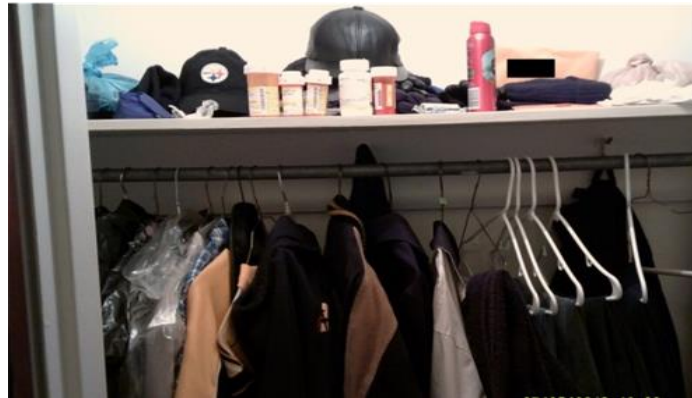
Further iterative analysis of the data showed that overcoming external and internal obstacles to wellness was also of central importance. Homeless and marginally housed Veterans used literal and metaphorical depictions of these themes in their photographs to illustrate health and wellness. Veterans described their health and wellness in positively-oriented, comprehensive, and reflective ways. Further, they relied on multiple sources of support to maintain or restore their health and wellness. Each of the themes—including the eight dimensions of health and wellness, as well as obstacles to wellness—are discussed in greater detail below.

**Physical.** The most common dimension described by the Veteran participants was the physical dimension of health and wellness. The physical dimension involved recognizing the need for things like physical activity, diet, sleep, and nutrition (Substance Abuse and Mental Health Services Administration, 2015). Veterans expressed awareness of nutrition, as well as the importance of avoiding situations that did or did not lend themselves to eating healthy. For one Veteran, cooking chili at home allowed control over the ingredients and connected him to childhood family rituals:

[I am often] cooking at home [with] healthy ingredients in your food...Eating out all the time, it ain't the healthiest thing in the world. I grew up under my grandmother. Basically, she cooked all the time so she made sure there was a homemade meal every night and on Sundays, too. I pretty much got that from her, that home cooking.

Some Veterans focused on the importance of adherence to medication and treatment regimens to maintaining physical health and wellness. Discipline, structure, and routine were important to one Veteran for medication tracking and taking. As one Veteran stated, "I have a plethora of pills that I have to take. Discipline and maintaining a routine on my medications is crucial to my health." Another Veteran strategically placed his medications in his coat closet to remind himself to take them (Figure 1). Also of importance to maintaining physical health and wellness was getting their healthcare through the VA. VA services included but were not limited to primary care, *Center for Treatment of Addictive Disorders (CTAD)*, and the domiciliary program. One Veteran even discussed the physical dimension of health and wellness in relation to his Young Men's Christian Association (YMCA) membership, which allowed him to engage in "exercise and things like that."

*Figure 1. Photograph of and quote about the physical dimension of health and wellness*



Because this is where I keep my pills at. I got a little pill container. But, I never forget not to take my pills because every time I take off my coat.

**Social.** The social dimension of health and wellness involved developing a sense of connection and well-developed support system (Substance Abuse and Mental Health Services Administration, 2015). The importance of positive relationships with family (e.g., significant other, children, grandchildren) and friends (e.g., neighbors) were central to these discussions. Several Veterans talked about the health benefits of having the support and camaraderie of other Veterans. One Veteran suggested that, without this grounding, Veterans' psychosocial health suffers (Figure 2). Echoing this view, another Veteran recovering from decades of heroin addiction recognized the impact of social disconnectedness. His photograph of a television represented the challenge of living sober, and the double-edged sword of self-imposed isolation:

That's just a picture of entertainment...It keeps me sedentary...constantly [watching] TV and videos and movies and television. So that's like an addiction to me, for real. And I consider it bordering on unhealthy because I depend too much upon it to entertain me, to keep my mind and body occupied 24/7.

*Figure 2. Photograph of and quote about the social dimension of health and wellness*



A lot of these soldiers now coming back, they're alcoholics or they're drug addicts. Or both. It's like a domino effect, it's not only just one [soldier], it's several. When it hits one, it hits them like they're in a platoon. For most of the Veterans, if you can get these Veterans together, they'll hang together as long

as they're together. But if you start separating them, putting them out there on their own, they're going to fall like dominos. As if they don't have no support, no help, no one to talk to, no one support them.

In contrast, another Veteran recognized the importance of building a strong social network through 12-step programs:

I'm a part of Alcoholic Anonymous...I don't care how strong you think you are, everyone needs someone, I believe. And these kind of groups do that for you. It's like an external family...After losing everything to the drinking. So, it's reconnecting with people.

One Veteran even explained how renewed public respect for his service represented a new connection to the community and a source of pride in his Veteran identity:

[This VA seal] was very symbolic. That means a lot to me. And I'm a proud American, I fought for my country and when we first came home [from the Vietnam War], we weren't treated very good. Now we are getting a lot of respect that we should have had before...This [photo] represents my pride. And a lot of people have come up to me and now they say, thank you for your service. And it makes me feel really, really good.

**Environmental.** The environmental dimension of health and wellness involved Veterans describing how occupying pleasant, stimulating environments supported their well-being (Substance Abuse and Mental Health Services Administration, 2015). More specifically, these discussions revolved around how macro-environments (e.g., institutions, organizations, or physical structures) and micro-environments (e.g., individual, communal, or familial settings) related to their health and health behaviors.

For macro-environments, Veterans expressed how the structure and stability of various programs, such as VA shelter services, facilitated their health and wellness:

It's a homeless Veteran type of thing [and] people that have addictions. And what this facility does is...gives you some place to stay, a place to eat, a place to go to sleep at night. You're not out on the streets...and it has implementations of teaching you about your addiction...And it also has opportunities, it helps you to get yourself back into society, helping you find a job. They make sure that you take care of your health there, 'cause it is affiliated with the VA.

Veterans also expressed how their physical housing environments impacted their mental and emotional outlooks. One Veteran explained how living in an environment of dilapidated housing had a negative effect on his well-being (Figure 3). Others also noted the negative effects of being in group environments, such as jail.

*Figure 3. Photograph of and quote about the environmental dimension of health and wellness*



When I look out my window, this is what I see. That'll keep me, that there—it's depressing. You depressed, you don't want to move... So, that'll keep you from not—that environment will keep you stagnant.

Veterans also described micro-environments within new housing or shelters that impacted their health and wellness. For example, one person said he “was staying down in the basement” and it was “eerie.” Several Veterans in transitional housing recognized that keeping their living quarters neat and clean both reflected and had a positive impact on their health and well-being. For example, one Veteran in recovery from a substance use disorder discussed companion photos he took of a made and unmade bed. For him, making his bed was symbolic of health and contributed to a positive self-perception:

To stay healthy means I can get up and I can make my bed up...and feel good about myself and say now that's the way I should live. Not in a bed that's all tore up and have my life like that, be sick and stuck to the bed. Got to get healthy and get up and make up your bed.

Likewise, another Veteran's photo of a made bed was symbolic of structure, order, and tranquility:

I'm starting to feel better and this is just a representation... When I come home from work and I go in and my bed is made and everything's in order, it's much easier to enter and relax than going into things in disarray, so it's real important for me to get up and make my bed, that's how I start my day.

Finally, Veterans took photographs of natural environments where they engaged in recreational activities to illustrate how they sought mental health through rest and reflection. With a photograph of his tackle box, one Veteran explained:

That is my relaxing, but that is also my health time because I could go to the river or on a boat and sit there and fish, let the water slapping back and forth, and the sound, no one around me. No one bothering me. Let my mind relax and rejuvenate and clear up anything there. I can talk to myself, whatever, think, but it's the total relaxation. I like to sit and relax in a quiet place, out in the woods, I get fresh air, nice environment and I can think and just let all my worries disappear because I literally go into a zone when I'm fishing.

**Emotional.** The emotional dimension of health and wellness was defined as developing skills or strategies to cope with stress (Substance Abuse and Mental Health Services Administration, 2015). Many discussed trying to cope mentally with their health and wellness through a variety of mechanisms. The positive mental and psychological effects of animal companions and hobbies, such as drawing, amateur photography, and model building, were frequently mentioned (Figure 4). In one example, showing a photograph of her dog, a Veteran described, “I’ve always had to have a pet in my life because I get lonely and having that unconditional love from a pet really helps me with my mental health.” As another Veteran stated in relation to his pastime of photography:

You can take some pictures...when you’re that down, depressed. Depression it’s physical, it’s not just mental, you don’t want to get out of bed, you don’t want...as soon as you wake up “boom” it hits you again. Wow, there’s nowhere to go, I mean it’s like you have no purpose.

*Figure 4. Photograph of and quote about the emotional dimension of health and wellness*



I’ve done [model building] all my life, so it’s kind of a hobby. It kind of helps me to be more creative. The doctor says that [it] gives you a sense of accomplishment when you’re done....In other words, takes me out of my head. I get into this stuff and while I’m doing it, I don’t have to worry about other stuff.

Many saw a connection between maintaining mental and physical health. As one Veteran conveyed, “If you lose control of your mind then, your body is going to go with it. No matter what.” Many had optimistic thoughts regarding their future health and wellness based on their own persistence. As one Veteran stated, “Never give up, there’s always hope. Never give up. Never quit.”

**Intellectual.** The intellectual dimension of health and wellness involved Veterans recognizing their creative abilities and discussing ways they could expand their skills and knowledge (Substance Abuse and Mental Health Services Administration, 2015). Often, discussions centered around the positive impact of activities such as reading, writing, drawing, watching television, making music and videos, travelling, model building, and amateur photography. One Veteran shared partial lyrics of his own poetry, stating, “Life aint complicated/It’s what you make it/If you get lemons you better make lemonade/It’s your situation you create it.” He further added:

And that's what it is. Everybody's situation is what they put themselves in because everybody got a choice. Whatever adventure, we're trying to manifest and bring to our life. Matter of fact, when we go back to before, what you put out is what you get back.

As another Veteran stated about a picture of his bookshelf in his bedroom which contained books, headphones, and videogames:

That's kind of like recreational and educational...I like to learn, I like to read, I like to keep my brain working and learn new things, I'm always curious about things and I always want to learn, I'm constantly trying to learn something. There's that and music, I love music, it's good for my spirit and I listen to music, I play the harmonica a little bit, I can sing a little bit and then there's the videogames that help me pass the time a little bit, beat some of the boredom.

One Veteran read books and watched educational television programs about different kinds of birds, using the knowledge he gained to teach his grandson (Figure 5). Some educated themselves about health-related topics. Through reading, one Veteran learned more about human immunodeficiency virus (HIV). Other Veterans educated themselves about health-related topics from watching television (e.g., cooking shows), such as the benefits of Omega-3s, so that they could make healthier food choices.

*Figure 5. Photograph of and quote about the intellectual dimension of health and wellness*



Now I got this book with all the different kinds of birds and...I'm teaching [my grandson] about birds. I like birds. I'm teaching him the names of birds and what they are. And those are my birds! This is Dusty, and this is Bud Light. (laughs) He was light colored and we had another bird that died and...we named Bud so we just called him Bud Light...They are relaxing. So that helps me relieve stress too.

**Spiritual.** The spiritual dimension of health and wellness that was reflected in the interviews and photographs focused on the search for meaning and purpose in the human experience (Substance Abuse and Mental Health Services Administration, 2015). Photographs of such symbols as a yin-yang and an ankh succinctly represented this dimension. Some Veterans found that having a spiritual foundation, such as engaging in prayer or Tai Chi,



motivated them to engage in healthy activities. As one Veteran stated, “You pray,...eat your soul food.” With a photograph of his Bible, one Veteran indicated:

Just to have a spiritual foundation where you can, almost like to springboard off to everything else...I know [God] wants me to be healthy so I’m going to make that appointment, I’m going to make that meeting and I’m going to get up on time, go to bed on time, and do what I have to do in between there.

Presenting his photograph of dogwood blooms, another Veteran explained how his spiritual outlook on life permeated other dimensions of health and wellness:

This is how I want my life to be lived, full and beautiful and that means mentally, physically, spiritually. And that’s what my flowers represent. This picture is like our lives, my life. I mean, you’re only as strong as the roots you have grounded and if you don’t nourish it, the roots that you have, you’ll throw them away...spiritual is supposed to be blooming...it’s supposed to come out of you...[As in saying to others] “I can help you, is there anything I can do for you today?” It’s nothing that I’m doing for the sake of glory, it’s just the way it’s supposed to be in life—a blooming flower...That’s how I try to be.

Other Veterans described how spirituality and other aspects of health, such as physical activity, intersected to support their physical and emotional health:

I like to be out in nature walking around and there’s that physical part to it that I do like, about being physical and walking around, but then there’s the spiritual part that keeps me in tune with the world we’re on. That’s being really relaxed.

One Veteran described the search for health and wellness as finding a source of light in the darkness that life sometimes offers (Figure 6).

*Figure 6. Photograph of and quote about the spiritual dimension of health and wellness*



Everybody needs some kind of light in their life and this little light in the back, I had to get that in there, cause everybody is looking for a little light. But most of us [are] totally in the dark, don’t know what’s going on, lost and that’s why I took that picture.

**Occupational.** The occupational dimension of health and wellness involved Veterans personal satisfaction with their job or enrichment from their work (Substance Abuse and Mental Health Services Administration, 2015). For example, one Veteran explained the satisfaction they received from their job when serving food to patients in the hospital. Another Veteran explained the pride he had in keeping his equipment cart at work like he kept his bed at home, neat, orderly, and organized. He stated, “Sloppiness, I’m not ok with that, and, I guess I’m constantly fighting the chaos that’s around me, or maybe it’s not chaos but maybe just disorder and trying to put it back in order.” He further stated:

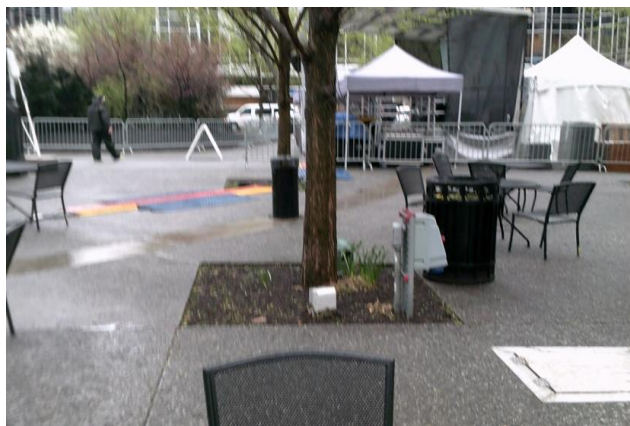
I guess that’s what that represents, I mean there’s my emotional health is tied up in that, my physical health and my spiritual health, plus mentally I mean it, there’s a little bit of my artistry at work there, so there’s a lot going on, it’s not just a symbol. I mean the bottom line of it is, is I’m doing the same thing everybody else is doing [at work], I’m taking a product, I’m putting it in a bag and I’m putting it on a shelf, but mine are totally different and they’re totally different, it’s a completely different animal and I guess that, that’s who I am and that me doing those things are, it’s indicative of me feeling good about myself.

Another Veteran explained the importance of the VA occupational training he received:

Prior to this, a few years ago, I was incarcerated and spent 4 years in the federal penitentiary, so, through the VA’s help, I was able to go through the training program and it uplifted me...it changed my life too.

While one Veteran noted that joining the military gave him a steady occupation, another noted the difficulties of getting a job after serving in the military, recalling that “nobody wants to give me a job” after returning from the Vietnam War.

*Figure 7. Photograph of and quote about the occupational dimension of health and wellness*



You might be at the job, what was a cry baby, [a coworker] gets on your nerves, crying and whaling. They don’t know what it is, working. I was out of work, almost evicted, I was going to court for the evicted...Now, it don’t stress me out...like from being unemployed and on the brink of being evicted from my house and things like that. After having worked, being laid off or fired...I know that it’s up to you yourself how you take care of yourself, because it really comes down to you...I work hard all the time.



Issues with Veterans health and wellness sometimes resulted from difficult work relations that made it hard for them to relax or not be stressed (Figure 7). Further, such discussions also highlighted their inability to work due to health issues (e.g., mental illness), a lack of steady available work, getting laid off, or even fired. As one Veteran stated:

I know all phases of construction...That's what I did for a living, but I'm not allowed to do it anymore because I have this pacemaker. And you can't use electrical stuff next to equipment when you have a pacemaker and a defibrillator.

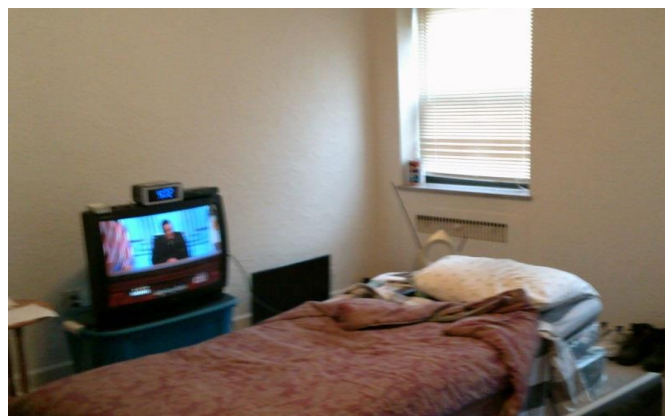
Others discussed being unable to work due to transportation issues. As one Veteran stated:

Without wheels it affects my occupation. Without that I can't bring income in, without income I'm on the street and there have been time when I lived in my car, at least with a car I've got a place to stay. It's not quite as nice as staying in a house, but it does it in a pinch. So that's how that affects my health, if I can't work I don't have the money to support my housing.

**Financial.** The financial dimension of health and wellness involved Veterans personal satisfaction with their current or future financial situation (Substance Abuse and Mental Health Services Administration, 2015). The financial dimension was often connected with the occupational dimension of health and wellness. This talk was largely negative, surrounding financial problems particularly due to not being able to work (Figure 8). Financial discussions often highlighted their debts and desire for more financial stability. As one Veteran stated:

Even though I can't work no more. I need more money...I can't really hardly work no more. And then when you do work, the check that they gave me, well-now they're trying to sue me for working. They take the money out of the check I guess, starting next year.

*Figure 8. Photograph of and quote about the financial dimension of health and wellness*



I'm feeling good, finally landed a job and then when the weather hits you get laid off...So now that cuts of my payments of my bills, landlord, he always dig me...But the money, the business, I told him just hold on, I'm shooting for some good jobs, just hold on, and I went and got another job...and then I started working.

The results of financial difficulties were also discussed by one Veteran as follows:

Finances,...it wears you down and the worry and the continuation of things going on, it makes it harder to make choices because sometimes you get to a point where you either gotta buy food or pay a bill, so which is going to be the best for you. A lot of times I'll go for the food instead of the bill. Because you have to eat. So the pressures of not being able to meet all your needs.

Some sought assistance from the VA through financial assistance, work training, or help in getting a job. As one retired Veteran stated about financial stressors in his life:

Oh yeah, it's financially...I'm worried if I don't get the money to pay for this I'm not going to do this. I've been over at Aspinwall [VA facility] to get into the program. And they are supposed to get in touch with me and find out when they going to start the new program so I can get into it and get work, an actual job. They said I can probably get one working here in the hospital...I can get a little extra money and I said that would help me out.

### **Overarching Visions for Better Health and Wellness**

Many Veteran participants situated their health-related challenges within the context of their personal philosophies about health and wellness. In metaphorical photographs, Veterans commonly depicted these global visions of health using well-known features of the Pittsburgh landscape, including rivers, bridges, and railways (Figure 9). Bridges were also a common theme for overcoming obstacles and accessing a healthier lifestyle. Another Veteran used his photograph of a bridge over a river to explain the metaphorical process of restoration:

You may have barriers to cross over, and to go upon. You may get obstacles in your way. There's a river underneath. You build the bridge and you crossed it. You may have to do things like that in your life as far as your health. You may come to a stop or you may see there's no way that I can get past this. There's always a way to get past things if you set your mind to do it. You know you need to get back in shape. You need to exercise. That's like that river. Your body is out of shape, there's no way to cross. Once you get in shape, you build enough energy to build a bridge so you can cross it.

*Figure 9. Photograph of and quote about overarching visions for better health and wellness*



See this fenced in? This is the good part out there. Down there in the river there then in the distance. Getting beyond this fence is a whole world out there, so I just gotta get around it. Even if I have to walk, get there some kind of way. I gotta make a way. I gotta make some positive moves, positive steps to get there and get what I need to get. I can't be fenced in.

### **Overcoming Obstacles to Health and Wellness**

Some Veteran participants spoke about overarching strategies for overcoming obstacles to health and wellness. Others described distinct psychologically and cognitively-oriented barriers. Both external and internal obstacles are discussed in detail below.

**External Obstacles.** Veteran participants described external obstacles, or barriers that were external to them and got in the way of maintaining their health and wellness. Such obstacles primarily included low income and lack of transportation. In an example of an external obstacle, one Veteran explained how low income impacts his ability to maintain a healthy diet:

That is a picture of a pack of processed baloney which, if it wasn't given to me, I wouldn't have had it. It's not something I typically eat or would buy, but when you go to the different giveaways, like food banks and so forth, you get stuff like that. I wanted you to see that I got that, but it's unopened, 'cause I know not to eat that. Because it's got salt, sugar, everything that's not good for you is in that. It's processed.

Other Veterans, with snapshots of a public bus or automobiles, explained how lack of transportation was a problem in their lives, sometimes preventing them from getting to a job or healthcare appointments (Figure 10).

Figure 10. Photograph of and quote about external obstacles to health and wellness



It is sometimes a challenge because I don't have a car. Without a car sometimes I might be out of bus tickets or my monthly pass might run out, and then I'm stuck with trying to get to the [VA healthcare] appointment and then I missed the appointment, and then I just can't, I just don't see, I just let it go.

**Internal Obstacles.** In other instances, Veterans described internal obstacles, or barriers that were internal to the Veteran that got in the way of maintaining their health and wellness. Examples included barriers such as not taking responsibility for one's actions (e.g., drug use), as well as feeling shame or stigma (Figure 11). Veterans also spoke about internal barriers like mental illness, which impacted their ability to navigate daily activities and healthcare appointments. Internal pressures, diversions, and disruptions were also discussed as challenges to making consistent health-related decisions. Interestingly, Veterans' overarching goals and visions for health and wellness helped them to maintain a sense of hopefulness and optimism in spite of these distractions. One Veteran explained how dietary adherence was difficult when unhealthy temptations abound:

I like the fatty, oily stuff. I gotta stay away from it for cholesterol reasons, but at my age you can't teach a dog new tricks...They tell you if you want to stay fit, don't eat fatty things, but you watch TV and sporting events like I do it's either burgers or beer or something that's going to make you fat...so I say...be like Adam, avoid temptation. It's kinda hard for me.

Figure 11. Photograph of and quote about internal obstacles to health and wellness



There's a lot of Veterans out there that's homeless that don't even know how to work the system 'cause they don't know how to get into the system. There's a lot of Veterans out there on the street that don't have the right mindset because they're totally lost. A lot of them don't come [to the VA] because they're homeless, they're shamed. You've got to take the steps to get there. It's going to have to be you. Get yourself there and take that opportunity to want to be helped.

Regarding the recovery process, one Veteran presented a photograph of a narrow road with "Do Not Enter" and "Wrong Way" street signs, commenting:

I got to do a better job decision making, take care of my health, eating right and all those things I talk about...I keep my eye on what's going on. I got to stay focused. That "Do Not Enter" sign leads to a roller coaster that goes all the way back there, it goes all the way. So, it starts with me disregarding what I know and just goes on. That's, for me, that's criminal activities, that's an everyday activity too...my health and what I'm doing and what I want to accomplish.

Metaphors, such as flowers, bridges, trains, and tunnels were commonly used by Veterans when discussing health and wellness. One Veteran used a snapshot of a hedgerow of white flowering bushes against a high chain link fence and an overpass to explain coping with depression:

All of a sudden, I fell into this deep depression that came out of nowhere because I've always been pretty much of an optimistic person. And, when I find myself getting depressed, I find a way to throw water on it and to pull myself up out of it...When I realized that I had the power to do that I just adopted that as a way of life, and surviving and making the most of things...that brand new awakening, that brand new coming to life, coming back to life. Because it's like those flowers that come back every year.

## Discussion

Wellness, or overall well-being, is particularly important because it has been found to improve quality of life, as well as increase length of life (Substance Abuse and Mental Health Services Administration, 2015). Using photo-elicitation methods with Veterans who are

homeless and marginally housed and receiving care in an H-PACT clinic, our analysis aimed to describe their experiences with health and wellness, health decisions, and health-related behaviors health and wellness. Our analysis of 20 audio-recorded interviews showed that Veterans' definitions of health and wellness mirrored SAMHSA's eight dimensions of wellness (Substance Abuse and Mental Health Services Administration, 2015). Physical, social, and environmental were most commonly discussed, followed by emotional, intellectual, spiritual, occupational, and financial health and wellness. As with SAMHSA's conceptual model of dimensions of health and wellness (Substance Abuse and Mental Health Services Administration, 2015), Veterans did not discuss the eight dimensions in mutually exclusive manner. Further iterative analysis of the data showed that, also of central importance, was overcoming external and internal obstacles to health and wellness. Veterans' photographs contained literal and metaphorical depictions of these themes. Veterans described their health and wellness in positively-oriented, comprehensive, and reflective ways. Further, they relied on multiple sources of support to maintain or restore their health and wellness.

Veterans in our PEI study, as in other studies, thought about their health in rich, multifaceted ways that included literal and metaphorical depictions of health and wellness, such as physical and mental well-being, specific practices and lifestyle habits, functionality, social interaction and affiliation, and positive mental states and coping (Cabassa, Nicasio, & Whitley, 2013; Daiski, 2007; Flick & Rohnsch, 2007; McCormack & Macintosh, 2001; Padgett, Smith, Derejko, Henwood, & Tiderington, 2013; Tran Smith, Padgett, Choy-Brown, & Henwood, 2015). Homeless and marginally housed Veterans in our study also consistently depicted how their own lifestyle behaviors and interactions with the healthcare system and their peers—including other Veterans—were important in their overall journeys towards health and wellness (Cabassa et al., 2013; McCormack & Macintosh, 2001). Further, some described how spirituality and religion provided them with order, meaning, purpose, peace, and serenity (Cabassa et al., 2013; Gravell, 2013) and how religious or spiritual beliefs and values affected their health and social behaviors (George, Larson, Koenig, & McCullough, 2000). Also, several Veterans' conveyed spiritually-related topics such as hope, life as a journey, and a holistic self-concept (Health Care for the Homeless Clinician's Network, 1998).

Veterans in our study, as in other studies, used "then versus now" comparisons to illustrate positive changes in their lives, such as those who presented bed-making and front porch photographs and descriptions when discussing the environmental dimension of health and wellness (Padgett et al., 2013). Veterans also described positive activities and interests in their lives, such as hobbies, pets and nature, physical activity, positive thinking, and the roles of these activities in their multidimensional conceptualizations of health and wellness. In contrast to other studies of homeless individuals' conceptualizations of health, our study results provide a largely positive, rich, strengths-based depiction of their lives (Cabassa et al., 2013; Tran Smith et al., 2015).

Veterans in our study largely accepted responsibility for and ownership of their health and wellness, and possessed insight and self-awareness about building a healthy life amidst innumerable challenges by harnessing both internal and external (e.g., system-level) resources. They also mentioned internal barriers to accessing care such as shame and stigma. Homeless individuals have been shown to have negative experiences in the healthcare system, and encounter discrimination (Hoffman & Coffey, 2015; Martins, 2008). In contrast, the Veterans in our study receiving care at an H-PACT described services as helpful and supportive in meeting their overlapping health needs for medical care, social support, housing, and recovery from substance use. These findings echo those of other more quantitative studies evaluating tailored VA healthcare delivery systems for homeless individuals (Kertesz et al., 2013; McGuire, Gelberg, Blue-Howells, & Rosenheck, 2009; O'Toole et al., 2010).



## Limitations

Our study has several limitations. Our results may reflect unique experiences of Veterans receiving VA healthcare. Our results also likely reflect the perspectives and experiences of a more stable subset of homeless and marginally housed individuals who are regularly engaged in structured healthcare services. Nonetheless, common definitions and conceptualizations of homelessness comprise a continuum of housing instability and, thus, include this group of individuals (U.S. Department of Housing and Urban Development, 2014). Also, homeless and marginally housed Veterans seeking care through VA channels may not face the same access, quality, or “social triaging” challenges faced by non-Veterans (Martins, 2008), especially in the context of current VA initiatives focused on ending Veteran homelessness (U.S. Department of Veterans Affairs, 2015). Also, as noted by other authors, some issues are too painful or complex to represent or talk about (Frith & Harcourt, 2007; Padgett et al., 2013). Social desirability may also have impacted Veterans’ focus on positive narratives. Finally, generalizability of our findings may be somewhat limited due to the relatively small sample size, our use of non-probability sampling, and the relatively homogeneity of the sample (e.g., gender, race, risk for homelessness, use of a single VA study site).

## Conclusions

When examining the impact of primary care medical home models of care, first-hand patient perspectives on health and wellness may prove important to ensure patient-centered care design and provision (Balbale, Locatelli, & LaVela, 2016; LaVela & Gallan, 2014). The patient-driven photo-narratives from our study may be useful in educating healthcare providers about and advocating for the needs of homeless and marginally housed Veterans. Presenting the complex, holistic understandings of health and the intentional wellness journeys of individuals who are homeless and marginally housed can help shatter negative stereotypes. Additionally, through the reciprocity and emotional engagement that these photographs and transitional narratives elicit, they can remind professionals of the rich and multi-faceted inner and outer lives of the homeless individuals they serve (Olliffe & Bottorff, 2007) and underscore the often overlooked capacity for reflection and insight in therapeutic and recovery processes. Ultimately, recognition by healthcare providers of individual patients’ multi-dimensional lives and perceptive capacity can serve as the foundation for more strengths-based orientations, enhanced advocacy, and augmented funding initiatives for recovery and reintegration within integrated primary care services (Cabassa et al., 2013; Halifax, Yurichuk, Meeks, & Khandor, 2008; True et al., 2015).

## References

- Balbale, S. N., Locatelli, S. M., & LaVela, S. L. (2016). Through their eyes: Lessons learned using participatory methods in health care quality improvement projects. *Qualitative Health Research, 26*(10), 1382-1392.
- Bradley, E. H., Curry, L. A., & Devers, K. J. (2007). Qualitative data analysis for health services research: developing taxonomy, themes, and theory. *Health Services Research, 42*(4), 1758-1772.
- Bugos, E., Frasso, R., FitzGerald, E., True, G., Adachi-Mejia, A. M., & Cannuscio, C. (2014). Practical guidance and ethical considerations for studies using photo-elicitation interviews. *Preventing Chronic Disease, 11*, E189.
- Cabassa, L. J., Nicasio, A., & Whitley, R. (2013). Picturing recovery: A photovoice exploration

- of recovery dimensions among people with serious mental illness. *Psychiatric Services*, 64(9), 837-842.
- Cox, A., & Benson, M. (2017). Visual methods and quality in information behaviour research: The cases of photovoice and mental mapping. *Information Research*, 22(2), paper 749.
- Creswell, J. W. (1998). *Qualitative inquiry and research design: Choosing among five traditions*. Thousand Oaks, CA: Sage.
- Daiski, I. (2007). Perspectives of homeless people on their health and health needs priorities. *Journal of Advanced Nursing*, 58(3), 273-281.
- Flick, U., & Rohnsch, G. (2007). Idealization and neglect: Health concepts of homeless adolescents. *Journal of Health Psychology*, 12(5), 737-749.
- Frith, H., & Harcourt, D. (2007). Using photographs to capture women's experiences of chemotherapy: Reflecting on the method. *Qualitative Health Research*, 17(10), 1340-1350.
- Gabrielian, S., Gordon, A., Gelberg, L., Patel, B., Manchanda, R., Altman, L., ... Kertesz, S. (2014). Primary care medical services for homeless veterans. *Federal Practitioner*, 31(10), 10-19.
- George, L. K., Larson, D. B., Koenig, H. G., & McCullough, M. E. (2000). Spirituality and health: What we know, what we need to know. *Journal of Social and Clinical Psychology*, 19(1), 102-116.
- Gravell, C. (2013). *Lost and found: Faith and spirituality in the lives of homeless people*. London, UK: Lemos & Crane.
- Halifax, N. V., Yurichuk, F., Meeks, J., & Khandor, E. (2008). Photovoice in a Toronto community partnership: Exploring the social determinants of health with homeless people. *Progress in Community Health Partnerships*, 2(2), 129-136.
- Harris P. A., Taylor R., Thielke R., Payne J., Gonzalez N., & Conde J. G. (2009). Research electronic data capture (REDCap)—A metadata-driven methodology and workflow process for providing translational research informatics support. *Journal of Biomedical Informatics*, 42(2), 377-381.
- Health Care for the Homeless (HCH) Clinician's Network Clinician's Network. (1998). Spirituality as a clinical tool: Care for the homeless mentally ill. *Healing Hands*, 2(8), 1-3. Retrieved from [http://www.nhchc.org/wp-content/uploads/2012/02/hh.12\\_98.pdf](http://www.nhchc.org/wp-content/uploads/2012/02/hh.12_98.pdf)
- Hoffman, L., & Coffey, B. (2008). Dignity and indignation: How people experiencing homelessness view services and providers. *Social Science Journal*, 45(2), 207-222.
- Kertesz, S. G., Holt, C. L., Steward, J. L. Jones, R. N., Roth, D. L., Stringfellow, E., ... Pollio, D. E. (2013). Comparing homeless persons' care experiences in tailored versus nontailored primary care programs. *American Journal of Public Health*, 103(Suppl 2), S331-S339.
- King, N. (1998). Template analysis. In G. Symon & C. Cassell (Eds.), *Qualitative methods and analysis in organisational research: A practical guide* (pp. 118-134). London, UK: Sage.
- King, N. (2004). Using templates in the thematic analysis of text. In C. Cassell & G. Symon (Eds.), *Essential guide to qualitative methods in organizational research* (pp. 256-270). London, UK: Sage.
- LaVela, S. L., & Gallan, A. S. (2014). Evaluation and measurement of patient experience. *Patient Experience Journal*, 1(1), 28-36.
- Martins D. C. (2008). Experiences of homeless people in the health care delivery system: A descriptive phenomenological study. *Public Health Nursing*, 25(5), 420-430.
- McCormack, D., & Macintosh J. (2001). Research with homeless people uncovers a model of health. *Western Journal of Nursing Research*, 23(7), 679-697.
- McGuire, J., Gelberg, L., Blue-Howells, J., & Rosenheck, R. A. (2009). Access to primary care



- for homeless veterans with serious mental illness or substance abuse: A follow-up evaluation of co-located primary care and homeless social services. *Administration and Policy in Mental Health*, 36(4), 255-264.
- Mitchell, M. A., Hedayati, D. O., Rodriguez, K. L., Gordon, A. J., Broyles, L. M., True, G., ... Conley, J. W. (2016). Logical lessons learned in designing and executing a photo-elicitation study in the Veterans Health Administration. *Qualitative Health Report*, 21(7), 1303-1315.
- Oliffe, J. L., & Bottorff, J. L. (2007). Further than the eye can see? Photo elicitation and research with men. *Qualitative Health Research*, 17(6), 850-858.
- O'Toole, T. P., Bourgault, C., Johnson, E. E., Redihan, S. G., Borgia, M., Aiello, R., & Kane, V. (2013). New to care: Demands on a health system when homeless veterans are enrolled in a medical home model. *American Journal of Public Health*, 103(Suppl 2), S374-S379.
- O'Toole, T. P., Buckel, L., Bourgault, C., Blumen, J., Redihan, S. G., Jiang, L., & Friedmann, P. (2010). Applying the chronic care model to homeless veterans: Effect of a population approach to primary care on utilization and clinical outcomes. *American Journal of Public Health*, 100(12), 2493-2499.
- Padgett, D. K., Smith, B. T., Derejko, K. S., Henwood, B. F., & Tiderington, E. (2013). A picture is worth...? Photo elicitation interviewing with formerly homeless adults. *Qualitative Health Research*, 23(11), 1435-1444.
- Rodriguez, K. L., Hedayati, D. O., Broyles, L. M., Wieland, M. E., Mitchell, M. A., Conley, J. W., ... Gordon, A. J. (2018). Homeless and marginally housed Veteran perspectives on participating in a photo-elicitation research study. *Patient Experience Journal*, 5(1), 115-125.
- Rosland, A. M., Nelson, K., Sun, H., Dolan, E. D., Maynard, C., Bryson, C., ... Schectman, G. (2013). The patient-centered medical home in the Veterans Health Administration. *American Journal of Managed Care*, 19(7), e263-272.
- Sestito, S. F., Rodriguez, K. L., Hruska, K. L., Conley, J. W., Mitchell, M. A., & Gordon, A. J. (2018). A photo-elicitation study of homeless and marginally housed Veterans' experiences with patient-centered care. *Patient Experience Journal*, 5(3), 123-148.
- Sestito, S. F., Rodriguez, K. L., Saba, S. K., Conley, J. W., Mitchell, M. A., & Gordon, A. J. (2017). Homeless Veterans' experiences with substance use, recovery, and treatment through photo elicitation. *Substance Abuse*, 38(4), 422-431.
- Strauss, A. (1987). *Qualitative analysis for social scientists*. Cambridge, MA: Cambridge University Press.
- Strauss, A., & Corbin J. (1998). *Basics of qualitative research: Techniques and procedures for developing grounded theory* (2<sup>nd</sup> ed.). Thousand Oaks, CA: Sage.
- Substance Abuse and Mental Health Services Administration (SAMHSA). (2015). *The eight dimensions of wellness*. Rockville, MD: SAMHSA. Retrieved from <http://www.samhsa.gov/wellness-initiative/eight-dimensions-wellness>
- Swarbrick, M. (2006). A wellness approach. *Psychiatric Rehabilitation Journal*, 29(4), 311-314.
- Tran Smith, B., Padgett, D. K., Choy-Brown, M., & Henwood, B. F. (2015). Rebuilding lives and identities: The role of place in recovery among persons with complex needs. *Health Place*, 33, 109-117.
- True, G., Rigg, K. K., & Butler, A. (2015). Understanding barriers to mental health care for recent war veterans through photovoice. *Qualitative Health Research*, 25(10), 1443-1455.
- U.S. Code. Title 42, Chapter 119, Subchapter I, Section 11302. (1987). *General definition of homeless individual*. Public Law 100-77. 101 Stat. 485. Washington, D.C.: U.S. House

- of Representatives, Office of the Law Revision Counsel.
- U.S. Department of Housing and Urban Development. (2014). *The McKinney-Vento Homeless Assistance Act as amended by S.896 HEARTH Act of 2009*. Washington, D.C.: U.S. Department of Housing and Urban Development. Retrieved from <https://www.hudexchange.info/resources/documents/HomelessAssistanceActAmendedbyHEARTH.pdf>
- U.S. Department of Veterans Affairs. (2013). *Homeless veterans: Homeless patient-aligned care teams*. Washington, D.C.: U.S. Department of Veterans Affairs. Retrieved from [http://www.va.gov/homeless/h\\_pact.asp](http://www.va.gov/homeless/h_pact.asp)
- U.S. Department of Veterans Affairs. (2015). *Ending veteran homelessness*. Washington, D.C.: U.S. Department of Veterans Affairs. Retrieved from <http://www.va.gov/homeless/index.asp>
- U.S. House. 111<sup>th</sup> Congress, 1<sup>st</sup> Session. *H.R. 1877, Homeless Emergency Assistance and Rapid Transition to Housing Act of 2009*. Washington: Government Printing Office.

### Author Note

Keri L. Rodriguez, PhD is a medical sociologist and Co-Director of the Qualitative Methods Core in the Center for Health Equity Research and Promotion at the VA Pittsburgh Healthcare System. She is also an Affiliate Faculty member in the Division of General Internal Medicine at the University of Pittsburgh School of Medicine. Correspondence regarding this article can be addressed directly to: [keri.rodriquez@va.gov](mailto:keri.rodriquez@va.gov).

Lauren M. Broyles, PhD, RN is a former addiction health services researcher at the VA Pittsburgh Healthcare System. She is currently a grant proposal writing consultant with Grant Writers Seminars & Workshops in Buellton, CA. Correspondence regarding this article can also be addressed directly to: [lbroyles@grantcentral.com](mailto:lbroyles@grantcentral.com).

Michael A. Mitchell, MA is a qualitative analyst with the Office of Data Analysis, Research, and Evaluation, Allegheny County Department of Human Services, Pittsburgh, Pennsylvania, and a former fellow in the VA's Interprofessional Advanced Fellowship in Addiction Treatment. Correspondence regarding this article can also be addressed directly to: [mitchellm593@gmail.com](mailto:mitchellm593@gmail.com).

Melissa E. Wieland, PhD, MPH is a Project Coordinator in the Center for Health Equity Research and Promotion (CHERP) at the VA Pittsburgh Healthcare System. Correspondence regarding this article can also be addressed directly to: [melissawieland@comcast.net](mailto:melissawieland@comcast.net).

Gala True, PhD is an anthropologist and Research Health Scientist at the VISN 16 Mental Illness Research, Education and Clinical Center Southeast Louisiana Veterans Healthcare System, and a Research Associate Professor at the LSU School of Medicine. Correspondence regarding this article can also be addressed directly to: [Jennifer.True2@va.gov](mailto:Jennifer.True2@va.gov).

Adam J. Gordon, MD, MPH is a physician and addiction health services researcher at the Department of Veterans Affairs Salt Lake City Health Care System. He is also a Professor of Internal Medicine, Adjunct Professor of Psychiatry, and Chief of Addiction Medicine at the University of Utah School of Medicine. Correspondence regarding this article can also be addressed directly to: [adam.gordon@va.gov](mailto:adam.gordon@va.gov).

This work was supported by a pilot research grant from VISN 4 Mental Illness Research, Education, and Clinical Center, VA Pittsburgh Healthcare System (PIs: Michael A. Mitchell, Lauren M. Broyles). This work was also supported by Department of Veterans Affairs, Health Services Research & Development (HSR&D) Service, locally initiated research funding (PI: Michael A. Mitchell; 72-079). Finally, this work was supported by the Department of Veterans Affairs, Office of Academic Affiliations Advanced Fellowship Program in

Addiction Treatment (Michael A. Mitchell), a Career Development Award (CDA 10-014) from the Department of Veterans Affairs, Health Services Research & Development service (Lauren M. Broyles) and with resources and facilities at the VA Pittsburgh Healthcare System, Pittsburgh, PA. The views expressed in this article are those of the authors and do not necessarily reflect the position or policy of the Department of Veterans Affairs or the U.S. Government.

Copyright 2019: Keri L. Rodriguez, Lauren M. Boyles, Michael A. Mitchell, Melissa E. Wieland, Gala True, Adam J. Gordon, and Nova Southeastern University.

#### **Article Citation**

Rodriguez, K. L., Broyles, L. M., Mitchell, M. A., Wieland, M. E., True, G., & Gordon, A. J. (2019). "Build a bridge so you can cross it." A photo-elicitation study of health and wellness among homeless and marginally housed veterans. *The Qualitative Report*, 24(2), 371-394. Retrieved from <https://nsuworks.nova.edu/tqr/vol24/iss2/14>

---