The Workplace Experiences, Practice, and Practice Knowledge of Mental Health Wounded Healers: A Collective Learning

by

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DEDICATION PAGE

This thesis is dedicated to all the mental health workers out there who are tending to and learning from our wounds so that we may use these wounds and our experiences of healing in our work with others.

This work is especially is dedicated to the seven women who made this thesis possible through the sharing of their knowledge and experience:

Anna, Chris, Jackie, Jill, Sarah, Patti, and Rachel (pseudonyms). I am forever grateful.

I also want to dedicate this thesis to my family in Spain, who taught me what it means to be part of something bigger than myself: what it means to belong to each other, and to a place.

También dedico esta tesis a mi familia de España, de quien aprendí lo que significa ser parte de algo más grande que uno mismo: lo que significa pertenecer los unos a los otros y ser parte de un lugar.

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ABSTRACT

Mental health workers who draw upon their own lived experiences of mental health challenges in their work (Mental Health Wounded Healers) often face stigma, discrimination, and oppression (Sanism) in the workplace. This can drive them to remain silent about their mental health challenges, and lead them to navigate their work in isolation.

Through the use of reconvened focus groups, the study created a community where participants could feel safer to reflect on their workplace experiences and their knowledge.

Participants' voices reflected a dominant medical narrative of mental health as well as two alternative narratives of resistance and connection. The narrative of resistance, mediated by anger and frustration, worked toward social change, and the narrative of connection, mediated by vulnerability, openness, and love, facilitated empathy and relationships. Research showed that these narratives mutually reinforce and extend each other, as these workers connect, learn, and organize toward change in mental health.

LIST OF ABBREVIATIONS USED

LG	The Listening Guide
FG1	Focus Group 1
FG2	Focus Group 2
FG3	Focus Group 3
MHWH	Mental Health Wounded Healer
RCT	Relational-Cultural Theory
RQ1	Research Question One
RQ2	Research Question Two
RQ3	Research Question Three

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CHAPTER 1 INTRODUCTION

I started to work at a clinic where I used to be a patient,
And [there was a nurse] who knew me as a former patient and […]
I said "Hi" to her in the hallway when it was my first day and she goes "Whatever!"
and she like walks away, and I was like "What's going on?" It was so intense.
I was like, "Oh I'm treating her as an equal that's not ok, right?
Oh, right, I'm a former patient"
And I had to like shrink, and shrink, and shrink
and that's how I ended up being able to function there for the next while. -Jill

This research explores the workplace experiences, and the practice and practice knowledge, of mental health workers who want to draw upon their own lived experiences of mental health challenges in their work (hereafter called Mental Health Wounded Healers or MHWHs).

Inspiration for this research developed from my experiences working in the mental health field as someone with mental health challenges, and from my difficulty in finding other MHWHs with whom to learn. Review of the literature indicates that Mental Health Wounded Healers working in traditional mental health settings often face stigma and discrimination in the workplace, which can drive them to remain silent (i.e., "closeted") about their mental health challenges (Moll, Eakin, Franche, & Strike, 2013; Zerubavel & Wright, 2012). Moreover, mental health workers with lived experience of mental health challenges seem to negotiate their identities and navigate their work in isolation, largely without examples of others with similar experiences (Adame, 2014). As I pondered the possible impacts of this silencing for MHWHs, such as the difficulty connecting and learning with other MHWHs, I decided to use this research as a way to subvert the impact of this silencing.

Qualitative methodology was used to explore MHWHs' workplace experiences, their practice and their practice knowledge. Reconvened focus groups method was employed: a single cohort met on three separate occasions. Through the use of focus groups, I hoped to undermine the impacts of MHWH silencing by exploring what would happen if a safer space were to exist for these workers, where we could connect with each other and learn from each other.

The objectives of this study were therefore twofold: The first objective was to learn about the workplace experiences and the practice and practice knowledge of Mental Health Wounded Healers (research questions 1 and 2 or RQ1 and RQ2.) The second objective was to explore MHWHs' experience of being part of a space where they could find and connect with each other, and where they would be able to have discussions about their workplace experiences and their practice (research question 3 or RQ3).

This research is rooted in a transformative-emancipatory paradigm (Freire, 1970). It aims not only at developing knowledge, but also at creating change. This study incorporates change through the creation of a "safer" space for MHWHs to find each other and connect. This research also embraces a feminist approach in its commitment to include context in knowledge production (situated knowledge), and in its stand against exploitation of research participants through ongoing reflexivity about power and privilege in the research (Wilkinson, 2004).

Relational-Cultural Theory (RCT), a theory with roots in feminist thought, was chosen as the primary tool for analysis and interpretation of the data. RCT posits that relationships are central for human wellbeing and explains that suffering results from disconnection, through a need to protect ourselves by keeping certain aspects of ourselves hidden from others (Jordan, 2001). This theory provides a framework for interpreting the individual and societal impacts deriving from MHWHs' need to keep experiences related to our mental health challenges hidden at work.

The research design involved the creation of a space where MHWHs could come together and share their experiences. A single cohort of research participants was invited to participate in a series of three focus groups (FG1, FG2 and FG3) where they were asked to discuss each of the three research questions. In FG1 participants were asked to discuss their workplace experiences as MHWHs (RQ1); in FG2 they were asked to talk about their use of lived experience of mental health challenges in their practice (RQ2); and in FG3 they were asked to reflect on the experience of coming together as a group of MHWHs through participating in the research (RQ3).

Data from the focus groups were analyzed using the Listening Guide (LG). This method of data analysis allows the researcher to attune to the interplay of dominant and oppressed narratives that is present in speech, especially in areas that are taboo or otherwise difficult to speak about (Gilligan, Spencer, Weinberg, & Bertsch, 2006). This method does not rush to simplify complex data into analytic themes; it allows the researcher to stay close to participants' voices and stories, and incorporates researcher reflexivity in the data analysis process. These commitments align with my own research priorities.

In this study, Carl Jung's (Conti-O'Hare, 2002) terminology of the Wounded Healer was chosen among related terms (Adame, 2011; Bennett, 2011; Frese & Davis, 1997; Kottsieper, 2008) Jung's archetype of the Wounded Healer expresses the idea that someone's wounds can be a vehicle for healing. This conceptualization of healing and helping stands outside of, and resists, being constricted by the mental health structure. It does not use the language of mental health and can help us speak of mental health outside and beyond the professionalized/medicalized narratives of mental health and “mental illness.”

Researcher Reflection:

As a researcher, and perhaps especially as a member of the same group of people that I am learning with (insider-outsider researcher), this thesis is the representation of a process of knowledge construction in which I am deeply intertwined. With an awareness that there is no neutrality and objectivity in research, and that all research decisions are political and influenced by the research (Macias, 2016), I have chosen to make researcher reflexivity, transparency, and accountability a priority across all research stages. Text boxes such as this one are used throughout the thesis to both highlight and incorporate my reflections as they arise alongside particular areas of content or process within the research.

1.1 Background and Purpose

Mental Health Wounded Healers working in traditional mental health settings often experience negative consequences when disclosing their experiences of mental health challenges at work, and thus may learn to keep these experiences hidden or silent (Zerubavel & Wright, 2012). There is extensive research, especially in the area of mental health peer support, about the benefits of connecting with others with shared experiences of mental health challenges (O’Hagan, Cyr, McKee, & Priest, 2010; Repper & Carter, 2011); however, when it comes to professionals in the mental health field, there is a lack of discussion and openness about our own stories with mental health challenges.

Silencing reflects and recreates the dominant mental health narrative that some people are “normal,” “healthy” and therefore can be helpers, and others are “pathological,” “ill,” or “unwell,” and are in need of help (Moll et al., 2013; Richards, Holttum, & Springham, 2016). This construction of “normalcy” and the categorization of people into normal versus pathologic, in turn contributes to “othering” and marginalization of individuals labeled or perceived to be “mentally ill”, including MHWHs (Richards et al., 2016). In a culture where providing help is seen as preferable over receiving it (Van Leeuwen & Täuber, 2010), people such as MHWHs, who embody both sides of this dichotomy, disrupt the status quo.

I hypothesize that the othering and silencing of MHWHs, who by our very existence embody a challenge of the dominant mental health narrative, works to re-produce dominant mental health narratives and structures by isolating us from each other, preventing and blocking the challenge of dominant conceptualizations of mental health and mental health practice, and impeding the construction of knowledge that incorporates the experiences of MHWHs.

Processes of professionalization and medicalization of mental health services and the privileging of mainstream mental health research and knowledge rest within and reproduce the dominant mental health narrative and are areas explored in this research. A commitment to transformative research, however, has led me to utilize this research to prioritize the ways in which MHWHs engage with and produce knowledge that rests outside and challenges the dominant mental health narrative, as a way of foregrounding resistance (Donovan, 2016; Holley, Stromwall, & Bashor, 2012; Macias, 2016). The use of the Listening Guide as a method of data analysis has been a useful tool for this purpose, as it helps the researcher attune to oppressed and silenced voices that speak alternative narratives (Gilligan et al., 2006).

This research works within and supports an alternative path of knowledge production in mental health, where knowledge is built from the experiences of individuals who have lived experience of mental health challenges. Specifically, it presents the silenced and marginalized voices of MHWHs by bringing them together through the focus group design. By unearthing, uplifting, and bringing together the voices of individuals who embody spaces of both Wounded and Healer, this study works to challenge the helper-helpee dichotomy; a dichotomy that underlies dominant mental health narratives and links to discrimination and oppression of individuals with mental health challenges. In addition, by building this research around creating community and connection, and doing so as a researcher who is a MHWH, this research attempts to provide an alternative to dominant knowledge production mechanisms that hold values of objectivity and distance, and tend to adopt the individual and not the community as the unit of analysis.

1.2 Gap in the Research

Most mental health literature is written by the experts from an expert perspective (Russo & Beresford, 2015) and, while literature about mental health workers who have mental health challenges exists, it is scarce (Zerubavel & Wright, 2012). Much of the literature that explores the experiences of mental health professionals who have lived experience with mental health challenges centres on the hardship experienced by these workers. Research shows, for example, that many of the workplace difficulties that

MHWHs experience relate to working within contexts that tend to see lived experience of mental health challenges in the worker as questionable or risky, and not as a potentially strengthening someone’s practice (Aina, 2015; Richards et al., 2016; Zerubavel & Wright, 2012). Richards and colleagues’ (2016) review of studies about mental health workers with experience of mental health challenges found that these practitioners face prejudice, stigma, and discrimination. These workers experience accusations of “overidentification and boundary violation” (p. 3) and issues regarding self-disclosure, as well as a discrepancy between their personal and professional identities; their energy, confidence, and emotional presence can be impacted.

While workplace challenges were most often stated, this same review (Richards et al., 2016) also found that these workers believe that their experiences of mental health challenges increase their emotional empathy and insight, facilitate useful self-disclosure, and increase their ability to hold hope for clients. While these workers are able to name how their lived experience of mental health challenges can strengthen their practice, they are often without examples of others with similar experiences (Adame, 2014) and are thus on their own learning how to use their experience in their practice.

Existing literature presents some of the challenges that MHWHs experience, as well as some of the potential benefits of being a MHWH. None of the studies reviewed, however, attempt to use the research process itself to create a different context for these workers. The use of focus groups in this thesis sought to create a setting where participants could feel safer to reflect on their workplace experiences. This context would allow MHWHs the opportunity to discuss and build upon their practice and practice knowledge in the company of others with similar experiences. By bringing forth and bringing together the voices and knowledge of MHWHs, this research subverts the silence and isolation that these workers experience, and makes this study a valuable addition to the literature.

1.3 Acknowledging Oppression and White Supremacy as Limitations of this Research

The book *Mad Matters* (LeFrançois, Menzies, & Reaume, 2013) and specifically the chapters by Gorman (2013) and Tam (2013) argue that race and anti-colonial lenses are not well integrated into discourses of mental health and of (dis)Ability. While this thesis aimed to be transformative and to work toward social justice, I want to acknowledge important limitations within this research relating to interlocking oppressions, such as the impact of racism and colonialism, which limit its transformative aims.

This study has been carried out by a middle-class, cisgender, white woman of European descent. Moreover, the participants in this study were also all cisgender white women. This is not a coincidence: it is evidence of the many ways in which oppressed people continue to have their voices and their knowledge silenced and excluded, and their opportunities in life limited; and as such this information should not be relegated to the limitations section at the end of this writing (section 8.1). Black people, First Nations' people, queer people, and all other oppressed people continue to experience pathologization and medicalization of their experiences, while having less access to supports that may aid their wellbeing (Rogers & Pilgrim, 2014). These people also experience poverty in a higher proportion than other populations (Rogers & Pilgrim, 2014). All of this can lead to individuals from these communities having less access to education required to become a professionalized helper. Because of the oppressions that they face, individuals from these groups may not have access to the healing and the education necessary to become a MHWH with a recognized professional job. Furthermore, individuals from these communities who do become professionalized helpers continue to experience oppression at work (Alleyne, 2004; Okechukwu, Souza, Davis, & de Castro, 2014). Experiences of oppression also mean that MHWHs from these communities may be less willing to participate in a study about MHWHs' workplace experiences, especially a study with a focus group design where they could encounter further oppression from fellow participants.

This study is white-dominated research, and, while it seeks liberation for MHWHs, it continues to silence those voices that are most oppressed, such as black voices and First Nations' voices. One way in which I, as a white researcher, may have inadvertently contributed to the exclusion of certain voices has been through my decision to use the term Wounded Healer. When I choose this term two years ago I did not reflect upon the co-optation of the term Healer from Indigenous heritage by the white, western, professionalized discourse. I took it up uncritically, unaware of its contested use. In this way, I can see now that I myself participated in contemporary colonialism, visiting my white supremacy upon the design of this research. Indeed, the use of the term Wounded Healer may have led to alienating effects in recruitment. Specifically, potential participants with a critique of the term Healer, concerned with the apolitical use of the term, may have considered this research to be cast within the dominant discourse paradigm, and avoided participation. This has been a sobering realization for me, given that a central driver for this research was to bring voices marginalized by the dominant discourse of health and “illness,” helper and helpee, to the centre, to be heard.

It is important that I reflect on this silencing of oppressed voices, because, as Diamond (2014) states: “The gains made by marginalized groups, which aim to achieve the status of the mythical norm for some of the group members, takes place on the back of those most oppressed in their communities” (p. 203). It is important to acknowledge that this research may work to support the legitimacy of the knowledge and experience of MHWHs that belong to dominant groups at the expense of MHWHs who are further oppressed. As Fellows and Razack (1998) say: “If, as women, our liberation leaves intact the subordination of other women, then we have not achieved liberation, but only a toehold on respectability” (p. 352).

This research has been unable to center the voices of those that are most oppressed. At the same time I hope that, with an awareness of its limitations, those who need it may be able to identify aspects of this research that may be helpful for them. As part of this, I offer the reader my commitment to researcher reflexivity through which I explore my journey, as a knower and as a researcher, regarding awareness of my privilege. For further reflection about this learning please refer to Chapter 4, and particularly to section 4.4.1.

1.4 Choosing Mental Health Language

There are many terms that have been used, and that are currently used, to refer to experiences that relate to mental health. The term that I have chosen to use in this writing is mental health challenges. I chose to use the term mental health challenges as a middle ground between “mental illness” and the more radical/political term madness. At times I do use the term “mental illness,” which is the term that is closest to the currently dominant medicalized understanding of mental health. I use “mental illness” when referring to other authors’ words; always in quotations, as a way of problematizing the term.

The term madness represents an alternative understanding of mental health that sees mental and emotional experiences as valuable, and as part of the human experience (Adame, 2009). This conceptualization resists the pathologization of these experiences, and the marginalization of those who experience them, making it a suitable option to use in this research. In this writing, I have used the term madness when sharing the words of authors that prefer this term, without quotation marks. I was hesitant to use madness as my chosen terminology, however, because I worried that many individuals living with mental health challenges may not currently identify with this term.

Researcher Reflection:

Upon further reflection, I realize that my hesitation to fully embrace the term madness may relate to my own journey of understanding my own emotional and cognitive experiences. Part of me seems to have come to understand my personal embracing of the term madness as necessitating full acceptance of my own experiences, and I don’t believe that I am there, as I find it challenging to fully embrace something that can be quite painful and difficult in my life. At the same time, I am able to see that there is value in my experiences, and acknowledge, for example, that this writing wouldn’t exist without them.

I am sharing this reflection here to illustrate that this, and all other aspects of this thesis, are bound in who I am as a person and as a researcher, and represent a specific context and time in my own learning and life.

My decision to use a “middle of the road” term may make it more appealing to a wider audience, but it does have limitations. The use of the word challenges, for example, conveys the idea that mental health experiences are always ones of struggle, which is not the case always, or for everyone.

1.5 Audience

The approach taken to this research problematizes dominant mental health narratives and presents knowledge and experience that rest outside and resist these dominant notions. This study discusses the oppression and discrimination that exist within dominant mental health structures potentially making this thesis easier for some audiences to “take in” than for others. Mental health workers who have lived experience of mental health challenges, as individuals who may have experienced stigma, discrimination, and oppression, may be open to hearing the stories and knowledge presented in this research. Conversely, for individuals unmarked with mental health labels and diagnoses, this thesis may challenge, disrupt, and threaten beliefs about the innocence, benign nature, and/or value neutrality of the mental health field and of those working within it. For those workers who are privileged in the area of mental health, facing the nuances of privilege and grappling with their complicity in oppression through the reading of this thesis could be painful and may trigger feelings of guilt and shame. These painful feelings may lead to dismissing the message that triggered them, thus dismissing this writing.

One challenge I face in this writing relates to my ability to reach both of these audiences, with their potentially differing degrees of openness to the messages contained within it. Plummer (2002) states that the telling of stories cannot be in isolation from the hearing or reading of stories. He points to the importance of the reader's interpretation and whether they will engage with, or dismiss, the text; stating that: "A voice with no listener is a silence" (p. 25). Similarly, Nelson (2001) suggests that:

> to be optimally successful a counter story must be culturally digestible and widely circulated, taken up not only by those who are on the receiving end of abusive power arrangements, but also by those who have benefited from those arrangements. (p. 151)

Researcher Reflection:

How can I write this thesis so that it will be heard by audiences who inhabit both oppressed and privileged positions? To challenge without alienating is a difficult goal, and one that I struggle with in my "real life." I have experienced my emotionality (especially anger) getting in the way of being heard by those in privileged positions. Emotionality is generally kept out of research, and excluded from the voice of the researcher. One way to increase the hearability of the messages in this thesis could, therefore, be to reduce or eliminate the emotionality within the writing. However, I believe that this form of self-surveillance is part of the mechanism by which dominant mental health narratives, such as the primacy of reason and the pathologizing of emotion, remain unchallenged. What I aim to do in this thesis, instead of excluding emotionality, is to speak about the harmful impact of dominant mental health narratives for everyone, even those who do not have experience of mental health challenges.

I firmly believe that we all can gain from questioning how we understand and handle pain, suffering, and difference in our society. In the Western world, pain and suffering has come to be seen as bad, something to avoid and overcome (Boler, 1999). When society constructs people who suffer as weak, the world becomes a place where weakness is concealed: We feel pressure to hide these vulnerable sides and to only show the "brighter" and "stronger" sides of ourselves; the ones that will make us look good.

The risk is that we all, whether or not we live with mental health challenges, may then carry that sense that there is something inside ourselves that is bad or shameful.

I also believe that we can all make attempts to shift things by, for example, choosing to drop our strong facade and by daring to be vulnerable and to show ourselves to others. This is the approach that I have chosen for this writing. In this thesis, I am making myself vulnerable and showing my flaws and shortcomings as well as my strengths. I do this by including researcher reflexivity throughout this writing. In this way, I challenge the assumption that vulnerability equals weakness, and take part in a process of working toward a world that understands emotions, pain, and suffering as part of the human experience.

1.6 Outline of Chapters

The chapters of this thesis review the following components of the research: Chapter 1 provides an overview of the research. Chapter 2 presents a review of the literature about the field of mental health and about Wounded Healers. Chapter 3 provides an explanation of the theoretical and philosophical underpinnings of this research. Chapter 4 explores researcher reflexivity and provides an exploration of the intricacies of being an "insider-outsider researcher." Chapter 5 goes on to describe the design of the research and the data analysis methodology that was chosen. Chapter 6 presents the findings from the three research questions and summarizes some of the learnings. Chapter 7 provides an analysis of the findings and a final researcher reflection, and Chapter 8 provides a conclusion, an exploration of the limitations of this research, and thoughts on ongoing and future research.

CHAPTER 2 LITERATURE REVIEW

2.1 Dominant Narratives of Helping in Mental Health

Dominant Western ideas of helping derive from medical understandings: they involve expert driven knowledge, categorize people and their behaviour as "normal" versus "pathological," and prescribe interventions that focus on reducing behaviours or feelings that the experts deem out of the norm (MacCulloch & Shattell, 2009; Smith, 2011)

The dominant mental health narrative in the West can be summarized as the belief that a professionally trained expert, assumingly free of any emotional challenges, has the ability to assess the health of their clients/patients and to guide them in overcoming their emotional challenges through symptom reduction, so that they can return to a "normal" baseline and function "normally" in society (Keyes & Lopez, 2002; Smith, 2011).

This narrative depends on the categorization of people as "us" and "them," where the rational, well, practitioner has the ability to distance themselves from and make decisions for the irrational, ill, user of services (Poole et al., 2012). The experts, who are part of the more powerful group, have the power to define what it means to be mentally healthy in a way that reflects the behaviours and experiences from their own group, while defining the behaviours and experiences of the "other," the "mentally ill," as pathological; in a process akin to that described by feminist critical (dis)Ability scholars as impacting individuals with physical disabilities (Wendell, 1996). This allows experts to decide for, and act on, those deemed "mentally ill" so as to shift their behaviour toward the dominant definition of health and normalcy. In this process, members of the less powerful group lose their ability to speak for themselves, to make their own meanings about health and healing, and to make decisions for their own lives (Poole et al., 2012; Wendell, 1996).

The dominant narrative of mental health, through the construction of narrow understandings of health and normalcy, and the categorization of individuals as either healthy or “mentally ill”, leads to the subjugation and oppression of the group of individuals deemed “mentally ill”. Sanism (Perlin, 1992), and to a lesser extent mentalism (Kalinowski & Risser, 2005), are the terms used to draw attention to the overt and covert discrimination against individuals perceived to have a “mental illness” and to their basis in constructions of normalcy (Poole et al., 2012). From this anti-oppressive perspective people deemed “mentally ill” suffer not only because the mental health challenges, but also because of prejudice and discrimination (Poole et al., 2012).

The medical model understanding of mental health challenges, characterized by this deficit and pathology perspective, is currently the strongest mental health narrative available (Adame & Knudson, 2007; Poole et al., 2012). The social work field, for example, “has been so loyal to the medical model that sanist aggressions, such as pathologizing, labeling, exclusion, and dismissal have become a ‘normal’ part of professional practice and education” (Poole et al., 2012, p. 20). Alternative ideas, knowledge, and approaches to healing and helping have been silenced and marginalized and are generally not considered as legitimate as the more dominant medical model helping modalities (Burstow & LeFrançois, 2014). As Poole and colleagues (2012) state: “the predominant use of the medical model has pushed other approaches to the periphery” (p. 22). Some examples of these approaches are native healing practices and shamanism (Conti-O'Hare, 2002), feminist counselling (Bondi & Burman, 2001), and practices inspired by the consumer/survivor/ex-patient movement (e.g., peer support) (Adame & Leitner, 2008). In addition, professionalized practices that value the knowledge that comes from lived experience (i.e., experiential knowledge), such as practices that incorporate understandings of the Wounded Healer, which are the focus of this thesis, are also marginalized (White, 2000).

2.1.1 Historical Underpinnings to the Current Context

Current dominant understandings of mental health, and the treatment of individuals labeled “mentally ill,” can be traced back to a long history of separation between reason and emotion, and of dominance of reason over emotion, that goes back to Plato (Jaggar, 1989; Ryan, 2005). Dominant understandings of mental health rest, as well, within a wider modernist paradigm of separation: separation between mind and body, and between humans and the natural environment (Wendell, 1996). This paradigm links to what Wendell (1996) calls “the myth of control”: a belief that nature and the body can, and should, be controlled. Speaking within the field of physical (dis)Ability, Wendell states that “the price of the illusion that most of us are in control is the guilt and stigma we inflict on those whose bodies are out of control” (p. 105). Within this framework of control, she writes, the risk is that healing practices may blame the victim, and disregard, discard, and ignore those whose bodies are out of control. From this primacy of separation, control and independence are paramount: lack of control, dependence, and need for others are pathologized, and human fragility and vulnerability are condemned and disallowed (Wendell, 1996).

These traditions of separation have influenced the treatment of individuals labeled mad or “mentally ill” since the 17th century through practices of confinement, hiding, and policing of madness (Foucault, 1965). Evidence of these practices can be seen throughout history, from the confining of madhouses (Foucault, 1965), to forced hospitalization and treatment, to current practices of labeling, medicalizing, and criminalizing “mental illness” (Ben-Moshe, 2013; Burstow, LeFrançois, & Diamond, 2014; Burstow, 2014).

Dominant conceptualization and treatment of “mental illness,” have been used as a tool of patriarchy, white supremacy, and colonialism to segregate and oppress women, people of colour, First Nations people, and other marginalized groups (Burstow et al., 2014). Jaggar (1989) links this oppression to the separation and subjugation of emotion to reason and states that:

> Not only has reason been contrasted with emotion, but it has also been associated with the mental, the cultural, the universal, the public and the male, whereas emotion has been associated with the irrational, the physical, the natural, the particular, the private and, of course, the female. (p. 151)

Psychiatry, as the oldest and most powerful and influential mental health institution in the West, has imprisoned and oppressed people labeled mad (Burstow et al., 2014). It has driven out its competitors and “completely medicalized any and all conceptualizations of madness;” therefore, it could be argued that it is “not about benevolence, care, or help” (Burstow & LeFrançois, 2014, p. 3).

Some changes have slowly taken place in the conceptualization of mental health challenges, however, the underlying subjugation and pathologization of emotion continues. The teachings from Freud and Jung, for example, advocated listening to and learning from the patients, and provided an alternative to the 19th century understanding that there was nothing that could be learned from the mad (Porter, 2002). Recent developments such as anti-psychiatry movement, the consumer-survivor movement, recovery perspectives, and mental health peer support models (Changing directions, changing lives: The mental health strategy for Canada, 2012; Adame & Knudson, 2007), which are explored later in this chapter, are also working to provide alternatives to the conceptualization and treatment of mental health. In spite of these changes, however, mainstream mental health continues to endorse expert knowledge and exercise social control, as evidenced in the use of taxonomizing and diagnostic tools such as the DSM (Porter, 2002), and in practices such as community orders (Burstow, 2014).

Mad Studies is an emerging field of study that centres the knowledge of individuals with lived experience of mental health challenges and works to provide a politicized alternative to medicalized mental health knowledge (LeFrançois, Menzies, & Reaume, 2013). Scholars in this field, for example, are committed to exploring intersectionality by studying how oppressions such as racism and colonialism relate to Sanism (Gorman, 2013; Holley, Mendoza, Del-Colle, & Bernard, 2016; Holley, Tavassoli, & Stromwall, 2016; Tam, 2013). This field is challenging dominant mental health constructs by constructing alternative, politicized mental health knowledge within academia and, as such, it is a promising avenue toward change in mental health.

2.2 Professionalization of Helping Work

The dominant medicalized narrative of healing and helping has laid claim to knowledge and knowledge development in helping work (Adame & Knudson, 2007) and has, in turn, led to the professionalization of helping (White, 2000). Professionalization in the mental health field, which began in the beginning of the 20th century through the influence of Sigmund Freud (Benjamin, 2005) has been part of Western culture long enough for its premises and assumptions regarding health and helping to become incorporated into what our society understands as reality (Shaw, 2002).

The process of professionalization works to exclude people with lived experience (Davidson et al., 1999; Nongauza, 2013; White, 2000). In helping fields, it results in the development of training programs based on scientific knowledge, in the devaluing of experiential knowledge, and, finally, in individuals who possess experiential knowledge losing credibility and being forced to retrain (Davidson et al., 1999; White, 2000). By adopting the values and practices of the medical model, including its knowledge production practices, and through professionalization, the mental health field has been able to acquire power and influence among the helping professions (Aho, 2008; Kottsieper, 2008).

2.3 Knowledge Production as Political Practice

The mechanisms by which the process of professionalization occurs are linked to mainstream professionals' and experts' ability to control knowledge and knowledge development (Carel & Kidd, 2014; Wardrope, 2015). Traditional research in the helping fields is situated within a positivist paradigm, which aims to discover objective truth through scientific inquiry (Van de Sande & Schwartz, 2011). This orientation to knowledge production has led to the development of an expert knowledge base that constructs itself as more valid, reliable, and true, and that excludes alternative knowledges, such as experiential knowledge (Adame, 2009). Beresford (2003) writes that not all knowledge is equally valued: “values of neutrality, objectivity and distance predominate in research” (p. 15), which tends to exclude the knowledge of people with lived experience of what is being researched. This development of a professional knowledge base has resulted in the medicalization of “mental illness” and addiction (Aho, 2008). Medicalization, in turn, has led to reconceptualizations of ideas of what helping is and who should be in charge of helping that exclude individuals with lived experience (White, 2000).

Alternative to the positivist perspective of truth and knowledge as objective, a transformative-emancipatory paradigm incorporates a social constructionist viewpoint that understands all knowledge as contextual. Within mental health, a social constructionist perspective sees the medicalized understanding of mental health as only one possible way of understanding reality, albeit currently the more dominant and accepted (Holley et al., 2012). This alternative perspective argues, for example, that “the group that society has labeled as people with mental illnesses is socially constructed” (p. 59). The field of Mad Studies rests within this paradigm (Diamond, 2013).

The creation of knowledge that provides an alternative to the dominant mental health narrative requires utilizing alternative research approaches that rest in a social constructionist viewpoint. A transformative-emancipatory approach to research is appropriate for this study because it acknowledges the influence of history and context in our understandings of truth and reality (Holley et al., 2012), challenges the knowledge hegemony of those with privilege, and works to create knowledge that addresses social inequities (Rose & Glass, 2008).

This study creates change through the development of a community of MHWHs through the use of reconvened focus groups. It also engages a researcher who is a member of the same community as participants. These characteristics allow this research to contribute toward an alternative to traditional knowledge production in the field of mental health and situate this research within a transformative-emancipatory paradigm.

2.4 Othering and Power Imbalance in Helping Relationships

Professionalization results in expert-driven practices, such as diagnosing and treatment prescription, which result in further stratification of differences and re-construction of people into separate categories, which in turn reflect a difference in status (Poole et al., 2012). Workers are the experts and hold the knowledge and clients are passive recipients of this knowledge (Wendell, 1996). Workers are healthy and clients have a pathology, a label, a diagnosis (Poole et al., 2012). Workers are constructed as powerful and clients as powerless (Richards et al., 2016).

A useful parallel can be made here with feminist critical (dis)Ability studies, wherein these process of categorization and subjugation are explained through the conceptualization of "the other" and processes of "othering" (Wendell, 1996). Wendell explains that "to the non-disabled, people with disabilities [symbolize] imperfection, failure to control the body, and everyone's vulnerability to weakness, pain and death" (p. 60). Moreover, she explains that, because the non-disabled have more power, they have the ability to define what humanity is, "and to make the world suit its own needs and validate its own experiences" (p. 60). Wendell explains that these processes of separation and exclusion prevent non-disabled and (dis)Abled people from connecting with each other. These processes of separation and exclusion, and of a dominant-defined humanity and worth, resonate in the literature and practices of Mad Studies.

The idea that relationships are a key element of healing and transformation is not new and is substantiated by extensive research in mainstream health literature (Lambert & Barley, 2001). However, power differences can get in the way of developing trusting relationships, and may curtail healing that can happen when two (or more) individuals can connect in a more egalitarian and genuine way (Kalinowski & Risser, 2005). In spite of this knowledge, and perhaps in order to enhance the profession's growth and status, the mental health field has aligned itself with the medical model with its values of detachment, objectivity, and expertise, possibly at the expense of workers' ability to develop trust in the working relationship (Poole et al., 2012).

Incorporating "shared experiential knowledge between the two parties troubles false dichotomies between 'us and them,' 'sane and insane,' 'healthy and sick'" (Adame, 2014, p. 458), and can reduce power difference and distance between worker and patient. This approach can be an avenue for change in the field of mental health. It is already taken up in broad terms in the practice of nursing, for example, where it is conceptualized as reciprocity; a term that includes an understanding of the co-construction of knowledge in relationship (Marck, 1990).

2.5 Questioning the Dominant Mental Health Narrative

In Canada, as well as across the Western world, there is a growing concern with, and a critique of, the ways in which our societies impact the mental health of individuals. The prevalence of mental health challenges is on the rise, and we are becoming more aware of the contextual and sociological factors that influence human emotional wellbeing (Srivastava, 2009). Adame and Kudson (2007) write, for example, that "contrary to the master medical model narrative, many people define the origins of their psychological distress in terms of social, political, spiritual, and economic factors" (p. 162).

In addition, there is a concern about the current capacity to support individuals living with mental health challenges, in the form of formal systems and their available treatments. Thornicroft and Slade (2014), for example, believe that traditional measurements of effectiveness of mental health interventions have focused on their ability to reduce symptoms and not on the quality of life of those receiving services. They advocate for the inclusion of the voices of those receiving services in the evaluation of those services, stating that it is "the point of view of the patient or service user that is the most important in deciding which outcomes to assess, and in making the actual outcome ratings" (p. 122).

2.6 Alternatives to the Medical Model

We are currently seeing a growing effort to improve mental health approaches and practices by including alternative conceptualizations of mental health, helping, and healing. Recent alternative perspectives include the anti-psychiatry movement and the consumer-survivor movement, as well as recovery perspectives and mental health peer support models (Changing directions, changing lives: The mental health strategy for Canada, 2012; Adame & Knudson, 2007). However, a deep incorporation of these different conceptualizations of mental health, helping and healing, into dominant expert-driven practices has not yet been realized. Kottiseper (2008) suggests that “this omission may be connected to [a] desire to be increasingly grounded in a scientific foundation rather than be considered a ‘pseudoscience’” (p. 179).

In the last 50 years, there have been a number of reactions toward traditional mental health structures, and more specifically toward psychiatry (LeFrançois et al., 2013). Groups such as anti-psychiatry have advocated for the complete restructuring or the eradication of mental health services. On the other hand, communities such as consumer groups and some survivor/ex-patient groups believe that individuals can sometimes derive benefit from existing mental health structures (Adame & Leitner, 2008). These groups advocate for changes in the mainstream mental health systems (such as the incorporation of peer support) and for individuals’ right to choose what kind of support they want (Adame & Leitner, 2008).

Some areas where there is potential for a drive toward change in the mental health field are mental health peer support, Mad-informed perspectives, recovery perspectives, and the emerging field of Mad Studies. These movements are built on experiential knowledge rather than exclusively on expert knowledge. With the possible exception of recovery perspectives, the values and practices of these approaches have not yet been co-opted into mainstream understandings of helping (Beresford, 2014; O’Hagan et al., 2010). Unfortunately, as much smaller and less powerful systems, their capacity to create change in the larger system can be limited.

Another possible avenue for change in the mental health field can come through mental health professionals who have lived experience with mental health challenges and who believe that these experiences can be of value in their work. These professionals challenge the dichotomy of helper-helpee (Adame, 2014), and incorporate lived experience and experiential knowledge of mental health challenges in their practice (Adame, 2009, 2014; Conti-O'Hare, 2002; Richards et al., 2016). These are the individuals who are the focus of this study, to whom I refer as Mental Health Wounded Healers.

2.7 The Wounded Healer

2.7.1 Background

A Wounded Healer can be understood a person who has experienced a wound, a suffering, and who, through their experience of the wound and of making meaning of this wound, is able to help others heal from similar wounds (Conti-O'Hare, 2002). The concept of the Wounded Healer has been present throughout history in multiple cultures, from ancient Greece to practices of shamanism throughout the world. It was not until the 16th and 17th centuries and the birth of reductionism, rationalism and the separation of mind and body that understandings of healing began to depart from this model in the Western world. This was a change that solidified in the 20th century through the practices of modern day science and medicine (Conti-O'Hare, 2002).

The term Wounded Healer was coined by Carl Jung in the beginning of the 20th century. Jung believed that "'only the wounded physician heals' and then 'only to the extent that he has healed himself'" (as cited in Conti-O'Hare, 2002, p. 123). He also believed it was important for health care professionals to examine their wounds openly. He thought that patients could "look into the souls of healers and determine how they handled their own problems and whether they practiced what they preached" (as cited in Conti-O'Hare, 2002, p. 198).

Conti-O'Hare (2002) presents a clear conceptualization of the Wounded Healer. She understands the Wounded Healer as a person who has experienced suffering, has acknowledged this wound, and has processed it. This processing involves the person finding meaning in their suffering, a process by which she believes the person emerges transformed. Conti-O'Hare sees this transformation as transcendence, a challenging of previously held beliefs, an acceptance of vulnerability and connectedness, and an ability to trigger the inner healer in the other.

Researcher Reflection: Reflecting on Co-optation

As I explored in Chapter 1, when I chose the Wounded Healer as a central term to use in this research I did not realize that my use of this term may constitute co-optation or colonization of an Indigenous concept. It has only been at the very last stage of the writing that I have come to be aware of this, and that I have begun to reflect on this. Because this new learning happened at a late stage in the project, I have not been able to come to a place of resolution about this, and have needed to proceed with this project with a keen awareness of its limitations.

When I first was made aware of this significant oversight on my part, I had a moment when I saw this thesis as a building that was crumbling: the foundation it had been built on did not seem solid. I had silenced the very voices that I hoped this research could help liberate (again!) This could have sent me into shame and fear, fear that my work (and myself) would be judged harshly. This is a place that I have visited many times during this writing, and that, after some struggle, I have come to learn to navigate with kindness and compassion. As this moment of fear and shame passed, I came to see this thesis as perhaps a rickety building, certainly imperfect; but here's the thing: everything life is rickety and imperfect, and the things that we create, in their imperfection, can still be beautiful and can still be of use. Learning to silence ourselves and our liberatory efforts because of learned ideas about perfectionism, is, after all, colonialist, capitalist, and patriarchic and does not help liberate anything, and so, I present to the reader my knowledge and my learning in humbleness: as a process and a journey, and, as always, flawed and limited.

2.7.2 A Politicized Understanding of the Wounded Healer

The majority of the literature on the Wounded Healer and related terminology is situated within an individualized understanding of mental health challenges (Conti-O'Hare, 2002). The focus has been on the individual experiences of wounding and healing, rather than on the societal forces that may influence how we come to understand and interpret our wounds (Conti-O'Hare, 2002) and that may, in themselves, be wounding (e.g., othering, oppression, and marginalization). Increasingly, however, literature is starting to examine the stigma experienced by Wounded Healers (Davidson, Chinman, Sells, & Rowe, 2006; Zerubavel & Wright, 2012). This indicates that the concept itself may be shifting and expanding to include a critical perspective of mental health, making it a suitable term to use in this research.

Conti O’Hare (2002), for example, writes that “ironically, it may not be the nature of the wound itself but rather the reaction to it that increases the intensity” of the experience of wounding (p. 53). This statement opens the door to speaking of wounding and healing beyond the constraints of individual experience to incorporate social aspects of experience. In the area of mental health, this can refer to cultural understandings of suffering and how these can impact a person’s experience of their mental health challenges. This includes acknowledging, for example, that the dominant idea that emotional suffering is bad, and something to fix (Adame, 2009) can influence the experiences of individuals who are seen as experiencing “too much suffering.” In a world where vulnerability is seen as a weakness and where suffering is both hidden and pushed away, both wounding and the showing of our wounding can lead to disconnection, isolation, and segregation (Conti-O'Hare, 2002; Moll, 2010). These are ideas that are represented in the tenets of Relational-Cultural Theory, which states that, as humans, we learn to hide those parts of us that others don’t accept, which leads to feelings of isolation and disconnection (Jordan, 2001, 2008b).

2.7.3 Choosing Wounded Healer Terminology

In the development stages of this research I pondered which term to use to describe the group of people I would be learning with. Academics have used a variety of terms to refer to mental health workers with experiences of mental health challenges. In addition to the Wounded Healer, some of the terms that have been used are prosumer (i.e., professional-consumer) (Frese & Davis, 1997), client-practitioner (Kottsieper, 2008), survivor-therapist (Adame, 2009, 2011), mental health professional as patient (Bennett, 2011), and professional with service user experience (Richards et al., 2016). Each of these terms offers a contrast or juxtaposition between the wounded/client side of a person and their healer/worker side. All of these terms are variations of a theme, each representing a slightly different understanding and orientation to the concept. I chose the terminology of Wounded Healer because it stands outside and resists being constricted by the mental health structure; it does not use the dominant language of mental health. By existing outside of this terminology it can apply to people other than professionals and service users. A Wounded Healer can, in fact, be inside of each of us, regardless of education, professional designation, or anything else. This terminology can help us speak of mental health outside and beyond the professionalized understandings of mental health and “mental illness.”

Moreover, the concept of the Wounded Healer challenges understandings of Healer and Wounded as a dichotomy and introduces the idea of duality (Zerubavel &

Wright, 2012): both Wounded and Healer can, and do, coexist (Conti-O'Hare, 2002). This approach can help normalize wounding and presents the possibility of discussing suffering as part of our shared human experience, rather than as pathology (Adame, 2011; Richards et al., 2016). Richards and her colleagues' (2016) study of mental health professionals who have also been mental health users suggests that these professionals see their experiences in this way. Participants in that study felt that their experiences with mental health challenges allowed mental distress to be seen in a "more ordinary light" and eroded the "'them-and-us barriers set up by more traditional 'professional' and 'patient' identity constructions" (p. 9).

In the area of mental health, looking at wounding outside of pathology can allow us to speak about mental health and mental health challenges as something that is part of the human experience, rather than as something that needs to be fixed or avoided. The combination of the concepts mental health and of the Wounded Healer led to the decision to choose Mental Health Wounded Healer as the term to be used in this research.

2.8 The Mental Health Wounded Healer

Dominant professionalized mental health discourse remains situated within our society's aversion toward suffering and vulnerability (Jordan, 2008c). This leads to stigmatizing beliefs about individuals with mental health challenges and can prevent mental health workers from speaking freely about their own mental health challenges (Moll, 2010; Moll et al., 2013; Zerubavel & Wright, 2012). Workers are expected to hide their own wounds from their clients, coworkers, and supervisors, or risk being scrutinized and discredited (Zerubavel & Wright, 2012).

Research shows that people learn to hide those aspects of themselves that they think they will be judged for (Jordan, 2008a). In the case of MHWHs, the risk of being stigmatized and discriminated against may keep a worker from speaking about their own mental health challenges (Zerubavel & Wright, 2012).

There is extensive evidence that supports the therapeutic importance of the relationship in mental health helping contexts (Lambert & Barley, 2001). There is also evidence documenting the benefits of receiving support from someone with shared mental health experiences (O'Hagan et al., 2010; Repper & Carter, 2011). In spite of this evidence, however, when it comes to professionals in the mental health field, there is a lack of discussion and openness about workers' own experiences with mental health struggles and their potential impact the helping relationship and the helping process. A review of the research about mental health stigma within the mental health professions concluded that there is a "relative absence of dialogue in the field regarding wounded healers" (Zerubavel & Wright, 2012, p. 482) and interpreted this gap as leading to shame and secrecy for these workers.

Zerubavel and Wright (2012) call attention to the discrepancy between professionals' commitment and practice of supporting clients through their woundedness but not extending this commitment to other professionals. Several authors have explored this inconsistency and have identified stigma and stereotypes as factors behind this silencing (Davidson et al., 2006; Zerubavel & Wright, 2012). A review of the research about mental health professionals who have lived experience with mental health challenges has found that these practitioners face dilemmas that include "issues regarding self-disclosure, experiencing stigma, prejudice and discrimination, being accused of overidentification and boundary violation, having reduced energy, confidence and emotional presence, and a discrepancy between their personal identity and their professional role" (Richards et al., 2016, p. 3). On the other hand, this review also found that these workers also felt that their lived experience enhanced their work through increased hope and empathy and through use of self-disclosure (Richards et al., 2016).

2.8.1 Silencing, Stigma, and Oppression

Much of the literature on MHWHs and related concepts has focused on the negative aspects of MHWH practice, including the potential detrimental consequences of stigma and silencing on individual MHWHs health and on their practice (Conti-O'Hare, 2002; Zerubavel & Wright, 2012). Less attention, however, has been paid to the social underpinnings and the social functions of these processes of silencing and stigma. Some of the authors who have written about Wounded Healer stigma from a primarily individual lens are Conti-O'Hare (2002) and Zerubavel and Wright (2012). While these authors do acknowledge the value that lived experience can have in the healing/helping process, their talk of stigma and silencing centres on potential challenges for the worker and the practice.

Zerubavel and Wright's (2012) discussion of mental health stigma focuses specifically on its detrimental effects to MHWH practice. They state that mental health stigma "encourages secrecy and shame among the wounded, thereby preventing access to support and guidance" (p. 482). These authors also write about the stigma that the "well" practitioner holds toward the Wounded Healer and link it to "wariness due to uncertainty regarding the stability of the wounded healer's recovery" (p. 488). Similarly, Conti-O'Hare (2002) warns that while the "hiding" of wounds may make the worker feel temporarily safe, there are risks that lay with the hiding: Hidden wounds risk remaining unexplored, preventing us from addressing them, and limiting our ability to transcend the wound. When wounds remain unaddressed, we risk becoming “the walking wounded”; remaining “unaware of [the] trauma's impact or unable to transcend trauma” (Conti-O'Hare, 2002, p. 39). Moreover, the frustration resulting from the inability to challenge dominant notions and the dominant group can lead to aggression toward others and to “spreading the wounding” (Conti-O'Hare, 2002, p. 144).

While presenting compelling and important arguments by focusing on the individual aspects of stigma, these authors, and others with a similar orientation (Cain, 2000; Gilroy, Carroll, & Murra, 2002), miss an opportunity to widen the lens from which they understand stigma in a way that incorporates its role in our society. There are, however, some authors who have started incorporating a social/political lens to the phenomenon of silencing and stigma in mental health workers with lived experience of mental health challenges (Adame, 2009, 2011, 2014; Joyce, Hazelton, & McMillan, 2007; Moll, 2010; Richards et al., 2016).

The majority of the existing politicized research about MHWH focuses on the impact of this oppression on the worker, and specifically on its impact in the identity construction processes of these workers (Adame, 2009, 2011, 2014; Joyce et al., 2007; Richards et al., 2016), including research that explicitly reframes MHWH stigma as oppression (Adame, 2009, 2011, 2014; Moll, 2010). This line of research identifies that dominant discourses of “professional” and “patient” are very different, almost exclusive, of each other, which makes it challenging for mental health workers with lived experience of mental health challenges to construct a professional identity that incorporates their lived experience and related knowledge to their practice (Adame, 2011;

Richards et al., 2016). Richards et al. (2016) believe that language and discourses are important aspects of identity construction and argue that “if the understandings of ‘service user’ and ‘professional’ tend to remain very different, then this presents a dilemma as to how professionals can talk about and openly value their service user experiences” (p. 2). Similarly, Adame and Kudson (2007) propose that there is a need for dialogic space and community in order to challenge dominant mental health narratives.

Identity production research addresses some of the societal impacts of silence and stigma. It explains that stigma and silencing of MHWHs contributes to the (re)construction of an us-versus-them social order, where the helper is constructed as healthy, normal, and free from emotional problems, and the person receiving help is pathological. These researchers’ arguments point to the need for research that uses the research context itself to create the conditions necessary for change in this area. This research does this through the development of a MHWH community where dialogue that challenges the us-versus-them binary of helper and helpee can occur.

Section 3.2 of the following chapter includes further exploration and critique of mental health stigma and a re-framing of this stigma as oppression in the form of Sanism.

CHAPTER 3 THEORY AND EPISTEMOLOGY

3.1 Epistemological Paradigm

This research sought to gather and share the voices and stories of Mental Health Wounded Healers with a goal of challenging the dominant mental health narratives that silence and oppress these workers. It approached the gathering of this knowledge by forming a community of MHWHs through the use of reconvened focus groups. Because of its goal of social change and social justice, this research fits within a transformative-emancipatory paradigm, rather than a positivist one (Van de Sande & Schwartz, 2011). According to positivism, the aim of research is to discover truth through scientific evidence. Truth is seen as an objective reality, and researchers as neutral and objective in their pursuit of scientific knowledge. Historically, it has been individuals with privilege who have produced this kind of research. For this reason, positivist research tends to "reflect the views and biases of the privileged" (Van de Sande & Schwartz, 2011, p. 15) and silences the voices of those less privileged.

This study departs from a positivist stance and embraces a transformative-emancipatory paradigm. Within this paradigm knowledge is understood as contextual, political, and historically dominated by those with privilege. Knowledge production within this paradigm challenges the knowledge hegemony of those with privilege and aims at knowledge production as a way to address issues of social inequity (Rose & Glass, 2008).

Within a transformative-emancipatory paradigm, truth is not seen as a single and objective phenomenon. Reality is understood as being socially constructed and contextual. From this paradigm, the truths that become dominant and come to be seen as reality are believed to be influenced by individuals and groups in power (such as the privileged individuals that have produced most positivist research.) These constructed truths work to maintain the current social order, preserving the privilege of some groups and the marginalized status of others.

Research informed by this paradigm (transformative research) is an effort at knowledge creation that acknowledges the role of privilege in knowledge creation. Transformative research “emerged in response to individuals who have been pushed to the societal margins throughout history and who are finding a means to bring their voices into the world of research” (Mertens, 2014, p. 3). The aim of this kind of research is not knowledge for knowledge sake, but rather knowledge that can be used to transform society into more equitable structures (Rose & Glass, 2008).

Structural and Anti-Oppressive social work fit within a transformative paradigm. These approaches analyze the larger socio-political forces that influence people’s experiences, and articulate the need to make social contexts more socially just. For instance, Van de Sande and Schwartz (2011) believe that “structural social work research should expose the effects of an exploitative and alienating social order and create a picture of individual and group experiences of stigma and discrimination” (p. 3). Moreover, the transformative-emancipatory paradigm is in line with feminist consciousness raising (Wilkinson, 2004), and with the liberatory/emancipatory perspectives of Paulo Freire (Mertens, 2014). Emancipatory Theory (Freire, 1970) encompasses a structural understanding of individuals’ challenges and also acknowledges that individuals can organize to create social change. Freire (1970) speaks specifically of the ability of oppressed and silenced voices to gain power by coming together and gaining an awareness of their shared reality of oppression, which he refers to as critical consciousness. His belief is that coming together allows for an awareness of the shared aspects of individuals' experiences of oppression, which they previously may have interpreted as limited to their individual experiences. Through this new awareness, individuals gain insight into the social mechanisms of construction of normalcy and difference that lead to oppression. This is a process akin to feminist consciousness raising, which can lead to reduced isolation, to a more positive and hopeful approach toward the future, and may inspire action to promote social justice (Wilkinson, 2004).

This research has sought to work toward change for Mental Health Wounded Healers by creating a community of MHWHs through the use of three reconvening focus groups. Through the discussion about their workplace experiences and their practice, MHWHs engaged in processes of critical consciousness/consciousness raising, challenging dominant narratives of mental health and collectivizing individual struggles.

3.2 Building Transformative Research

3.2.1 Reframing Stigma as Oppression and Foregrounding Resistance

Research that aims to be transformative for MHWHs needs to rest on a politicized analysis of the workplace context and the experiences of MHWHs. Holley and colleagues' (2012) review of different perspectives on mental health stigma and reframing of mental health stigma as oppression provides such a framework. These authors discuss individualized interpretations of stigma and share a critical anti-oppressive understanding of the concept, which reframes the issue as one of oppression, and emphasizes an analysis of privilege. With an understanding that parallels that of critical (dis)Ability scholars (Wendell, 1996), these authors propose that, like all forms of oppression, mental health oppression constructs one group of people as “different from,” “less than,” and “other,” which in turn constructs and elevates another group of people, which is seen as “normal” and “better.” This kind of oppression has been named Sanism (Holley et al., 2012; Poole et al., 2012) and refers to the “systematic subjugation of people who have received ‘mental health’ diagnoses or treatment” (Poole et al., 2012, p. 20). Holley and colleagues (2012) write that:

> This proposed paradigm expands our lens from a focus on individual-level cognitive processes and the negative effects of oppression on people with mental illnesses. It emphasizes power dynamics inherent in current system-level structures that privilege those who are perceived as not having mental illnesses while disadvantaging others who are perceived to have mental illnesses. (p. 60)

Holley and colleagues advocate for transformative research in the area of mental health: research that challenges Sanism and works toward social change for individuals with mental health challenges. Specifically, they argue that research centering on oppressed groups needs to focus on resilience and on resistance to oppression, and not only on the negative effects of oppression (Holley et al., 2012). In line with this premise, this thesis foregrounds resistance (Donovan, 2016) through: 1) the choice of participant population, 2) the design of the research, and 3) the location of the researcher as “insider-outsider researcher.”

1) The population that is the focus of this study comprises mental health workers who not only have lived experience of mental health challenges, but who also believe that

there is value in the knowledge that derives from those experiences and draw upon these experiences and knowledge in their work in the mental health field. In their very being, these individuals embody resistance to the dominant, medicalized, mental-health-as-pathology discourse. Having this as the research population constructs a research context where alternative narratives to the dominant mental health narrative are likely to be present.

2) This research also foregrounds resistance with the creation of a MHWH community through the focus group design, which helps break the isolation that can result from oppression. The dialogue in which the research participants engage within this research can help break the silence about the workplace experiences and the knowledge of MHWHs and can help build and strengthen narratives that are outside the dominant mental health narratives.

3) As part of their recommendations for transformative mental health research, Holley and colleagues (2012) recommend the inclusion of lived experience of mental health challenges in the design and writing of research. Engaging a researcher with lived experience of mental health challenges, as this research does, is one avenue toward the incorporation of lived experience in mental health research and contributes to the emancipatory aims of this research.

3.2.2 White Privilege and Oppression as Limitations to Transformative Research.

As explored in Chapter 1, this research was carried out by a white cisgender female researcher with participants who were also white cisgender females. As such, it has not been able to center the voices of black people, First Nations people, queer people, or other oppressed people, which limits and diminishes the transformative potential of this research. For further exploration about this topic, including the related learning journey of the researcher, please refer to sections 1.3 and 4.4.1.

3.3 Theoretical Approach

This section explores the theoretical lens guiding this research. The linear nature of thesis writing suggests that the lenses used to guide research are chosen a priori, which was not the case in this research. A transformative-emancipatory epistemology was chosen a priori because of its social constructivist lens and its orientation of knowledge production for social change, and was used as a guiding principle or compass to orient the research. The process of choosing a specific theory to use for analyzing the data, however, involved ongoing integration: it involved analysis of the data, and returning to theoretical concepts. This was an iterative process, where what I learned about the knowledge contained within the research helped me choose Relational-Cultural Theory as a theoretical lens, and where as I increasingly understood this theoretical lens I better understood the data. This iterative non-linear approach to research is considered to be in line with anti-oppressive research (Potts & Brown, 2005).

The research process involved a series of iterative cycles where one aspect of the research influenced other aspects of the research in a process of increasing fit between the different aspects of the research. Specifically, during initial data analysis, a careful look at all the different aspects of the research showed that they all shared a **focus on relationships**: The research questions originated from the observation that MHWHs have difficulty finding and connecting with each other, the research design created a context where these connections could occur, and the initial data analysis showed that participants spoke about different topics from the perspectives of connection and disconnection.

Researcher Reflection:
Alongside these realizations about the importance of relationship throughout the research, I realized that my own beliefs were in alignment with this focus on relationship and connection. I believe that a lot of the pain and suffering in the world comes from holding on to a sense of separateness and that healing comes through the awareness and the experience that we are all interconnected. The healing potential of connection is something that I have witnessed and experienced in my own work as a coordinator of a peer support program.

The increasing “good fit” among the aspects of the research could be understood as a sign that this study was designed and engaged in with a high degree of integrity. Alternatively, the alignment between my positioning and aspects of the research could indicate that my beliefs, and my location and experience as a MHWH, may have been unduly influencing research, making researcher reflexivity, transparency and accountability important aspects to continuously engage in throughout this research (Doucet & Mauthner, 2008; Doucet, 2008; Mauthner & Doucet, 2003). For more discussion on this topic please refer to section 4.3.4: Insider-Outsider Researcher.

These realizations about the centrality of relationship and connection in this research led to adopting Relational-Cultural Theory to use for interpreting the research findings. A description of this theory is presented in the section that follows. There are other theories that share some commonalities with RCT and could be used to contextualize or expand upon RCT. Humanistic nursing theories such as Swanson’s

Theory of Caring (Swanson, 1991), Watson's Theory of Human Caring (Jacob, Holmes, & Buus, 2008; Watson, 2006), and Rizzo Parse's Theory of Human Becoming (Jacob et al., 2008) all emphasize the relationship between the helper (nurse) and the patient. These theories also emphasize the importance of the co-creation of meaning between the nurse and the client, which challenges expert driven mental health conceptualizations, making them applicable in this study. From these humanistic nursing traditions developed a nursing mental health model called the Tidal Model. This model emphasizes a person's expertise about their own experience, supports a person's wishes, and assists people in reclaiming their story, their voice, and their identity (Jacob et al., 2008), all aspects which are congruent with the orientation of the present study. While these theories have not been utilized in depth within the thesis, due to the researcher's need to constrain the scope of the research, mention of them is made is made in areas where their input could be used to enrich mental health knowledge.

3.4 Relational-Cultural Theory

Relational-Cultural Theory (RCT) is rooted in an understanding that relationships and connection are key in human development and are central throughout a person's lifespan. This theory challenges the **"separate-self"** model of human development which focuses on the individual and understands human development as a movement from dependence to autonomy (Jordan, 2001, 2008b).

This theory developed within the feminist tradition as a result of dissatisfaction with traditional models of development. RCT authors state that these models emerged out of patriarchal thinking, which delimited what was considered truth and ignored and pathologized what did not fit, which were primarily women's lives and experiences (Comstock et al., 2008; Jordan, 2001; West, 2005). While RCT initially explored the lives and experiences of women, and posited that "women […] grow through and toward connection," in recent years authors within this framework increasingly believe that this is the case for all people (Jordan, 2008b, p. 2). West (2005) credits Carol Gilligan, the author of the Listening Guide (which is the method of data analysis utilized in this research) as one of the early contributors to this theory.

Relational-Cultural Theory states that the construct of the "separate self suggests that we get stronger and healthier by building firm boundaries [and] being more independent, and that power over others is what leads to a sense of safety or wellbeing" (Jordan, 2008b, p. 2). RCT proposes the **"connected-self"** as an alternative construct, and suggests that "we all need relationships throughout the lifespan and that it is through building good connections that we achieve a sense of well-being and safety" (Jordan, 2008b, p. 2). Correspondingly, this theory sees disconnection as the root of human suffering.

Drawing from its roots in feminist thought, RCT pays close attention to how power differentials impact interpersonal relationships and disconnections (West, 2005). In her writing, Jordan (2001, 2008b) explores the dynamics of disconnection, stating that disconnections are normal occurrences in human relationships. Disconnections are not necessarily harmful and can either strengthen or compromise the relationship depending on how they are addressed. Jordan (2001, 2008b) explains that when a person who holds less power in a relationship (for instance, a child) feels hurt by the more powerful person and is able to communicate their hurt and feel heard, the disconnection is resolved. When a disconnection is positively resolved, the less powerful person learns that they matter to the more powerful person, and that they have value. They learn that it is safe to be themselves in the relationship, they learn that they are important in the relationship, and that they have ability to impact the relationship. "This leads to relational images that contain expectations of being able to be who one is, of staying connected with self and other people, and of being able to have an effect on relationships" (Jordan, 2001, p. 95). Disconnection, if resolved, can thus actually lead to increased connection.

On the other hand, when the less powerful person expresses their hurt and is ignored, ridiculed, responded to with anger, or the pain is not acknowledged in some other way, the less powerful person learns that it is not safe to show themselves fully in the relationship. They learn that there are parts of themselves that are best left hidden or kept outside of the relationship (Jordan, 2001, 2008b). This allows the less powerful person to preserve the relationship with the more powerful person, but, as the less powerful person learns to present themselves in a light that is favourable to the more powerful person, the relationship becomes less "authentic." Jordan (2001) explains that, as the less powerful person begins to hide certain aspects of themselves,

> there is self-blame and disconnection from certain aspects of inner experience, and one's sense of reality is altered. The [less powerful person] begins to act inauthentically in relationships and, thus, although feeling superficially safer, feels less real, less seen, and less understood. (p. 96)

Jordan (2001) explains that these kinds of situations lead to chronic disconnection, which in turn lead to isolation, self-blame, shame, fear, and isolation. She explains that while people learn these strategies of disconnection as a manner of survival, they still yearn for connection, which results in what RCT calls the **paradox of connection**. This paradox describes the conflicting pulls toward connection and separation. The desire is still there to connect fully, but the vulnerability needed in order to do so triggers fear and feels dangerous (p. 96).

Relational-Cultural Theory addresses the effects of disconnection at a societal level as well as an individual level (Walker, 2008b). It posits that prejudice, stigma, and discrimination force oppressed groups of people to keep some parts of themselves hidden, if they are to take part in or interact with the dominant culture. Dominant groups have the power to define what is seen as “normal” and “good.” They are able to centre their own experience and call it normal and good while pushing the experiences of others who are different to the margins, thereby othering, marginalizing, and pathologizing these groups of people. In Jordan’s (2008b) words:

> Disconnections occur at the societal level when there is a stratification of differences and when the group at the centre denigrates and shames the groups at the margin. People are silenced, isolated and shamed as a way of exercising power over them and weakening the representation of their reality in the dominant discourse. RCT offers a way to link experiences of individuals with social phenomena. (p. 3)

3.4.1 Using Relational-Cultural Theory with MHWH Research

Relational-Cultural Theory (RCT) is well suited for use with MHWH research. Wounded Healers’ experiences of silencing, othering, and discrimination can be interpreted through RCT through its analysis of disconnection. In fact, Wounded Healer literature has addressed the issue of disconnection directly. Conti-O'Hare (2002) writes that

> a major impediment to transforming and transcending trauma has been the continuing sense of disconnection experienced by the victim. Anyone who has known what it means to feel segregated and isolated from others can understand the meaning of the wounded survivor. (p. 150)

Relational-Cultural theorists Miller and Steven believe that "chronic disconnection is accompanied by a drop in energy, lack of clarity, withdrawal from social engagement, feelings of depression, and lower levels of creativity and productivity" (as cited in Jordan, 2001, p. 97). A review of the research on mental health workers with mental health challenges (Richards et al., 2016) has found that, due to stigma and discrimination, these workers can experience reduced energy, confidence, and emotional presence. The similarities between these experiences and those described by Miller and Steven suggest the presence of disconnection, making Relational-Cultural Theory well suited for the topic of this research.

Adopting RCT as a theoretical lens for this research can also help inform the research process. Research shows that MHWHs are often not safe to share their lived experiences of mental health challenges at work and learn to hide their experiences (Zerubavel & Wright, 2012); something that, according to RCT, would result in disconnection and suffering. This interpretation of MHWH experience emphasizes the importance of supporting the development of trust in the group and of engaging in practices of ethical use of power (Comstock, Duffey, & St. George, 2002). This analysis supports the use of practices of collaboration, power sharing, and researcher reflection. These have been emphasized throughout this research.

Relational-Cultural Theory provides an explanation of the individual impact of oppression and also explores the societal dynamics that create and reproduce this oppression, which work to reproduce the status quo. This makes RCT a theory that is well suited to the approach taken in this research: the construction of a MHWH community that can lead to identifying commonalities in individual accounts which can be used to bring attention to the social processes underpinning them.

One area that RCT does not explore in depth, however, are the processes by which social change happens for oppressed people. This theory often does not explore or emphasize the agency of oppressed people to work toward social change and social justice. This may relate to the privileged location of many RCT scholars and is a limitation of this theory in relation to the transformative aims of the current study.

RCT first developed in the interactions between privileged white women of European descent (West, 2005). While RCT scholars have acknowledged the limitation that privilege places on their knowing, and have attempted to incorporate less privileged voices (West, 2005), the emphasis on the more powerful persons when discussing disconnection and the relatively little attention placed on agency of the less powerful person(s) may be a result of the privilege of many RCT scholars. In contrast to the majority of RCT literature, an exploration of Walker's (2008b) and Sparks' (Hartling & Sparks, 2008) conceptualizations of RCT demonstrates an analysis of disconnection that emphasizes the agency of the less powerful person(s). The life experiences of these black authors may account for this different lens and points to the importance of the knowledge that comes from lived experience of oppression in the journey to challenging and overcoming oppression.

CHAPTER 4 RESEARCHER AS WOUNDED HEALER

4.1 Introduction

This thesis is the representation of a process of knowledge construction in which I, as a researcher, am deeply intertwined. This would be the case for any researcher, particularly any qualitative researcher, and may be even more the case for me, as a member of the same group of people with whom I am learning.

Researchers have power within the research, and, because of this, we need to be aware of how we exercise power through research decisions (Macias, 2016). As a Mental Health Wounded Healer learning with other MHWHs, I believe it is particularly important that I engage in researcher reflexivity, transparency, and accountability. In alignment with Macias'(2016) belief that "if research is always situated within social power relations, all research work is somehow complicit in those power relations"(p. 3), this chapter provides the reader with an account of the researcher reflexivity process that I have engaged in throughout this research, with a particular focus on researcher power and privilege. Within this chapter, I share with the reader my background and motivation in relation to this research as well as the reflexive processes and reflexive learnings that I have gained from my engagement with this research. In addition, the discussion chapter includes a final reflection of my own journey as a MHWH and as researcher, as it has been impacted by this research (please see section 7.5).

4.2 Researcher Reflexivity: Background

4.2.1 Looking for a Framework for Practice and Looking for Others

I live in the intersection between helping professional and mental health consumer/survivor. Through my schooling and life experiences I have learned about traditional, expert-driven, mental health understandings and services. More recently, I have also learned about mental health peer support, and have been able to draw from my lived experience of mental health challenges to support others and to access support myself. I have had the opportunity to witness and to personally experience the benefits that can come through the use of shared experience, experiential knowledge, and mutuality principles, all of which underpin peer support practices.

Working directly with individuals to support their mental health has been an ongoing passion and drive for me. Having come to learn, within the peer support model, that my lived experience and experiential knowledge of mental health challenges can be of value in mental health work, I have found myself reticent to leave that knowledge aside to take on a traditional professional role, which advocates that we bracket the personal from the professional (Fischer, 2009).

As my education in social work was drawing to an end I wanted to have access to a frame of practice that felt genuine and that I could use in direct clinical work. I wanted to be able to incorporate this experience and knowledge into my practice but I was not able to find such a model within mainstream mental health. In addition, I also had difficulty finding and connecting with others like me, with whom I may be able to learn.

An initial motivation for this research, therefore, came from a desire to speak with others like me and to learn from them about how they use their lived experience in their practice. I have since come to see this thesis as one very small and tentative step in a much longer term goal of building empirical support for an emerging model of mental health practice that values and incorporates lived experience and experiential knowledge of mental health challenges.

4.2.2 Research as Part of a Healing Journey

This research is part of my journey of being/becoming a Wounded Healer. I have lived through painful experiences in roles where I have been a worker with mental health challenges and this research is part of my healing journey. Living in a culture where mental health challenges are cloaked with shame and secrecy, I have internalized this shame and this secrecy. By engaging in this research and connecting with other MHWHs, I am working to break this cycle of silence. Moreover, through this research and this writing, my challenges and struggles can transform from something that is painful to something that may help others. Finding meaning and purpose in my pain is an important step in my healing journey and my journey as a Wounded Healer.

This research project is part of my healing journey, and, for this reason, it is important that I explore the ways in which engaging in it may benefit me. Part of the initial motivation for this research related to its potential to help me reclaim my voice, my story, and my knowledge, thus increasing their perceived legitimacy. Encasing my voice in the cloak of academia, in the form of a researcher voice, can help give my voice a degree of legitimacy. While I do not think that healing and finding legitimacy in one’s voice are unethical motivations for research, it is important that they do not become my main motivations or overshadow the experiences and the knowledge of the research participants. This makes researcher reflexivity, transparency, and accountability key tools for me to utilize throughout the research.

4.2.3 My Hopes for this Research

It is my hope that this writing can help others with similar struggles along their journey of being/becoming Wounded Healers in the mental health field. Research shows that personal experiences are one of the most often stated reasons behind pursuing schooling and work in the helping professions (Tillett, 2003). Learning that there are many others like me, individuals caught in the intersection between client and practitioner (and constricted by narrow conceptualizations of professionalism, healing, and helping) has allowed me to see that this research is timely and important.

I see this research as a multilayered effort at repair: a hope of examining and rebuilding the structures that oppress MHWHs, while I recover from the oppression that I have experienced as a MHWH. I hope that this and future research helps pave a path for the many practitioners who will follow. I envision workplaces where MHWHs don't feel isolated, silenced, and unsupported; and where they have access to guidance and to work environments that can help them practice in a way that is safe and effective. I hope that this work supports the voices of these practitioners, so that the knowledge that comes from out lived experience will be heard and recognized. I want to work to include the voices of MHWHs in the mental health conversation; I believe these voices can offer new insight, with hopes and visions for the future.

4.2.4 Compelled, Afraid… and Hopeful

I feel compelled to use this research to address the workplace oppression and stigma that affects MHWHs. I believe this oppression directly affects MHWHs but also indirectly affects all individuals with mental health challenges. Sanism obscures the strength, hope, and ability of MHWHs and therefore contributes to the construction of all individuals with mental health challenges as other, inferior, and deficient.

Even as I am compelled to do this work, I am also afraid that I will experience further harm as a result of exposing myself, again, as a MHWH. Writing this thesis means losing a lot of the control that I have to create a safe and supportive environment for myself. This research, which I hope can help support the well-being of MHWHs, could hinder my recovery. I am making myself vulnerable and putting myself at risk of being further harmed by oppression. I fear exposing my vulnerability, my difference, and my challenges, and giving people the opportunity to harm me with this knowledge. I see my apprehension reflected in MacDonald's (2004) words in her autoethnographic piece about (dis)Ability:

> I tell my story … with trepidation, attributed to feeling vulnerable and exposed, fearing that through the relating of my story I might be judged, misunderstood or inadvertently dismissed. Yet my fundamental beliefs in the rights of the sufferer and the need for storying one's experience leaves silence no longer an option. (pp. 19-20)

By putting myself *in* the research I expose myself and risk criticism. I feel an added sense of pressure in my writing: this thesis may be judged, not only for its rigour and meaning, but for its writer. In order to feel safe and to protect myself I imagine that I need to write a piece that is flawless, which can stall my creativity and my work.

In addition, as I work to support MHWHs' ability to break our silence and show more aspects of ourselves at work. I feel the pressure to hide under a veneer of "health" and "competence." I have often felt torn: do I stay open and use this openness to work toward change or do I hide and protect myself? In this research, I have made a conscious choice to remain open and vulnerable and hope that doing this can offer an example of an alternative path to knowledge building that inspires others. I hope that recording my experience within this writing can shed some light into the experiences of anyone who feels that they need to hide aspects of themselves in order to protect themselves. Whether a researcher, a Wounded Healer, or someone who feels pressured to hide in any other way, I hope that this recording of my self-reflection has something to offer the reader.

4.3 Researcher Reflexivity: The Research Process

There are challenges and complexities about engaging in research that aims at being transformative. In particular, the power inequalities between researcher and participants can lead to the privileging of the researcher's voice and the silencing of participant voices, risking continuing to re-produce the oppression of MHWHs, instead of working toward social justice.

I am aware of contradictions inherent in my research that limit my ability to develop a piece of research that sits outside of the positivist paradigm. One such contradiction is my desire to engage in transformative research while being the sole author of this research. The knowledge that the power differences within the research cannot be erased makes researcher reflexivity, and specifically attention to my use of power and privilege, paramount in this research. This section explores processes and practices of researcher reflexivity that I have used in an aim to minimize the risk of my misusing my power and privilege within this research.

4.3.1 My Location of Privilege and Oppression

As an academic voice and as the sole researcher and writer of this thesis, I hold a privileged position within this research. I have made the majority of the decisions, from the research questions, the design research, and the facilitation of the focus groups, to the data analysis, and the writing. My voice is, therefore, prominent in the research, making it important that I engage in reflection throughout the research process. Reflexivity can help me gain awareness of the ways in which my privileged position may be impacting the research and can help me prevent my voice from overshadowing the voices and knowledges of MHWHs, which I am seeking to support.

While my researcher position confers me power in the study, as someone with lived experience of mental health challenges I also inhabit a place of relative oppression within broader society. This is, of course, relative compared to others living with more stigmatized labels relating to their mental health challenges, as well as others with multiple positions of oppression such as being racialized or having a physical (dis)Ability, which interlock with mental health challenges. As a Wounded Healer I hold both positions of oppression and privilege. I hold the privilege of having professional credentials, but also face the oppression of being marginalized within this professional structure. Lastly, as a researcher I also hold both positions of oppression and privilege. The privilege of being a researcher may allow legitimacy to my voice and knowledge (as well as those of participants), but my position as someone who is part of the same population that I am learning with (an insider-outsider researcher, see section 4.3.4.) may take away from the legitimacy ascribed to a researcher voice, due to the privileging of distance and objectivity within research (Beresford, 2003).

4.3.2 Research is Not Innocent

In my commitment to emancipatory research, I did not want to contribute to the oppression of those I was researching and felt the desire to construct myself as innocent. Macias (2016) challenges the attainability of this innocence and writes that, because of the researcher's position as someone who is not neutral, and whose power influences the research, "ethics [in research] can never be about the search for spaces of innocence or certainty in research work" (p. 3). This author goes on to write that researchers can deal with the "impossibility of innocence by remaining critically reflective and aware of the power differentials between themselves and the people and communities participating in their research" (p. 3).

Throughout this research, I have attempted to engage in critical reflection and have worked toward gaining awareness of power differentials and not to blindly strive toward claims of innocence. In spite of this, it has sometimes been difficult to distinguish which of my decisions have been ethical and not an abuse of my power, and which may have worked toward preserving innocence in my role as a researcher. The answer probably depends on who is making the judgement, and their orientation toward research and toward this topic. What seems clear is that an intention toward ethical use of power, and even a thoughtful practice of ethical use of power, offers no guarantees that abuse of power will not take place.

Something that I wish to offer the reader is my awareness that, being a MHWH, I *so much* want not to abuse my power that my efforts at doing ethical work could slip toward efforts at claiming innocence. For example, in my attempts at doing ethical research, and with the hope of minimizing power differential between myself and participants, I designed some elements of this project as a way to enhance collaboration in the thesis, with different degrees of success. One initiative that was not very successful was my attempt to engage in collaborative data analysis (please see section 4.4 3.) While I did, at the time of the research design, have the cognitive awareness that it is not possible to divest of one's power, the discomfort with my own power led me to design this aspect of the research in a way that would help me let go of my misgivings about my privilege. Unconsciously, I believe I may have been trying to construct myself as innocent.

4.3.3 Practices of Reflexivity, Transparency and Accountability

Throughout the research process, I have engaged in reflexivity in a few different ways. I have asked myself questions such as: which research decisions am I making unilaterally? How am I using my power to influence research decisions? And how am I influencing the final product because of my role as the primary writer? One reflective practice has been keeping a research journal where I have written field notes and reflections. I have journaled throughout all the stages of the research as a way to explore and organize my thoughts, impressions, and learning; and as a way to keep a record of these reflections. I have incorporated the learning from these reflections in the writing of this thesis. An additional reflexivity practice has happened through consultation with Marion Brown, my supervisor.

In an effort toward reflexivity and transparency, I have focused both on "process" and on "content" during the focus groups and in the writing. During our focus groups, this focus on process meant that I presented the research questions (content) but tried to let the group find its own flow and rhythm (process), which allowed the group more power to direct the conversation toward the topics that participants wanted to talk about.

In the writing of this thesis, this focus on process is evident in the analysis of the third research question: “What is the experience of being part of a community of Mental Health Wounded Healers through participating in these focus groups?” The current chapter provides information to the reader about the context in which the content of the learning happened.

4.3.4 Insider-Outsider Researcher

In this research, I am not constructing myself as a separate and objective entity, as is prescribed in more traditional, positivist research (Hesse-Biber, Leavy, & Yaiser, 2004; Van de Sande & Schwartz, 2011). I am very much *in* this research and have learned, changed, and grown with it. My motivation for this research is rooted in personal experiences and involves conducting research on a population that I am part of. This is what some authors describe as having insider status (Dwyer & Buckle, 2009). The way I understand myself in this research, however, is more of a combination of insider and outsider (Potts & Brown, 2005). I am an insider because I am part of the same population that I am studying, a MHWH. I am also an outsider because of my role as researcher, which grants me power and additional responsibilities in the research process. This position is what Dwyer and Buckle (2009) refer to as a “third space,” an in-between place outside of the insider-outsider binary. These authors understand this third space as complex “space of paradox, ambiguity and ambivalence” (p. 60). These authors believe that there are some challenges involved in being an insider-outsider researcher, for example, they think that “being an insider might raise issues of undue influence of the researcher’s perspective” (p. 59). In order to increase my awareness of personal biases and perspectives, I have engaged in reflection about my role of insider-outsider researcher, which Dwyer and Buckle believe can “reduce the potential concerns associated with insider membership” (p. 59).

When self-reflexivity is written about, the focus is often on the researchers’ power as it relates to the power difference from those researched. Writers speak of wanting to maximize the impact of the research while minimizing detrimental effects for participants. Bishop’s words (2002) are one such example:

> researchers, politicians, helping professionals and others in privileged positions often have greater latitude to boldly contest oppressive master narratives than do individuals most directly affected by them, and thus must proceed with significant caution and self-reflexivity to ensure that marginalized power dynamics are not reproduced. (p. 10)

As an insider-outsider researcher, I recognize both benefits and challenges of this position. My commitment to build knowledge in an ethical manner means that I engage in the self-reflection needed to lessen the risk of this research reproducing existing power dynamics. At the same time, being an insider can lead to my knowledge and writing being discredited, constraining my ability to contest dominant narratives to the same degree as an outsider researcher (please see section 4.3.5).

I have also felt the tension between the insider and the outsider facets of my role in my encounters with research participants. The role of outsider, which is more closely linked with traditional research and academic knowledge through the valuing of distance, neutrality and objectivity (Beresford, 2003), seemed to allow me to focus on differences, and on power differences in particular. The role of insider, which rests outside of traditional research and incorporates experiential knowledge, allowed me to focus on similarities. Focusing on my insider status has made me feel more able to connect with participants through our shared experiences. I believe it has led to the development of a mutual understanding that is more “felt” than rational (i.e., experiential knowledge.) Conversely, focusing on my outsider status constructs me as more distant and places me in a role closer, perhaps, to that of an ally (Bishop, 2002), and has helped me address some ramifications of researcher privilege in this research. While power difference between researcher and participant cannot be eradicated, focusing on my outsider location has helped me bridge and explore this topic with the research participants. This may have minimized the potential detrimental effects of my researcher privilege in this thesis. Moreover, focusing on my role as a researcher may also have helped me hear the voices of participants as their own voices, and not as a version of my own. I believe that the ability to focus both on similarities and differences in relation to participants can be a benefit of being an insider-outsider researchers.

I have found writing as an insider-outsider research difficult. The models for researchers to follow situate the writer on the outside of the research, as an objective observer, and the language of research represents this stance. I don’t want to write about my research from an “outsider position,” but I don’t have a clear model or an accepted language to use to write as an insider. This leads to a worry that if I situate myself too much *in the research* and write in a way that differs from the traditional research writing prescriptions my research will be discredited. This, in turn, links to a related question: “How much space is too much space to take in the research?” which I discuss in the following section. I can see benefits in this style of writing, however: situating myself and my knowledge within the knowledge emerging from this research may invite readers to reflect on their own beliefs and their own knowledge on the topic, situating their own knowledge. This can potentially make learning more meaningful and long lasting.

4.3.5 My Knowledge

My knowledge and my learning about mental health are situated in who I am, the whole of my life and experiences. The knowledge that I have about the experiences of MHWHs is both experiential and academic. Beresford (2003) writes that not all knowledge has equal value: “values of neutrality, objectivity and distance predominate in research” (p. 15). He believes that the knowledge of people with lived experience tends to be devalued over that of people writing about things of which they have no lived experience, and that “being close to something through having direct experience of it has frequently been seen as a form of ‘bias’” (p. 15). Ironically, but perhaps not surprisingly, while I engaged in this research with hopes that the voice and knowledge of MHWHs would be heard as legitimate, I have internalized ideas of what is “good research” (Brown & Strega, 2005), such as the privileging of distance and the idea that my knowledge is biased by my experience.

I have felt that my approach has helped build trust and relationship with participants, while I have also worried that by being open about my values and beliefs I might have excluded or missed alternative perspectives. I have worried about using self-disclosure in the focus groups and about “taking too much space” in our discussions. I have worried that this meant that I was making this research “about me.” Interestingly, this worry about making a space too much about me is something that participants spoke about at length when they spoke about self-disclosing to their clients (please see section 6.6.2).

The positivist roots of academic research mark my position as official researcher as somewhat separate from research participants. Even if it were accepted that I have similar lived knowledge as participants, it is my expected role within academia to hear and represent their voices and their knowledge; "bracketing" my own (Fischer, 2009). For example, Dwyer and Buckle (2009) warn that while an insider status can facilitate access to the research population and provide common ground in the beginning of the research, it can impede the research process through an emphasis on similarity, which can lead participants not to explain their experiences fully and can make it difficult for researchers to separate their own experiences from those of participants.

While I do not want to co-opt participants' stories (see following section), engaging in this research has shown me that bracketing my experiential knowledge is an exceedingly difficult, perhaps even impossible, thing for me to do. The knowledge that I have about the experiences of MHWHs is not divided into clean compartments, one being scholarly knowledge and the other experiential knowledge. For me, these knowledges are intertwined; each informs, and is informed, by the other. What I am able to do, instead, is utilize researcher reflexivity to make my values, experiences and the roots of my knowledge as explicit as possible. Committing to "transparency and honesty in naming the influences on my knowing process" (Doucet & Mauthner, 2002, p. 134), while remaining aware that "there may be limits to reflexivity, and to the extent to which we can be aware of the influences on our research" (Doucet, 2008, p. 77). In addition, it is important to remember that "some influences [may be] easier to identify and articulate at the time of our work while others may take time, distance and detachment from the research" (Mauthner & Doucet, 2003, p. 425). I don't see this distance and detachment as the separateness imposed a priori espoused within positivist research. In this research I understand it as time, which can allow for new perspectives for re-interpreting, can help centre the voices of participants, and help counteract any over-identification that may have occurred.

4.4 Researcher Reflexivity: Research Stages

4.4.1 Use of Power During Design

The power and privilege that I have because of my social location and because of my role in this research have influenced this research in many ways. My awareness of the impact of my privilege is evolving, some I am probably not aware of, and some I have come to be aware of at the very end of this writing, with the problematizing of my use of the term Healer as colonializing an Indigenous concept. There is, however, one specific way that my privilege impacted the research design that I wish to share here in more detail as an example. It relates to my decision to utilize focus groups as the avenue for data gathering in this research.

Through focus groups I hoped to create a context where MHWHs could come together and connect with each other; presenting an alternative to the silencing work contexts that are common for MHWHs. What I did not realize is that not all MHWHs would feel equally comfortable or safe in a group with other MHWHs. I believe that this oversight relates to my own locations of privilege, which I explore henceforth.

I have had experience coming together with others who have shared experiences of mental health challenges through peer support contexts. For me, coming together with others with similar experiences has been a positive experience. In these contexts I have felt a reduced worry that I would be judged for my experiences and challenges, which led to a lessened need to protect myself. These experiences provided a sense of comfort and safety for me, and I felt that coming together with other MHWHs would provide the same sense of safety for research participants.

As someone who is white, middle class, physically abled, and generally able to “function,” and “pass” in society in spite of my mental health challenges, I inhabit many locations of privilege that contribute to my ability to experience comfort and safety in many social situations. These advantages contributed to my inability to anticipate that this comfort and safety may not be shared by others by shielding me to the experiences of others who do not enjoy the same privileges. MHWHs, particularly those who inhabit multiple locations of oppression, such as being racialized or physically (dis)Abled may not share in the comfort and safety that I am privileged to enjoy. MHWHs inhabiting several locations of oppression may not find a group of MHWHs a safe space, since they could be at risk of oppression because of their other locations of oppression. Based on my experience and my assumptions, I thought a group space would be safe for MHWHs. My privilege led me not to be aware of the impact of interlocking oppressions that would make a focus group design not equally safe for all MHWHs. This lack of awareness led to the decision to utilize focus groups, thus constructing a research space that was not equally safe for certain groups of MHWHs and may have excluded certain MHWH voices. In fact, all the individuals who participated in the research are white, cisgender females.

By utilizing a research design that might have led to the exclusion of the voices and stories of those MHWHs experiencing interlocking oppressions I have risked homogenizing the experiences of MHWHs. My own privilege has, therefore, led to research design decisions that have limited the ability of this research to be emancipatory, and, like Fellows and Razack (1998) say, “if, as women, our liberation leaves intact the subordination of other women, then we have not achieved liberation, but only a toehold on respectability” (p. 352).

For further discussion as well as a look at how future research could ameliorate these shortcomings see sections 6.6.3 and 8.1.

4.4.2 Use of Power During Data Gathering

Throughout the research, I have engaged in conversation with participants about my power and privilege in the research. I have encouraged dialogue about this topic and welcomed input from research participants about to how use my power most ethically. For example, during FG2 I shared some of my initial data analysis with participants and asked for their feedback and opinion about those initial findings. I have looked to use my power ethically by focusing on research as a process (Potts & Brown, 2005), where ongoing dialogue about the research was requested and encouraged. Through focus on process I sought to increase our ability and comfort to negotiate the complexities of leadership and power in this research context, with the goal of constructing a research context as egalitarian and non-hierarchical as possible. One thing that I did was ask the group to decide where to focus our time toward the end of FG3, so we could use the limited time in the way that participants felt was most useful. In spite of my efforts to welcome dialogue about issues of power and privilege in the research, participants may not have felt comfortable discussing concerns directly with me as a researcher, but may have been more open to doing this had an independent person been made available.

In addition, the design of this research as focus groups can, in itself, help “shift the balance of power” (Wilkinson, 2004, p. 279). Focus groups provide a context where the voice of the researcher is de-emphasized and the voices of participants gain prominence (Kamberelis & Dimitriadis, 2013).

4.4.2.1 Use of Self as a Researcher

During this time of preparation there was a key moment that steered me toward choosing a research path that diverged from the prescribed objective and distant researcher. As the time of the first focus group approached my nervousness increased and I noticed a desire to "pull myself together" in time for the group. The irony of wanting to present as "normal" to a group of people who, like me, believe that there is value in our emotions and struggles (and who may regularly face pressure to act normal) became evident to me. I realized that I needed to bring this realization to the group, as a way of "showing up" for them. I felt it was important that I present my vulnerability to them rather than uphold a dominant idea of normalcy. This led me to choose a research path that included self-disclosure of my emotions and struggles.

I am sharing a segment of interaction that includes my self-disclosure as a way to show transparency about my use of self in this research. This excerpt shows an interaction during FG2, where I decided to share with the group a recent loss to suicide that I had experienced through my work, and how it had impacted my thesis work. Interestingly, this disclosure led to a discussion that focused on normalizing emotions, sadness and grief. All names, except for mine, are pseudonyms.

Piedad: I was sad because somebody died and that made me—was really sad, but then I doubt myself, like "oh is this turning into depression?" like cause—it was, it's complicated! Like I had strong feelings of like umm… just overwhelm… there's too much wrong in the world because that loss was not—shouldn't have happened.

Jill: yeah yeah.

Piedad: Um… and so those kind of thoughts of desperation or despair like what's the point!? Well that looks very much like depression, right? So then I then I get—

Nicki: But it's all about how long you spend there!

Piedad: I know, I know.

Nicki: Right? Just, I'm…

Chris: But you went there.

Piedad: Yeah.

Chris: And you processed it.

Piedad: Yeah.

Chris: And you realized it wasn't' getting depressed, I was experiencing [grief] something that was, made me really sad. It's ok.

Piedad: But I—

Chris: but I know what you're saying.

Piedad: I did have people around me… think—worrying.

Chris: Worrying that you were going down.

Piedad: That this was taking too long on whatever timeline they had, you know what I mean?

Chris: yeah.

Jill: It's been…

Piedad: I know, it's bullshit. It had been one week, it's bullshit.

Jill: It had been one week and they said that?! Ohhh my God.

Nicki: And remember! "You only got a set bereavement time before it turns into major depression according to DSM." [mocking tone]

Jill: DSM 5, yeah, it's true. [chuckles]

Nicki: And that's based on what research?!

Piedad: But in any case…

Patti: The DSM is constructed by white middle… European men!
[yeah]

Jill: Yeah, absolutely.

This excerpt from our conversation, particularly the interspersing of ideas and partial statements, shows that participants were very engaged in this conversation. I was sharing my sadness and despair, and how these had led me to worry about my mental health and had led others in my life to worry too. We were finishing each other's statements, and participants were supporting me: They were naming as well as challenging the dominant discourse of mental health where emotion equates pathology that I was expressing, and were helping me understand my experience as normal human suffering, in this case grief. Participants were questioning dominant mental health knowledge, such as the DSM, and naming the limiting effects of holding on to these understandings.

I am not able to say whether this kind of interaction is "appropriate" for a researcher in a formal interview setting. The answer depends on the orientation of the person you ask. For example, Wright (as cited in Comstock et al., 2002) proposes, from the lens of Relational-Cultural Theory, that relational group leadership involves a more egalitarian "coparticipant" approach. In addition, Comstock and colleagues believe that, from a relational perspective, "group leaders grow with group members" (p. 265), which allows for the possibility that my benefiting from this exchange could be acceptable in the research process. This kind of interaction might, in fact, have added to the trust in the room. At the same time, a different perspective may argue that I was taking "too much space" or swaying the conversation too much in a certain direction. Something interesting in this case is that the opinion that I present in the beginning of the quote is definitely not taken up by participants; they are not swayed toward agreement with me about sadness equating with depression, but rather in the opposite direction of the one I present.

I am choosing to show the reader the heightened emotion that I was experiencing in this exchange, which is evidenced by my choice of words in "it's bullshit." This kind of interaction is something that might not be seen as “proper” for a traditional researcher, who is supposed to be objective, distant, and neutral. Interestingly, in this case it seems to have given permission to participants to express themselves in less emotionally monitored tones. The idea of emotionality being used as a tool against MHWHs is something that is explored in Chapter 6. Perhaps my use of emotion helped create a space where the show of emotion was allowed. Further, in being an example that stood in contrast to the lack of acceptability of experiences of emotionality at work that participants reported, I argue that it furthered the group process and allowed access to deeper sharing. Comstock et al. (2002) state that relational leadership is characterized by vulnerability in the leader. Showing emotionality in a world that privileges rationality is indeed a vulnerable act and may have deepened the creation of a safe environment for participants.

4.4.3 Use of Power During Data Analysis and Writing

In my writing, I wanted to portray participants’ own words, and to allow those words to speak for themselves. There have been some important limitations to my desire to do this.

One such limitation came from the realization that the realities and constraints of this thesis mean that I have to use the power I have as a researcher to decide which quotes and interview excerpts are included in the final write-up. I have made these selections through engaging in the process of data analysis, and utilizing the key findings from the data, looking for quotes that most closely and vividly represented these findings.

In an attempt toward collaboration, I designed this research to include collaborative data analysis by allocating time at the end of each focus group to “in-vivo” data analysis, where we were to identify the main themes that we had discussed during our group. I was aware of the all-encompassing power that I would have in the data analysis stage and felt discomfort about having this much power at that stage of the research. Reflecting back, I believe I wanted to minimize this discomfort, which may have led to a decision to incorporate collaborative data analysis in a way that was not well integrated. During the focus groups it became evident that we did not have the time to devote to data analysis as a group. I felt like I was forcing it, trying to "squeeze it in," when participants wanted to talk about their experiences with each other. My attempts at collaborative data analysis didn't really fit with what was possible in the time that participants and I had together. Moreover, it did not fit with what participants wanted.

As I came to the realization that I would not be able to divest of my power during the data analysis and the writing, I had to come to accept that I am the one who decides which parts of our conversation are most important or evocative and are included, and which are not as important and are excluded. Certainly, this process is mediated through the use of data analysis tools and researcher reflexivity, however, there are limits to my own self-awareness (Doucet, 2008) that may lead to emphasizing certain data for reasons that I am not conscious about (Mauthner & Doucet, 2003).

Another concern regards the use of my power in the process of **representing participants**. I have had concerns about misunderstanding participants and about the possibility that I may be telling a totalizing, single story through this writing. Donovan argues for resisting totalizing stories by "politically and socially contextualizing violence, foregrounding resistance, transgressing normative representational practices, and building solidarity" (as cited in Macias, 2016, p. 7). Foregrounding resistance instead of telling stories of pain and struggle is something that I sometimes have difficulty with. I find it easier to dwell in challenges than to find examples of hope, at least in my own life, and I worry that this tendency might come through in my interpretation and writing of participants' stories.

Donovan (2016) warns about the risk of constructing survivors of violence as passive through the research. I consider oppression a form of violence. With this in mind, I have been committed to foregrounding resistance within this research. In line with this, I have worked to present research findings in a way that isn't too focused on the individual and their challenges, so as not to construct individuals as passive victims of oppression. This is demonstrated in Chapter 6, through the use of data analysis (the Listening Guide) that tunes in to oppressed narratives, and in the choice to present findings in a way that highlights alternative narratives of mental health.

Another concern has come from the realization that my evolving understanding of my own experiences as a MHWH seem to parallel the findings in the thesis. Specifically, the understanding of my own suffering as a result of disconnection and a need to hide certain aspects of myself, closely resembles the research findings. I have wondered if this means that I am more able to see in the data those stories that most closely fit with my own, which raises concerns about my status as an insider researcher. Dwyer and Bucke (2009) point out that "being an insider might raise issues of undue influence of the researcher's perspective" (p. 59) (Please see section 4.3.4: Insider-Outsider Researcher). Alternatively, it is possible that my lived experience might help me identify certain cues more clearly in the words of participants. In addition, the cyclical process of knowledge development and meaning making in this research may account for some of the parallels between the research stories and my own story. My initial understandings of my own challenges influenced the direction of this research, and the learning from this research has supported my own process of meaning making of my own experiences.

What I am learning is that I am not able to divest of my power as a researcher, nor can I put aside my own background and biases, all I can do is attempt to be as aware and reflective as possible about how I use my power.

4.5 Conclusion

During this research process I have worked to become, and to remain, aware of my privilege so that I may use it "for good." I have attempted to use my privileged position as someone with academic and professional credentials to contribute to justice and liberation for MHWHs. Through this process, I have become aware of the contradiction between my goal of privileging oppressed voices and my choice to engage in a research that is not fully collaborative. As the stated researcher and author, the knowledge gathered in this research is unavoidably filtered through me. This makes it impossible to eliminate the influence of my voice, which colours the knowledge produced. In an effort to be as transparent and accountable as possible (Doucet & Mauthner, 2008; Doucet, 2008; Mauthner & Doucet, 2003). I have made efforts to be as explicit as I can be of the instances in which I am aware of myself influencing the research.

Both the design of the research and the process of engaging in this research have involved ongoing reflection about my use of power, which have been explored in this chapter. One main learning I have gained through researcher reflexivity relates to my hope, during the design of this research, that this research could ensure that all participants’ voices would truly be included (Van de Sande & Schwartz, 2011). As I engaged with participants and reflected on our conversations, I have become increasingly aware of the unfeasibility of fulfilling this goal. I have learned that my privilege can silence the voices of individuals participating in my research and even inadvertently exclude certain MHWHs from participating in the research. Silencing through a lack of awareness of my own privilege and power can happen in all phases of the research, from design and recruitment, to data gathering and analysis.

The realization that my knowledge and my awareness have limitations has been both humbling and freeing. Realizing the impossibility of searching for innocence in research has been humbling. With this realization, I have started to acknowledge and accept that the limitations in my awareness will lead me to make mistakes. This, in turn, has freed me from the idea that my work has to be perfect in order to be worthwhile.

I have learned that as a researcher, with my strengths and my limitations, I am part of the context in which the knowledge of this research emerges. Taking up a social construction lens toward knowledge, it is important, and congruent, to acknowledge that the researcher is a necessary and integral part of the context impacting the research.

CHAPTER 5 METHOD

5.1 Introduction

This research explores the meaning of MHWHs' workplace experiences, practice and practice knowledge through the construction of a space in which their voices and stories can be safely expressed. Understanding the meaning of MHWHs' experiences, through the inclusion of their own voices, is best approached through the use of qualitative methodology, as this kind of research is used "as a means of exploring subjective experiences, meanings and voices" (Edwards et al., 2002).

The aim of this research is not only to gather knowledge but also to initiate change for MHWHs. Within this research, change is facilitated through the creation of a space where MHWHs can come together, connect, and explore their knowledge and experiences. This orientation toward change places this research outside of a positivist paradigm and within a transformative-emancipatory paradigm (Barnes, 2003). The transformative-emancipatory paradigm understands knowledge as situated and socially constructed, "it has oppression as its central focus [and] social change as its key objective (Rose & Glass, 2008, p. 13). Emancipatory research involves knowledge production about the structures that oppress and marginalize certain groups of people (Barnes, 2003) with "the intent to challenge inequities and disrupt the status quo" (Rose & Glass, 2008, p. 13).

This study was designed as repeated or reconvened focus groups (Morgan, Fellows, & Guevara, 2008) in which a single cohort participated in 3 consecutive focus groups. Repeated focus groups are particularly useful in research that focuses on the “process” through which knowledge emerges. This orientation toward the process of knowledge building situates this research within a constructivist epistemology and a transformative-emancipatory paradigm.

5.2 Design

5.2.1 Summary of Research Design

The study was designed as a series of reconvened focus groups where a single cohort met on three different occasions. The three focus groups were held in the spring of 2015, three weeks apart from each other. Each group was 2.5 hours in duration. The focus groups were held in meeting rooms within the Dalhousie School of Social Work, in Halifax, Nova Scotia. A more informal and welcoming space was sought for the meetings but was not found. As the researcher, I tried to make our meeting space as welcoming as possible, within existing constraints. I ensured that our meeting spaces had privacy, and provided snacks and beverages. There is literature that shows that food can have an important role in research, as a kind of “gift exchange,” and a symbol that everybody should get something from the research (Kamberelis & Dimitriadis, 2013). The individuals who participated in the study reportedly did not find the university setting a barrier and spoke of it as similar to other professional settings that they are familiar with. It is possible, however, that the university setting may have posed a barrier for other individuals wanting to participate in the study.

Research participants were individuals who self-identified as MHWHs. This study’s departure from a medical model understanding of mental health challenges led to a decision not to require a formal mental health diagnosis, or to have received mental health services. This decision was congruent with a valuing of lived experience and experiential knowledge outside of medical model understandings of mental health.

The individuals who partook in the study represented diversity in age, professional background and discipline. Participants' professional backgrounds included social work, psychology, nursing, recreational therapy, and creative arts therapy. The age of participants ranged from mid 20s to early 50s and represented early, mid, and late career. While the research did not require participants to disclose specific information regarding their lived experience of mental health challenges, a rage of experiences seemed to be represented within the group. Moreover, participants also showed different degrees of openness, at work, about their lived experiences of mental health. Participants were homogeneous in terms of race, gender, and gender identification. All participants identified as white cisgender women. Participants were informed of the study through a recruitment notice that was shared with key community members, universities, agencies, and professional organizations

5.2.2 Focus Group Design

A main objective of this research was learning about the workplace experiences of MHWHs through the development of a temporary community or "peer group." A series of reconvening focus groups was chosen for their ability to facilitate the creation of a context in which MHWHs could come together and connect.

Wilkinson (2004) reflects that researchers have tended to shy away from using this method in instances where the topic, the epistemological viewpoint (i.e., social constructionist stance), and the research design would have made it a preferable method due to concerns about their inability to ensure participant anonymity and confidentiality. While these concerns could be interpreted as a reason not to utilize this methodology, literature supports the use of this method when it will enhance the quality of this study (Wilkinson, 2004). The decision to utilize groups as a methodology is central in this research. Traditional mental health workplaces are often not conducive to MHWHs opening up about their lived experiences with mental health challenges (Zerubavel & Wright, 2012), which can prevent these individuals from knowing about, finding, and connecting with each other. Establishing a community of Wounded Healers as part of the methodology of this study is a way to create a context in which MHWHs can find and connect with each other.

The focus groups in this research were designed on the principles of consciousness raising, and within a transformative-emancipatory paradigm, based on the idea that knowledge exists within individuals and is constructed in the group through the interactions and dialogue between participants (Freire, 1970). Transformative-emancipatory approaches to social change state that it is through dialogue with others in similar marginalized situations that knowledge is generated (Freire, 1970). Further, feminist literature speaks about using focus groups as consciousness raising groups:

> Feminist researchers using focus groups in this way hope that, through meeting together with others and sharing experience and through realizing group commonalities in what had previously been considered individual and personal problems, women will develop a clearer sense of the social and political processes by which their experiences are constructed and perhaps also a desire to organize against them. (Wilkinson, 2004, pp. 284-285)

Sharing individual experiences of struggle in a group context with others who have similar experiences can help bring to attention the societal circumstances that contribute to individuals’ struggles and can allow participants to denounce the privatization of human challenges (McKenzie-Mohr & Lafrance, 2014b; Wilkinson, 2004). Groups can therefore be powerful locations for challenging dominant discourses and “externalizing oppressive master narratives” (McKenzie-Mohr & Lafrance, 2014b, p. 200). McKenzie-Mohr and Lafrance (2014b) believe that individuals make meaning of experience through stories, and propose that “in order for stories to take root and grow, they must be heard and validated” (p. 200). Having an audience, such as the one created through a focus group, can provide a context in which participants are able to explore, expand, and establish understandings of their experience and their knowledge as MHWH outside of oppressive master stories of mental health. This indicates that using group methodology can help generate a different kind of knowledge, one that is situated in the experiences of MHWHs.

Through this research, I wanted to support dialogue about the workplace experiences of being a mental health professional with lived experiences of mental health challenges and wanting/attempting to use these experiences in their work. Reconvening focus groups would provide contact between members over time, allowing for the observation of knowledge development processes, group processes, and relationship development. Morgan and colleagues (2008) believe that reconvened focus groups are useful for gaining “insight into the ways that belief systems, social norms, and interaction styles are revealed” (p. 195) within social interaction, and can help assess how things said in one group impact what is said in later groups. Moreover, these authors state that repeated focus groups “give participants time to react to information before meeting again” (p. 195).

As the sole researcher in this study, and due to student budget constraints, the focus groups were facilitated, audio recorded, and transcribed by me. Having a fellow MHWH as the focus group facilitator was congruent with, and needed for, the creation of a MHWH space within the research.

Each of the focus groups (FG1, FG2 and FG3) addressed one of the three research questions:

Focus Group 1 (FG1) addressed Research Question 1 (RQ1):

"What are Mental Health Wounded Healers' experiences as workers in the mental health field?"

Focus Group 2 (FG2) addressed Research Question 2 (RQ2):

"How do Mental Health Wounded Healers use their lived experience in their practice?"

Focus Group 3 (FG3) addressed Research Question 3 (RQ3):

"What is the experience of being part of a community of Mental Health Wounded Healers through participating in these focus groups?"

5.2.3 Considering Participatory Action Research

A research design that was fully participatory, such as Participatory Action Research (PAR) would have been an ideal approach, due to its fit with the emancipatory-transformative orientation of this research. In PAR, participants are involved in all aspects of the research from the research question, to the methodology, data gathering, and analysis. This research approach most closely aligns with my goal of promoting social justice through research, and specifically with my aim of gathering knowledge from the voices of a group that has been historically silenced. Unfortunately, certain constraints prevented me from adopting a PAR approach in this research. One challenge was the time constraints of a master's thesis. PAR, because of its collaborative approach, tends to take more time to complete than more traditional research (McNicoll, 1999). Moreover, this kind of research usually starts with an already established community or group; a group that has a self-generated need or desire to study a specific topic. Unfortunately, I was not able to find a group of individuals that are already exploring similar questions to mine, within my local community (Halifax, Nova Scotia, Canada). My lack of awareness of a local group of mental health professionals who are organizing for the use of their own lived experience in practice may, in fact, relate to the very stigma, discrimination, and shame that surrounds this population, which often drives these individuals to secrecy.

Within a cultural context that may be preventing MHWHs from finding each other, it seemed worthwhile to explore my research questions, even if it meant sacrificing some of the collaborative aspects of a fully PAR approach. The creation of a community of MHWHs within this research could be a first step toward change for MHWHs, and might even help set the stage for future research that is more collaborative. Specifically, I considered the possibility that the connections developed between participants and with myself could lead to the forming of a group that may have an interest in pursuing social action or further research, which could then be carried out within a fully developed PAR framework.

5.2.4 Considering Individual Reflection

This research was initially designed to include both group and individual components. Circumstances, however, limited the gathering of data to only group data. Rationale for the decision to include both individual and group data pertained to the ability of combined methodologies to offer richer and complementary views of the phenomenon and provide triangulation (Lambert & Loiselle, 2008). A guiding principle of qualitative methods is to adopt a research design that fits with the phenomenon that is being studied (Lambert & Loiselle, 2008). In this research, combining two qualitative methodologies (in the from of group and individual data) fit the phenomenon being studied: mental health can be understood as constructed of elements that are both individual (e.g., experiences of emotion) and societal (e.g., stigma and discrimination).

The decision to gather individual data was made as a way to give participants an opportunity to explore their experiences of the group outside of the constraints of the group itself. Specifically, participants might be more apt to explore negative or conflicted feelings outside of the group, especially participants who may disagree with the majority or have critical comments about the group itself or about connecting with other MHWHs.

Two different approaches to the gathering of individual data were considered: individual interviews and individual reflections. The time limitations of this master thesis prevented the inclusion of individual interviews. Individual reflections were included in the design due to their ability to include individual data without adding additional work for the researcher. Participants were invited to create an individual reflection between FG2 and FG3, in the form of writing or through art, which they could then share during FG3. Each participant's sharing of their reflection within FG3 would be considered data for this study and not the reflections themselves. Individual data in the form of reflection was also considered more in line with the aim of creating a community of MHWHs than the inclusion of separate individual interviews.

Unfortunately, none of the participants brought a reflection to share during FG3, which meant that only group data were gathered and utilized in this research. While I did not inquire participants regarding their decision not to partake in this aspect of this study, it may have placed too high a demand on participants, within a study that already required a significant time commitment from participants.

5.2.5 Addressing Power and Privilege.

Dominant understandings of knowledge production value expert knowledge over experiential knowledge (Beresford, 2003). These same understandings also award power to the role of the researcher (Van de Sande & Schwartz, 2011). A central commitment in this research was the inclusion of the silenced voices and stories of MHWHs. This commitment signals the need to focus on power dynamics and uses of power within this research in order not to continue to reproduce this silencing.

Several practices were followed in order to create conditions where silenced voices can be expressed, with a focus on egalitarian practices and power sharing. Some of the specific actions undertaken have been:

- Engaging in ongoing reflection about my use of power to influence the research process (please see Chapter 4).
- Including, in my thesis committee, individuals who identify as Wounded Healers (in concept, if not in wording), as well as one individual who is not a member of academia.
- Designing the research as focus groups, which “reduce the researcher’s power and control” (Wilkinson, 2004, p. 279).
- A focus on process rather than solely on outcome. While outcomes, in the shape of conceptual findings, were a goal of the research, how the group engaged with each other and with their knowledge and experience, in the

process of discussing concepts, was deemed important. For example, I limited the instances where I interrupted and redirected conversation back to the research questions, as a way of centering the voice and the knowledge of participants and their interactions with each other.

- Commitment to accountability and transparency with participants, specifically, sharing my motivations for this research, sharing an account of the processes by which research decisions were made, and sharing samples of data analysis.
- Welcoming input and feedback from participants for this and future research projects.

Moreover, while participants were presented with a written list of questions at the beginning of the focus groups (please see appendices A, B and C), these questions were intended as a starting point of discussion with participants rather than a strict or exclusive guide.

While the aforementioned practices were engaged in, there were two additional practices that were not successful: individual reflection and collaborative data analysis. As mentioned in the previous section, individual reflection was sought, unsuccessfully, as a way to encourage all voices and opinions; especially those that diverge from the majority. In addition, I was not able to incorporate participant input in data analysis due to time constraints, researcher skill limitations, and participants' preference to engage with each other instead of engaging in data analysis (please see section 4.4).

5.2.6 Participants

5.2.6.1 Study population

Research participants sought were Mental Health Wounded Healers. In this study MHWHs are defined as mental health professionals who self-identify as having lived experiences with mental health challenges, who are committed to using their lived experience in their practice, and who have experience attempting to practice this way.

Because of our dual positioning within the mental health system, both as providers and as consumers, MHWHs can be valuable sources of information about oppressive elements in the mental health system. According to Van de Sande and Schwartz (2011) "only people who have been oppressed by a system can fully understand how that system functions" (p. 18). From this perspective, MHWHs have a unique vantage point from which to understand the stigma and oppression that exists within dominant mental health structures.

5.2.6.2 Social / Cultural / Safety Considerations

As individuals living with mental health challenges, the participants in this research could be constructed as part of a "vulnerable population." In the tradition of the Wounded Healer, however, there is a belief that having lived experience with mental health challenges does not necessarily mean being more fragile or less able. Vulnerability, for Wounded Healers, does not equal weakness. The presence or history of mental health challenges is not seen, in itself, as a limitation. Mental health challenges may become a source of strength or a hazard, depending on whether and how they are addressed (Conti-O'Hare, 2002). It is important to note, however, that mental health challenges can be a source of wounding and, if not dealt with, these wounds may lead to professional impairment; what is sometimes referred to as “the walking wounded” (Conti-O'Hare, 2002, p. 39).

The task in this situation, therefore, related to assessing where participants were in their journey of making meaning of and transcending (Conti-O'Hare, 2002) their own wounds.

Researcher Reflection:
I believe that healing journeys are not linear journey or with a final destination. In addition, through this research I was committed to center the experiences of participants and to acknowledge my belief that individuals are most knowledgeable about their own experiences. From this position, I was reluctant to use my power to declare whether a person was “sufficiently healed” to participate in this study. I also wanted to acknowledge that health, healing, and wellness are changeable, which limits the usefulness of obtaining a one time assessment about a person. The way I decided to proceed was to engage with participants and support their own self-assessment, as well as offer support as needed within the research. This research design was approved by Dalhousie University Health Sciences Research Ethics Board.

The literature suggests that even if a research participant believes that their own wounds are being triggered, the response that they receive can trigger resilience (Zerubavel & Wright, 2012). Thus, the orientation of this study was that the group itself could help mitigate possible negative impacts or potential of re-wounding.

5.2.6.3 Inclusion / Exclusion Criteria

In order to participate in the research, individuals needed to have university training with a bachelor or higher level degree in a helping field such as social work, psychology, nursing, medicine, occupational therapy, recreational therapy, counselling, creative arts therapy or spiritual/pastoral counselling. A university education in a helping field was required because professional education and practice rest within dominant narratives of mental health that understand mental health challenges as pathology and that categorize people as either healthy helpers or pathological and in need of help (Poole et al., 2012). Professional education and practice, therefore, involve learning about, taking on, and being expected to perform according to dominant, medicalized, professional discourses of mental health. This research hypothesized that these dominant discourses and related roles impact the workplace experience and the practice of MHWHs that are the object of this study.

Participants were required to have a minimum of one year of experience working in a mental health role requiring university education. A year of practice experience was deemed to be a sufficient length of time for a MHWH to encounter dominant notions of mental health in the field and to reflect on their impact on them as a person.

Interested individuals needed to self-identify as currently living with mental health challenges. This study espouses a critical lens to dominant, medicalized, mental health knowledge and mental health structures and works to incorporate alternative understandings of mental health. As such, participants were not required to have a formal mental health diagnosis to participate in this research.

Participants needed to be interested in and committed to using their lived experience in their work. They also needed to self-identify as having made attempts to use their lived experience of mental health challenges in their work as a mental health professional. Being a mental health worker who has lived experience of mental health challenges does not, in itself, make someone a Wounded Healer. What makes someone a Wounded Healer is the understanding that their experiences of wounding are valuable for their work and the desire to incorporate their experiential knowledge of lived experience of mental health challenges in their work.

Participants were required to be conversant in English in order to simplify the focus group process. In addition, due to the in-person focus group design of this study, participants were required to reside within commuting distance of Halifax, Nova Scotia.

Within these parameters, I sought to recruit individuals with a range of experiences, professional backgrounds, and theoretical orientations. Including a range of professions and experience has been identified by Richards et al. (2016) as an important avenue for research in this area. Diversity was attained to various degrees. A diverse range of professional backgrounds was represented: participants were in the fields of psychology, social work, recreational therapy, and creative arts therapy. Participants also expressed a range of openness about their lived experience of mental health challenges at the workplace. Varied experience in regards to activism and experience within mental health peer support was also reported. Participants ranged in age from mid-20s to early 50's and had professional careers that varied in length. Diversity was not achieved in the areas of gender and race, however, as all individuals that participated in the study were white, cisgender females. A reflection about some of the factors that may have contributed to this lack of diversity can be found in sections 1.3 and 8.1.

5.2.7 Recruitment

Number of participants: The goal was to have six participants take part in this study. This number was determined because the group needs to be small enough for a sense of connection to be achieved in a short amount of time yet also large enough that different perspectives and experiences are present. Literature supports the rationale for a six-member focus group, citing Morse, Onwuegbuzie and Leech Onwuegbuzie and Leech

(2007) state that, “qualitative researchers use at least six participants in investigations where the goal is to understand the essence of experience” (p. 116). Given that the commitment to 3 meetings (2.5h each) is significant and may result in attrition challenges, I hoped to recruit 8 participants to provide a buffer should attrition challenges happen. This was especially important given the desire to recruit individuals with a range of experiences, professional backgrounds and theoretical orientations.

Five participants participated in all three focus groups, with two additional participants taking part in FG1 but not in FG2 or FG3.

Recruitment tasks: A purposive sampling method was used. This method, also known as the key informant technique, it is a type of non-probability sampling that is used “when one needs to study a certain cultural domain with knowledgeable experts within” (Tongco, 2007, p. 147). This study does not aim to reach a representative sample of MHWHs, therefore the additional effort that would be needed to attempt to reach the mental health community at large was deemed unnecessary. I contacted individuals who had, in previous interactions, stated their interest in the project and requested that they share the Recruitment Notice (please see Appendix E) with their networks and/or with specific individuals who they thought may fit the study’s criteria. In addition, I forwarded the Recruitment Notice to local university departments and to regulatory bodies and requested that they forward it to their contacts. Having a few key contacts who were familiar with, and interested in, the project was an effective way of reaching potential participants. Only two out of the seven participants were individuals who heard about the research through means outside of the key contact.

The Recruitment Notice provided a description of the study, presented the inclusion and exclusion criteria and directed prospective participants to contact the researcher (please see appendix E for Recruitment Notice.) Once I was contacted I shared the informed consent form with the prospective participants and engaged in a telephone or in-person conversation with them (please see Appendix D.2 for Phone Contact and Overview.) This conversation aimed to ensure that participants were fully informed about the research and able to provide informed consent, and to support prospective participants in their process of self-assessment regarding their level of comfort and safety about engaging in this research. Participants were encouraged to take a couple of days to reflect on this conversation prior to agreeing to participate in the study. Participants' signature of the Informed Consent Form (please see Appendix, D.1) was taken to mean that they were fully informed and had assessed their capacity to participate in the research.

5.2.8 Ethical Considerations

Three of the challenges of this research included the possibility that participants' mental health challenges could be triggered, the inability to guarantee the confidentiality of participants because of the group format of the interviews, and the fact that the researcher is part of the same geographical, professional, and MHWH community as the research participants. This section addresses these concerns, with the aim of mitigating any possible risk for participants involved in this research.

5.2.8.1 Emotional Safety

As individuals living with mental health challenges, the participants in this research could be constructed as part of a "vulnerable population." In the tradition of the Wounded Healer, however, there is a belief that having lived experience with mental health challenges does not necessarily mean being more fragile or less able (Conti-

O'Hare, 2002). Mental health challenges may become a source of strength or a challenge, depending on whether and how they are addressed (Conti-O'Hare, 2002). Within a transformational-emancipatory paradigm, our individual and community capacity to support each other through emotional difficulties and toward a sense of recovery cannot be understated. This research, therefore, incorporated measures to build emotional safety that fit within a transformational-emancipatory paradigm. Within this paradigm the group itself can be a potential source of support, caring, and possibly recovery and healing. The creation of a supportive, safe environment was, therefore, a priority and was seen as the responsibility of all involved in the research: researcher, participants, and even supervisor and thesis committee. Because of the importance, and harm mitigating potential, of interpersonal support (Zerubavel & Wright, 2012) the researcher emphasized the importance of the group devoting sufficient time to building cohesion and trust.

Building and ensuring emotional safety for participants also involved helping participants self-assess whether and to what extent participating in this research could re-trigger their wounds, as well as helping develop an informal safety plan. In line with peer support traditions, which emphasize a person's right and ability to make their own decisions regarding any support they may need, working toward emotional safety also involved encouraging participants to monitor their own wellbeing and to utilize the resources and coping techniques that they already have in place in their lives.

In addition to these measures, more traditional risk-mitigating measures were also put in place, and discussed with participants. These related to exploring what in traditional research would be considered an "adverse event" (i.e. any situation where the researcher is not able to obtain reassurance from a participant that they are feeling emotionally and physically safe), and which actions I would take if such an event were to take place. This kind of intervention was not needed during the research.

5.2.8.2 Confidentiality

Anonymity could not be assured for participants during the data collection stages of the research study by the nature of focus groups. Confidentiality was possible within the written thesis, however, through the use of pseudonyms and through the exclusion of identifying information.

The identity of the participants was revealed to the interviewer and to other research participants during FG1. As a first step in addressing this, participants and I engaged in conversation regarding the importance of creating and maintaining safety in the group, and collaboratively developed confidentiality guidelines for the group and its members. Group guidelines included items such as agreeing to not share what was discussed outside the focus groups and agreeing not to disclose who took part in the focus groups. For more information regarding the development of group guidelines please see Appendix A.

The decision to utilize a research method where anonymity and confidentiality cannot be guaranteed requires that careful consideration be given to minimizing the potential risk for participants. Two measures were employed as avenues to ensure the maximum degree of safety and comfort for research participants. The first measure was the researcher's commitment to full disclosure about the design of this research, including explanation and justification about how and why this research was designed to include focus groups, both through the Informed Consent Form (please see Appendix D.1) and orally during the intake process and during the focus groups themselves. In addition, I discussed issues of limits of anonymity and confidentiality inherent in focus group research and introduced the use and purpose of group confidentiality guidelines for minimizing some of the confidentiality risks.

Concerns regarding inability to ensure privacy and confidentiality due to the use of focus groups are lessened when we consider some of the characteristics of these groups and of the research participants themselves. Participants are practitioners who have attempted to use their lived experiences in their work; giving them an awareness of some of the personal risks involved in challenging dominant notions and practices in mental health. For this reason, this particular group of research participants are aware of the social justice potential of this research and, as part of that, the importance of using of group interviews as a way to break the silence, shame, and discrimination that MHWHs often experience. In addition, participants may benefit from engaging in conversation with others in similar marginalized positions (Wilkinson, 2004). According to Yalom these benefits may include a strengthened sense of hope, increased connectedness and belonging, a sense of shared experience of oppression, new learning and inspiration, insight into one's experience, a sense of helping others, and learning regarding how to engage with confrontational situations (as cited in Donaldson, 2005).

These considerations may minimize these individuals' perceived risk of surrendering a degree of privacy and confidentiality within the groups. This is in alignment with transformative-emancipatory paradigm, where the desire and commitment to challenge dominant oppressive narratives and practices and working toward improved material conditions of oppressed groups may be more prominent than the desire to ensure full privacy and confidentiality for the individual.

Given that this project aimed to be as collaborative as possible, issues of anonymity and confidentiality were discussed within the group. This aimed toward the development of a group culture where all members of the group could be seen as an active and important part of the group, and where we were all accountable to the wellbeing of the group and to each other (please see section 5.2.6.1.) Researcher and participants discussed and generated guidelines and preferences in regards to confidentiality at the start of Focus Group 1.

5.2.8.3 Handling of Data

While anonymity and confidentiality cannot be assured for participants during the data collection stages of the research, in the final write-up (this thesis) they can both be guaranteed for those participants who desire it. In the Informed Consent form (please see Appendix D.1), participants were given a choice whether to link any direct quotations to an alias of their choice or to their real name. Identifying information was removed from any verbatim data excerpts. All participants choose to remain anonymous in the final thesis. Following transcription, all identifiers (information which includes names, community names, regional descriptions, and any information that might identify an individual or his/her community) were removed (or cleaned) from the transcript by the researcher. Only I, Piedad Martin-Calero, have access to interview transcripts. Electronic files of original (not "cleaned") transcriptions from participants are password protected.

All data collected by the researcher during the course of the research has been kept confidential. Contact information and data has been kept in locked cabinets and/or password protected electronic files. Only the researcher has access to the data. For this study, the interview scripts and the digital recordings of the interviews will be kept for five (5) years following reporting and publication. At that time, all paper documents will be shredded and all electronic documents will be permanently deleted.

The only identifiers collected have been name, phone number and email address for the purposes of making and maintaining contact. Each participant's name has been linked to an alias. A master hard copy list indicating participant names, and linking aliases has been kept in a separate file from the data and stored as noted above. Consent forms have been secured in a separate section of the filing cabinet from the interview transcripts in order to ensure that personal information contained in transcripts cannot be linked with a participant's identity.

5.3 Data Analysis

5.3.1 The Listening Guide

The data analysis method that I use in this research is a variation of the Listening Guide (LG). The Listening Guide is an approach to data analysis that was developed by Carol Gilligan (2015) and that has been used and adapted by other researchers (Mauthner & Doucet, 1998). The Listening Guide originated within the field of Psychology (Woodcock, 2010) as a way of analyzing research data that "allow[s] the researcher to truly hear the nuances of a client's story" (p. 145).

The Listening Guide rests on the assumption that a single person embodies more than one voice, and that these voices are shaped by culture and relationships (Gilligan et al., 2006). The Listening Guide acknowledges that some experiences are difficult to put into words, especially experiences that are taboo or challenge social conventions, or experiences that, if shared, could have adverse consequences (Sorsoli & Tolman, 2008). This makes the Listening Guide "most appropriate for research questions that ask clients to draw upon complex, internal dialogues, which they may have never previously shared" (Woodcock, 2010, p. 152). Because of MHWHs experiences of silencing at work (Zerubavel & Wright, 2012) the ability of this method to tune in to oppressed and silenced voices and stories that was seen as particularly fitting with this research.

Individuals, especially those in oppressed contexts, may not be able to speak about their experiences directly, therefore, "when talking about 'forbidden' experiences, participants may offer accounts that are nuanced, multifaceted and densely packed with diverse meanings and cryptic messages" (Sorsoli & Tolman, 2008, p. 498). This phenomenon, referred to as multivocality (Chadwick, 2014), depicts the embodiment of more than one voice or story within a single person, where one voice(s) represents a dominant narrative and another voice(s) resists this dominant narrative.

Ontologically, the Listening Guide differs from dominant individualistic understandings in that it sees individuals as developing in interconnection with each other (i.e., relational ontology). Theoretically, it rests within what has come to be referred to as Relational-Cultural Theory; which itself rests within feminist thought and Feminist Theory (West, 2005).

The Listening Guide provides a "series of steps, which together are intended to offer a way of tuning into the polyphonic voice of another person" (Gilligan et al., 2006, p. 254). In other words, this method tunes into the many voices that one person expresses; it does so through a series of "readings," where researchers listen to interview recordings and/or read interview transcripts several times with a different focus each time. Proponents of this method state that many qualitative data analyses tend to simplify complex stories and propose the Listening Guide as an alternative (Gilligan et al., 2006).

These authors believe that the multiple readings that make up the Listening Guide allow researchers to tune into different facets of an individual's voice or story, instead of rushing to reduce a complex story into codes and themes. The sequential readings within this method allow researchers to focus on the voices of participants and help the researcher to locate their own experiences in relation to the research, centering participants' stories and preventing researchers from telling our stories through the voices of research participants" (Woodcock, 2010, p. 152).

The method is characterized by a sequential reading or listening of a research interview. The interviews are listened to or the transcripts read four or more times. The first two readings are prescribed (Gilligan et al., 2006) and are shared in all variations of the method. The last two (or more) readings "are shaped by the particular question the researcher brings to the interview" (Gilligan et al., 2006, p. 256) as well as by the theoretical, epistemological, and ontological orientation of the researcher and the research (Doucet & Mauthner, 2008; Mauthner & Doucet, 1998).

5.3.2 The Readings

This section presents a succinct description of each of the readings that make up the Listening Guide. For a representation of the listening guide 'in action' see the section "Sample of the LG in action" at the end of this chapter.

In **Reading 1** the researcher listens for the plot and for the reader's reactions (Gilligan et al., 2006). Listening for the plot means identifying the stories that are being told by paying attention to "what is happening, when, where, with whom, and why" (p. 257) and by noticing repeated words, themes, metaphors images, contradictions and absences (what is not expressed). The social context in which these stories are happening is also identified. Listening for the reader's reactions means "identifying, exploring, and making explicit our own thoughts and feelings, and associations with, the narrative being analyzed” (Gilligan et al., 2006, p. 257). This is a reflexive process where the reader reflects on our social location in relation to the participant, on our relationship with the participant, including where we connect or don’t connect with the person and the stories, as well as a reflection about “how our own responses might affect our understanding of this person and the stories being told” (p. 258).

In **Reading 2** the researcher listens for “the voice of the ‘I’” (Mauthner & Doucet, 1998. p. 128). In this reading the researcher pulls out all of the “I statements” in the transcript and places them sequentially in the form of an ‘I Poem.’ This allows the researcher to pay attention to how the speaker (i.e., the research participant) sees and presents themselves and “highlights where the respondent might be emotionally or intellectually struggling to say something” (Doucet & Mauthner, 2008, p. 406). Sometimes ‘I poems’ include segments where the speaker refers to themselves in the second person pronoun “you,” as this can be evidence that a person is “separating themselves from a particular statement” (Woodcock, 2010, p. 148). Paying attention to this use of you is important, especially when someone is speaking about things that are taboo or outside of the norm, and where a speaker may silence themselves as a form of protection (Woodcock, 2010).

‘I poems’ highlight multivocality and shifts in voice and compel the reader and/or researcher to listen to what the participant knows about themselves before talking about them (Gilligan et al., 2006; Mauthner & Doucet, 1998). These poems offer “a way of coming into relationship that works against distancing ourselves from that person in an objectifying way” (Gilligan et al., 2006, p. 259).

Researcher Reflection:
As the researcher in this project, engaging in the process of construction of ‘I poems’ was a powerful experience. I found that the ‘I poems’ highlighted emotional intensity and inner conflict that had not been as evident within the narrative as a whole. This emotional intensity compelled me to stay present with each of the participants, and granted me a sense of understanding of the experiences that was less intellectual and more visceral or emotional. This sense of emotional knowing that I found in the ‘I poems’ fits within the realm of experiential knowledge, and makes the choice to use the LG and ‘I poems’ exceptionally fitting methodology to use within a research project that seeks to increase the value and legitimacy of experiential knowledge within academia.

As previously mentioned, **readings 3 and 4** (and beyond) vary depending on the researcher and the research question, and the theoretical framework. In Gilligan’s version of the Listening Guide, Readings 3 and 4 focus on finding and tracking what she calls ‘contrapuntal voices’ (Gilligan et al., 2006; Gilligan, 2015). The term contrapuntal derives from the musical term counterpoint, where two or more melodic lines “are played simultaneously and move in some form of relationship with each other” (Gilligan et al., 2006, p. 262). The Listening Guide understands that within a person’s story “simultaneous voices are co-occurring” (Gilligan et al., 2006, p. 256), thus, following these contrapuntal voices can help the reader explore the ways in which these voices interact, whether melodiously or in tension with one another (Woodcock, 2010).

The third and fourth readings bring the attention back to the research questions. Specific contrapuntal voices chosen are shaped by research question and can be guided by the theoretical approach to the research (Gilligan et al., 2006; Sorsoli & Tolman, 2008). After the researcher has chosen the two or more contrapuntal voices they dedicate one reading to each of the contrapuntal voices. During each reading the researcher underlines the segments of speech that are evidence of the voice that is being tracked. After all the readings have been completed the researcher explores how the voices relate to one another. Voices can be complementary or contradicting, for instance (Gilligan et al., 2006).

In the case of this research, the contrapuntal voices were not chosen a priori but rather emerged from analysis of the data. As is further explained in the next section, the data indicated that participants, across research questions and across groups, talked about their knowledge and experience from two different perspectives: a perspective of connection and a perspective of disconnection.

The theoretical approach was also important in this research, although it was through this initial analysis of the data that the original anti-oppressive, emancipatory, and feminist theoretical lens was further refined and that Relational-Cultural Theory was taken up as the main theoretical lens for this research.

Following the four readings, the researcher is instructed to compose an analysis in the form of an essay, pulling together, interpreting, and synthesizing the learning from the four readings (Gilligan et al., 2006). This is a process of bringing all the findings from the readings, “back into relationship with one another, not to reduce the complexity of a person’s expressed experience” (Gilligan et al., 2006, p. 267).

Moreover, in a study, such as the present thesis, that includes multiple interviews “these *Listening Guide* analyses may be examined in relationship with one another, illuminating similarities in the themes that may begin to emerge across several interviews and also marking distinct differences between them” (Gilligan et al., 2006, p. 267). In this thesis, the data analysis chapter presents mainly this last level of interpretation, incorporating the different readings and comparing and contrasting the findings from one focus group with the findings from the other two groups. Examples of specific readings, such as 'I poems' are included to illuminate specific findings. As an example for the reader of how each of the steps of the Listening Guide can be operationalized, the end of this chapter includes a fully detailed analysis of a short passage.

5.3.3 Adapting the Listening Guide to this Research

The Listening Guide is an approach to data analysis that is flexible and that needs to be adapted to each research project (Gilligan et al., 2006). In order to adapt this method to this research I needed to address several questions. The first question related to choosing the specific contrapuntal voices to use in readings 3 and 4. Additional questions related to the use of focus groups, and specifically about whether this approach could be helpful in answering Research Question 3: "What is the experience of being part of a community of Mental Health Wounded Healers through participating in these focus groups?"

5.3.3.1 Using Contrapuntal Voices to "Tune in" to Counter-stories

This research rests on the idea that the voices and stories of Mental Health Wounded Healers are often silenced and oppressed. This research, then, aims to create change for MHWHs by helping bring forth these voices and stories through the fostering of connection and relationships between MHWHs.

McKenzie-Mohr and Lafrance (2014) write that a person's speech is multivocal, it expresses elements of dominant stories as well as elements that resist those stories, which they call counter-stories. Individual speech contains elements of dominant and oppressed narratives and, through Gilligan's version of the Listening Guide, I can use contrapuntal voices to help track these narratives in participants' speech. This indicates that Gilligan's version of the LG, with the use of contrapuntal voices, fits with the emancipatory aim of creating change for MHWHs. Listening to contrapuntal voices (in readings 3 and 4), I am able to listen to individual accounts and still get information about structural factors impacting the individual. Specifically, listening for dominant narratives in participants' speech allows me to hear elements of how mental health structures impact participants' lives. At the same time, listening to instances where participants resist these dominant narratives and bring forth other, alternative narratives, can help me hear how MHWHs attempt to live their lives and make sense of their experience outside of these dominant narratives.

5.3.3.2 Choosing Contrapuntal Voices

In an effort to determine which contrapuntal voices to choose in this research I went back to the data, and specifically to readings 1 (plot and researcher's reactions) and 2 ('I poem'). I looked at these readings across the three focus groups, each of which focused on one of the three research questions, to determine whether there were commonalities that could be understood as contrapuntal voices. As I looked through the data, I observed a pattern across conversation topics: The majority of the topics were spoken about in two different ways: from a perspective of connection and a perspective of separation/disconnection.

When participants spoke in terms of connection they spoke about things such as relationships, cooperation, showing vulnerabilities (e.g., speaking about own mental health challenges and showing emotion), listening and being adaptable, and normalizing challenges. On the other hand, when participants spoke in terms of separation or disconnection, they spoke of things such as judging, burnout, diagnostic labels and not showing vulnerabilities (e.g., not speaking about own mental health challenges, not showing emotion). They also spoke about wanting to protect themselves (e.g., from re-traumatization) by not engaging in certain activities such as activism and ongoing relationship with other MHWHs, and spoke of experiences with other mental health workers as “going into battle.”

This realization led to the decision to **dedicate reading 3 to the voice of connection and reading 4 to the voice of disconnection**. These readings form the basis of data analysis presented in chapter 6.

5.3.3.3 Use with Groups

The Listening Guide, because of its relational lens, seemed like a method that would be particularly suited for a group methodology. Surprisingly, even though it is a method that refers to itself as relational, it is designed solely for use with individual interviews. A search for group adaptations of the guide revealed only two articles that used the guide to analyze group data. Moreover, the articles that I did find (Byrne, 2009; Van Puyenbroeck, Loots, Grietens, & Jacquet, 2014) did not adapt the method to a focus group setting and were thus not very helpful.

The research by Byrne et al. (2009), for example, focused on teenagers dropping out of school and included a focus group component. The researchers taped a group conversation between research participants (teenagers), one academic, and one artist. Interestingly, however, only the teenagers’ input to the conversation was analyzed. In the article, the researchers state that the teenagers found this to be a problem. In the writing, the authors acknowledged this criticism and reflected on traditional understandings of research and researcher as reasons for this oversight (Byrne, 2009, p. 74). While this research had a focus group component the researchers did not analyze it as such, and therefore missed an opportunity to adapt the method to a group setting.

As I contemplated how to adapt this method to focus group methodology I focused on Research Question 3. RQ3 “What is the experience of being part of a community of Mental Health Wounded Healers through participating in these focus groups?” relates specifically to the focus group design of this research and provided an avenue to explore the use of the LG with focus group methodology.

As a way of adapting the LG and/or assessing its fit with focus group methodology I explored whether the chosen contrapuntal voices of connection and disconnection could help me answer this last, “meta,” question. I went back to the interview transcripts and to the 1st and 2nd readings and realized that participants’ words and behaviours about, and toward, each other could also be looked at through this lens of connection/disconnection. This analysis of the data showed that RQ3 was answered in two ways: directly when participants spoke about their experience being part of the focus group and indirectly through their interactions with each other (please see section 6.6.3). In other words, RQ3 is about content and process; the content aspect relates to explicit, verbal answers to the question of MHWH experiences of coming together, whereas the process aspect relates to how participants relate to each other.

While the chosen contrapuntal voices of connection and disconnection were helpful in answering the content aspect of RQ3 (i.e.; the explicit answers the question), they did not specifically track the process aspects of RQ3. I decided to go back to the interview transcripts and pay attention to performance of connection and disconnection within the contrapuntal voices. Paying attention to performance of connection and disconnection, I observed, for instance, that participants chose which kind of stories to share with each other and at which time, often revealing increasingly more personal and/or sensitive information as we spent more time together. Participants also interacted with each other in non-verbal ways such as through laughter and other vocalizations.

Looking at performance of connection and disconnection within the contrapuntal voices showed that participants performed connection when they shared stories that were similar to another participant's story, when they laughed with each other, when they showed agreement with each other and when they spoke of the value that they found in developing connections with each other through the focus groups (and beyond.) While the instances of performed disconnection were fewer, participants seemed to perform separation when they interrupted each other, when they disagreed with each other, and possibly when they spoke of finding connecting with each other painful or re-traumatizing.

5.3.4 Iterative Data Analysis

The research process involved a series of iterative cycles with one aspect of the research influencing other aspects of the research in a process of increasing fit between the different aspects of the research. I found, for instance, that, similarly to how the research questions are used to modify the Listening Guide (specifically readings 3 and 4), the initial data analysis emerging through the listening guide helped refine and "fine-tune" the data analysis itself. This happened namely through the process that led to choosing Relational-Cultural Theory as a lens through which to analyze the data.

A careful look at all the different aspects of the research showed that they all shared a **focus on relationships**. The research topic, the research design, and the data analysis method share that focus. This realization led to adopting Relational-Cultural Theory to use for interpreting the research findings.

5.3.5 Using the Listening Guide: Data Analysis Sample

In this section I use a quote from one of our focus groups to demonstrate how I used the Listening Guide as a method of data analysis in this thesis. This section presents a detailed explanation of the LG in use, including readings 1, 2, 3 and 4 and a summary and interpretation of the findings from the four readings. As this is a lengthy process, the data analysis chapter does not depict findings with this level of detail, making the inclusion of a fully detailed example of the LG in use appropriate here. Including this sample of detailed data analysis is methodologically important within the Listening Guide, as it provides the reader with an example of the kind of paper trail that is created through the four readings, which helps the researcher stay close to the data (Gilligan et al., 2006).

Toward the end of FG1 participants and I were talking about challenges at work and discussing some strategies that participants have used to deal with these challenges and to try to prevent further challenges. In the following segment Chris (pseudonym) shared with the group the importance of having people "who can validate you" at work.

Note: In the transcription of the focus group interviews brackets have been used for two purposes. When included within the speech of the main speaker (see [sigh] below) they are used to represent vocalizations by said speaker. When they are used in their own line they represent words and vocalizations by other group participants, specifically when it is not clear which group member they originated from.

5.3.5.1 Interview Segment

You start encountering people who can validate you, right? Because like I said, I thought there was something wrong with me. I thought I wasn't a good nurse, right? You know, and all this stuff, and then I'm finding out "Chris, you're awesome." I always found out every time I was leaving. […] "Here's your two apple trees. We loved you, you were great." Well, why didn't you tell me that while I was here, right? Well, why didn't you tell me that while I was here, right? Instead of … [sigh]…when I was falling apart, right? -Chris

5.3.5.2 Reading 1: Plot and Researcher Reactions

In Reading 1 I listened for the plot of the story/stories and for my reactions to the story being told.

Plot: In this quote, Chris starts by talking about the importance of having people at work who can validate and understand her. As she talks, however, she tells us what seems like its reverse: she talks about feeling alone and internalizing the sense that there is something wrong with her.

Researcher Reaction:

Having co-workers show their support as she is leaving seems painfully ironic to me. Was the support there but not shared or perhaps not known or received by Chris? Or was there, in fact, no support and these words are "just words"?

Chris's words remind me of times when I have spoken up in a group of people and stood alone in my challenge. In several occasions people have come to me after those kinds of meetings and thanked me for speaking up. I feel twisted inside when this happens. Part of me feels some comfort in knowing that others shared my feelings and opinions, comfort in knowing that I am not the only one who sees things the way I do. More than that, however, I feel anger at those people, who choose to stay safely quiet, do not risk anything, and may even benefit from my intervention.

Chris's words resonate with times when I have experienced myself as different from others and have stood alone in that difference. Perhaps because of this I believe that I can feel Chris's pain as it emanates from her words. Reading her 'I poem' (below) further intensifies these feelings for me.

5.3.5.3 Reading 2: 'I Poem'

To create this 'I poem,' I pulled out all of the "I statements" in Chris's quote and placed them sequentially. This process is a tool of the method that helps pay close attention to how Chris sees and presents herself and "highlights where the respondent might be emotionally or intellectually struggling to say something" (Doucet & Mauthner, 2008. p. 406).

In this case I have also included statements that start with you, as Chris seems to be talking about herself using the second pronoun.

Chris:
You start encountering people
Who can validate you

I thought there was something wrong with me
I thought
I wasn't a good nurse
then I'm finding out "Chris you're awesome"

I always found out
every time I was leaving

I was here
I was here
I was falling apart

In this 'I poem,' Chris starts by talking about receiving support then quickly switches to talking about not getting support and feeling alone. As the content of her message shifts, she switches from referring to herself in the more distant "you" toward using "I." I interpret this to mean that the experience of feeling alone and unsupported feels closer to her, maybe more real, than that of being seen and validated.

Moreover, when Chris talks about encountering people who can validate her she speaks in the present tense, while, when she talks about her experiences not getting validation she speaks in the past tense. To me this suggests a sort of journey toward connection. I interpret this as a journey where Chris is trying to find two things: she is trying to find connection and she is trying to arrive at a sense that she is "ok."

In this 'I poem' Chris seems to be grappling with two deep questions: "Am I ok?" and "Am I alone?" She seems caught in between "I am alone," and "I am not alone;" as well as between "I am ok" and "I am not ok." This makes me wonder whether she may also be grappling with a third question: "Can I be ok if I am alone?"

In Chris's words I hear confusion and contradiction. It seems that Chris relates thinking that there was something wrong with her with feeling alone. If not getting validation from coworkers relates to her belief that there is something wrong with her, does this belief change once she hears co-workers say that they did appreciate her? Also, did others actually appreciate her?

The last three verses feel so powerful in expressing how alone Chris felt. They also seem like a call out, a call out to be heard, and seen, to connect:

I was here
I was here
I was falling apart

There is something about 'I poems' that I find quite powerful, and this one is no exception. The knowledge in 'I poems' seems different: it is a knowledge that goes beyond thinking and tugs deep; it tugs at the heart. 'I poems' really appeal to me and seem particularly fitting in this research because they help incorporate felt knowledge, experiential knowledge, into academic research.

5.3.5.4 Readings 3 and 4: Contrapuntal Voices

For readings 3 and 4, I underlined all the segments of Chris's quote that were evidence of the two contrapuntal voices that I have chosen to follow: the voice of connection and the voice of disconnection. The contrapuntal **voice of connection** is shown in **bold** and the contrapuntal voice of disconnection is shown underlined. After doing this, I looked at how these two voices relate to each other. Voices can be complementary or contradicting, for instance (Gilligan et al., 2006).

> Y**ou start encountering people who can validate you**, right? Because like I said, I thought there was something wrong with me. I thought I wasn't a good nurse, right? You know, and all this stuff, and then I'm finding out **"Chris, you're awesome."** I always found out every time I was leaving. […] **"Here's your two apple trees. We loved you, you were great."** Well, why didn't you tell me that while I was here, right? Well, why didn't you tell me that while I was here, right? Instead of … [sigh]…when I was falling apart, right?

As I read through this quote I noticed that for Chris, in this quote, the voice of connection seems to be distant, while the voice of disconnection seems closer. The voice of disconnection appears through the use of the "you" pronoun while the voice of disconnection appears through the use of I. Moreover, the voice of disconnection comes through Chris's own words, while the voice of connection is expressed indirectly twice, as the words of Chris's coworkers.

I wonder if Chris's words indicate that she "knows" disconnection intimately, but that perhaps the same cannot be said of connection. She seems to be 'trying to get to know' the voice of connection. Connection seems further away, seemingly out of reach.

As I read, I also felt that there were two different voices of disconnection. One voice where Chris feels disconnected from her coworkers: "why didn't you tell me while I was here?" and one where she seems disconnected from herself: "I thought there was something wrong with me. I thought I wasn't a good nurse."

The voices of connection seem further away or perhaps just hard to believe. When I first read the quote I thought that Chris did not believe her co-workers when they said they appreciated her. After all, why would they only share appreciation to Chris as she was leaving? However, when I looked at the bolded words that represent connection, they popped out at me and that made me pay more attention to them:

"Chris, you're awesome."

"Here's your two apple trees. We loved you, you were great."

Researcher Reflection:

After considering these words more closely I thought that perhaps Chris did believe her coworker's words and I wondered whether, having empathized strongly with her feelings of being alone, I might have been biased against believing (or perhaps accepting) their appreciation. When I paid closer attention to her words I did notice that Chris does not go on to say that she did not believe them, she says, instead "why didn't you tell me?" which might indicate that what mattered was not just whether her co-workers appreciated her but whether she was able to know and feel that appreciation and not feel alone. This is an example of how engaging in the four readings allows the researcher to stay close to the data, instead of rushing to interpretations. In this example, if I had rushed toward interpretation I may have unintentionally and without awareness imposed my own bias toward disconnection in this passage.

As I looked at the pattern or picture that the voices of connection and disconnection present in this quote, I noticed that these two voices alternate: connection-disconnection-connection-disconnection. There isn't a tidy transition from disconnection to connection, for example, which might signal a tidy progression toward connection; perhaps a clear resolution. Instead, the voices of connection and disconnection go back and forth, like a tug of war. And there is not a clear winner.

5.3.5.5 Summary and Discussion

Chris talks about the importance of finding people that validate her at work. As she talks about this, she tells us a story of trying to find this validation. She tells us about feeling alone and taking in the idea that there is something wrong with her. Through this journey, Chris grapples with making meaning of the words of acknowledgement that she does receive, which come too late and seem insufficient.

Chris's words show that finding connection through validation is an important drive for her. This is in alignment with Relational-Cultural Theory, which states that relationships and connection are central to humans' wellbeing (Jordan, 2008b).

Considering the importance of connection for Chris a question that could be asked is: even if she does believe her co-workers' appreciation, has she been able to find a way to get this appreciation before she is leaving? The first two lines in the quote: "you start encountering people who can validate you," suggest that she may have. On the other hand, the alternating pattern of voices of connection and disconnection suggests that her questions have not been answered to the point of resolution. Finding appreciation and not feeling alone seem to be a process and a journey rather than a destination that she has arrived at.

After having engaged in all these layers of analysis, I wonder if the question that needs to be asked might be whether Chris is getting (or could get) enough appreciation and validation to meet her needs. I specifically wonder about how we may come to understand validation when we take into account the dominant rules and narratives that social structures, such as mental health structures, work within.

In a world where we are expected to be self-sufficient and not to need one another, especially at work, acknowledgement is likely not to be found in abundance. In addition, in a world where competition is paramount, propping someone up by offering validation may not be in the interest of a co-worker. However, that risk is not there when a worker is leaving, which may account for appreciation being shown to Chris at those times. Moreover, in a culture of competition it generally pays to “play by the rules,” openly supporting someone that follows a different perspective or belief system, such a MHWH, may be risky. There is extensive literature that explores the issue of toxic workplaces in healthcare (Colligan & Higgins, 2006; Conti-O'Hare, 2002; McVicar, 2003).

I believe this has repercussions for MHWHs, and for anyone who works from a perspective that deviates from the dominant narrative. When MHWHs are not able to find others who see us and validate us we start to internalize the message that the issues rest within us. We may start to believe, like Chris did, that “there is something wrong with me.” Moreover, these individual repercussions have structural consequences. Very micro level dealings, like the ones Chris is referring to here, which locate the problem *in* the MHWH, can lead to an internalization of issues; to a belief that “the problem is (in) me,” and result in MHWH isolation and self-doubt. As Jordan (Jordan, 2008a) states: “We should always remember that part of the work of a dominant group is to get the subjugated or non-dominant group to internalize the following construction: ‘I am the problem because I feel the pain’” (p. 421). Once the issues have been located *in* the individual and away from the structures that created the challenges for these individuals, those structures are able to remain unchallenged. Small level interactions like the ones referred to above, therefore, work to reinforce the status quo.

5.4 Conclusion

This chapter described the research methodology, including the population, sample, data collection and data analysis instruments, as well as strategies used to ensure the ethical standards of the study. The process through which decisions regarding methodology and data analysis were made was explored in detail, and was identified as an iterative cycle of increased fit between all the different aspects of the research.

A series of 3 reconvened (i.e., repeated) focus groups with a single cohort of MHWHs was utilized as the avenue for data gathering. The Listening Guide (LG) was used as the tool for data analysis. This chapter explored the suitability of focus group methodology as methodology for this study, as well as the rationale for the use of the Listening Guide for data analysis.

The following chapter, Chapters 6, is dedicated to presenting and discussing the research findings from each of the three focus groups.

CHAPTER 6 FINDINGS

6.1 Introduction

The data analysis of the three focus groups yielded several findings, one of which reached across all focus groups and research questions. This finding related to three contrasting ways participants conceptualized mental health, which I understood as representing different narratives or discourses about mental health. I have come to identify these three mental health narratives as a dominant mental health Narrative of Disconnection and two alternative narratives: a Narrative of Connection and a Narrative of Resistance.

In this chapter I have taken these three narratives and used them as a lens through which to analyze other research findings. In sections 6.2 and 6.3 of this chapter I present information about the use of quotes, and a process summary of the three focus groups, respectively. In section 6.4 of this chapter I present the three mental health narratives as emerging from analysis of the data in the research. Following that, in section 6.5 I interpret the functionality of these narratives using Relational-Cultural Theory and linking back to concepts of Wounding and Healing that are central for the Wounded Healer. Finally, in section 6.6 I use these three narratives as a framework to interpret the findings of this research by research question.

In the chapter 7: Discussion, I discuss each of these narratives separately: their social functions, and their impact for MHWHs. In this chapter I also present a reflection of my own experience and learning as a MHWH through the lens of these three narratives.

6.2 Use of Interview Excerpts

I have edited interview excerpts slightly so that they do not take up an excessive amount of space and so they are more readable. I have attempted to do so in a way that least modifies the meaning that I believe the speaker intended. I have, for instance, at times excluded some of the interaction between participants, especially when there was one main speaker and others' remarks were encouraging or supporting the main speaker's story (e.g., instances of laughter, "uh huh," or gentle prompts). I have been sure to include some excerpts that portray rich instances of interaction between participants in order to counteract these edits.

All quotes used in this writing are linked to pseudonyms for the protection of the research participants. Moreover, in instances where the content of a specific quote is particularly sensitive or identifying even the pseudonym is not used, as an additional level of protection. These are instances where a quote could be connected its author and/or when a participant expressed feeling that she could suffer repercussions if the quote was linked to her.

Transcribed dialogue is presented in this way:

… Pause

— Interruption in speech

[…] Edited out segment

Emphasis in speech is shown in italics

In instances where a word or words has been substituted by another, less identifying or clearer in meaning, the new word or words are presented between brackets: [less identifying word]

6.3 Process Summary

The three focus groups were facilitated by me. Groups were spaced three weeks apart from each other and each was 2.5 hour in length.

6.3.1 Focus Group 1

The first half of the focus group was dedicated to introducing myself and the research, welcoming participants, and participants introducing themselves. Special attention was paid to encouraging the development of a supportive and safe group environment (please see section 5.2.6). In the second half of the group I introduced Research Question 1: "What are Mental Health Wounded Healers' experiences as workers in the mental health field?" and we engaged in discussion about workplace experiences. Toward the end of the group I attempted to engage in "in-vivo" (i.e., in-situ) data analysis of our discussion, as I had planned, but I realized that there was not enough time to do this properly and participants seemed less interested in this than they were in connecting with each other. Please see section 4.4.2 for further reflection.

6.3.2 Focus Group 2

The beginning of FG2 involved sharing with participants some of the learning and reflection that I had engaged in after FG2. For example, I shared some specific examples of data analysis with the group. Participants then checked in and we dedicated most of the 2.5 hours to the discussion of Research Question 2 (RQ2): "How do Mental Health Wounded Healers use their lived experience in their practice?" Toward the end of the group I attempted, once again, to engage in data analysis of our discussion, as I had planned. Once again, I realized that there was not enough time to devote to this, especially considering that participants were much more interested in connecting with each other than in engaging in data analysis. Please see section 4.4.2 for further reflection.

6.3.3 Individual Reflection

At the end of FG2 I invited participants to engage in individual reflection about their experiences of the first 2 focus groups (i.e., experiences of connecting with other MHWHs) that they could share with the group in FG3. Individual Reflections were to be created by participants independently from the researcher. I gave participants copies of Appendix B: Individual Reflection Guide, which they could use as inspiration or guidance for engaging in individual reflection about their experience of coming together with other MHWHs. Participants were encouraged to utilize creative modes of expression, if they felt these could help them express themselves. Individual reflections were not be used as data within this study. Rather, it would be each participant's sharing of their reflection within Focus Group 3 that would be considered data for this study. As I discuss in the next section none of the participants chose to bring an individual reflection to share during FG3.

6.3.4 Focus Group 3

None of the participants chose to bring an individual reflection to share for FG3. Perhaps this request placed too high a demand on participants, within a study that already required a significant time commitment from participants.

During FG3 participants discussed Research Question 3 (RQ3): "What is the experience of being part of a community of Mental Health Wounded Healers through participating in these focus groups?" Participants answered the question directly, but spent most of the time discussing current and past experiences in relation to mental health and to the experience of being a MHWH. Specifically, participants discussed their experiences within dominant structures (i.e., workplaces and educational) and listened to and supported one participant who had recently experienced loss in the family to suicide.

Participants were very engaged in discussion (and I was hesitant to halt their conversation) which left limited time to fully engage in some of the planned activities, which included presenting initial findings, inviting feedback about the research, reviewing our learning, and engaging in participatory data analysis. I asked participants which of these areas they wanted to discuss and our last conversations centered on processes to ensure participant confidentiality in the writing, on knowledge translation, and finding an audience for the thesis. Participants also wanted to discuss future plans to connect with each other.

6.4 Mental Health Narratives

When I asked participants to speak about their workplace experiences as MHWHs most of the stories they told had elements of wounding. Participants spoke about wounding within their workplaces as well as within other structures such as university settings. As participants told their stories they referred to a lack of fit between how they understand mental health and how they observed mental health to be understood within these structures. Participants spoke of dominant understandings of mental health in terms of judgement and othering, which I came to interpret as a dominant narrative of mental health that is based on disconnection. Participants then spoke about their own understandings of mental health in terms of connection and relationship, which I interpreted as an alternative mental health narrative of belonging. In sections 6.4.1, 6.4.2

and 6.4.3 I speak about these two narratives as well as a third narrative; a narrative of resistance, which I interpret as generating in the meeting of the first two narratives.

6.4.1 Dominant Narrative of Disconnection

Participants identified a dominant narrative of mental health congruent with that reviewed in the Introduction and Literature Review chapters operating in their jobs in the mental health field. They understood this narrative as working from a place of othering and separation, an us-versus-them mentality which constructs people with mental health challenges as "different from the norm" and "deficient."

Participants spoke of noticing, in the mental health jobs, a practice of separating people into categories of helper and helpee. Rachel, for example, told about colleagues speaking about clients in stigmatizing, 'othering' ways:

> The staffroom chat […] was so stigmatizing and I'd be sitting in there and every single time I'd have to open my big stupid mouth and say "I have that diagnosis too and what you just said was incredibly offensive." Every single day. -Rachel

She then explained that this us-versus-them mentality led to having to distance herself from clients:

> I got chastised for eating lunch with the patients because they were nice and they were awesome— And they weren't talking and saying mean things about each other. But I wasn't allowed to do that because I was part of the "them" group, whichever "them group" I belonged to. So I wasn't allowed to engage in a way that was human, and thoughtful, and kind. You know, I was expected to partake in this horrible stigmatizing back room discussions and *I couldn't do it*. –Rachel

Similarly, Jill spoke about observing workers judging clients and told about coming to the realization that "there's certain types of vulnerability that are not welcome" in mental health spaces. She told of a time when she felt unwelcome in her new role as a worker, after going from being in a client role to worker role:

> I started to work at a clinic where I used to be a patient, and [there was] a nurse who was never my nurse but who knew me as a former patient and […] I said "Hi" to her in the hallway when it was my

> first day and she goes "Whatever!" and she like walks away and I was like "What's going on?" It was so intense. I was like "oh I'm treating her as an equal that's not ok, right? Oh, right, I'm a former patient" And I had to like shrink, and shrink, and shrink, and that's how I ended up being able to function there for the next while. -Jill

Jill's experience shows that ideas of clients as different and deficient appear to be operating within the mental health system. This nurse seems to understand client and worker as two 'natural' categories that are distinct and exclusive from each other. When Jill arrives as a worker, this nurse does not have a way of making sense of the change in roles.

Participants also observed that, within the mental health system, there is a belief that people can't recover from mental health challenges. Rachel said that, for her,

> It's not the people that I'm working with that are making me feel horrible. And it's not my co-workers either. It's the fact that I work in a system where the philosophy is not recovery, even though that's what they say it is—it's "don't make it worse." -Rachel

Rachel's words point toward a mental health system that is built upon the idea that mental health challenges are not something one experiences but rather are part of one's identity. Within the system, mental health challenges are constructed as a permanent feature of some people (the clients) and not others (the workers). This could be seen as evidence that the system constructs (and is constructed within) a discourse whereby people with mental health challenges are seen as fundamentally different from those who don't have them; a construct that does not leave room for MHWHs, who inhabit both of these social locations. From a Relational-Cultural perspective, this suggests that dominant notions of mental health are situated within a separate-self paradigm that sees individuals as separate from each other, and primacies autonomy, independence, and establishing firm boundaries as a way to separate us from each other

(Jordan, 2001, 2008b). This analysis supports the argument that the dominant narrative of mental health is a narrative of disconnection.

6.4.2 Narrative of Connection

In contrast to participants' depiction of dominant understandings of mental health, which emphasized difference and pathology, their own understandings of mental health challenges centred on connection and relationship. Participants linked their departure from the dominant narrative to their experiences of mental health challenges. Sarah, for example, shared that:

> The experiences I've had and the way I've been treated through the system, and just my own experiences have really changed how I am as a professional and the way I treat people. -Sarah

Participants spoke about working from a place of connection and relationship. Chris, for example, said:

> That's the way I've always practiced, what I've done, I've followed the person and what my instincts said, to listen to the people even though it was out of the norm. –Chris

This approach de-emphasizes differences between client and worker. Sarah, for example, does not like using diagnostic labels, and instead focuses on showing empathy about the client's experience:

> Labels for me are tricky. I don't feel there's a whole lot of value depending in the label. So for me I just approach it as, "whatever kind of problem you are having it's really hard to talk about something like that because you don't know when it's going to be used against you." -Sarah

Participants also spoke about their lived experiences of mental health challenges allowing them to see the humanness in all people. Chris stated:

> My current job is so busy that I lose the humanness and I think what everybody needs is that humanness, and […] whatever experience we have that's what makes us really good at what we do and we can't lose that. -Chris

Lastly, participants also linked their experiences to a capacity for hope and for the possibility of recovery:

> I *really, passionately, believe* in recovery because I live it. You know, recovery for me is not a unicorn, it's a real thing […] I hold that hope for every single person who walks through the door whereas the system does not. The system is putting people into a place where they are expected to maintain, or—and the staff to not make it worse, and [vocalization of frustration] and that's not fulfilling at all. - Rachel

From participants' words we can see that their lived experience of mental health challenges has led them to question the dominant narrative of mental health as difference and as pathology. Participants spoke about wanting to work through connection and relationship; they spoke about their lived experience of mental health challenges allowing them to see the humanness in all people, affording them greater ability for empathy and compassion, and a greater capacity for hope and for the possibility of recovery. They questioned that experience of mental health challenges is, or becomes, a fixed trait in people. Participants also questioned the idea that they, as workers, are different from those they serve, challenging the dominant "us-versus-them" dichotomy. This line of conversation reflected a different understanding of mental health challenges; one that, from a Relational-Cultural perspective, is based on an understanding of the connected-self, which argues that "it is through building good connections that we achieve a sense of well-being and safety" (Jordan, 2008b, p. 2). Participants' reference to a focus on connection and relationship, and their challenging of the us-versus-them dichotomy, supports my argument that this alternative mental health narrative is a narrative of connection.

6.4.3 The Development of the Resistance Narrative

Participants are caught between a dominant narrative of mental health of disconnection that is rooted in understandings of the separate-self (Jordan, 2001, 2008b) and a preferred narrative of connection, rooted in understandings of the connected-self (Jordan, 2008b). The dominant separate-self paradigm is one that emphasizes individuals and difference. This paradigm leads to a narrative that focuses on categorizing and separating and, in mental health, to a narrative of disconnection that is built on ideas of normalcy and deviance, pathology, and cure. The alternative connected-self paradigm acknowledges that relationships are central. It posits that we are not separate from each other, and thus not that different from each other. This paradigm emphasizes similarities instead of differences, which promotes empathy and understanding and, in mental health, leads to a narrative of connection with a focus on shared human experience and on relationship with clients.

As participants spoke about the dominant mental health narrative of disconnection and about their preferred narrative of connection it became evident that the places where these two narratives met were challenging for MHWHs in various ways, and led to wounding. It is in this place of meeting of opposing narratives where I have identified characteristics of a third narrative: a narrative of resistance.

This narrative begins from participants' attempts to work from their preferred narrative of connection within mental health structures working from a narrative of disconnection. Sarah, for example, reflected about **feeling in opposition** to others in the mental health system, which she referred to in terms of 'walking into a fight,'

> Sometimes it's like walking into a fight. Sometimes when I feel passionate about something that's not necessarily the view people take, I feel like I'm walking into a fight. -Sarah

The ways in which participants' preferred practice was met by the mental health structures seems to work in a way that excludes, silences, and alienates MHWHs, leaving a wound. Sarah talked about how workplace interactions have impacted her as a worker:

> We… would have discussions about cases but the way that people discussed a case would always… I couldn't, I was left feeling…burned out…invisible…incompetent. -Sarah

In addition, participants spoke of **feeling marginalized, scrutinized and silenced** within the mental health system in several other ways. Participants, for example, felt that emotionality at work was pathologized and used to de-legitimize their work:

> When you start challenging the system and start crying and you're angry [laughter] or whatever else, […] it's like then you become an emotional—the person that's mentally unstable or whatever. -Patti

Rachel also spoke of being **scrutinized through license registration**. She shared that licensing boards request that people with mental health and addictions self-identify and said:

> I struggle with that every time I renew my professional certification cause they ask that question […] "Do you have any disabilities that would affect your practice? Do you have any addictions or mental health problems?" -Rachel

As participants attempt to work from an alternative narrative of connection, they are faced with opposition from the dominant structures, and experience wounding. What happens as a result, is that participants distance themselves and disconnect from these dominant structures in order to protect themselves (Jordan, 2001), and their ability to hold on to the preferred narrative of connection is compromised.

One way that participants distanced or separated themselves from the dominant structure was through **emphasizing differences between MHWHs and workers practicing from a dominant perspective**. For example, Jill portrayed non-MHWHs in a negative light when she talked about emotion and vulnerability not being acceptable/accepted at work:

> That [lack of acceptance of vulnerability] is behind why people can get away with being so oppressive and aggressive and judgemental and gossipy and weird in the workplaces. -Jill

The narrative that emerges from this tension is not one that is fully rooted in the connection narrative. MHWH's construction of mental health, while attempting to break down the us-vs-them paradigm, ends up constructing another divide. The divide goes from an us-vs-them where us is the "well-workers" and them is the "pathologized other," to a divide between an "us" of people with mental health challenges, and a "them" of non-MHWHs who are working within dominant structures and/or paradigms. This is what Lafrance and McKenzie-Mohr (2014) call a 'photographic negative' of the dominant narrative.

I saw evidence of this new narrative in participants' **use of the word judgemental** during our conversations. The term "judgemental" was used often as a way of describing dominant practice of mental health, almost as a personification of "the system." Participants used this term to refer to mental health services and practices that are set within dominant mental health narratives of othering and pathology:

> Being judgemental and not being where somebody is at… right? Because it's very easy […] You start taking on the persona of the system. -Chris

Participants talked about this judging as something that they needed to be mindful to distance themselves from. They spoke of noticing judgement within themselves and of a desire to shift away from judging. In Chris's words:

> I'm always, always re-learning and when I'm being judgemental I catch myself being judgemental, I catch myself! I'm a human! And then it's "ok what does that mean?" Ok… How do I get back to not being judgemental and being where they're at? -Chris

Distancing themselves from "being judgemental" was a mechanism that participants used to construct themselves as different (and perhaps better?) than non-MHWHs. The **irony** is that, because of the harm experienced and because of the need to protect from further harm, in the process of attempting to work from a narrative of connection participants ended up reproducing disconnection, but this time disconnection from the dominant group. In their use of the term "judgemental" participants demonstrated a shifted alliance, from an alliance with workers, which is what would be expected from a dominant narrative of mental health that emphasizes difference between the helpers and the helpees, to an alliance with clients.

6.4.3.1 Third Narrative as "Photographic Negative"

Participants spoke about being drawn toward a practice based on connection, which they saw as different from that upheld by the dominant narrative. However, their ability to envision and to realize a completely alternative narrative of connection was curtailed by their location within a separate-self culture and within a dominant narrative of mental health, which led to the construction of another alternative narrative; a kind of "photographic negative" (Lafrance & McKenzie-Mohr, 2014) of the dominant narrative, where distancing remains, albeit with a shift in focus toward distancing from non-MHWHs who are working within dominant structures and/or paradigms. In the process of advocating for connection, participants end up re-producing disconnection, but this time it is *disconnection from other workers*, instead of disconnection from clients.

Lafrance and McKenzie-Mohr (2014) warn that "when a contesting narrative is situated as the photographic negative of the master, the image itself is left intact" (p. 9). They highlight the importance of considering who may benefit from a counter-story and who may be put at risk by it. These authors' position led me to consider in which ways this new narrative may benefit the dominant narrative and dominant structures and in which ways it may benefit MHWHs. Looking at this narrative from the perspective that it leaves the dominant, or master, narrative intact led me to explore the idea that this narrative could indicate a failure of MHWHs in overturning the dominant mental health narrative of disconnection. This process of counter-storying could be understood as a sign of the dominant narrative working to reproduce itself, through its ability to influence and limit what alternative narratives are able to be produced. After all, the underlying narrative of disconnection has not been set aside, only shifted in focus. Moreover, I could imagine how this new narrative could result in further harm for MHWHs. MHWHs working from this photographic negative narrative of disconnection may challenge dominant practices by placing themselves in positions of opposition toward (or direct challenge of) the dominant structure, which could lead to these workers being ignored or disregarded and potentially being excluded from the dominant structure (e.g., through loss of employment). From this perspective the mirror narrative could then lead to the dominant structure learning to further other and distance MHWHs. Understanding this narrative solely as a reproduction of the master narrative, however, does not emphasize the agency of MHWHs.

6.4.3.2 Third Narrative as Narrative of Resistance

Understanding this narrative as a failure on the part of MHWHs places them in a passive position, and highlights their location of oppression and their woundedness. In addition, this understanding does not allow for the possibility that this narrative may be serving a function both for these workers as well as a wider societal function. Holley et al. (2012) have argued for transformative research in the area of mental health and suggest focusing on resilience and resistance to oppression and not only on the negative effects of oppression. Their reasoning justifies a reframing of this alternative narrative and a look at how it may serve as a tool of resistance for MHWHs. Centering the agency of MHWHs allows me to look at this alternative narrative as one of resistance, where participants are using their voice to speak up against and to challenge dominant mental health understandings and structures. A re-envisioning of this alternative narrative from one of failure to one of work toward change justifies my decision to refer to it as a narrative of resistance.

In the following quote, for example, we hear resistance in Jill's words. Re-claiming her own voice and her own knowledge, she challenges the dominant notion that rationality is preferable over emotionality and re-interprets and politicizes this dominant notion as relating to privilege:

> I finally was able to sort of articulate that […] being objective and being non emotional is a privilege that a lot of white men in power have that a lot of people who have vulnerabilities don't have. […] It's not a privilege I have sometimes because I'm affected by things so directly. -Jill

This reconceptualization can be helpful in understanding MHWHs' agency and their engagement in processes of healing that help this kind of worker make meaning of and overcome their wounds so that they can use them in their healing work with others, through their role of MHWH. The following section explores where this narrative of resistance fits within the processes of connection and disconnection that Relational-Cultural Theory attends to and inquires as to where it, and the other two narratives, fit within the process of healing for MHWHs.

6.5 Mental Health Narratives Through the Lens of RCT

In this section, I present a model of how each of the three mental health narratives impact the wounding and healing of the MHWH through processes of connection and (re)connection. In this analysis I am drawing on and expanding from Relational-Cultural Theory (RCT). In subsequent sections of this chapter I use this model as a framework to answer the three research questions (MHWH workplace experiences, MHWH practice, and MHWH experience of coming together through this research) while emphasizing agency, resistance, and healing in the MHWH.

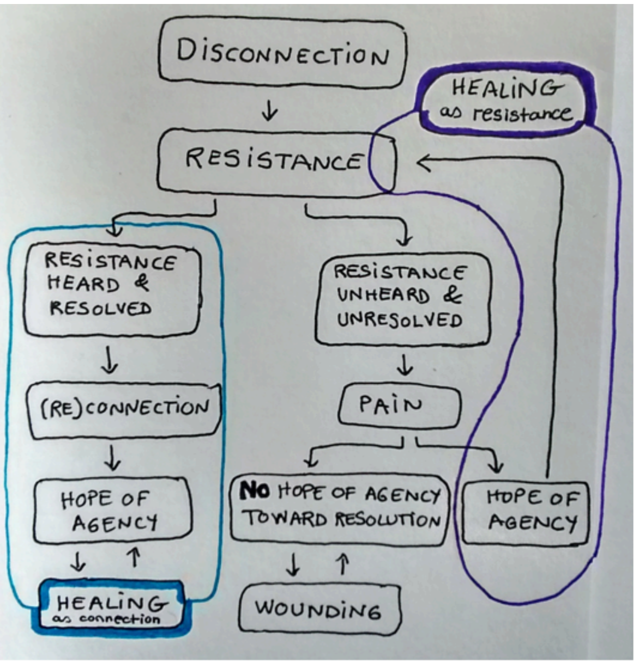
Relational-Cultural Theory posits that unresolved disconnection leads to pain and that (re)connection leads to wellbeing (Jordan, 2001). In relation to MHWH's experiences, a RCT perspective would argue that unresolved disconnection leads to wounding and that (re)connection leads to healing of that wound. The more traditional RCT perspective on connection and disconnection presented by Jordan (2001), however, emphasizes the role of the more powerful person (the one responsible for the wound,) both in the disconnection, and in the possible resolution of this disconnection. This perspective does not help us understand how MHWHs work toward healing (or toward social change). I believe that a fuller incorporation of the concept of resistance, as addressed by RCT scholars Walker (2008b) and Hartling and Sparks, (2008), to Jordan's RCT model of disconnection and re-connection could be a helpful avenue for expansion of the theory, and could aid in the understanding of the alternative narrative of resistance.

In line with Holley et al.'s (2012) encouragement of work about oppression that emphasizes the agency and resistance of the oppressed, my own understanding of how connection and disconnection happen emphasizes the actions of the person in the position of lesser power (the person who felt mistreated), thus emphasizing the *agency* of the oppressed person. I therefore propose that, following a disconnection, if the person who feels mistreated has hope that their voice of resistance may be heard and attended to, they will want to speak up to let the more powerful person know about the harm, so that the issue can be addressed and potentially resolved. I understand this speaking up as resistance; resistance which may or not be "heard," attended to, and resolved by the more powerful person. If the more powerful person acknowledges the harm, the resistance is heard and the disconnection can resolve, which would then lead to (re)connection. RCT literature explains that, when a disconnection is thus positively resolved, the less powerful person learns that they matter to the more powerful person, and that they have value. They learn that it is safe to be themselves in the relationship, they learn that they are important in the relationship, and that they have ability to impact the relationship (Jordan, 2001, 2008b). On the other hand, if the resistance goes "unheard" and unresolved, for example if the person with more power further ignores, ridicules, or otherwise hurts or dismisses the resistance, this leads to pain or to a wound.

Incorporating, and expanding upon what I have learned within RCT literature in order to emphasize agency and resistance of the oppressed, as well as to incorporate a focus on healing, I propose that, when there is a wound, the hurt person will attempt to prevent further harm and/or work toward healing. If the person who received the wound has hope that they have some agency or capacity to rectify the harm they may again offer resistance, which could at that point be heard and resolved, or not. It is only when the person who has received a wound has lost hope that their resistance might be heard and that (re)connection could be achieved, that this person may arrive at a place of wounding and self-protection, where there is shame, internalization of issues (e.g., self-stigma), and the hiding and silencing that have been observed among MHWHs at the workplace (Zerubavel & Wright, 2012). In other words, it is only when a person has lost hope that that their perspective will be heard and acknowledged, and their personhood valued, that a MHWH may remain in a place of wounding. This **hope of agency** may be mediated by

RCT conceptualizations of the importance of connecting with likeminded others (Fletcher, 2001; Hartling & Sparks, 2008).

Figure 1: Process of Disconnection and (Re)connection



From this perspective, wounding, for the MHWH, relates to the dominant narrative of disconnection and to experiences where their resistance has gone unheard and unresolved. This thesis has a specific focus on workplace experiences of mental health, which often included aspects of wounding. Therefore, a lot of the discussion about MHWH wounding relates to wounding at work, rather than what might have been the “initial” mental health wound for this worker. This workplace wounding is understood within this research as evidence of Sanism at work.

Subsequently, as a result of this analysis I propose that the path toward healing, for MHWHs, incorporates using both alternative mental health narratives: 1) the narrative of resistance and 2) the narrative of connection. I believe that both of these narratives relate to healing: healing through resistance and healing through connection. The enactment of the Resistance Narrative relates to speaking up and challenging disconnection and wounding. Healing at this stage is healing as resistance, it represents finding and using one's voice to challenge wrongs and demand change. The enactment of the Connection Narrative relates to finding belonging, finding meaning, and finding worth. Healing at this stage is healing as connection; it is arriving at a place of inclusion and acceptance.

6.6 Going Back to the Data

This section addresses each of the three research questions: MHWH workplace experiences, MHWH practice, and MHWH experience of coming together through this research, by looking at evidence of processes of disconnection, resistance, and connection within the data.

In this section, findings are presented in relation to each research question in order to learn how disconnection, resistance and connection happen within each of the questions. This is not to suggest that these three narratives occurred in equal proportions or discretely from each other within each of the research questions, but rather as a way to emphasize MHWH agency and resistance, and to highlight specific areas of resistance and connection that could be utilized to further positive change for MHWHs within each of the areas explored in each research question.

In chapter 7 the findings are discussed through the lens of each the three narratives, across research questions. This approach helps take a more structural, macro view to the issues faced by MHWHs. This section highlights the social functions of each of these narratives and their relevance for MHWHs, both in terms of future work toward change for MHWHs and in the area of mental health more generally, as well as in terms of understanding the processes of healing from workplace oppression and wounding for MHWHs.

6.6.1 First Research Question

The first research question was: "What are Mental Health Wounded Healers' experiences as workers in the mental health field?" The data are presented in three groups according to whether they reflect a narrative of disconnection, resistance or connection.

6.6.1.1 Disconnection

When I asked participants to speak about their experiences at work as MHWHs many experiences included disconnection and wounding. The experiences that led to disconnection and wounding reflected instances of disconnection that had not been resolved. These were situations where participants engaged in their preferred narrative of connection and were faced with disapproval within their workplaces, which participants identified as working within a dominant mental health narrative of disconnection. These experiences of wounding became salient through the tracing of the contrapuntal voice of disconnection. As I traced the voice of disconnection I found that, as participants faced negative consequences to their attempts to practice from a narrative of connection and in a way that includes their experiential knowledge, they learn to disconnect in order to protect themselves. Participants disconnected from the harmful environment, as well as from themselves, their knowledge, and experiences.

Participants disconnected from the work environment in different ways. Some participants expressed a sense of **pressure to "play normal:"**

> The head psychiatrist there said "are you ok? like you're not gonna like relapse or anything, like our clients are depending on you" and like [laughter] it was like the beginning of the year when I started working there, I was like "oh… alright, yeah I'm good, you know." -Jill

The psychiatrist that Jill is talking about is not offering to support her. Instead, he seems to be asking her to reassure him that she is "ok." He does not make room for her to be able to discuss any challenges that might come up in relation with her mental health, effectively silencing discussion on that topic.

Other participants choose to **stop sharing their perspective**, hiding their opinions from others who might otherwise disapprove, criticize, challenge or exclude:

Sometimes when I feel passionate about something that's not necessarily the view people take I feel like I'm walking into a fight [...] Yeah. So that's why I like to check how much I engage in stuff that I don't—I use it with the people I work with and the people that I'm with and that's all. I've tried to stop engaging in some of the bigger things cause it's just draining for me and doesn't change much. -Sarah

Several participants spoke about **burning out, quitting and changing career paths**. Rachel shared:

I...I left working in the inpatient system because I couldn't handle the staffroom chat. Because it was so stigmatizing. -Rachel

Interestingly, participants linked feeling burned out to relationships with coworkers, managers, and the system, and not to clients:

Nicki: We were [at a training], filling out the Copenhagen Burnout Inventory, it was like "how often do you feel burnt out because of your patient?" That, you know...all of these patient questions. And, we're all like... and there's several of us at the table..."I don't feel burnout because of my patients, no."

Chris: No, no not the patients.
Nicki: It's my colleagues and management

Chris: The system!

[Yeah, Yeah!]

One participant also spoke of **"over-intellectualizing"** as a way of protecting herself from potential negative responses coming from dominant perspectives:

> I find I sort of sometimes over-intellectualize. I sort of pre-emptively think "where's the anti-oppressive feminist theory argument around why this is not okay to stigmatize me in this way" so I can jump ahead of them when they start to come down and stigmatize me. -Jill

Over-intellectualizing helps Jill distance and protect herself by preventing interactions becoming more personal and potentially damaging. Jill is protecting herself by hiding certain aspects of herself that are related to vulnerability or emotionality, which participants found not to be accepted or acceptable within the mental health system.

In addition, participants also **learned to disconnect from themselves, their knowledge, and experiences,** perhaps as another way to protect themselves. As participants experienced negative reactions within the mental health system and learned to disconnect from that environment and the people within it, they seemed to learn to doubt the way they practice, and their practice knowledge (which includes experiential knowledge.) Sometimes they even doubted the very experience of wounding and blamed, or judged, themselves.

One participant **minimized the harm** resulting from interactions with the dominant structure by referring to some things as "funny" when they appeared to be quite hurtful:

> It's really funny … to be a poster child is a very strange thing cause it's very invalidating at the same time. […] They say ridiculous things and they patronize you.

Sometimes participants **blamed themselves** for the harmful consequences of challenging the system. One participant shared:

> I feel like I needed to learn some hard lessons that way, maybe… I don't know… Like kind of be like "maybe you should have thought that through before you went and challenged the oppression that was happening at work. - Meaghan

Some participants spoke in terms of **dissociation**. An 'I Poem,' excerpted from Sarah's words exemplifies this:

I would just sit in these meetings thinking

"I don't know"

I'm there
But I'm over here
        watching everybody

I would leave so angry

And I'm new
I'm new
I'm new

Finally, participants spoke about their workplace experiences of wounding leading to them **not engaging in activism in the way they used to**. When participants stop engaging in activities that they used to find important they seem to be disengaging from important personal values, and therefore disconnecting from aspects of themselves. One participant spoke about painful experiences as a MHWH worker and activist, in which she was unable to challenge injustice, leading to her disengaging from other activist efforts:

a lot of folks who were in that [activist] group were coming from positions where—they could speak out and it was ok for them to speak out in their jobs too and I started getting really like umm… like ummm… pissed off at them, resentful towards them for being able to be in such privileged positions to be able to do that! And then I started like being burned out by that activism, I don't know if that makes sense… so I quit as well. [laughter]

Other ways in which participants were impacted by the dominant narrative of disconnection was through difficulty finding language to communicate their approach to practice. Sarah shared:

I don't know how to explain [what I] do `'do you do CBT? do you do this or that?" It's like "I don't know what to tell you I do exactly, it's the stance that I take, it's the theory I approach people from, it's my interpersonal dynamics stuff," like I don't know what I *do* exactly. -Sarah

And when you can't easily explain what it is that you do, your approach, **this can lead to further discrediting and questioning the competence of people working from a different approach**:

> The experiences I've had and the way I've been treated through the system and just my own experiences have really changed how I am as a professional and the way I treat people, which goes against the grain of maybe what some of the other people in my field do, which then trips them up because they think I'm not as competent. -Sarah

6.6.1.2 Resistance

Participants demonstrated engaging in resistance to the dominant narrative of mental health in a few different ways. I present here two of the resistance approaches that I interpreted within the data: a questioning of dominant understandings of mental health related concepts (leadership and labels), and an engagement in activism.

The conversation about **leadership** was interesting. It started as a discussion of the woundedness related to the impact of internalizing dominant conceptualizations of the term and shifted to a challenging of the dominant understanding of the term. Jill talked about her struggle with dominant notions of mental health and leadership:

> Saying out loud all the time "I have lived with these mental illnesses" is essentially saying I'm broken. So then when I stand up in front of people… and I work with people or I sit with them individually or whatever I'm… I'm coming from a place of brokenness and that's *weird* because [chuckles] it's sort of an antithesis to the role of like…leader as someone who's who's …like it gets in the way […] like if I have a moment of doubt in myself like it comes back "your broken" you know like, whatever, and that's not self-imposed necessarily I know that initially it came from the outside. -Jill

Jill believes that her mental health challenges have led to her being placed in a location of brokenness, one that she finds difficult to lead from. This understanding of leadership is rooted in a paradigm of the separate-self that presupposes that in order to lead, you are supposed to already be "well ahead" and not currently sharing in the struggles of those that you are working with. In our world leaders are not supposed to be "broken," they are supposed to be healthy, whole. Leaders are supposed to be strong, not vulnerable. For Jill, these dominant notions of mental health and of leadership disrupt the confidence in her ability to do her work well, in her words: "it gets in the way."

Patti, in response to Jill, offered an alternative understanding of leadership. Her understanding values cooperation and "working with" and is politically informed, and thus a form of resistance to the dominant narrative:

> That's not my definition of being a good clinician, like when I—like I try as much as I can to be like a collaborative partner … and so and I see traditionally the dominant assumptions around leadership is like patriarchal defined [chuckles] […] I know a lot of the clinicians that I work with would consider me maybe a little too vulnerable and or misinterpret that as being not confident ? Where I don't see myself as not being confident I just see myself as being like uhh… ok with apologizing to someone. [One time] I told other people—my fellow clinicians—that I apologized to this person […] and they were like "why did you feel like you had to do *that*?" [mocking tone] and blah blah blah. To them, to this leadership, that [is] like foreign to them, like 'cause you're supposed to be the expert. If you're a true leader you're unwavering, you always make good decisions…- Patti

Patti resists dominant understandings of leadership that dictate that a leader is supposed to be an expert, to be perfect, and all-knowing, even as she states this is the dominant construction; so clearly she knows it. She does this by allowing for the possibility that she may make mistakes and by being open and vulnerable enough to apologize for her mistakes when they occur.

Later in our discussion Chris also challenged dominant notions of leadership and offered an **alternative notion of leadership that is more in line with connectedness**.

> I went in the military…I'm supposed to be a leader, I'm supposed to be in charge, right? Umm very stressful concept, right? I'm in nursing school, you're learning about leadership, right? I'm supposed to be in charge! And you know—but what is leadership? […] To me leadership is how you present yourself. Every day when you are talking to somebody you are being a leader, you are being an informal leader. As a nurse I, by my practice, by the way I treat people, by the things I speak about, the things I do, I'm being a leader. I'm demonstrating some positive things, some thing that are doable, so leadership is […] By just taking responsibility for what I do, I'm a leader. -Chris

For Chris leadership is not about being a leader but about **doing leadership**. This allows for the idea that leadership is not something that only an elite group can be, but rather something that anyone can do, something that is, perhaps, in the small things; in "demonstrating some positive things, things that are doable."

Participants' discussion about **labels** also included elements of resistance, mixed with elements of wounding. Jill experienced labels as imposed from the outside and as diminishing her:

> All the responsibility is taken from you when you have […] a label like [the one I have] and all of the accountability is also taken away from you and all of the res—all of the parts that make you a vital, contributing human. -Jill

In contrast, Chris, explains experiencing **labels as an anchor**, a place that was useful for a time but one from which she eventually "gets past" and "moves on."

> For me it was an anchor at the time when I was in a moment of "holy crap I don't know what the hell is wrong" […] It was my anchor to ground me, and say: "huh, life's out of control" and then I move on. -Chris

Patti, on the other hand, expresses the view of **labels as limiting**, especially when they are used as reasons to justify or explain why a person cannot do certain things in their life that they may want to do:

> The hyper focus on the label that seemed to be a barrier to these people being able to go back and do the things that they *love* and go to school, like, because they wanted to go back to school… they would—I would always hear them go back to "well that's because I have this… diagnosis" […] A self fulfilling prophecy of like really self-defeating perpetual cycle and I found that to be *so* frustrating, and then I wanted to be able to say "actually I have found my anxiety to be *really* helpful in getting really good grades!" -Patti

Both Patti and Chris seem to **question the permanence of labels**, something that is held on to tightly, without room to change. Nicki, however, shares that she still identifies with some but not all of her labels:

> "For me [one label] is something that I still hang on to, like [many] years later, I still like, because I'm scared, you know, […] and yet there's other things that I don't [hang on to]" -Nicki

How participants felt about labels seemed to depend on the perceived helpfulness of these labels. However, participants questioned the usefulness of mental health labels as permanent, lasting, and fixed beyond the period of time when they might be helpful. Here, participants are resisting the idea of permanence of mental health labels, which they had earlier identified as part of the dominant mental health narrative. The limited usefulness of diagnostic labels points to the need for other approaches with which to understand mental health, beyond those of the dominant mental health narrative.

A final way that one participant engaged in resistance was through **activism**. This participant spoke about looking for a way to do social justice work outside of her paid employment, she spoke of feeling disconnected at work (disconnected from her values and beliefs in social justice) and looked for other avenues to re-connect with herself and others:

> I joined [an activist group] when I realized that I couldn't actually do social work in my social work job […] so I decided that I would put my energy somewhere else and that was actually very fulfilling, [to] sit around and feel validated by like my new people.

Through the words of this participant we can see how resisting the dominant narrative of mental health can happen through finding connection with likeminded others, in this case outside of the workspace. This reflects the nature of the resistance narrative as encompassing is both connection and disconnection, disconnection from the work structures and connection with likeminded others.

From this data, I interpret that building connection with likeminded others may strengthen voice and hope in the MHWH (or in people in other situations of oppression), energizing the worker toward further resistance to the dominant discourse that was the source of oppression.

6.6.1.3 Connection

While participants most often identified dominant discourses at play within their workplace structures, there were a few instances where they discussed noticing evidence of a narrative of connection within the workplace. In a few occasions participants spoke of **finding allies and/or alignment within the mental health structure**. Patti, for example, talked about noticing that **not all workers keep themselves as separate from the clients**:

> We do recovery groups a lot and so, and you always do them with a co-lead and [some] have told me […] "you don't share, you don't check in," but then I'll be with others who do check in and are a little bit more transparent about themselves. -Patti

Chris talked about **encountering the recovery model of care** and how it supported her approach to her work:

> For me it (the recovery model of care) solidified where I was mentally with myself but also how I dealt with people […] it doesn't matter what your diagnosis is, it's "what are you doing now?" -Chris

One participant talked about **finding a workplace where she feels safe**:

> I finally feel safe working in a place. I'm unionized now… I can actually share and like know that I'm not gonna be consequenced and fired for it, and not have like—be abused anymore.

Lastly, Chris also talked about a positive work experience where she was allowed to work in mental health, even though (or possibly because) she had her own challenges in this area:

> She saw that I was not doing well and I just lost it in the med room and she was there. I was so lucky. And, then they said "you know what […] I think you can go work in the psych unit now." And, they sent me… -Chris

In addition to the instances where participants encountered evidence of the narrative of connection at the workplace, there were a few occasions when participants also talked about **enacting this narrative of connection with colleagues at work**. Nicki talked about believing that other workers have good intentions, even those that she disagrees with:

> His views *totally* went against my, my politics, against my um… all my experiences with my …. in… the queer community, and I went into it with "get to know your enemy" right? […] so… however, when I got to know him the guy cares *so much* about his clients, I just disagree with his approach of caring, like what his caring looks like in practice. –Nicki

Anna talked about finding commonalities with managers and trying to empathize with them through shared experience:

> Even, you know, among management I can see challenges that I've faced and sometimes I'm like I may be more patient or more understanding with a decision or a lack of a decision or action or lack of action because I'm like "oh well, yeah, I can see how that would, you know, I would make that that you know, I would not do that by accident too" or … and it's because I understand because I live with ADHD, chronic ADHD as well as anxiety and depression and sometimes I can see aspects – especially around the ADHD. -Anna

Rachel spoke about wanting to be seen as a complex human being who is not only her mental health history. While she is not speaking of this directly, it could be extrapolated that this 'complex humanity' is part of her orientation toward others beyond her:

> I've just tried to be a good a human being and eventually people will look past this … and that's very idealistic but you know, I'd like to be seen as Rachel the human being who has lots of great skills who happened to have a lot of scars. Cause that's not the most interesting thing about me. It really isn't. -Rachel

It is important to note that there were only a few times when participants spoke of finding and enacting the narrative of connection with colleagues. I interpret this as a sign that participants' efforts of resistance at work do not often result in resolved disconnection. It appears that **MHWHs' ability to recover from the negative work experiences (i.e., disconnection) *at work* is limited**. Participants seemed, instead, to put their energy in other areas of their lives, making relationships and interests outside of work more of a priority. In the next interview segment we can hear Anna's struggle in this regard. She feels unsafe bringing her opinions to her managers, wonders about how she can stay in her work environment and "be at peace," and turns to relationships and activities outside of work for support and connection:

> [The managers] are slamming this diagnosis and we may or may not have people on the staff team […] with that diagnosis and […] it's like do you stand up do you not? If I do, does that mean that there's a bigger file on my … my employee file? and how does that go because I've heard of challenges in the past, you know? […] But, if that's that culture how do you be in it and be at peace? […] I would often ahm, because we'd feel like that full burnout compassion fatigue, plan with my friends like steak night every Tuesday night so I'd just leave work and go be with friends so I could get out of the work space. -Anna

Most often participants spoke of looking for connection outside of their workplace, as a creative approach to fulfill this need for connection when it is not met at the workplace:

> One of the most like awesome things for care […] is chatting among peers or with my counsellor or even somebody who maybe works in health care but maybe not in the same thing (mental health) and having people identify how much of a shit storm that it is … yeah, this is really fucked. […] That and playing outdoors. -Anna

Participants talked at length about working toward connection outside of the workplace, in contexts and with people that seemed safe; these are people such as friends, family, activists groups, and other MHWHs, with whom participants can fully be themselves and feel accepted. Nicki, for example, shared: "my partner is incredibly supportive, knows, you know, my entire history…" By accepting them, people in the lives of MHWHs may in turn help them accept themselves:

> I was so accustomed to try to make sure that everyone else was ok when I was crying "I'm gonna be ok I'm gonna be ok, I'm just really emotional" he was like "You don't have to be ok, ever!" Like, and it was super validating, and since then we are so aware, so sensitive, it's this subculture that we have with each other. -Jill

Through Jill's words we get a sense that, in connecting with others who accept them, participants may also be engaging in a process of re-connecting with themselves.

Lastly, participants also talked about **participating in this research as a way to find connection**. Sara shared:

> I've been feeling really stuck, in so many ways, maybe this is the real reason I was attracted to this group, is to find people who feel the way I feel. -Sarah

6.6.1.4 Discussion

For the MHWHs who took part in this research, workplace experiences were most often experiences of disconnection; experiences of exclusion and oppression that lead to wounding. This fits within a large body of literature within the helping professions that explores toxic workplaces and workplace stress (McKenna, Smith, Poole, & Coverdale, 2003; McVicar, 2003; Vickers, 2004), and parallels findings from nursing literature that show that working as a nurse with a "mental illness" is largely a negative experience (Joyce et al., 2007; Joyce, McMillan, & Hazelton, 2009). Often, participants spoke about workplaces where there was no room for them as MHWHs, and where they had to shift their interactions with colleagues in order to protect themselves, which relates to RCT's conceptualization of disconnection as an avenue toward protection (Hartling & Sparks, 2008; Jordan, 2001). Participants spoke about "playing normal," not sharing their opinions, burning out, quitting, and changing careers. In addition, participants spoke about learning to disconnect from themselves, through what I interpreted as internalizing some of the dominant mental health messages that they were exposed to at work. Participants, for example, minimized some of their struggles, blamed themselves, disengaged from personally meaningful activities such as activism, and even spoke in terms of dissociation. In addition, participants also spoke of a lack of language with which to describe their practice, and spoke of their approach being dismissed or disapproved. Patti, for example, shared a response she received about helping a client process the impact of receiving a diagnostic label:

> A lot of people would not think it was appropriate to like talk about. Like "Patti's getting philosophical" or something? -Patti

All of this is evidence of oppression; these workers are stigmatized and oppressed because of their lived experience of mental health challenges. It is a concrete expression of **Sanism**. Chapter 7 further explores the impact of the dominant discourse of disconnection in terms of Sanism.

My interpretation of these workplace experiences is that a process of wounding is taking place, where MHWHs learn, as they come in contact with dominant narratives of mental health through their employment, that there is no place for them. Their point of view, their concerns, do not matter. What develops, then, is a situation that works to erase MHWH voice. As MHWHs experience harm within the workplace they learn to fear further harm and work to protect themselves from future harm, either by leaving the place of employment or by learning to hide, which results in the workplace not having to hear from, or deal with, the MHWH. An interesting aspect of this process is the ways in which this exclusion becomes internalized for the MHWH, mediated through processes of shame (Jordan, 2001, 2008a).

However, in spite of this wounding and erasure, participants were still able to enact alternative narratives of resistance and connection. Participants did not passively absorb dominant narratives and dominant concepts of mental health, but actively questioned them and looked for alternatives, which are practices that have been identified by feminist researchers (McKenzie-Mohr & Lafrance, 2014b). They, for example, challenged dominant conceptualizations of mental health labels and dominant concepts of leadership. In addition, participants looked to connect with others who were working toward social change through engaging in activism.

Even while impacted by these oppressive workplace contexts, participants demonstrated using their voices and developing their own knowledge outside of the dominant narrative and the dominant structure. In addition, they actively connected with others who could support them in their journey of challenging this dominant discourse. I understand this as a drive toward healing through resistance.

Further, I also interpret participants as actively and creatively engaging in healing through connection, even as they are exposed to a context that is not receptive to it.

Participants mentioned the few instances of connection that they found within their workplaces. These occasions, while few in number, seemed salient, meaningful, and memorable for participants. Outside of these few examples, participants also actively looked for connection outside of work, in what I interpret as an effort to fill the void of connection left by a workplace full of disconnection, in a pursuit of healing. Lastly, it is noteworthy that, even in these work contexts, which are heavily embedded in the dominant narrative of disconnection, some participants spoke of extending connection toward their colleagues and managers. This demonstrates that some participants actively reach across and connect through difference, even with those who have harmed them or can harm them. This is something that RCT scholar Walker (2008) has written about as evidence of a person's connection with their own thoughts and feelings leading to their ability to risk connecting with someone more powerful.

6.6.2 Second Research Question

The second research question was: "How do Mental Health Wounded Healers use their lived experience in their practice?" The answers to this question are presented in three groups according to whether they reflect a narrative of disconnection, resistance or connection.

6.6.2.1 Disconnection

As we spoke about how participants use their lived experience of mental health challenges at work, some of their answers indicated the use of a dominant mental health narrative of disconnection. Participants spoke of not receiving guidance on how to use their lived experience, such as whether and how to self-disclose their lived experience of mental health challenges. In addition, several participants did not disclose their lived experience, or their use of lived experience, with coworkers. Finally, as discussed later in this section, participants also showed evidence of having internalized dominant understandings of mental health challenges, specifically regarding dominant understandings of professional boundaries, and how these relate to ideas about how much of the focus of a therapeutic relationship can ethically be placed on the worker versus a client, in what came to be spoken about as “too much about me.”

Participants talked about **not receiving enough guidance** about how to self-disclose:

> We all learn in communication class… you know “disclosure, don’t.” or whatever, right? What does that mean!? -Chris

The implication of the lack of guidance seems to be an underlying notion that workers should just not do it; that taking up this kind of space in a working relationship is inappropriate, and crosses professional boundaries.

Lack of guidance means that MHWHs are largely on our own when trying to decide whether to self-disclose, and are also alone in evaluating the appropriateness of an instance of self-disclosure. Moreover, if the message is “don’t do it,” we are more than on our own, we are outside of what is permitted. Workers, facing this unspoken, yet clear, boundary may conform and err on the side of no self-disclosure. By not disclosing aspects of themselves that relate to their experiences of mental health challenges MHWH construct themselves to their clients and coworkers as non-MHWHs and situate mental health challenges as solely in the experience of clients and not of the workers. This continues to recreate an us-versus-them dichotomy and an image of the world where people are separate from each other and is a missed opportunity to attempt to challenge current dominant views. In other words, lack of guidance on how to self-disclose also means, unfortunately, a lack of opportunity to explore alternatives to the dominant understanding of the self as separate and in competition, as well as a missed opportunity to challenge the us-versus-them dichotomy that pathologizes those with mental health challenges.

Some participants have learned not to speak about their lived experience of mental health challenges, not only with their clients, but also with their colleagues. Here, Patti speaks about having observed other **workers being judged** after their mental health challenges became known to co-workers, and learning that it is not safe to disclose one's own mental health to one's co-workers:

> I had a co-worker …who like struggled with the exact reason we see clients and must have disclosed along the way… to different clients, and somehow it came back in the gossip mill [chuckles]. And the attitudes… and—for me I'm like 'oh my god this co-worker is going to be the best ally!' Because I was like—saw it as really…yeah I don't know like a genuine approach that he had… and—but a lot of the people that he worked for saw that as like a big ahh…weakness or vulnerability that he probably shouldn't have … admitted…? […] and then totally judged him from that point onward…? and so that gives you a sense as well in terms of your own safety in doing so. Well I'm not gonna go there then! You know… -Patti

Through Patti's words we see how this practice of silencing and this learning to silence MHWHs prevents them from connecting with each other and maintains a culture of disconnection.

Keeping self-disclosure hidden from co-workers is something that other participants also talked about. Nicki, for example, said that she will not put it in progress notes and does not share in team meetings.

> The reason I am not out is because, it's just, if I express my opinion and you think it's coming from […] a place of my own issues, then automatically my opinion is invalid.- Nicki

Chris speaks about **not wanting her practice to be judged**:

> No I don't go back and tell anybody that I disclosed something because I'm still going "should I have said that? Should I have not said that?" … I really don't want them judging me and saying I said something I shouldn't because this is my practice so I'm gonna do it my way, but I don't need to tell you and have you judge it, because I don't want the battle. -Chris

Reading Chris's words it is clear that she wants to do her work her own way. One reason that she does not share with co-workers is to avoid judgement and "a battle." At the same time, we also note that Chris also wonders aloud whether she should or should not have self-disclosed. It seems that even when the battle with the outside is avoided, there is still a battle happening inside.

Patti, Chris, and Nicki are speaking about hiding an aspect of themselves that they believe co-workers or supervisors would perceive as questionable or inappropriate. By doing this they are seeking to protect themselves, protect their sense of safety at work, avoiding a battle, avoiding being judged, and perhaps even protecting their employment. There is a sacrifice or a price to be paid where, through doubting and blaming themselves, they are learning to distance themselves from their preferred narrative of connection, perhaps distancing themselves from the experiential knowledge that informed their preferred way of practice through connection.

We can see evidence of this in participants' discussion of "how much space" or how much of the focus is appropriate for a worker to take in a working relationship. The phrase **too much about me** was used often in our conversation about use of lived experience in practice, in a way that I interpreted to represent a dominant notion of the role of the worker and the idea of "professionalism." Participants' lived experience motivated them to use their lived experience in their writing, while dominant ideas of professionalism, and specifically dominant ideas of professional boundaries, told them not to.

When participants talked about disclosing their lived experience of mental health challenges to their clients, I saw evidence of an inner struggle. Participants seemed to be pulled in opposite directions: they spoke of **wanting to self-disclose and also worrying that disclosure would be "wrong."** The tension is whether to use one's lived experience and experiential knowledge or to align with dominant understandings of professionalism. In the following interview segment Patti reflects on her experiences negotiating the expectations and understandings of her role as a worker, which tell her not to self-disclose, with her identification with clients and the related desire to share her own experiences with them:

> The message I was getting from my boss was "you're the [professional] so you wear that hat" and so there was— I was placed— had some more privilege and power in that way but then […] I felt kind of like on the outside even though I was not like at all in my experience on the outside with— especially with folks talking about anxiety and stuff. And sometimes I felt like I could contribute some really useful tidbits of information based on my own personal experience but I never felt that that was appropriate or even fair of me to do… like I wondered "Is that more about me?" –Patti

The role of the professional is one that Patti seems to understand as imposed on her. She sees it as coming from her boss, and likens it to being placed in a position of power and privilege. Patti's lived experience seems to pull her in the direction of feeling similarity and connection with her clients, and leads her to want to share her lived experience with them. Simultaneously, her role as a professional, with the expectations embedded in it (and expressed, in this case, by her boss), pulls her in the direction of feeling different from her clients, on the outside, disconnected. Her role as a professional leads her toward not self-disclosing to clients, and, when she does self-disclose, it makes her doubt her decision. When Patti speaks about self-disclosing she uses terms such as "**second guessing myself"** and wonders whether the disclosure made the interaction **"more about me.**" The following excerpts delve more into these subjects:

> I remember working with a young person who had the exact same diagnosis as me and she would say to me "I have this diagnosis and you don't understand and blah blah blah" and sometimes I felt I would get frustrated, actually, and want to say "I have the exact same diagnosis as you!" But also recognizing that there are very different experiences of those same diagnoses. -Patti

> There was a young man who was like—he came from another country where it was—mental health stuff was never ever talked about, like that was so stigmatized and I think I just mentioned to him, I was like "I experience anxiety and blah blah blah" and he was like "*you do*?!" And he couldn't believe it because I was the professional and I was like "oh… ok" and then immediately started second guessing myself and wondering "was that more about me?" -Patti

While Patti feels the pull to self-disclose, dominant understandings of professionalism and related expectations from her boss limit her ability to do so. They urge her not to connect in this way, and in doing so they push her toward disconnection. She stresses that client experiences might be quite different from her own, perhaps worrying that self-disclosing might minimize these differences. It seems that, generally, Patti stops herself from sharing, and then, when she does share, she feels unease about it, she double guesses herself and wonders if the disclosing was "too much about her."

Participants worried whether self-disclosing made conversations where self-disclosure takes place too much about them. The phrase **more about me** seems to be rooted in an understanding of individuals as separate from each other. The implication is that there is a limited amount of resources: limited space or time, and that as one person takes some of the available resources there are less available for the other person. Because in the relationship of worker-client the focus is on the needs and goals of the client, holding a separate view about human beings would lead to the conclusion that the worker taking up space would move the focus away from the client and could be detrimental. The assumption is that self-disclosing is "taking too much space" and the implication is that this would be damaging to the client. When a MHWH internalizes and works from this conceptualization alternative knowledge and narratives are silenced and dominant knowledge and dominant mental health narratives get reproduced and reinforced.

6.6.2.2 Resistance

While participants talked about the ways in which they are impacted by a dominant narrative of mental health in their practice, they also spoke of ways in which they resist this dominant narrative and enact a narrative of resistance. Participants continued to find ways to incorporate their lived experience in their practice, both through direct self-disclosure and in other ways. In addition, they also questioned dominant notions of mental health that posit that a worker is not supposed to take too much space. The analysis of MHWHs' use of self as resistance in this section points toward Feminist Therapy as a potentially helpful approach for these workers to engage in use of self and self-disclosure. The end of this section explores Feminist Therapy's approach toward self-disclosure, along with its potential usefulness for MHWHs.

Anna disclosed her concern that she over-shares, which led to questioning the unidirectionality of helping that is prescribed within dominant understandings of mental health:

> Sharing in that conversation was definitely more about me, yeah. I feel like I got a lot from it and maybe they did too but what I shared was directly trying to make me feel better. Ummm which I am not happy about but it was what it was. -Anna

In response to Anna, Nicki asked **"can't it also be both?"** and went on to say:

> If I'm trying to convey this is a real relationship between equals, yes, there's power—but you know this is a *real* relationship and part of it is "Is it *bad* for me to bring my insecurities into the room?" You know, to an extent? But there is a big difference between like, […] say 'you know I was really struggling with that, what do you think?' and 'I'm feeling really suicidal will you take care of me?' Right? -Nicki

Rather than demonstrating an understanding that we are all human and share many human experiences, in Anna's words we see the dominant idea that humans are separate and in competition with one another, and that if something benefits one person it must hinder the other person. While Anna does acknowledge the possibility that both parties may benefit, she is still left feeling uncertain about her self-disclosure. Nicki, in asking "can't it also be both?" questions the idea that something that helps the worker necessarily harms the client. She also seems to believe that it might be *helpful* for the client to feel that they are helping the worker, as long as this doesn't put undue pressure on the client to take care of the worker. In doing so she is questioning the idea of the unidirectionality of helping that is dominant in the Western world: helping others may actually help the giver (Jordan, 2008a). This unidirectionality is something that Nursing Theories of Care have also problematized (Marck, 1990); these theories value reciprocity and see a lack of opportunity to reciprocate as a potential barrier to seeking and using help.

Nicki goes on to problematize the lack of guidance on use of self that was discussed in section 6.6.2.1 :

> They say [not to self-disclose] and then there is no guidance. I'm figuring out, well what is appropriate in what situations, when is?—and guess what!? *Even doing therapy to a certain extent when I'm not mentioning me is about me because I feel like I'm contributing to somebody, like, so it's always about me.* -Nicki

In addition to questioning dominant notions of mental health, participants also demonstrated resistance to the dominant mental health narrative of disconnection by continuing to practice from a place of connection and continuing to engage in use of self and self-disclosure:

Participants spoke about learning to **practice in alignment with their own beliefs but in secret**. Sarah mentioned:

> I can affect change behind my door and that's what I do. […] Behind my door in my office [laughter]. -Sarah

While keeping this part of their practice secret could be seen as a way of hiding and aligning with and, in fact, re-creating the dominant narrative and, the fact that they are still **engaging in self-disclosure** with their clients can be seen a form of resistance, even if they have conflicting feelings about it:

Patti: I find that you gotta [self disclose] secretly or something

[I know!]

Nicki: I will not put it in progress notes either!

Jill: laughter

Nicki: I never do and I never share in team meetings

Patti: *you do self-disclose? In your role?*

Nicki: yes I do I do I do and see I feel guilty for it

Participants also spoke about finding ways to use their lived experience without directly self-disclosing their own experience. Patti, for example, spoke about having found a way of using her lived experience of mental health challenges without self-disclosing in a way that employs resistance to the dominant narrative. By doing what she refers to as 'indirectly self-disclose' she attempts to **provide a safe space for her clients to explore their experiences and feelings outside of the constraints of the medical model**:

Like talking [with a client] about they're doing really well in their recovery then the psychiatrist slams this label on them and then they're reeling from that experience. And then just being able to facilitate a dialogue where it's like "let's talk about that actually, though." -Patti

When prompted to explain how her lived experience comes through in that kind of conversation Patti offered this explanation:

Just like umm… just like having my own experience of being defined in certain ways and then just like having… ah… trying to figure out what that actually means for me? Like um… like umm… I never knew what feminism meant or… anything. […] And when I finally had a safe space to be able to explore that and how that felt really empowering and made me feel like gaining some control of where I didn't feel control in the past… so like kind of trying to provide a similar safe space for

> folks… But not self-disclosing either but like… just remembering, I guess, that experience and how I benefitted from it and then trying to also just provide a similar… space, I guess, if that makes sense. -Patti

Patti wants to offer her clients a space to question the dominant mental health narrative, with its medical framework, where labels and diagnoses are imposed on people. Patti mobilizes the lessons she learned from having had a safe space to come to her own understanding of her life experiences, and extends that opportunity to her clients. She aims to offer a space where clients have permission to question understandings of themselves that are given to them (e.g., labels and diagnoses) and where they are encouraged to draw their own meaning from their experiences.

Patti is engaging in a use of lived experience that draws from the meaning that she has made from their own experiences, a knowledge that is based on experience and filtered through a political understanding of issues and a resistance to the dominant narrative. It seems that she wants to extend to her clients this very ability to question and to come to their own meanings about their lived experiences.

6.6.2.3 Connection

When participants spoke about their practice, they referred to their approach through words like **connection and relationship**. Participants spoke about their **lived experiences** leading them to be more aware of their role in the helping relationship:

> Our experiences make us more aware of how we treat other people and the way we use that in our professional capacity and the power we hold as a professional. -Sarah

Sarah spoke in terms of **responsibility in the relationship**:

> [Something] that I keep for myself is my responsibility in what's happening to the person in terms of the relationship, […] you know, what am I doing that's going to either set something off or contribute to the person's reactions? […] at least I'm accepting some responsibility […] here instead of saying you're just a repeat customer. Or whatever. -Sarah

Sometimes participants had difficulty explaining exactly what it is that their practice *is*, but spoke about it in terms that clearly demonstrated connection:

> I can't tell you why the women that I saw in the military who came into the hospital talked to me, the ones that had been survivors of a variety of stuff… like maybe its cause I listened? [laughter] and didn't say anything, or when they're crawling on the floor and crying I'm sitting on the floor with them and listening right? -Chris

When participants talked about why they choose to self-disclose the most salient answer was that it was in an attempt to "be with" their clients: **to empathize and connect with clients who are in crisis.** This sounds like a sound therapeutic goal, and yet, participants spoke of the guilt and shame they felt in doing so, which indicates the influence of the dominant narrative of disconnection. Nicki explained that she only self-discloses about her own mental health challenges in crisis situations:

> A client was *really acutely suicidal* and, and I, I said "been there in terms of the acute—in terms of the feeling that intensity and you know it really does pass, really try to just…" -Nicki

Nicki mentioned that her self-disclosure about other aspects of her life is done in a planned and calculated way, in contrast to her use of self-disclosure of mental health challenges. In response to these words there was an interaction between several participants, who built onto and expanded Nicki's exploration of the reasons why she may disclose in moments of crisis.

> Patti: Maybe it's got something to do with the crisis, it's like, I don't know, I just feel like when "oh my God" you feel so much, like you wanna—the compassion stuff.
>
> Chris: Yeah, yeah.
>
> Nicki: and it's also, to be honest I feel a little bit—I'm desperate. I'm pulling out anything in my toolkit!
>
> Patti: That's—yeah! That's what I mean! Like the crisis itself, yeah.
>
> [mmm]
>
> Jill: Maybe a mix of that and then also the compassion the level of like sometimes you really resonate with someone and you feel…

Nicki: Or you try to normalize something.

Jill Yeah yeah.

Nicki: 'Cause a lot of our clients feel *really really different,* and you're trying to say… without minimizing their experience "you're not *that different.*"

[Yeah, yeah]

This interaction suggests that the dynamic of self-disclosure in moments of crisis is something that is familiar for others in the group. What is it about these moments that makes these workers act in ways that are not the norm for them and that are perhaps even risky? It seems that the desire to reach and connect with the client, and to help through the relationship and the shared experience, is strong when these workers are faced with clients who the worker considers to be really hurting and in imminent crisis. **The decision** to do so is not carefully thought through or rational, it is quick, and it **is emotional**. Time is not given to a careful weighing of pros and cons, especially in regards to operating outside of the constraints of the dominant mental health narrative of disconnection. It seems that it is an emotional knowledge that is driving the decision, and that knowledge is informed by the narrative of connection. The more rational side seems to follow afterward, perhaps worrying about the consequences of stepping outside of the constraints of the dominant narrative:

I worry about… see this is what I think I do. I think I disclose in the moment of crisis and later on I go "eehhh… ahhh…" [chuckles] you know. -Nicki

It seems that, **when a client is really in crisis, participants draw from their emotional knowledge and the narrative of connection** instead of their academic/scholarly knowledge, which is informed by the dominant mental health narrative of disconnection. The fact that participants do self-disclose in an attempt to connect, despite the challenging ramifications to self-disclosure such as doubt and guilt, I interpret as evidence that the narrative of connection takes a primary role in crisis situations. Moreover, this narrative of connection seems to trigger a body of knowledge outside of scholarly knowledge: experiential knowledge. This experiential knowledge is referred to in nursing Theories of Caring as "knowing." This "knowing" is a shared knowledge that is acquired in relationship and that may be intuitive (Marck, 1990, p. 52).

Several participants explored ways they use their lived experience in less direct ways that may be less risky than self-disclosure. Chris, for example, shared that one of the ways she uses her own experiences of mental health challenges in her practice is by **talking about the direct experience of the challenges instead of talking about the labels**:

> I don't need to say "I have anxiety, I have depression" or whatever or "I've been suicidal" what I need to say is what the actual experience is: *that's disclosure* and that's the thing that I want to work on[…] so you take your experience and you don't say this is my experience, but you use it to communicate back the black hole, the emptiness, the blah blah blah […] describing it and how you're talking about it: true empathy, right? -Chris

Here, Chris is talking about attempting to empathize with a client by offering a way of understanding experiences of mental health challenges that is outside of medicalized language. We can see she utilizes metaphors such as "the black hole" to describe the experience instead of using diagnostic labels. Chris believes that this use of self may allow for greater empathy with clients, and also suggests that sharing diagnostic labels might be a barrier to empathy and connection.

Chris's use of lived experience in this less direct way involves her making sense of her own experiences of mental health challenges, and doing so outside of the medical model. Reading Chris's words we can see that use of lived experience is not a simple process. It involves a development of knowledge based on experience, an **experiential knowledge**, to draw from at work. It also involves the use of language that rests outside of the medicalized language that informs the dominant mental health narrative. I believe this involves the construction and use of a narrative of connection: Chris seems to be operating from a belief that her own experiences are part of a shared human experience that others will be able to understand and connect with. Chris seems to believe that clients will be able to hear that this understanding of the experience comes from having "been there." This knowledge and this approach are part of the narrative of connection.

6.6.2.4 Discussion

During our conversations about how participants use their lived experience of mental health challenges in their practice, participants' referenced all three mental health narratives: the narratives of disconnection, resistance, and connection. None of the narratives seemed to take precedence over the others, in contrast with the prominence of disconnection within research question one.

Participants' words reflected the narrative of disconnection when they talked about not receiving guidance about how to use self-disclosure. In addition, participants enacted the dominant mental health narrative of disconnection when they spoke about their worry that using their lived experience and self-disclosing would be inappropriate and unprofessional, which they expressed as "too much about me." I interpret this as an internalization of dominant mental health concepts of helping. However, even as participants took on aspects of this dominant narrative, they did not do so fully or readily (McKenzie-Mohr & Lafrance, 2014b). Instead, they questioned their given roles and expectations and problematized, for example, dominant understanding of helping, such as the prescribed unidirectionality of helping.

Some participants chose not to share their lived experience of mental health challenges and/or their use of lived experience with colleagues, which can be seen as enacting the dominant narrative of disconnection. However, the fact that they did continue to engage in use of lived experience and self-disclosure with clients, is a sign of resistance to the dominant narrative. In addition, some participants worked to create spaces where clients themselves could engage in questioning dominant understandings of mental health that they found harmful, helping further the resistance to the dominant mental health narrative of disconnection.

A lot of the conversation about participants' preferred way of practice focused on an approach to their work that centres connection, shared experience, and relationship. Participants spoke of their lived experience of mental health challenges leading them to an orientation to practice that focuses on "being where the person is," and to a capacity for empathy and hope that comes from their own lived experience of recovery.

As I explored in the disconnection section within this research question (RQ2), participants doubted themselves; they felt guilt and shame in relation to their practice of self-disclosure. Patti, for example, shared that after self-disclosing:

> [I] immediately started second guessing myself and wondering "was that more about me?" –Patti

This is something that Usser and Perz (2014) have found in their research: they observed that when participants spoke up from a place of emotion, their expression was "invariably followed by guilt and self-criticism" (p. 87).

The phrase "more about me" demonstrates the impact of the dominant mental health narrative of disconnection on MHWHs. The implication is that clients and workers are separate from each other and that any space that the worker uses takes away from a focus on the client. The lens of Relational-Cultural Theory allows us to question the truth behind the statement of too much about me by suggesting that **genuine relationships** are central in our work with others. Jordan (2001), further challenges the concept of unidirectionality of helping and says that

> the concept of mutuality and mutual growth takes us away from the model of self-development, which keeps us focused on ways to internalize strengths, become more independent, and develop a 'good', independent self. RCT suggests instead that we grow by building growth fostering relationships and community. We grow through and toward relationships. (p. 2)

This stance allows us to question the blanket statement that tells us that it is better not to self-disclose. Relational-Cultural Theory can offer an alternative to the dominant understanding about a worker "taking up space." It proposes that people are not separate from each other. It suggests that we are interconnected and that **it is through relationships that we understand the world and ourselves** (Jordan, 2001). When two people come together there isn't only the space you take and the space I take, with a clear boundary that separates us. Instead there is a connection, a relationship, a space we create, and a boundary that is understood as a place of meeting. Relational-Cultural Theory explains that when people learn to keep certain things about themselves hidden relationships become less genuine (Jordan, 2001). This theorizing suggests that self-disclosure by the worker may be beneficial for the client, because it allows for a joining, which itself leads to a more genuine relationship.

Jordan (2008a) states that being in relationship with someone more powerful than oneself can make some clients feel unsafe and afraid. She explains that traditional psychotherapy reflects dominant values of separateness, which manifest in working situations where **only the client is expected to be open and vulnerable**. Jordan believes that for trauma survivors in particular, “a power-over, authoritarian attitude and opaque stance on the part of the therapist can only be triggering and re-traumatizing, even when imposed with the most benign intention” (p. 246). MHWH self-disclosure could be a way of reducing some of the distance between client and worker. There is also a possibility that MHWH self-disclosure could be particularly helpful in working with people with histories of trauma and perhaps especially trauma within the helping professions.

An approach to self-disclosure that may be helpful for MHWHs is that provided by Feminist Therapy. This is a particularly interesting approach, as it considers self-disclosure as a political tool, which is relevant for MHWHs, especially within the narrative of resistance. Feminist Therapy understands “gender, power, and social location as determinants of distress and resilience in human lives” (Brown, 2010, p. 125). It has roots in early consciousness-raising groups, which were egalitarian spaces where “the sharing of personal experiences led to increased political awareness of women’s oppression” (Mahalik, Van Ormer, & Simi, 2000, p. 191). As a result of this tradition, feminist therapy has come to use self-disclosure as a tool to attend to these principles.

Feminist therapy appears to be the only approach to therapy with a “proactive embrace of self-disclosure” (Brown & Walker, 1990, p. 135). Its approach to self-disclosure is also different than that of traditional therapy approaches. Self-disclosure in traditional therapy contexts is generally used to convey shared or “universal” feelings and aimed to foster a relationship with the client (Mahalik et al., 2000); characteristics that seem to relate to the mental health narrative of connection within this study. Self-disclosure in feminist therapy, however, is used as a way of equalizing power differences between client and worker, as a way of transmitting feminist consciousness, and as a way of fostering solidarity with the client (Mahalik et al., 2000). Feminist scholars suggest that it is appropriate to disclose information about the therapists' beliefs and lifestyle, such as class background and political beliefs; something that would not be seen as appropriate within traditional therapeutic approaches (Mahalik et al., 2000), as well as feelings, emotions and vulnerability (Eyal-Lubling & Krumer-Nevo, 2016). This suggests that a Feminist Therapy approach to self-disclosure could help guide MHWH use of self. A feminist approach could provide a political framework from which to approach self-disclosure, which could be particularly useful as a tool of resistance of the dominant mental health narrative.

The analysis of the data illustrates that MHWH practice incorporates an alternative knowledge about mental health in their work with clients. This is a knowledge that rests outside of the dominant discourse of mental health and that incorporates knowledge acquired through lived experience of mental health challenges. This kind of knowledge is often referred to as experiential knowledge. I believe that this alternative knowledge is a building block to the development and establishing of alternative narratives of mental health. In our conversations about practice, this knowledge seemed mostly acquired in a private, individual manner, and though what seemed to be painful process of challenging internalized dominant conceptualizations of mental health, such as the unidirectionality of helping.

A review of the literature shows that an incorporation of knowledge that rests outside of the dominant discourse is already being incorporated within the field of nursing. Mack (1990) writes that "for the nurse, this knowledge is acquired by skilled efforts to understand the perspective of the other …this 'knowing'…may be occurring in what has been described as an intuitive manner" (p. 52). This author explains that this perspective acknowledges that human experience has multiple meanings, that "human interaction produces mutual learning; and that knowledge is attainable by personal and intuitive as well as rational and empirical means" (p. 54). This approach also questions unidirectionality and explores the value of self-disclosure and reciprocity. It suggests that a lack of opportunity to reciprocate can be a barrier to seeking and using help; which supports the concept of mutuality addressed within this research.

One of the insights from this research process is that MHWH's learning and knowledge production need not be such a painful and lonely affair. The research demonstrates that, in coming together with likeminded individuals through the creation of a community of MHWHs, the process of challenging dominant mental health narratives and developing alternative narratives can be greatly facilitated. This can be seen as evidence of continuation of, and ongoing need for, feminist consciousness-raising groups (Wilkinson, 2004), as well as Freire's (1970) critical consciousness, both of which emphasize the importance of groups in the collectivizing of individual challenges and in the development of liberatory knowledge.

In addition, this research suggests that knowledge construction and theorizing about MHWH experiences, practice, and knowledge can support MHWHs in their professional practice. Making this kind of knowledge available for MHWHs can support their practice and wellbeing, even if they don't have connections with other MHWHs. The use and expansion of existing theories, such as RCT above (Comstock et al., 2008; Hartling & Sparks, 2008; Jordan, 2001; Walker, 2008a; West, 2005) critical Anti-oppressive Theory (Holley et al., 2012; Hopton, 1997; Larson, 2008), and further theorizing within the new mental health field of study called Mad Studies (Adame, 2014; Beresford, 2014; Beresford & Russo, 2016; LeFrançois et al., 2013; Poole et al., 2012; Reid & Poole, 2013; Russo & Beresford, 2015; Wolframe, 2013) can help individual MHWHs feel less alone in developing their practice knowledge and their framework of practice.

6.6.3 Third Research Question

The third research question was: "What is the experience of being part of a community of Mental Health Wounded Healers through participating in these focus groups?" As with the first two questions, the data generated by this question is presented in three groups according to whether they reflect a narrative of disconnection, resistance or connection.

From an analysis of the data in relation to this third question I theorize that participants answered the question in two ways: they answered the question directly and they interacted with each other in ways that I interpret as providing data regarding experiences of being in the group. This interpretation is consistent with other focus group research, which recognizes participant interaction as a source of data (Belzile & Öberg, 2012; Morgan, 2010). Both the verbal and the performed responses are explored in this section.

6.6.3.1 Disconnection

Most of the ways that participants spoke about coming together through the research, and most of the ways in which they performed this coming together through their interactions, represented the use of both alternative narratives of resistance and of connection. While there were only a few instances in which our discussions reflected disconnection in the interactions within the research, there were two major ways in which

I interpreted the dominant discourse of disconnection impacting the research. One was through absence: the people who did not choose to take part in the research. The other was through the kind of hiding in terms of self-censorship that this writing necessitated in order to protect the safety and wellbeing of participants. Both are explained and expanded below.

While it is not possible to know all the reasons why some MHWHs chose to take part in the research and others did not, I believe privilege was a factor that may have impacted which MHWHs felt safe connecting with others in a group and which did not. MHWHs who are racialized or otherwise marginalized beyond their mental health status might risk marginalization *within* the focus groups due to their other locations of oppression if they joined this study. I have come to understand that my own unexamined privilege as a white, able-bodied, middle class person prevented me from recognizing that a focus group of MHWHs would not be equally safe for all Wounded Healers. This highlights the importance of becoming aware of our privilege. A lack of awareness about privilege can, and did for me, lead to overlooking othering and oppression of other groups and to re-producing a dominant narrative of oppression.

At the beginning of FG2 I shared with the group the realization that my privilege had contributed to a focus group research design, and that I believed the design might have excluded the voices of some groups of MHWHs. This led to a lively discussion about privilege, and how it relates to who is, and is not, invited or allowed in certain spaces. Nicki reflected on the privilege "in the research room" and how it might relate to our ability to work in the mental health field. She spoke, for example, to our ability to access supports because of our locations of privilege (e.g., all participants being white) and to our “being articulate” as a factor in being able to access employment in the mental health field. Nicki’s words suggest that this matter of exclusion reaches well beyond this study, for individuals with mental health challenges. The demographics of the people who participated in this study reflects, not only the fact that some MHWHs may not have felt comfortable with a focus group design, but also the likelihood that many individuals living with mental health challenges may not become mental health professionals because of lack of opportunities for healing and for leadership relating to oppressive discourses within the mental health practice field.

A deeper analysis of privilege leads to the reflection that the writing of this research has also been curtailed by the dominant mental health narrative of disconnection. This dominant narrative has impacted the writing by limiting the kinds of things that can be safely put into writing (i.e., without compromising the employment and reputation of participants.) Participants spoke, throughout the research, of fear and concern about being identifiable through the writing and requested, on several occasions, that specific information be held back from the writing. Participants wanted to protect themselves from harmful consequences by excluding certain information from the writing. This can be interpreted as a way of performing disconnection.

While discussion among the individuals who did participate in the research was mostly lively and open there were some instances where some **hesitance and discomfort** could be felt, which I interpreted as evidence of fear of being harmed (again) in relation to being a MHWH, and as a signal of need for increased trust. Sarah, for instance, initially shared impersonal motivations for participating in the research:

> I don’t know, it was just interesting the topic of the study I’ve 10—over 10 years’ experience of research background so I know how hard these things are to get people to that contribute to this

> kind of qualitative research, so that was part of it and the other it's just interested in what people would ah… I guess what it would be about. I'm not really sure how to explain it, so that's it. -Sarah

Later, she shared more personal motivations for participating, which I interpret as evidence of increased trust and comfort, and a letting go of the dominant narrative of mental health and related fears:

> It's just like I've been feeling really stuck, in so many ways, maybe this is the real reason I was attracted to this group, is to find people who feel the way I feel. -Sarah

Another example of the dominant narrative of disconnection surfacing during our time together occurred when I asked participants about their experience of coming together through this research. While most of their responses were positive some participants spoke about being concerned that ongoing connection with other MHWHs could be detrimental to their wellbeing. This was a **fear of re-wounding**, or vicarious re-traumatization from hearing others' stories of wounding in the workplace. Patti spoke about this in terms of re-triggering through hearing others' stories of powerlessness:

> Sometimes I find it to be uhhh a burnout thing to even like spend the time talking about it.[…] Because there is nothing that you can really control. –Patti

A fear of re-wounding, which literature on vicarious trauma has found to have significant negative impact on individuals (Valent, 2002), could lead to wanting to disconnect from other MHWHs in order to protect one's health.

6.6.3.2 Resistance

Participants' experiences of coming together through this research demonstrated a narrative of resistance; both in the verbal and the performed answers to the third research question. One salient way in which participants offered resistance to the dominant mental health narrative of disconnection was through lengthy discussions about their **experiences within structures** that work within this dominant narrative. Participants were driven to discuss their experiences at specific workplaces and within educational settings. I have chosen to not include quotes from these discussions, as doing so could compromise participant confidentiality. It was clear, however, that these conversations were emotionally charged and reflected anger. I interpreted these conversations as a demonstration of a strong need to vent and verbalize their experiences of harm to a receptive audience.

Researcher Reflection:

It was emotionally challenging, painful even, to be present with these discussions and, at times, I could empathize with Patti's' concerns quoted above about the emotional impact of being stuck in this place of anger and hurt without an avenue toward change. I could understand the desire to disengage from this line of conversation, and the need to disconnect from other MHWHs in order to prevent further harm.

Patti spoke on several occasions about the impact of hearing others' stories of struggle within the system. She shared, for example,

> In terms of coming here together, like it's not enough for me anymore to just talk about it because that makes me really depressed, even more and anxious or whatever. –Patti

Patti also shared a desire for change through resistance:

> All the organizations are structured in very similar ways where workers—like their mental health declines because of the nature of the structures of the place they work and like having no support […] It's like… call out those contradictions […] So like, like, what strategies can we actually implement? -Patti

Patti's words represent both a place of wounding and a drive toward healing through resistance. Patti's wounding is expressed when she speaks of being "really depressed and even more anxious." She then speaks of a desire to leave this place of wounding when she says "it's not enough for me anymore," "call out those contradictions," and "what strategies can we actually implement? Patti shared a belief that there is "nothing you can really control," however, her words of resistance suggest that a part of her believes that she does have some control. The interpretation of the processes of connection and disconnection that I presented in section 6.5 identifies that a loss of hope that disconnection will be heard and resolved relates to wounding and the presence of hope relates to healing. Patti's words suggest an additional avenue toward healing via resistance. This resistance is not aimed directly at the person responsible for the wounding but is expressed as **a call to social action**. The words from one participant reflect this sentiment and show the display of anger as a driving emotion to this kind of resistance:

> Like I've thought many times about, like, why the fuck don't we go to the fucking media and just like *say this shit* and just let people know and hang out their dirty laundry, like why are we letting them get away with…

MHWHs often experience situations where enacting resistance toward the person responsible for the disconnection and wounding has been unsuccessful and has led or could lead to further wounding. In these situations, looking for other ways to enact resistance and demand social change, as this participant does when she discusses going to the media, is a sign of resilience; it demonstrates agency, creativity, and an ongoing drive toward resistance. This is evidence that resistance can take different shapes. Research shows that engagement in social action relates to a strong sense of social identity, and is mediated through a perception of injustice and a sense of efficacy (Van Zomeren, Postmes, & Spears, 2008). This suggests that social action as resistance could be facilitated by connection with other MHWHs.

One way in which participants used the research space to resist the dominant narrative of mental health was using it as a "**safe" space to question and challenge dominant understandings** of mental health and of professionalism. While analyzed earlier in regards to labels and leadership (section 6.6.1.2) the questioning of dominant understandings of mental health concepts is relevant here as well, as participants felt comfortable enough in the research space to engage in this questioning. An additional example of questioning was participants' conversation about **boundaries**. Here Patti talked about co-workers' response to a client having relapsed:

> Sometimes the response from other clinicians […] comes from a place of frustration and a way that so lacks compassion [chuckles] and th—but in a way also like accuses you or me of like […] "you're working harder than your client, blah blah blah." Saying all those kinds of things that I hear them say. - Patti

Patti talked about choosing to remain connected to this client, and choosing to support him

> No, I don't think I'm working harder than the client […] I think that he deserves like the best quality of life that we can support him in having, […] and me providing like good rapport like a good just relationship of just like non-judging understanding. I think that's important. -Patti

Participants interpreted this kind of non-MHWHs' behaviour as using 'textbook expertise,' which I interpret as using knowledge derived from the dominant mental health narrative:

> That analysis of the client's situation comes from this *textbook exp*ertise […] and it's like "Oh this person is not motivated enough, and like that's a waste of resources you know to like really be like… yeah…But then I always go back to "well, like yeah this person might end up just drinking for the rest of her life and she might have those 6 to 8 weeks every couple of months where she's sober and is able to like have some good moments and…" and that's like valuable and important. –Patti

Participants spoke about non-MHWHs enacting firm boundaries in order to distance themselves from clients and protect themselves from self-judgement when clients' outcomes are poor:

> Patti: They're saying "well they are not motivated so I'm not gonna work with them" it's like…
>
> Jill: it's like the ego. It's people not taking care of their own limits and not realizing that they have their own ego involved in whether or not someone is committing to the relationship, which is […] I think in a lot of clinical training there isn't, there isn't teaching anymore about how to use your self, how you are involved in the relationship. It's like "I am this benevolent omniscient sort of like benevolent weird purveyor of health onto people" Like what is that!? It's kind of—like there isn't

this sense of like how do you use your own self that is flawed and dynamic and lots of things in the relationship

Nicki: well and if you have to be all-powerful there is so much pressure! So of course you are gonna feel like you are failing your clients.

Jill: yeah, yeah, yeah.

Nicki: of course you are going to wanna blame your clients, cause it's a threat.

Participants also showed resistance to the dominant narrative of mental health by **showing vulnerability and wanting to learn from each other.** Anna, for example talked about her **fallibility as a worker** and using the group to ask for support. She asked the group for guidance on a specific practice question:

Anna: I could use some like tools on like how do you check in with somebody in the moment? When you think you just F-ed up in the moment? What are some good phrases? "Did I just fuck that up?" like, what can I say to…that's appropriate?

Chris: that's great! yeah… I think it's just ask the question, I think that's what you need to do, right? […] and I think we have to—I mean I don't know about everybody else but like that 's the only way to correct, it is to ask in the moment, you know? "Did I just screw that up?" or whatever… or did I say the wrong thing?

Nicki: "Oh wow! That didn't come out the way I expected"

Anna's asking shows a willingness to be vulnerable in the group, by acknowledging that she does not have all the answers, and by acknowledging that she, in fact, makes mistakes in her practice. The group was very engaged in addressing Anna's question and questioned the idea that a leader has to be perfect or not make mistakes and suggested that holding on to ideas of infallibility might be harmful for clients. Nicki shared her thoughts about this:

If we are teaching our clients that—that you are not allowed to fuck up… then what kind of message are they walking away with? […] when they've got all these impossible demands of themselves […] that they feel that they are constantly failing. -Nicki

In addition, participants spoke about **participating in the research** as a helpful tool to check what they referred to as feeling complicit or complacent within the dominant mental health structures. Nicki spoke about finding this challenging but useful:

> I think for me the experience of coming together has been both really validating but to be honest it's also been really quite painful…in that it makes me aware of my cognitive dissonance like about the things where I don't feel you know, where I feel like I've gotten lost in the system and bought in too much, and you know it makes me aware of ah…you know the extent to which I've gotten more distanced from my feminism, […] And don't get me wrong when I say it's been painful for me, I think that's for a good reason, I think it's reminded me of a lot of things and *I want to be reminded*. - Nicki

And later, when I asked Nicki to elaborate about finding the experience of being in the group painful she and others shared:

> Nicki: I want to make very clear, I do believe I need to challenge myself.
>
> Jill: I feel like it's hard but [also] I've become complicit, you know.
>
> Nicki: complacent, yeah exactly!
>
> Jill: complacent *and* complicit in it…
>
> Nicki: yes! You're right.

It seems that some of the value that Nicki and Jill see in this group is about the group's ability to provide a "safe" space where dominant narratives of mental health can be challenged and where alternative narratives and knowledges can be explored and strengthened. I interpret this to mean that they are speaking of this research space as a space of resistance, akin to spaces that work toward critical consciousness Freire, 1970), and consciousness-raising groups (Wilkinson, 2004).

Another layer of analysis to Nicki's quote is that she talks about pain not being something bad, but being something useful. This in itself **challenges the dominant, medicalized, mental health narrative that pathologizes emotion**. She speaks about finding the group useful in reminding her of her own values, and re-connecting with the

MHWH side of herself, which seems to have been pushed aside through her work within the system. In fact, later in that group participants talked about the possibility of continuing to meet after that third and last focus group and Nicki said she would be interested in meeting "on a monthly or whatever basis. For me this is good for my mental health so… I'm definitely game if other people are." Nicki is saying that being part of the group has been good for her mental health, even though it brought up challenging emotions. Both being part of a MHWH group and working with challenging emotions further resists the dominant mental health narrative.

Lastly, participants also spoke about the possibility that the research itself could be an avenue of resistance in its ability to access non-MHWHs an audience:

> Do you want [your audience] to be mental health professionals who *don't* have mental health problems? So that they get shaken up a bit? - Nicki

Having non-MHWHs as an audience of this thesis would expose them to alternative knowledge about mental health, thus enacting a form of resistance to dominant mental health narratives.

Patti also spoke of the **importance of connecting with likeminded others in the pursuit of challenging dominant mental health narratives**. In this excerpt both Chris and I are being affected by what Patti is saying:

> Patti: it's very hard to give in to yourself that it *isn't true* because there's so much power in the person that is saying it […] And then your livelihood is at risk, you need to pay your bills somehow, like you just paid 40 thousand dollars for this degree [chuckles] to be a social worker and now you don't have a good reputation anymore.
>
> Piedad: that's what I worry about.
>
> Patti: But then uh… my friend kind of talked about— she was like "have you looked into narrative approaches?" and was kind of asking me really good questions about like "why are you believing that narrative around yourself and whatever, how come you can't see it in the way that I see it as being someone that was courageous and really a strong woman" and whatever else, and like to have those people be able to reflect that back to you is like so important. […] But also like you feel like you need

that… I was joking like a couple months ago that I need someone to hold my hand sometimes [chuckles]

Piedad: I need so much reassurance, that's what I feel.

Patti: Yeah! Because there's so much uh… to fight against like it's too heavy of a weight to bear, soo…

Chris: Oh my God!

Patti: so…

Piedad: [reading from her journal] "I need some guidance and so much support" right there! [chuckles] That's what I wrote [chuckles]

Patti is speaking about the value of this kind of connection to get support to not internalize the negative messages that the dominant structures place on us, specifically in relation to times when our location as MHWHs has led to challenges in the workplace. She identifies the need for others to help her challenge dominant ideas, externalize problems, and provide support. In speaking about this surrounded with others with similar experiences she is further working toward naming this need and creating this change, solidifying alternative narratives of both resistance and connection.

6.6.3.3 Connection

Most of the data derived from the third research question related to the **alternative narrative of connection**. Participants spoke directly about finding the group useful because it allowed them to connect with other MHWHs. They used the space to perform connection with each other through supporting each other and being vulnerable with each other as well as by challenging and disagreeing with each other, thus engaging in processes of disconnection and (re)connection (Jordan, 2001). Participants also spoke of the research itself being an avenue of connection with other MHWHs.

Participants spoke about **being able to connect with other MHWHs** as a benefit of participating in the focus groups. Chris, for example, talked about feeling alone and finding that the group helped her reflect on and give validation to her experiences, normalizing them:

> It's been good here because it's just having me sort of re-look at things, right? And then, um…and all of you speak so eloquently, all of you speak so well, right? You say things well […] I'm sitting here listening to the two of you talk and going "I remember that, I remember feeling like that, I remember feeling like that" […] I had those insecurities lalalala, I wish I had someone to talk to. […] Because I had to figure it out all by myself before—and have, right? But, so… so hearing you guys say that just tells me "hey well, that's where I was" right? Or I've experienced that. -Chris

As the data excerpts in this section and throughout this chapter evidence, participants also performed or enacted connection through supporting each other and showing vulnerability, as well as by challenging and disagreeing with each other.

Participants **shared personal stories and experiences and engaged with each other's stories**. One prominent discussion happened during FG3 when one participant shared a recent experience of loss in the family to suicide. The group encouraged this participant to share her experience and devoted time to listening to and supporting her. How this member was supported addresses the focus of Research Question 3. One participant, for example, showed her support by sharing her own experience of suicide in her family. This group member was able to offer the grieving participant empathy and understanding as well as a personal experience of making meaning of loss, all of which were powerful ways of performing connection. In doing so, she demonstrated the importance of relationship and connection in healing and helping.

The supportive participant's ability and decision to make herself vulnerable through the sharing of a very personal story in order to support the grieving participant suggests a high level of engagement with the group. Importantly, both of these participants spoke of ways of making meaning of their losses outside of the dominant narrative of mental health and through narratives of connection, in a way resembling the nursing approach espoused by Marck (1990):

> I [believe] that their energy is going to go out there and reconnect cause there's a reason why we connect with people that you think you know them and stuff… And I said: […] "you'll be out there floating around someday with all your other friends."

During this focus group (FG3) participants also seemed **more able and willing to show more vulnerable sides of themselves**. Toward the end of our time together, for example, Chris shared that she worries about being fully open with others and explained how that has played out for her during the focus groups:

> I'm sitting here going "well is this even the group, does this group even wanna hear from me", right? […] Would I be… would I be a burden? […] 'Cause in the beginning I was talking a lot and I thought "Oh god, I'm monopolizing" you know, remember when you guys said about when does this turn into 'me', right? […] So that's where I am at, I do not think I'm important enough. -Chris

Chris talks about being **worried that she does not belong in the research group** and shares her fear that she is "taking too much space," making the room "too much about her," which, as explored in our discussion about MHWH practice (please see section 6.6.2), is a sign of the dominant narrative of mental health.

Researcher Reflection:

When Chris shared this with the group, I thought that she was very brave in sharing this vulnerable side of her and also felt that I knew her enough to have witnessed that she is able to understand and connect with others in meaningful ways through the use of her lived experience. I wanted to honour Chris's courage by reflecting back a picture of herself that was different than the one she was seeing. A picture that demonstrated her capacity to connect with others and that may allow her to see her value in the group. I felt comfortable challenging Chris and shared with her:

> Piedad: I've gone *super slowly* over all of our conversations, right? […] and I have seen all the times when you have asked people, like questions to get them to think more . [And you] connected with them very…poignantly.
>
> Chris: really?
>
> Piedad: and caringly, absolutely.

Chris: see I don't even know if I do that.

Piedad: *yes*. Yeah, *many many many times*.

Chris: I wanna do that! You know?

Parallel to my interaction with Chris, as participants increasingly engaged in supporting each other and showing more vulnerability to each other, they also started **showing more disagreement and challenging of each other**. While disagreement can be interpreted as a sign of disconnection, in this case I saw disagreement as part of a process of disconnection and (re)connection; a *resolved disconnection* that, from a Relational-Cultural perspective, leads to increased connection (Jordan, 2001).

I was not the only one who gently challenged others' points of view. Other participants also seemed more comfortable challenging each other. For example, Nicki challenged Jill when she spoke about a peer support worker becoming an "oppressor sympathizer:"

> When you move from—when you start to move from when you are used to having no power […] and suddenly you have a little bit of power […] in the system because you are working there […] You start to like justifying things psychiatrists are doing because you're on their team now, because you are identifying with them, because you have a *job* and you are not one of the clients anymore, you want to distance yourself in that way. [This peer support worker has]come to really….be a like, an oppressor sympathizer, which is weird, and I think that can happen to any of us. –Jill

Jill is saying that participating in a mental health structure carries the risk for the MHWH of going from aligning with clients back to aligning with the workers, thus taking on the dominant narrative of mental health embedded in that structure. To this, Nicki challenged:

> I agree but I'm gonna say […] I understand what you are saying about the sympathizing with the oppressor and perhaps this is me being a bit defensive, but it's—[…] I really do believe that at those—at a lot of those tables people are well intentioned. -Nicki

Examples such as these, where participants disagreed with each other and challenged each other, can be interpreted as performance of disconnection. However, they could also be seen as part of a process of re-connection that is linked to an **increased level of trust** in the group, as participants come to feel more accepted and secure in the group. RCT literature states that the healing of disconnections develops trust (Jordan, 2008c), which indicates that these disconnections may have been avenues used by participants to develop trust, and suggests that trust building was an active and engaged process for participants. These disagreements appeared toward the end of our time together, which supports the conceptualization of trust as a process. I interpret these disagreements as a sign of increased trust over time and of a sufficient sense of connection with participants so as to reduce the fear that showing disagreement could lead to disconnection in the form of judgement or exclusion.

Further, participants were interested in this information reaching others through the use of knowledge translation, which I interpreted as a sign that they saw this thesis as a way of performing connection with other MHWHs who may read this thesis. Anna shared:

Theses have to be done for a targeted audience but I think it's also valuable that other people who are doing what we do hear it. And I don't know if there is a way…- Anna

Other participants had a lot of ideas about how to go about this:

Piedad: for me, I really—I think there's value in all of our experiences and I would like it to reach people, I don't exactly know… *how.*

Nicki: you're gonna publish it!

Piedad: yes, but who's gonna read… I mean sure…

Nicki: not as a thesis.

Chris: a book! Let's just write a book!

Nicki: you can write articles!

Chris: a little book! A little book with narratives…

Jill: the OT department got funding to do knowledge translation creatively with some of their research.

Researcher Reflection:

Lastly, in relation to connection through participating in the research I also observed, within our group, **a reframing of what community is**. This reframing occurred through a discussion about whether to invite the two participants that had not attended FG2 to join FG3. I had designed the research so that if participants missed one group, they would not attend later groups, and had informed participants accordingly. My thinking was that these participants may miss some potentially sensitive material during FG2 that could get revisited in FG3, which could be uncomfortable for those that had shared that sensitive material in FG2. I thought that, because of this, it may potentially be unethical to welcome participants back.

However, as I reflected on concepts of collaboration and of community development, I realized that it was important that I do not make this decision alone. The overwhelming feedback from the group was one of welcoming back. This led me to assess that ideas of ethics and of safety in community and community development are also impacted by a dominant discourse of separation. This, in turn, led to an interpretation of this group's desire to build community by staying/being open, inclusive, and welcoming as an enactment of the narrative of connection.

In the end, the two participants were welcomed back, although they did not end up attending.

6.6.3.4 Discussion

Data generated by the third research question most often fit within narratives of resistance and connection, although there was also evidence of the mental health narrative of disconnection.

The narrative of disconnection, while less salient in response to the third research question, was evident in several different ways. It was evident through some early evidence of hesitance to trust the group and open up to the group, perhaps as a way to avoid risk of hurt or rejection (Comstock et al., 2002). This narrative was also evident through some participants' concern that being in relationship with other MHWHs could be re-triggering, which again identified disconnection a form of protection from further harm. In addition, presence of disconnection could be inferred by looking at the types of MHWHs who took part in the research and those who did not. My interpretation, as well as the interpretation from participants, and from the literature (Walker, 2004), hints at an intersection of oppression being responsible for the homogeneity, at least in terms of race, within the research participants. Lastly, the impact of the dominant mental health narrative of disconnection was evident through participants' concerns about being identifiable through the research, which curtailed which parts of our discussion could be written about without compromising the confidentiality and safety of participants. The emotional undercurrent of this narrative of disconnection is one of fear**: fear of being hurt or rejected**, which can keep MHWHs from connecting and/or sharing with other MHWHs and with the wider community (Jordan, 2008a).

Alternative narratives of resistance and connection were significant in relation to the third research question. Resistance was evident in participants' use of the research space to discuss their challenges in mental health workplaces as well as in educational institutions. Participants also used the research space to question and challenge dominant conceptualizations of mental health-related concepts such as boundaries and emotionality (as well as labels and leadership, which were explored in section 6.6.1.2). Participants also used the research space to learn from each other, thus working toward building alternative mental health knowledge. What became evident, through an examination of our time together, was that a crucial element of enacting resistance to the dominant mental health narrative occurred through **connecting with likeminded others**. Connection is something that Hartling and Sparks (Hartling & Sparks, 2008) have also found helpful as individuals engage in resistance: staying connected to a network of likeminded others increases resilience in the face of institutional practices that use stratification, disconnection, separation and power-over.

Participant **performance of connection** was central to this research question. Participants showed increased levels of vulnerability with each other. They connected with and supported one another through sharing personal stories, they spoke of finding validation to their workplace experiences through their connection with each other. They also demonstrated feeling comfortable enough, and trusting their belonging in the group enough, to disagree and challenge each other. Comstock (2002) believes that "the ability to manage disengagement is an indicator of one's relational resilience" (p. 263), which suggests that participants' relational resilience may have strengthened in connection with each other. This could be seen as a product of "supported vulnerability" (Comstock et al., 2002), which are processes of establishing safety by committing to "the creative yet difficult process of working through disconnections."

Lastly, participants demonstrated an alternative narrative of connection through their understanding of community as an open, inclusive, and welcoming place. They did this through their desire to invite the two participants who did not attend Focus Group 2 back to the group for Focus Group 3.

CHAPTER 7 Analysis

Having analyzed participants' responses to the three research questions by looking at the three mental health narratives identified earlier in this research (narratives of disconnection, resistance, and connection) allows me to have a closer look at these narratives; in particular, this allows me to understand these narratives as tools that have *social functions*. This chapter presents and substantiates the dominant narrative of disconnection as a narrative of preservation of social order, the alternative narrative of resistance as a narrative of challenge toward social change, and the narrative of connection as a narrative of inclusion and acceptance.

7.1 Dominant Mental Health Narrative of Disconnection: A Narrative of Social Preservation Through Social Control & Sanism

In this section, I summarize MHWHs experiences within structures embedded in dominant mental health narratives and identify these experiences as process of oppression, and specifically Sanism, at work in mental health workplaces and other structures. The experience of being part of this research is included here, as this research is embedded within a larger culture that espouses this dominant narrative.

The dominant mental health narrative of disconnection is a narrative that is rooted in medicalized understandings of health and helping, which categorizes individuals as either healthy and potential helpers, or pathological and in need of help. The evidence in this research points to this narrative as serving as a tool of preservation of the status quo through social control. For MHWHs this narrative plays out in very specific ways that result in harm and wounding through Sanism, which is “the systematic subjugation of people who have received ‘mental health’ diagnoses or treatment” (Poole et al., 2012, p. 20).

From the research findings I interpret the dominant narrative of disconnection being enacted within dominant mental health structures, educational institutions, and professional regulatory bodies. These structures work from a dominant mental health narrative that constructs persons as either helpers or helpees; a model that does not allow for the existence of MHWHs (Richards et al., 2016). MHWHs, by being both helper and helpee, embody a disruption of this dominant narrative. This results in MHWHs being challenged, discredited, dismissed, and excluded. Their concerns and their knowledge are ignored, and their practice scrutinized. Nicki, for example, spoke about her experiences at school: coping by silencing herself and trying to fit in,

> I did a lot of like […] suppressing, fitting in, I—*I passed really well.* [Grad school is] where you do *whatever your supervisor wants* because she has all the fucking power in the world. –Nicki

Mental health challenges are constructed, within the dominant narrative of mental health, as individual concerns relating to emotionality and pathology. This research challenges this construction and shows that the ways that MHWHs are treated in structures operating within this dominant narrative demonstrate practices of othering and exclusion that are the trademarks of oppression. Young (as cited in Holley et al., 2012) speaks of oppression as a complex and pervasive web of structures and processes “that inhibit the ability of members of less-powerful social groups to develop and exercise their capacities and express their needs, thoughts, and feelings” (p. 53). This understanding of oppression keenly represents the experiences of MHWHs.

A closer look at how these processes of oppression impact MHWHs shows that these workers are harmed by their workplace interactions. **MHWHs learn to be afraid** of the repercussions of their interactions with these structures and attempt to protect themselves from further harm. Relational-Cultural Theory suggests that “fear is not an accidental consequence of institutions that exercise power over others; it is the driving force that deepens and expands the power and the potential for abuse” (Jordan, 2008a, p. 237). MHWHs, through fear, learn to silence themselves so as to “pass” and remain within the structure, protecting their employment and their reputation. Alternately, they distance themselves from these structures by leaving jobs and changing careers. Even those workers who choose to be “out” about their mental health challenges at work continue to be faced with a dominant discourse that questions and undermines their knowledge and their practice through messages that can reinforce internalized dominant messages about mental health, indirectly silencing. Relational-Cultural Theory understands these practices of silencing as practices of disconnection (Comstock et al., 2002; Hartling & Sparks, 2008; Jordan, 2001; Walker, 2008b), where MHWHs learn to keep certain aspects of themselves hidden to protect themselves and to fit with what is more socially acceptable. Moreover, Relational-Cultural Theory explains that often, in a state of disconnection, “we are immobilized and self-blaming” (Jordan, 2001, p. 97). This is reflected in this study’s participants, as they take in the dominant messages they receive at work and learn to doubt and question themselves. According to Relational-Cultural Theory, when we learn to hide a part of ourselves from others there is also a “disconnection from certain aspects of inner experience, and one’s understanding of reality is altered” (Jordan, 2001, p. 95). One of the repercussions of disconnecting from others is that MHWHs end up disconnecting from ourselves and from our beliefs about the world (Jordan, 2001).

This internalization of messages that tell a MHWH we don't exist or should not exist, can lead to **shame**, which further works to silence these workers. Jordan (2001) understands that "shame is an essential relational affect and that it can be defined as a sense of unworthiness to be in connection, an absence of hope that an empathic response will be forthcoming from another person" (p. 100). It is a place where "one feels unworthy of love, of connection. One feels that something about one's being locks one out of connection" (p. 100). This process is part of how oppression, and in this case Sanism, works: the dominant system uses shame to isolate and silence, subverting challenges to its power from subordinate groups (Jordan, 2008a). "We should always remember that part of the work of a dominant group is to get the subjugated or non-dominant group to internalize the following construction: 'I am the problem because I feel the pain'" (p. 241).

When MHWHs are operating within a dominant, medicalized, narrative of mental health as disconnection, we are living in **fear and shame**. These are places of protection and isolation, and mechanisms of social control: while temporarily protecting the Wounded Healer from further harm from the dominant structures, fear and shame do not help the MHWH heal from the wound experienced within the dominant structure, nor do they incite social change. MHWHs' internalization of issues that have a structural origin leads to silencing our voices, suppressing conflict and challenge that could come in the form of dissenting voices (Walker, 2008b). This works to preserve the social order and to keep power in the hands of the powerful under the guise of consensus (Walker, 2008b).

Participants themselves identified structural factors as the source of some of their workplace challenges. Chris, for example, related the experiences of MHWHs to the discomfort of those in power:

I think a lot of it has to do with power… people being uncomfortable with what we might have to say.-Chris

When Chris speaks about people with power being uncomfortable, what I interpret is that there is also fear in those who are more powerful. Jordan (2008a) writes that fear is an intrinsic tool of oppression, both as an experience of the less powerful as well as the more powerful: "Fear is first created within the non-dominant groups in order to control them, and then fear of the non-dominant groups is created within the dominant group to rationalize their control over the non-dominants" (p. 237).

In addition to Jordan's words I suggest the possibility that fear in the more dominant may also refer to a possible loss of security, status, or even identity. Participants, in fact, made links between their individual experiences of othering and the reproduction of dominant structures. In the following segment they talked about emotions and emotionality not being allowed in the workplace and interpreted this as a way for dominant structures to exclude and oppress:

Patti: I only cry when I'm angry and that's served me not well at all at the workplace.

Chris: That's the oppressive culture.

Patti: Especially when you're angry 'cause crying is interpreted as being weak or whatever but you're really trying to be strong cause you're pissed off! So it's like…

Anna: Sometimes I cry when I'm pissed off.

Patti: Yes, it counteracts what you are trying to express. It's very frustrating.

[laughter]

Chris: And then somebody interprets it.

Patti: That's what I mean, yeah yeah.

Chris: as wrong!

This discussion is an example of how not allowing emotion and vulnerability in the workplace is a way to construct some people as "less than," and is in line with critical (dis)Ability understandings of "othering" and oppression (Wendell, 1996). This othering then allows structures, and people working within these structures, to become oppressive to the "less than" people and helps them preserve their own power-over.

By learning about the workplace experiences, the practice, and the practice knowledge of MHWHs, this research helps us see how processes of classification, othering, and marginalization occur for MHWHs, thus offering us a way of linking individual experiences with structural and social factors. It offers a way of linking the personal to the political (Wendell, 1996). By silencing and dismissing the voices of MHWHs, dominant structures control which opinions and whose knowledges are heard and which are silenced: this controls which mental health narratives get produced and re-produced. Wardrope (2015) refers to this as epistemological injustice, where some people's capacity as knowers is impeded, and where only certain perspectives (e.g., medicalized perspectives) are considered knowledge. By only allowing the voice and knowledge that is in alignment with their preferred narrative, these processes assist dominant structures in retaining their power and legitimacy.

This power and legitimacy, combined with their silencing effects, allow these structures to remain unchallenged and unchanged. For MHWHs, the process by which this occurs can be understood as Sanism and operates in the following way: The dominant structure engages in a process of othering MHWHs (such as not allowing and/or pathologizing emotionality,) which de-legitimizes their voice and their knowledge and makes them a target of discrimination. MHWHs learn to fear the consequences of challenging dominant narratives and dominant structures. These dominant structures have the power to instill this fear, since they are capable of impacting the lives and livelihood of MHWHs. In order to protect themselves (e.g., their health and livelihood), MHWHs learn to silence mental health perspectives and opinions that challenge the dominant narrative and structure. Through fear, dominant narratives and dominant structures remain unchallenged and dominant structures remain unchallenged and unchanged (Jordan, 2008a).

The ability of the dominant mental health narrative to silence discord and disagreement through these mechanisms, means that the processes by which dominant structures retain their power remain largely invisible. This means that the power and dominant position of these dominant structures come to be seen as legitimate and deserved, which further reinforces a construction of these dominant structures as "naturally deserving" of placement at the top of the social hierarchy. Similarly, the body of knowledge that reinforces the dominant narrative remains unchallenged, and further solidifies a claim of "truth" relating to the dominant narrative.

Participants' requests that certain parts of our conversations (most often examples of active challenge of structures) be excluded from the writing is evidence of the dominant mental health narrative of disconnection. The mental health community in Halifax, Nova Scotia is relatively small; participants worried that they could be recognizable in the writing and feared the consequences that could come if they came to be recognized. The fact that this rich part of our discussion must largely remain unwritten is a limitation of this research, albeit one born once again of the dominant mental health narrative (please see section 8.1). The process of instilling fear and its relationship to reifying the power and truth claims of dominant social structures is at play in this writing. The need to protect the safety of participants by not reproducing some of their words of discord in this writing is an example of this process at work. As a result, a significant amount of knowledge has needed to be excluded from this research, contributing to a false idea of consensus within mental health (Walker, 2008b); making this research complicit in the re-production of the dominant narrative. Even the protection and “relative safety” that research can provide for participants, with its oft cited ability to present oppressed knowledge (Barnes, 2003; Beresford, 2013; Danieli & Woodhams, 2005; Strier, 2007), is not able to fully counteract the silencing power of these dominant mental health structures.

7.2 Resistance Narrative: a Narrative of Challenge and Social Change

Mental Health Wounded Healers embody resistance to the dominant mental health narrative of disconnection. Our very existence challenges the idea that people are divided into those who are healthy and can be Healers and those who are Wounded and in need of healing. By being both Wounded and Healers, MHWHs challenge the dichotomy of normal versus other. MHWHs problematize the existence of a divide between healthy and pathological, challenging non-MHWHs’ claim to health and making them face their own vulnerability and wounds.

However, even though MHWHs embody resistance to the dominant discourse, this does not equate with the production or enactment of an alternative narrative, such as a narrative of resistance. A narrative of resistance involves regaining voice, constructing an alternative body of knowledge, and finding and connecting with likeminded others. This voice of resistance is also one of **frustration and anger** that can fuel action toward social change (Lafrance, 2014). This narrative, mediated by emotion, works to challenge social injustice and works toward justice. We can see evidence of this process through an exploration of Patti's frustration at work:

> The hyper focus on the [mental health label] seemed to be a barrier to these people being able to go back and do the things that they *love* and go to school, like, because they wanted to go back to school… they would—I would always hear them go back to "well that's because I have this… diagnosis," you know. [It was] a self fulfilling prophecy, like really self-defeating perpetual cycle and I found that to be *so* frustrating, and then I wanted to be able to say "actually I have found my anxiety to be *really* helpful in getting really good grades!" -Patti

Patti's frustration speaks to two different things: on one hand it is a frustration with the dominant discourse present in the words of the young person with whom she is working:

> I remember working with a young person who had the exact same diagnosis as me and she would say to me "I have this diagnosis and you don't understand and blah blah blah" and sometimes I felt I would get frustrated, actually, and want to say "I have the exact same diagnosis as you!" -Patti

In addition, the frustration is in regard to her inability to freely and safely use her lived experience, and the knowledge derived from it, to reduce stigma and challenge the limiting effects of this dominant narrative:

> There was a young man who was like—he came from another country where it was—mental health stuff was never ever talked about, like that was so stigmatized and I think I just mentioned to him, I was like "I experience anxiety and blah blah blah" and he was like "*you do*?!" And he couldn't believe it because I was the professional and I was like "oh… ok" and then immediately started second guessing myself and wondering "was that more about me?" -Patti

This frustration, this anger, seems to serve as a signal to Patti that something is not right and that something needs to change. A feminist analysis of anger supports the idea that anger can be a driver toward resistance and political change (Holmes, 2004). However, the potential of anger to be effective in creating social change can be curtailed by the superiority of reason over emotion prevalent in the West (Ryan, 2005), and by gendered ideals of emotionality that construct women as passive (Brown, 1999). As Holmes (2004) writes: “Oppressed groups who are characterized as emotional, rather than rational, are commonly discouraged from being angry, [therefore] being angry alone will not bring positive political change” (p. 223). This suggests that the narrative of resistance, especially as it relates to anger, may not be effective, on its own, as an avenue of social change for MHWHs.

A drive toward change was present in the work and personal lives of participants as they engaged in resistance in multiple ways. Participants engaged in resistance by developing their own knowledge, by making meaning of their own experience, by including their lived experience in their practice in subversive ways, and by connecting with others in their community and engaging in activism.

The narrative of resistance was also clearly present within the research space. Participants were angry, they wanted, they *needed*, to talk about their experiences. Participants were eager to share their experiences with others who would understand them: they were reclaiming their voices and their stories. This is congruent with some RCT scholars’ belief in the importance of creating communities of allies to counteract the doubting of our knowledge that can occur through workplace experiences of disconnection (Fletcher, 2001; Hartling & Sparks, 2008). Participants also talked at length about different conceptualizations of mental health, challenging those informed by the dominant narrative, and sharing and developing alternative knowledge.

With respect to learning about how to support this alternative narrative of resistance, the findings from this research point toward two main avenues, both of which can help MHWHs reclaim their voice and their stories. It is evident that finding likeminded others to connect with and possibly to organize with toward social change through activism can support resistance (Fletcher, 2001; Hartling & Sparks, 2008) and is very important for MHWHs. Thus, facilitating avenues of connection for MHWHs is needed. In addition, there is a need to develop an alternative body of knowledge and making it accessible for MHWHs, so that we are not on our own in questioning and challenging dominant mental health conceptualizations.

When participants and I addressed the question of using our lived experience in practice, it became apparent **that resistance was mostly enacted in isolation and was in itself isolating.** Building upon some RCT scholars' understanding of the importance of community in resistance efforts (Fletcher, 2001; Hartling & Sparks, 2008), developing mental health knowledge that challenges the idea that mental health issues are private concerns may allow for more open discussion about how mental health work can and should be a political practice; practice that includes resistance and connection and not only an avenue for symptom reduction. A safer avenue within which to discuss MHWH practice and practice knowledge, and where MHWHs can challenge the dominant mental health narrative of disconnection, would then help further alternative discourses. Endeavours such as this research can be valuable avenues of knowledge production for MHWHs.

7.2.1 Resistance as Healing

My analysis of the data illustrates that participants are engaging in healing through resistance, and working toward social change in the process. This healing is about trying to **make the world a better place** so that the harms that we have endured do not happen to others. I saw lots of energy from participants in this very active drive toward change. This healing happened as participants paid attention to their own lived experiences of mental health challenges, and made meaning of these experiences outside of the dominant narrative of mental health, often in connection with likeminded others (Fletcher, 2001). In finding and claiming their knowledge, participants were beginning to challenge this dominant narrative and the mental health conceptualizations informed by it. This is a reclaiming of one's knowledge and one's story. It was in the interaction among participants that dominant conceptualizations of mental health including emotionality, boundaries, labels and leadership were named and challenged. Knowledge building happened through the connection with other MHWHs, which shows that connection with likeminded others can foster healing through resistance.

7.2.2 Limitations of the Narrative of Resistance

Alongside a drive toward change, something that is also evident in this narrative of healing, is angst and pain. There is a **focus on the wound**. There is hope for change, in enacting this narrative, but when the challenge is great and the change is not realized it can be **a place of re-wounding**:

> Sometimes I find it to be uhhh a burnout thing to even like spend the time talking about it. [...] Because there is nothing that you can really control. -Patti

Patti spoke of a desire not to stay in this place of resistance if this challenge does not lead to change:

> In terms of coming here together, like it's not enough for me anymore to just talk about it because that makes me really depressed even more and anxious or whatever. -Patti

This points toward this narrative not being a fulfilling sole narrative to enact, and concurs with the above analysis of the limit of anger as a tool for social change (Holmes, 2004). In addition, if enacting the narrative of resistance is too much of a struggle, unsuccessful, or otherwise upsetting or demoralizing, Patti's words suggest that there may be a risk of going back to the dominant narrative of disconnection as a way of finding safety and protection, which suggests, again, a limitation in taking the narrative of resistance as the sole alternative narrative.

I posit that the narrative of resistance, paired with the narrative of connection, can form a more well-rounded alternative mental health narrative, through an incorporation of the desire for social change with an acknowledgement of the desire toward connectedness, belonging, and acceptance.

7.3 Connection Narrative: a Narrative of Acceptance and Belonging

The narrative of connection was most evident in participants' interactions with each other as well as in their identification with a preferred approach to practice through relationship and connection. In our time together, participants became increasingly open with each other, sharing their vulnerabilities and fears, sharing their stories of pain and struggle, and supporting one another through empathy and shared experience. Participants also challenged and disagreed with one another in ways that seemed to solidify their connections rather than weaken them. These participants' behaviours demonstrate, from an RCT perspective, practices of connection through supported vulnerability, which develop trust, create safety, and promote relational confidence and resilience (Comstock et al., 2002).

Participants also spoke about deeply caring about those they work with, about their desire to be present with their clients, to connect with them, and to remain aware about their own role in the helping relationship. Participants remained committed to using their lived experience of mental health challenges in their practice, even in working contexts that frown upon it, demonstrating a belief that shared experience can be an avenue for connection; a "place of meeting," and can be the base of a shared understanding that can promote hope and healing.

Participants' experiences at work reflected difficulty in finding belonging and connection in mental health workplaces, which suggests that these are what Hartling and Sparks (2008) call non-relational spaces that, "as many work settings…continue to reinforce the normative values of separation and disconnection" (p. 165). This led them to actively work to find connection elsewhere through relationships with family, friends, other MHWHs, and through being in nature. In spite of the challenges finding connection at work, some participants actively strive to extend this narrative of connection to colleagues, through empathy and a belief in shared humanity. This is relevant as it demonstrates openness and vulnerability in a context where participants have experienced harm: There is courage in this "capacity to act meaningfully and with integrity in the face of acknowledged vulnerability" (Jordan, 2008c, p. 211).

If the narrative of resistance is a driver toward change, the narrative of connection is one of arriving at this change. It is a narrative of finding inclusion; a narrative of belonging, acceptance, and self-acceptance. It is a place of acknowledging the value in one's meaning making process and one's knowledge, and a place where the same consideration can be extended to others. A structural enactment or realization of this narrative is the achievement of change through rights, protections, and large-scale attitudinal changes. A more personal enactment of this change is the acceptance of difference within a framework of shared humanity: we are all unique, but not all that different. Nicki expressed this sentiment when speaking about her clients:

Nicki: a lot of our clients feel *really, really different,* and you're trying to say… without minimizing their experience "you're not *that different*"

If the emotions that represent the dominant narrative of disconnection are fear and shame, and the emotion that best represents the narrative of resistance is anger, what may be the emotion that represents the narrative of connection? I am not sure that our current lexicon, which rests, after all, in the dominant narrative of disconnection, contains such an emotion. If I were to describe this emotion, based on participants' words, it would be an emotion of vulnerability and an open heart; it would be an emotion of belonging and connectedness. Interestingly, Jordan (2008c) understands vulnerability as openness to the influence of others, as well as to the need for others, and points to a related gap in knowledge in mainstream research, that has traditionally believed stress as leading to either freezing or fighting. This move toward others in times of stress has only recently been incorporated.

The understanding of belonging and connectedness might expand to include a sense of love or joy, or even spiritual enlightenment: an awareness that everything is interconnected, and that we are not a separate self. This understanding fits within what could be an expansion of or extrapolation from the Relational-Cultural Theory, which speaks of humans as interconnected. In fact, West (2005) writes about RCT and concludes that "it seems as though this theory is at the edge of something other and that future conceptualizations and explorations may include a spiritual component" (p. 108). West writes that, within Relational-Cultural Theory, there is "the intimation that something immeasurable and intangible is occurring" through connection (p. 108):

> there is clearly a suggestion of integrating body and mind and the sense that we can begin to know another's experience by being with them on a moment to moment basis, feeling with them as well as thinking about them. (p. 108)

This ability to understand one another suggests to me the existence of universal shared knowledge that we are tapping into when we connect with another. Nursing Theories of Caring incorporate a concept of "knowing," which seems analogous to this. This "knowing" is knowledge understood as mutual learning: it is acquired in relationship, through "efforts to understand the perspective of the other" (Marck, 1990, p. 52) and may be intuitive.

While RCT's concepts focus on the importance and necessity of connections with other humans Jordan (2001) acknowledges that

> this does not mean that we are in actual physical relationship with people at all times but that there is an attitude of relatedness, of mutuality, of openness, of participating in experience. This can occur in solitude, in nature, when we feel connected and in relationship with our surroundings. (p. 97)

This sense of connectedness that goes beyond tangible connections with specific people, and of knowledge through connection, lies at the core of spiritual beliefs and many spiritual and religious traditions (Tolle, 2005). It involves a sense that we are not separate but rather we are interconnected with everything. This interconnectedness goes beyond human beings to include other living beings and the universe.

7.3.1 Connection as Healing

My analysis of the data illustrates that participants are engaging in healing through connection. This is a healing that is about being able to be open and vulnerable to others; able to help others with one's knowledge, as well as open to receive help from others, concepts that relate to RCT's understanding of vulnerability (Jordan, 2008c). This healing is also about finding self-acceptance in one's journey and experiences. In the research, participants reconnected with themselves and their knowledge through connection with likeminded others. Within the connection that occurred through the research, participants spoke of feeling validated in their experiences and less isolated, which suggests healing through connection, which reflects RCT's analysis of the importance of connection with likeminded people in reclaiming one's knowledge (Fletcher, 2001).

Connection as healing is finding a sense of meaning and of worth, both in oneself and in others. It is a quiet place, a restful place. It is both a source of hope and a place where things already are as they should be. For one participant healing through connection involved acknowledging and accepting that there are limits to how much she can engage in challenging the dominant narrative:

> Trying to balance the reality of you can't always be the one to speak out or put your neck on the line. It's just too much, like you really do seriously harm yourself […] And so like it'd be nice for people […] to recognize that—sometimes you give yourself permission to like recognize and validate that about yourself. -Patti

Healing as connection happened as participants offered of themselves both to clients and to each other in the research. For some participants it even happened as they were able to extend empathy, compassion, and a sense of shared humanity to people in positions of power over them. They demonstrated courage and self-acceptance that allowed them to make themselves vulnerable to those people. Connecting with one's feelings and thoughts is something that RCT scholar Walker (2008b) has linked to an ability to "risk empathetic attunement" with someone more powerful (p. 138).

7.3.2 Limitations of the Narrative of Connection

From participants' eager and ongoing pursuit to build and find connection in their lives I interpret the narrative of connection as a desired narrative for MHWHs. Connection seems a much more appealing place to land than staying in the fear and shame of the dominant narrative, or in the anger of the resistance narrative. However, while this narrative may be a more appealing place to arrive to, and represents an additional process of healing for MHWHs, participants spoke of concerns regarding letting go of the narrative of resistance. Several participants, for example, talked about having shifted away from activist work and toward their private lives (which I interpreted as a move toward a narrative of connection) and discussed feeling complicit and complacent in relation to the dominant structure and dominant mental health narrative as a result. I present Chris's words as an 'I poem,' as it allows the reader to see the challenge in making meaning of these changes in her life:

Chris:
I wanna take on all the causes
But I can't
I've learned […] to protect myself
I don't know if this is a good place I'm in
I feel like I've become complacent
maybe I'm still ok
I'm just like
I'm just doing my job

[…]

I don't know
if I'm just happy
am I too old and
I'm stressed out and burned out?

In Chris' words I interpret a struggle between the three narratives. Chris is talking about the importance that activism once had for her, which reflects the narrative of resistance, and looks at narratives of disconnection and connection to explain why she does not engage in activism as much as she used to. The narrative of disconnection is evident in phrases such as: "I've learned […] to protect myself," and "I feel like I've become complacent." The narrative of connection is evident as well, through words such as "maybe I'm still ok, and "I don't know if I'm just happy." From Chris' words, as well as from those of other participants, I interpret unease about allowing themselves to settle into this narrative of connection. The ways in which participants attempted to make meaning of this change suggests a concern that letting go of the narrative of resistance which drove the activism equates aligning oneself with the dominant narrative. There does not seem to be an easy way for participants to reconcile their need for connection, self-acceptance, and peace with the ongoing struggle of working within and against a context that is oppressive and dominated by disconnection.

7.4 Bringing Together the Two Alternative Narratives

What I propose as **the resistance narrative** helps understand challenge and change, which can lead to social change. Most Relational-Cultural Theory does not focus on the agency of the less powerful person in resisting and working to change dominant narratives and is thus not very helpful in understanding the narrative of resistance (Comstock et al., 2002; Jordan, 2001, 2008b). The RCT approaches of Walker (2008) and Sparks (Hartling & Sparks, 2008) can be helpful, however, as they do center resistance. These approaches, together with literature on feminist resistance, such as Lafrance's work (2014), bring in a transformational lens and help explain the processes of social change through a change in narratives that can allow a reclaiming of one's voice, story, and knowledge. Lafrance, for example, reframes individual struggle as collective struggle through connection with others who have faced similar oppression. She also incorporates emotion and particularly anger as a driving force of change. What the resistance narrative does not incorporate, however, is a look at the instability of this narrative as a resting place. I suggest that there is only so much energy that a person has to challenge and struggle before they wear out, especially if the challenging is unsuccessful (Cox, 2010). When a person becomes worn out from their challenge, there is a risk of a slip back to the disconnection narrative. There can be a draw to disconnect again, and going back to aligning with the dominant discourse, in order to protect oneself. This leads to a need to expand alternative narratives to include a narrative of connection.

The connection narrative, as I have theorized in this thesis, helps understand inclusion and acceptance, incorporates self-acceptance, and the acknowledgement there is a limit to one's ability to challenge. Relational-Cultural Theory is helpful in understanding this narrative, as it includes a detailed analysis of the importance of connection and relationships for human wellbeing. The challenge of holding this narrative as the sole alternative narrative is that it risks being co-opted by the disconnection narrative. In other words, the disconnection narrative can use the connection narrative for its benefit. Promoting the pursuit of acceptance can be used by those espousing the dominant narrative as a rationalization for accepting one's pain and struggle, as well as larger scale oppression, without complaint, thus becoming another tool of social control, This means that an uncritical acceptance of the connection narrative, without the lens of the resistance narrative, can result in dominance and oppression under a mirage of peace, through a kind of "doublespeak" (Orwell, 1949).

I propose that these two alternative narratives need and augment each other. The first represents an uprising; the second, an arrival at peace. Healing, both individual and societal, in the form of freedom from oppression, necessitates both. I am aware, however, that it is difficult to hold on to these two narratives at the same time, as they seem to contradict each other in important, or indeed fundamental, ways. The connection narrative tells us that we are not that different from each other; that our shared human experience means that we can understand, include, and accept each other. The resistance narrative tells us that our knowledge is better and "more true" than the alternative, and thus we come to see ourselves as different than the other, whose opinion we feel compelled to challenge. How does one reconcile these two seemingly opposite positions and hold them at the same time?

In thinking through this question, I would like to borrow a fable that spiritual teacher Osho (1999) shared in his book *Courage*. It is an Eastern story of two beggars who lived in the forest. One was blind and one had no legs. One day the forest caught fire, spreading rapidly, threatening their lives. These men were competitors—in the same profession, begging from the same people—and they were always angry with each other. They were enemies, not friends. When the forest was on fire the two beggars thought for a moment. They were not even on speaking terms, but this was an emergency. The blind man said to the man who had no legs, "The only way to escape is if you sit on my shoulders; we will use my legs and your eyes. That is the only way we can save ourselves" (p. 30).

Osho uses this fable to explain how intellect and heart need each other. While this is quite relevant in this thesis' exploration of integrating experiential knowledge (including emotional knowledge and spiritual knowledge) with intellectual, academic knowledge, I believe this fable also provides an avenue for bringing together the alternative narratives of resistance and connection. Consider that the blind man is anger and that the man without legs is love. Anger has legs, it can run fast, yet can burn out, not knowing where to go. Love sees and feels, but has no legs; it cannot move on its own, it remains where it is. However, as Osho says: "Both together can come out of the fire; there is no problem at all" (p. 31). For this to happen, however, the anger, (the frustration, the drive toward change), need to accept the love (the connection), above its shoulders; the anger has to listen to the love and follow its directions. Love and connection can show us where to go; anger and resistance can be the energy that gets us there.

These ideas are taken up by activist Sandra Kim in the work of Compassionate Activism (2016), which addresses similar conceptualizations. An exploration of this activist endeavor is explored in section 8.2.2.

7.5 The Researcher and the Three Narratives

As I analyzed the data, and especially as I focused on each of the research questions through the lens of the three narratives, I realized that my own journey as a MHWH and as researcher was also impacted by these three narratives.

7.5.1 Disconnection

I have been impacted by the dominant mental health narrative of disconnection in several ways, from the motivation for the research all the way to my experience of writing. I have experienced wounding as a mental health worker in roles where I was expected to use my own lived experience in my work. I felt powerless to defend myself and unable to have my voice heard. I felt robbed of my voice, my story, and my truth because the more powerful people in the situation had a claim to the “official” story of what happened. Even as a large part of me “knew” that I was not to blame for these experiences, the part of me that did not have a voice blamed herself. I began to feel ashamed about my own mental health and to see myself as weak or broken.

Disconnection was also evident for me throughout the writing of this thesis. I felt it as intense fear. A fear about what may happen to me once someone read this thesis. I had been wounded in a situation where I had been open and vulnerable about my mental health and worried that this could happen again. In this thesis I am also “showing myself”: I am open and vulnerable, and thus at risk of being harmed again; re-triggered, re-traumatized. It takes a lot of determination and commitment and, truthfully, a leap of faith, to put oneself “out there,” as I am trying to do; to bare the softest places of myself, where I have been deeply hurt. The fact that I am, however, I see as evidence of the narratives of resistance and connection.

Another way in which the dominant narrative of disconnection has impacted the research has been in curtailing my ability to express myself through my writing. Academia remains strongly rooted in a positivist paradigm that is informed by a notion of the separate-self. Within this paradigm, the researcher is constructed as distant and objective, which is reflected in the kind of knowledge that is valued and in the kinds of writing that are taken as good academic writing. In research, intellect and rationality are valued over emotion, which I believe leads to practices of what Jill, during one of the focus groups, referred to as “over-intellectualizing.” Jill spoke about over-intellectualizing as a way of distancing herself and protecting herself, and I can see parallels between it and over-intellectualizing in academic writing. I have come to see this over-intellectualizing as a socially accepted practice of hiding, a practice that helps avoid scrutiny and thus helps protect status. Academic writing, by engaging in use of language that is complex and inaccessible to most audiences, is protected from criticism. Through their writing, researchers and academics are able to construct ourselves as intelligent and educated; the implication being that lay people are somehow less intelligent. This notion is then reinforced in that it is impossible to criticize and challenge something that one doesn't understand, and moreover, even if the person does understand, a critique that is not framed in the same language is more likely to be dismissed. In respect to this writing, I am aware that I am taking part in this academic style of writing. While I try to write in a way that is the least complex that I can, I have been trained in writing within academia, and this writing is expected to fit within academic writing parameters. One thing that I have worked to do is to make myself visible and genuine to readers by engaging in self-reflection and self-disclosure through the writing, and hope that these practices help me remain closer to my audience, counteracting some of the impact of this over-intellectualizing in academic writing.

An additional way in which this writing has been impacted by the dominant narrative regards the challenge of presenting knowledge that rests outside and/or challenges the accepted norm. As opposed to master narratives, alternative narratives do not rely on culturally shared meanings that simplify the process of explaining and understanding. They rely, instead, on careful and sophisticated explanation and justification of their premises (McKenzie-Mohr & Lafrance, 2014a, p. 193). In this writing I have found the need to carefully and painstakingly explicate my arguments, findings, and interpretations in an attempt to fairly and accurately represent knowledge and experience that rests outside of the dominant narrative. The care that I have taken represents my commitment to the alternative narratives of resistance and connection.

7.5.2 Resistance

Even as I felt that my voice had been taken from me when I was wounded at my workplace, there was a part of me that was able to hold on to my voice. This part of me wanted to reclaim my voice and my knowledge, and to shout it out loud so that it would be heard. This part of me led me to connect with people that were developing a mental health program based on peer support. Surrounded by others like me, who also lived with mental health challenges, I was able to feel safe and feel heard. I saw how others had reclaimed their voices and were speaking them out loud. I was able to not feel alone. I learned that I could, in this context where I felt safe, begin to see the value in my pain, because it helped me help others. Here was where I learned to truly understand the importance of mutuality in mental health. Nobody here was an expert or had all the answers; we were all a little broken; and it was this that made our space feel safe and it was this that made our space healing.

It was in this context where I was no longer alone, that I was able to strengthen the part of myself that knew that I was not to blame for what happened to me at work. In conversation with others who have also been mistreated we were able to reinterpret and retell our stories. We were able to name oppression as a source of our pain. We were able to point to dominant understandings of normalcy, of health, and of development (i.e., adulting milestones) as sources of pain for us. And we were angry!

Through coming together with likeminded others and firmly reframing my story as one of oppression—of Sanism—I started to regain my voice, a voice that I could then use as a tool of resistance.

This research has been another way for me to regain my voice, to reclaim my story. And, by connecting my story with similar stories of other MHWHs, our voices become stronger as part of a collective voice. And beyond this, our voices and our stories, brought together through research, become knowledge that has a degree of legitimacy that it would not have outside of academia.

Through this research I wanted to be able to speak my truth and my knowledge out loud, in a way that would not be dismissed as it had been earlier in my work experience. To me, this is healing: healing through resistance.

To connect with others through this research and to collectively put our stories and knowledges "out there" is healing as well, in a larger and deeper sense, as it works toward social change and righting wrongs; possibly helping other people. My pain and our collective pain acquire meaning in this way: we are taking our pain and channeling its energy through anger and frustration, toward challenging oppressive practices and contexts and working toward social justice in mental health.

Even as I find resistance such an important narrative to hold on, and a place to work from, I do find it is tiring and trying. It is full of angst. It is a place of struggle and of fighting, and there is only so much of that that a person can do! There is only so much of my own emotional wellness that I am willing to sacrifice to any political cause.

7.5.3 Connection

In this section of the writing what I have learned from my experiences veers into the realm of the spiritual or philosophical. I am aware that this kind of knowledge is not often part of academic writing. I feel vulnerable writing in this way, but this is an important part of my knowledge and my healing and I want to share it here. You may take my sharing as a performance of resistance if you wish; I see it that way.

For me connection represents an easier resting place than staying in resistance. It is another layer of healing. It is finding connection with myself in terms of self-acceptance, connection with others, and connection with the universe. For me, connection is arriving at a place of safety or peace and is an avenue toward healing. This sense of safety can be inside myself, through arriving at a place where I love, accept, and can be compassionate toward myself. This, for me, includes valuing my knowledge, and working to embrace the experiences that are part of me and have helped shape me, even when they have been painful, such as some of my workplace experiences have been. I believe this safety can also be out in the world, through things like having visibility and rights or finding a safe workplace. For me, having the time to devote to this thesis, working for myself, and having the privilege to surround myself with people that are safe has been this kind of peace. This sense of safety or peace can also come through love toward others, connection with nature or through spirituality; in ways that help me let go of my protection armour, "let others in," show my tender, vulnerable places; and perhaps come to a sense that separateness is only an illusion and that we are all, indeed everything is, part of one whole. These are all ways of finding connection that I have some personal experience with, but I am sure there are many others.

In my personal healing journey, this healing through connection has come through a mix of all of these elements. Therapy has helped me feel stronger in myself. Peer support has helped me let go of protections, connect with others, and reclaim my story and my knowledge. Nature has been a portal though which I can feel in connection with the universe. Family, friends and children bring me a sense of belonging and joy, and my dog brings me outside of my self, and gets me out on walks.

This thesis has helped me heal through connection in several ways. It has helped me re-connect with my own story. It has been an opportunity to connect with my own knowledge and to connect with others. It has been an opportunity to open myself to others through my writing and to find connection in this way. This thesis has also helped me find meaning in my experiences of struggle with my ability, through this writing, to use my challenges to connect with others.

This thesis has even offered a way to practice compassion and connection toward non-MHWHs who have been and can be again, sources of oppression and wounding. It has been an exercise in finding ways of communicating that are not stuck in anger and thus potentially polarizing and creating resistance toward the messages in this thesis. Through my writing I have hoped to convey a sense that the struggle of MHWHs is a shared human struggle. It is the struggle of being faced with a tight little box of “normal” and of trying to make oneself fit into it, when it does not fit us and can wound us. I believe this box is constricting for everyone, and we all have something to gain from expanding or busting it.

However, even as I value and strive for this place of connection that feels more peaceful, I am left with the scars resulting from workplace experiences of Sanism. I believe that these scars are there for a reason as they remind me of my struggle, of the fact that others are still struggling, and of the fact that I am not immune to struggle myself. These scars represent my wound and are important. I need and accept all of my parts: Wounded, healing, Healer.

CHAPTER 8 CONCLUSION

I *really, passionately, believe* in recovery because I live it.
You know, recovery for me is not a unicorn, it's a real thing […]
It's not a unicorn, you know and—or I'm a unicorn, either one. -Rachel

This research expands on existing literature that explores the experiences of Mental Health Wounded Healers (Adame, 2009, 2011, 2014; Joyce et al., 2007; Moll et al., 2013; Richards et al., 2016) by adding to the understanding of these workers' workplace experiences, practices, and practice knowledges. This research contributes to existing knowledge by creating a research context, in the form of reconvened focus groups, which undermines the silencing experienced by MHWHs that is at the root of the Sanism that these workers often experience in the workplace. In doing so, this research brings attention to, challenges, and provides alternatives to existing workplace practices that isolate, dismiss, and exclude the voices, experiences, and knowledge of MHWHs.

The exploration of MHWHs' workplace experiences, practice, and practice knowledge within this research sheds light into the processes by which dominant mental health structures construct and reconstruct themselves as legitimate. An examination of the Sanism experienced by these workers (e.g., silencing and isolation,) shows that the dominant mental health system prevents alternative perspectives and knowledges from developing, halting questioning and criticism of the structure, which could destabilize its power and claim of legitimacy.

This research identifies a dominant mental health discourse that is informed by the medical model, and constructs mental health challenges as pathology and as permanent traits of individuals. This discourse is based on an understanding of individuals as separate from each other, and constructs people as either healthy and capable of helping, or “mentally ill” and in need of help. It is a discourse that provides a base for othering, oppression, and discrimination, not only of MHWHs but of all individuals living with mental health challenges. This research shows that MHWHs embody a challenge of the dichotomy that constructs people as either helpers or helpees. This research also shows that MHWHs actively challenge the dominant mental health narrative that constructs this divide by developing and enacting two alternative narratives: a narrative of connection and a narrative of resistance. These workers utilize a narrative of connection that centres relationship and understands people as connected to each other. This narrative is mediated by emotional experiences such as vulnerability, openness, and love, which facilitate empathy and connection. While this is the preferred narrative for these workers in their practice as well as in their private lives, the research showed that work contexts are often not safe for these workers to enact connection, which leads to the development and enactment of a narrative of resistance. MHWHs enact a narrative of resistance as a way to call out the detrimental impact, both for themselves and their clients, of the dominant mental health narrative that others, silences, and pathologizes. Through this narrative, participants work to reclaim their voice and their knowledge. Mediated by emotions such as anger and frustration, the resistance narrative is a powerful driver to challenge injustice. Further, resistance is facilitated by MHWHs’ ability to connect, to learn, and to organize with others with similar experiences, showing that the narratives of connection and resistance mutually reinforce and extend each other.

This research has provided an avenue for an exploration and expansion of both alternative narratives of resistance and connection. By providing a context where

MHWHs were able to find and connect with others like them, in a safer setting than the workplace, it has supported the voices and the knowledges of these workers. This research points toward the importance of connection and community as avenues toward valuing, supporting, centering, and recording MHWH voice and knowledge.

This research works to undermine and subvert the silence that impacts MHWHs. In so doing, it centres experiential knowledge and connection, and incorporates a drive toward social justice in mental health. By foregrounding MHWH knowledge, this research destabilizes the claim to knowledge and legitimacy of the dominant mental health narrative and the structures it upholds, and suggests avenues for change.

In addition, the identification and exploration of the dominant mental health narrative and of the two alternative narratives within this research provides a theoretical framework with which to understand the experience, the agency, resilience, and resistance of MHWHs. An understanding of the impact of the dominant narrative on MHWHs, as well as an understanding of the need and the drive toward both connection and resistance may help MHWHs navigate their workplace contexts, by contextualizing their pain and their anger, as well as validating their drive toward two seemingly contradicting goals: to fight injustice and to find a place of connection and peace.

8.1 Limitations

Some of the limitations of this research are a result of the impact of the dominant mental health narrative of disconnection. I observed this narrative’s impact on the writing in several ways, from who felt safe participating in the research and who did not, to the kinds of things that were more or less safe to write about, to the prescribed writing style and, of course, to the very nature of the wounds that we addressed in this research.

The nature of the wounds that participants and I discussed most related to workplace experiences as MHWHs. As discussed throughout this research, these wounds are a result of the dominant mental health narrative of disconnection that posits that mental health challenges are a pathology and that people can be divided into either healthy and with an ability to offer healing or pathological and in need of healing. Something that was less directly explored were other sources of wounding for MHWHs: we spoke to a much lesser extent about the impact of the "original" mental health challenges, or about the challenges related to living in our society as someone with experience of mental health challenges. As an aside, I am not sure that these sources of wounding can be fully separated as most people hold internalized dominant ideas about mental health prior to experiencing mental health challenges. Even if the different sources of wounding for MHWHs cannot be separated from each other, it would be interesting to learn more in depth about these other sources of wounding for MHWHs. For example, it would be interesting to engage in research that follows MHWHs who work in contexts where they feel safe and supported, or with MHWHs who work for themselves. Learning from these MHWHs could offer interesting insight about how they learn to use, and how they put into use, their lived experience in their practice. In addition, this kind of research would be a source of information about workplace experiences that are less wounding, which could offer insight about the kinds of workplace contexts and practices that can be supportive for these workers.

Another limitation of this research that relates to the dominant mental health narrative of disconnection pertains to who may have been excluded from this research. As I explored in section 6.6.3, during the research I came to the realization that the focus group research design may have excluded certain MHWH populations. Mental Health Wounded Healers who are racialized or otherwise marginalized beyond their mental health status might risk marginalization within the research in relation to their other locations of oppression. As a way of redressing this shortfall Tam (2013) recommends "historically locating ourselves and our privilege, and [suggesting] anti-colonial and anti-racist strategies for creating subversive 'Mad' narratives." This is something that I have attempted to do through researcher reflexivity, by engaging in a reclaiming of experiential knowledge within the research, and by proposing avenues to future research. Knowledge that I have gained from this experience points to the importance that researchers work to increase awareness of our privilege in order to minimize the ways in which we may create and engage in research that unintentionally excludes or oppresses (which are signs of the dominant narrative of disconnection.)

Possible ways to address this limitation include research that incorporates individual interviews, where there may be less fear of experiencing oppression. While being able to ensure a higher degree of safety, this avenue does not provide the same kind of research context as focus groups do; it misses the opportunity to create a community of MHWHs and to learn about the impact that breaking isolation can have for these workers. Other ways to create focus group research that is safer for MHWHs who inhabit multiple locations of oppression should be explored. One such avenue would be to engage in research where a specific subgroup of MHWHs is sought, and where the researcher or at least the focus group facilitator is part of this same subgroup.

In addition to the likelihood that this research excluded the voices and stories of certain MHWH populations, the writing of this thesis also required excluding some of the knowledge that *was* recorded. The content of this thesis had to be mindfully curated in a way that protects the safety of participants. Working to ensure participant safety is an important ethical pillar in research and it is not suggested that this be foregone; however, an analysis of the kinds of material that were less safe to write about points toward the pervasive impact of the dominant mental health narrative of disconnection in this research. In the writing of this thesis it was a lot safer to write about the beliefs and behaviours of individual participants than it was to write about the structures that were a source of wounding and oppression for these workers. Challenging structures is not easy; it is fraught with risk of harm for the challenger. The risk is that censoring certain information by excluding critical information about structures leads the writing to focus more on the individual's role in recreating dominant narratives, helping obscure the ways in which structures themselves work to recreate these dominant narratives. This places too much responsibility for social change in the hands of those that are oppressed (silenced) by these structures; in this case MHWHs. The challenge is, then, finding a way to emphasize the responsibility of those with privilege, and the structures that hold this privilege, and to successfully ask for and promote change without compromising the safety of participants. Taking the time to explicitly name this issue is one way I have tried to navigate this challenge.

Some other limitations of this research are its small size and my inability to provide compensation to participants. Even though the time commitment for this research was significant (three evenings for the groups, and an additional hour or two for informed consent,) I was not able to provide compensation to participants. I believe this is a limitation in two different ways. Firstly, financial compensation might have been an additional motivation for participants and may have led to increased retention. Out of the seven initial participants, only five took part in the three groups, and the other two only were present for Focus Group 1. The experiences, knowledge, and opinions of these two participants would have made this research richer. In addition, within the capitalist world that we live in, a way of valuing the knowledge and the time commitment of an individual comes through monetary compensation. While this may seem counterintuitive, I see remunerating participants as a political statement. The knowledge and expertise of some people is valued over others: academics and career researchers receive remuneration for their work, graduate students do so in a much lesser degree, and participants are very often not remunerated at all or only as a token. The ability to remunerate participants can be an important way to demonstrate that we, as researchers, value these individuals' knowledge and their contribution to this knowledge production work.

The construction of this research as a single cohort of participants is a further limitation of this research. Additional cohorts would have enabled more diversity of experience and knowledge to be included. As I mentioned earlier, creating a cohort of individuals from a specific subgroup of MHWHs, such as queer, racialized, physically (dis)Abled, or First Nations MHWHs, for example, could help include the knowledge and experience of these workers into discourses of mental health and of (dis)Ability where they are currently not well integrated (Gorman, 2013; Tam, 2013).

8.2 Future Directions

8.2.1 Future Research

There are multiple possibilities for future areas of study in relation to MHWHs. Some that have been mentioned within the writing and relate to larger scale research are: research that invites and includes MHWHs who are also members of other oppressed groups, research that focuses on MHWHs that work in supportive contexts, and research that is participatory and works toward social action (participatory action research). Two specific action items that are important in counteracting the isolation, silencing, and oppression of MHWHs are the dissemination and knowledge translation of MHWH research, and the creation of safe spaces for MHWHs to connect (e.g., in-person peer support groups and online peer support groups.)

Another important future area of study is learning from those individuals who MHWHs serve. MHWHs strive to use our lived experience of mental health struggles in our work because we believe that there is value in the knowledge that we derive from those experiences that can support our practice. It is therefore important and imperative to learn from people who have experience working with MHWH providers. These are the individuals best equipped to identify MHWH practices and experiences that they experience as useful, enriching, or helpful to healing and recovery.

8.2.2 This Work is Happening Now: Learning From and With Community

"Future directions" sections of research writing generally speak to how the researcher or the research community can continue to further research and knowledge within the area of focus. In this section I critique this conceptualization by acknowledging that this work is already happening in our communities.

The tradition of academic research of looking to academic research as the only legitimate source of knowledge and knowledge production can prevent us from recognizing other avenues to knowledge and to change that may currently be taking place. As I consider where this research fits with other efforts at justice in mental health, and wonder where all this learning could lead, the most exciting and promising avenues seem to lie outside of academia and within activist community work.

The academic complex is not a very politicized arena. Moreover, academia is deeply rooted in a paradigm where reason is valued over, and seen as separate from, emotion and experience (Jaggar, 1989). These considerations point toward academia being, at best, a slow avenue toward a politicized change in the area of mental health that reclaims the importance and value of emotional experiences and of knowledge derived from them.

Many people outside of academia have been and are engaged in work and knowledge production that is very relevant to the work of this thesis, people we ought to pay attention to and learn from. Through connection with Jude Ashburn, a phenomenal activist in my community and a member of the advisory committee for this thesis, and with the help of the internet as a tool for knowledge equalization, I have learned about key terms that I wish to present to the reader, which I believe represent and enrich the learnings within this writing: Emotional Justice and Compassionate Activism.

I want to contextualize the terms Emotional Justice and Compassionate Activism and to give credit to the individuals and communities engaging in work related to these concepts. This is work that is happening in the margins: it is primarily the work of black women and women of colour; it is gendered work. It is work that grows out of the experiences of pain and oppression; it is work steeped in emotion and emerging from emotion. This is work and knowledge that academia remains largely unaware of due to the academic complex being embedded in a largely white, male, European and colonialist society.

I want to offer my gratitude to the work and effort of these women and these communities. I also want to encourage the rest of us to listen and pay attention. I want us to acknowledge that there is much that we can all learn from these communities, and to commit to approach this learning in a way that centres the communities where this knowledge is originating and germinating, and to do so in a way that is not voyeuristic or tokenistic. Using these concepts without mentioning race, for example, would equate with stealing and co-opting this knowledge for my own benefit.

This is, truly, not my knowledge, but it stretches and enhances my understanding of emotion. This is also not academia’s knowledge, but it is important knowledge and knowledge that can help academia stretch and expand beyond its reductionist focus on reason.

8.2.2.1 Emotional Justice

The concept of Emotional Justice is currently helping me look at the learning in this thesis in a way that centers emotion. This writing, influenced by and constrained within an academic knowledge framework, has centered knowledge over emotion. In this writing, I have advocated for the acceptance and inclusion of experiential knowledge of MHWHs in mental health. I have not centered emotion and emotional experiences as much, even though emotionality and its suppression was spoken about by participants from the very start of our conversations. While I was able to identify the emotional underpinnings and drivers within each narrative, this happened toward the end of the research, and I believe was facilitated more by the reflection about my own (definitely emotional) journey (please see section 7.5) than by the formal data analysis.

In a world where reason is seen as superior and separate from emotion, those who can suppress emotion are seen as superior to those who cannot or will not suppress their emotionality. Individuals belonging to the group that can suppress emotion are respected and valued while the others are de-legitimized, scrutinized, discredited, and ostracized. This is injustice, it is **emotional injustice**. Emotional injustice then leads to the kind of epistemological privileging of certain knowledge (rational, scientific knowledge) over other (emotional knowledge, experiential knowledge). This is also injustice: **knowledge injustice, or epistemological injustice**.

The term Emotional Justice was coined by journalist, radio host and political commentator Esther Armah (Akili, 2011). Bringing a black feminist lens to understanding injustice and oppression, Armah believes that oppression is trauma (and leads to intergenerational trauma) and sees emotional justice as a tool toward remedying this trauma (Paul, 2015). Expanding on this conceptualization, Akili writes that:

> Every form of inequity has a traumatic impact on the psychology, emotionality and spirituality of the oppressed. The impact of oppressive trauma creates cultural

> and individual wounding… that becomes an impediment to the individual and collective's ability to transform and negotiate their conditions. (Akili, 2011, para. 1)

Emotional justice is about working with the wounding that results from the trauma. It invites us into our feelings and our bodies and helps us find ways to transform our individual and collective wounds into power (Akili, 2011), which is congruent with the analysis, within this thesis, of the parallels between healing and challenging oppressive dominant narratives.

Emotional justice can be a tool to help us find and create a language to describe this trauma, making it "real," "creating space to explore it; dealing with it by developing a counter-narrative" (Paul, 2015, para. 8).

> Emotional justice requires that we find the feeling behind the theories. It calls on us to not just speak to why something is problematic, but to speak to the emotional texture of how it impact us; how it hurts, or how it brings us joy or nourishment. (Akili, 2011, para. 2)

Within this framework, the primacy of rationality is acknowledged and identified as linked to patriarchy, sexism and misogyny:

> because feeling and intuition are culturally and psychologically linked to the construct of "woman", a construct that we have all been taught to invalidate and silence. So by extension we invalidate and silence the parts that we link to "woman" in ourselves: our feelings, our intuition, and our irrationality. (Akili, 2011, para. 2)

Akili (2011), speaking from this basis of emotional justice, explores the exclusion of emotion and emotional justice that can happen within advocacy. He speaks of a dearth of language and literacy about understanding and working with emotions. He speaks about a patriarchy-informed discomfort with emotionality that encourages us to deny, dismiss, and quickly more away from emotions. Akili also speaks about "time cost" leading to excluding emotionality from justice endeavours. This could be seen as the impact of capitalist conceptualizations that equate value with productivity, which can lead to neglecting working with emotions, which can be time consuming, and hard to "timeline." This is valuable knowledge that provides practical tips and tools for change toward accepting, including, and learning about emotionality, which can be extrapolated to areas such as academic and workplace contexts.

8.2.2.2 Compassionate Activism

Compassionate Activism is a project of Everyday Feminism, an intersectional feminist "educational platform for personal and social liberation" led by Sandra Kim (Kim, 2016, para. 2) that includes a web-based magazine and training resource. The Compassionate Activism model articulates the relationship between oppression and disconnection and aims to help people address everyday oppression with love and justice (Kim, 2016), much in the way explored within this research. Kim writes that:

> Systemic oppression hurts both the privileged and the marginalized and leads us to disconnect from each other as well as from ourselves in order to protect ourselves from that pain. Too often in response to that individual and collective pain and trauma, we harden ourselves towards each other and consequently ourselves. (Kim, 2016, para. 5)

Kim proposes the need to bring together love and justice in the pursuit of social change. Kim's concepts of love and justice seem to parallel this research's concepts of connection and resistance, and the underlying emotions of love and anger. She writes that "love without justice can often become silencing of those being marginalized and coddling and enabling of those in power. Whereas justice without love can perpetuate the dynamics of dehumanization, domination, and elitism that it's seeking to correct" (Kim, 2016, para. 6). Kim believes that love and justice must be taken interdependently, which directly mirrors the analysis of the two alternative narratives of connection and resistance within this research and strengthens the assertion to use them together toward social change.

8.2.2.3 Final Thoughts

I want to recognize the value that activist thought and activist work can have in future expansion of how we understand emotion, mental health, social justice, and social change. I wish I had reached for this knowledge earlier in the process of writing this thesis as it would have enriched the learning within. I also want to acknowledge that this work is doing a much better job than my own work within this research of centering the experiences of those who are most oppressed.

I commit to continue to adopt a more political lens to my work that is informed by, and centers, the work of these communities. Alongside the concepts of Compassionate Activism and Emotional justice, I will consider further politicizing some of the concepts used within this research. Terms such as Knowledge Justice (Epistemological Justice) and Emotional Knowledge, for example, can politicize and reframe the concept of experiential knowledge addressed in this research, and offer exciting possibilities for learning and action in mental health, and possibly in other justice arenas.

8.2.3 Links to Other Disciplines: Reaching Across Difference

It is possible that the framework constructed within this research, which identifies and incorporates the alternative narratives of connection and resistance, could be a useful framework for other areas of study. For research that focuses on structural analysis and emphasizes resistance, such as anti-oppressive research, adding a valuing of the importance of connection could be enriching in several ways. Acknowledging the importance of connection may help understand (and support) the need for some individuals to not engage or stop engaging in social justice efforts. In addition, a conceptualization of connection could help extend understanding and compassion to those with different political beliefs, research agendas, or even those who we identify as oppressors. This approach incorporates humility and the possibility of ongoing learning and collaboration, which could increase understanding across difference, and reduce animosity and disconnection.

Further, for research with a more micro lens that focuses on individual health and wellbeing, incorporating the narrative of resistance can help politicize these concepts as well as emphasize the agency, resourcefulness, and resilience of individuals in marginalized positions. Incorporating an analysis of resistance can also help acknowledge, for example, that resistance can include political action, especially in situations where it is not safe to speak up and directly challenge the more powerful person or group. A focus on resistance, in this kind of research, could also help reinterpret connection, when it happens with likeminded others, as one possible avenue toward social change.

Each approach to knowledge construction and to research, from micro to macro, has a unique viewpoint and thus unique knowledge to contribute. Openness and collaboration between different fields and orientations can help make mental health research and knowledge richer, and strengthen its transformative potential. Moreover, the incorporation of knowledge that has traditionally been excluded from research, such as experiential knowledge, emotional knowledge, and spiritual knowledge, some of which are currently being explored in activist circles, is also an important avenue to thicken alternative mental health narratives and knowledge.

Connecting and learning across difference is a key way forward in research and in knowledge construction. From this stance, researchers, and, in fact, all of us as knowers, may learn to embrace humility and collaborate across field lines, and political frameworks. From this stance, we may be able to let go of othering and learn to value, embrace, and collaborate across difference. Together, in our difference, we can create knowledge and we can do work that aids in the liberation of both MHWHs and those whom we serve.

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APPENDIX A GROUPS 1 & 2 INTERVIEW GUIDE

Group Guidelines Process (For Group Interview 1)
As a group of Mental Health Wounded Healers our voices and our knowledge have historically been silenced within the dominant mental health field. Today we are here, together, and have an opportunity to create a space where we are comfortable speaking our own voices and exploring and expressing our knowledges.

We can work to create a space where we strive to see, hear, and hold each other, both in our similarities and our differences. It is my hope that this can be a space that is supportive, engaging and transformative.

How can we create a space that is safe enough for each of us to be able to take the risk to show a part of us that we may not often show?
What kinds of things can we do to create such a space?

One first step is to develop group guidelines that may best support the space we are hoping to create. In order to do this I will offer some topics that we can discuss, please feel free to add other topics to this list.

- <u>Confidentiality</u>. Not disclosing the identity, experiences or opinions of other participants outside of our shared group time.

- <u>Humility</u>. For example:
    - Presenting our voices and experiences as our own, and allowing for the possibility that others may have different experiences and opinions.
    - Allowing for the possibility that we may make a transgression toward another; acknowledging the discomfort that we may experience in this kind of situation and making an effort to repair the damage and the relationship.

- Space for learning. For example:
    - Taking a stance of openness toward others' experiences and knowledges.
    - Allowing for both similarities and differences in our stories and knowledges.

- <u>Work toward balancing power differences</u>, so that all voices will indeed be heard. For example:
    - As the researcher, I need to remain aware that I do not impose my own agenda and inadvertently silence voices or knowledges that are different from my own. I will employ different strategies in order to do this (i.e., self-reflection, journaling and consultation with supervisor). I also encourage you to speak either in the group or to me individually if you find that there are things that I could do to be more inclusive of others' perspectives.
    - As participants, some of us are likely to belong to social groups that have more privilege. These are some things that may make some of our voices more or less marginalized or likely to be heard: Gender, race, class, gender identity and sexual orientation as well as the privilege embedded in professional designation, the years of work experience and the 'social stigma' linked to our individual experiences of mental health challenges. What can we do so that we work to include all voices?

Interview Questions

Note: There is a need to be mindful of my use of power and to incorporate group reflection about the process of this research, so that participants have a voice in what we are doing and how we are doing it. This is a tentative list of possible questions, which I wrote prior to any possible consultation with research participants, thus it will be presented as a starting point of discussion with an option for participants to incorporate different questions. Participants will be given a printed copy of the questions, without the 'prompts for researcher.'

Question 1- What do we know about the experiences of the Mental Health Wounded Healer within mental health structures?

- What are some challenges?
  - Prompts for researcher: challenges in employment, wellbeing, internalized stigma, re-traumatization/triggering
- How do we care for ourselves and each other?
  - Prompts for researcher: while working differently and while attempting to use our stories and vulnerability
- What are some successes?
  - Prompts for researcher: current inroads, 'friendly' agencies, helpful government and work policies, useful supervision, support, knowledge & research?

Question 2- What do we know about how to practice as a Mental Health Wounded Healer? (Prompt for researcher: where did we learn this?)

- What are our understandings of help?
  - Prompts for researcher: reciprocity, expert driven
- What are our thoughts on healing?
  - Prompts for researcher: linearity of healing, symptom reduction vs. quality of life
- What are our thoughts on professionalism, use of self (prompts for researcher: self-disclosure and boundaries, etc.) and help for the helper,.
- How do we go from walking wounded (Conti-O'Hare, 2002) to Wounded Healer?

APPENDIX B INDIVIDUAL REFLECTION GUIDE

Between Group Interviews 2 and 3, you are invited to engage in individual reflection about your experience of coming together with other mental health professionals who are also interested in using their own experiences of mental health challenges in their work.

Please feel free to use creative modes of expression if you feel they may help you express yourself. Individual reflections may take different forms, including but not limited to prose, art work or poetry.

Here are some questions that may help guide your reflection. Please treat them only as prompts or suggestions and use them as much or as little as you feel is helpful.

- How, if at all, has coming together (with other 'Mental Health Wounded Healers') changed how you feel about your experiences of being a mental health professional with lived experience of mental health challenges?
- How, if at all, has coming together changed how you feel about wanting to use the knowledge you've gained from these experiences in your work?
- How, if at all, has coming together had an effect on how you feel about yourself and your wellbeing?
- How, if at all, has coming together had an effect on the confidence that you have in your practice and your practice knowledge?
- How, if at all, has coming together helped you learn about how to use your lived experience in your work?
- How, if at all, has engaging in this research been surprising to you?
- How, if at all, has engaging in this research carried any discomfort for you?

This is, as all other aspects of this research, voluntary. During our Final Group Interview you will have an opportunity to share your reflection with the group if you wish. Only what you share with the group about your reflection will be used in this thesis, however, you may choose to give Piedad Martin-Calero a copy of your reflection for possible use in future research.

APPENDIX C FINAL GROUP INTERVIEW GUIDE

The order of items is not fixed; it will be discussed in the group.

1- Invite participants to share their individual reflections

2-
    - Discuss reflections (at the prerogative of each reflection's author)
    - Engage in informal data analysis (i.e., 'pull' themes from the data)

3- Presentation of initial data analysis: Researcher presents themes that came up in analysis, any theorizing that researcher may have engaged in, briefly explore researcher self-reflection journey in this process, the contradictions in the research between power-sharing goals and top-down research design.

4- Gathering of feedback.

    Does any of the information from my analysis resonate? Are there places where I may have misunderstood or misinterpreted? Do you feel that your voices are being represented? Can you think of any ways in which I can limit my misinterpretation of the group's knowledge?

    -

5- Review of the learning

    What stands out for you about this research? Did you learn/experience anything interesting? Was there anything that surprised you or excited you?

    -

6- Review of the process

    What do you think about how this study was designed? E.g. the focus groups followed by individual interviews, the researcher identifying as a Mental Health Wounded Healer, the degree of collaboration versus top-down approach, etc.

APPENDIX D.1 INFORMED CONSENT FORM

Title of the project :
Workplace experiences of Mental Health Wounded Healers: A collective learning

Principal Investigator :
Piedad Martin-Calero Medrano, master in social work student, School of Social Work, Dalhousie University. Contact information: (902) xxx-xxxx or Piedad.martin@dal.ca

Supervisor:
Marion Brown, PhD, Associate Professor, School of Social Work, Dalhousie University
Contact information: (902) 494-1192 or Marion.Brown@dal.ca

Funding provided by: Nova Scotia Health Research Foundation

Interviews will be conducted by:
Piedad Martin-Calero Medrano

Invitation to Participate

I invite you to take part in a research study being conducted by me, Piedad Martin-Calero Medrano. I am a Master of Social Work student at Dalhousie University, and a fellow mental health professional living with mental health challenges.

Your participation in this study is voluntary and you may withdraw from the study at any time. The study is described below. This description tells you about what is involved in the research, what you would be asked to do, and any risks, inconvenience, or discomfort you might experience. Participating in the study might not benefit you directly, but through the process we might learn things that will benefit others.

As part of the recruitment and informed consent process, if you are interested in participating, I (Piedad Martin-Calero Medrano) will have a phone conversation with you to provide additional information about the project, answer any questions you have, and talk about possible risks and benefits of the study. I will encourage you take time to consider whether or not you wish to take part and whether you have access to supports should your participation raise discomfort or trigger wellbeing concerns.

Purpose of the Study

This study is an exploration of the workplace experiences of Mental Health Wounded Healers. For the purpose of this study, a Mental Health Wounded Healer is a professional(ized) mental health worker who lives with mental health challenges and who wants to use their experience and lived knowledge in their work.

Mental Health Wounded Healers often feel that their workplaces are not safe spaces to discuss their own lived experiences of mental health challenges, this may prevent them from disclosing and/or engaging in dialogue about their experiences. For this reason, this research aims to understand the workplace experiences of Mental Health Wounded Healers by creating a space where Mental Health Wounded Healers can feel safe to discuss their experiences.

The goals of this study are therefore twofold. The first goal is to learn about the workplace experiences of Mental Health Wounded Healers. The second goal is discovering what learning we can gain through the creation of a space where Mental Health Wounded Healers are able to have these discussions.

My own workplace experiences as someone living with mental health challenges, as someone who believes in the value that my lived experiences can bring to my work, inspired me to engage in this research. Myself, and all research participants, will be people that fall within the criteria of Mental Health Wounded Healers.

Some questions that this research looks to explore are:

1- How do these workplace experiences affect Mental Health Wounded Healers' ability to use their experiences in their work
2- How do these workplace experiences affect Mental Health Wounded Healers' wellbeing?
3- How do these workplace experiences influence connections among these workers?
4- To what extent does creating a setting where Mental Health Wounded Healers come together lead to knowledge development in the field of mental health?

This research values collaboration, therefore participants are encouraged to bring forth their own questions relating to this topic.

Inclusion criteria
To take part in this research, you must:

- have university training with a bachelor level degree or higher in one of these fields: social work, psychology, medicine, occupational therapy, recreational therapy, nursing, counselling, creative arts therapy or spiritual/pastoral counselling
- have a minimum of one year of experience working in a mental health role requiring university education
- self-identify as currently living with mental health challenges.
- be interested in and committed to using your lived experience in your work.
- self identify as having made attempts to use your lived experience of mental health challenges in your work as a mental health professional.
- be conversant in English
-

Due to the in-person group interview design of this study participants are required to reside within commuting distance of Halifax, Nova Scotia.

What you will be asked to do
As mentioned above, this research aims to explore the workplace experiences of Mental Health Wounded Healers in the context of a group of Mental Health Wounded Healers. Because this study involves the creation of a community, albeit a temporary one, it requires that the group meets more than once. Piedad Martin-Calero will be the facilitator in these groups.
The study is designed as follows:

- A group of approximately 6 individuals that meet the criteria for Mental Health Wounded Healer will be formed.
- This group will meet on two occasions to discuss workplace experiences as Mental Health Wounded Healers. While some questions have been developed to guide discussion

the group will collaboratively decide exactly what topics to focus on.

- Each research participant will be invited to create an individual reflection of their experiences being part of this group.
- Finally, the group will meet one last time. During this meeting participants will have the opportunity to share their individual reflections with the group. This meeting will also serve to consolidate our learning and experiences with this research, as an opportunity for me to present some of my impressions/analysis and as an opportunity for you to provide feedback.

All three group interviews will be held in a private conference room at Dalhousie University. Group interviews will be facilitated by me, Piedad Martin-Calero; they will be audiotaped and transcribed.

If you volunteer to participate in this research, I will ask you to meet briefly in person or over the phone to review the informed consent form, address any questions or concerns, discuss supports should they be necessary and, if you are interested in participating in the study, to review interview dates and sign the informed consent form.

Group Interviews will be conducted in the Spring of 2015

Overall involvement, including giving your informed consent, should be 10-13 hours, broken down as follows:

Phases of research	**Time Commitment**
Consent Form	1 hr.
Phone Conversation	.5 hrs.
Group Interview 1	2.5 hrs. plus transportation (approximately 45 minutes)
Group interview 2	2.5 hrs. plus transportation (approximately 45 minutes)
Individual Reflection	Variable (1- 2 hours)
Group Interview 3	2.5 hrs. plus transportation (approximately 45 minutes)

Possible Risks and Discomforts

I anticipate that disadvantages or risks in taking part in the study will be minor. The main potential risk that has been identified in this research is that engaging in conversation about workplace experiences relating to mental health could trigger difficult emotions or mental health symptoms. Should your participation in this research lead to thoughts or memories that are upsetting, I, Piedad Martin-Calero, will be available to debrief, or to refer you to a suitable support upon request. A list of local mental health resources is attached to this consent form and will be openly available to all participants at each group session. You may access these resources if you choose to.

I ask that you please let me know if you will not be attending any of our meetings. If you do not attend one of our meetings I will give you a call to check in with you.

Within the group, time will be devoted to the creation of safety and support, which can help minimize risk and/or discomfort. Moreover, and paralleling mental health peer support, the group itself may be a source of support for participants.

If you are considering participating in this study we will arrange to have a phone conversation where we will discuss at greater length any possible concerns and risks and develop a plan to support your wellbeing.

Possible Benefits
Taking part in the research process will allow you to reflect on your workplace experiences as a Mental Health Wounded Healer, which may be beneficial. Being part of a group of Mental Health Wounded Healers may also offer an opportunity for learning and inspiration.
In addition, the information gathered from this research project will record the knowledge of Mental Health Wounded Healers and help contribute to a body of knowledge that is based on the voices and experiences of Mental Health Wounded Healers themselves.

Compensation / Reimbursement
No monetary compensation will be provided.

How your information will be protected
Participant anonymity cannot be assured during the data collection stages of the research study, given the group design. The identity of the participants will be revealed to myself, the researcher, and to other research participants. Moreover, it is not possible to guarantee that the information you share within the group will remain confidential

Participants and researchers will engage in conversation regarding the importance of creating and maintaining safety in the group, and will collaboratively develop confidentiality guidelines for the group and its members.

In the final product (the thesis) anonymity can be guaranteed, for those participants who desire it. Participants will decide the name they wish to be linked to specific contributions in the research. This name can be an alias or you may decide to use your own name.

All data collected by the researcher during the course of the research will be kept confidential and secure. Contact information and data will be kept in locked cabinets and/or password protected electronic files in the researcher's office. Only the researcher will have access to the data. For this study, the interview scripts and the digital recordings of the interviews will be kept for 5 years after the end of the study and may be used in future research.

The only identifiers collected will be name, phone number and email address for the purposes of making and maintaining contact. Each participant's name will be linked to a number and/or alias. A master hard copy list indicating participant names, and linking numbers will be kept in a separate file from the data and stored as noted above.

Occasionally, data gathered for one research study is used, at a later date, as part of other related studies, presentations and/or publications. In order to account for the possibility that your contribution to this study could be useful in the future, you will be asked whether you agree to your contributions to this research being used in future studies and/or publications.

Conflict of interest
Halifax is a small city and the community of mental health workers within it is relatively small. Because of this, it is possible that I (Piedad Martin-Calero Medrano) may know one or more of the research participants. I am also someone who meets the same criteria as fellow research participants and could have, under different circumstances, been a fellow participant rather than researcher. These circumstances carry with them particular considerations. Being part of the same community/communities could be a source of comfort for participants. On the other hand, having a member of your community in the position of researcher creates a power differential, making it particularly important for the researcher to take steps to minimize risks of undue influence and/or power imbalance, which could lead participants to feel that there is a conflict of interest. Some measures that will be employed to minimize undue influence or misuse of researcher power are:

- Transparency: you will always be informed about the rationale for research decisions and encouraged to ask questions.
- Collaboration and participant input: your feedback and questions are always welcome. It is ok to disagree!
- A focus on the process of the research rather than just on the final product (i.e., the thesis). The 'how' matters.
- Researcher reflexivity: I will keep field notes in the form of journal entries and will consult with dr. Marion Brown, supervisor, regarding my reflection process.

Acknowledgement
The name you choose to be used in the research, whether it is an alias or your real name, will be given credit in the final thesis.

Questions
Please direct any questions you may have about this study to Piedad Martin-Calero Medrano, who can be reached at (902) xxx-xxxx and at Piedad.martin@dal.ca

This study has been granted ethical approval by the Dalhousie University Health Sciences Research Ethics Board. If you have any ethical concerns about your participation in this research, you may also contact the Director, Research Ethics, Dalhousie University at (902) 494-1462, or email: ethics@dal.ca

Workplace experiences of Mental Health Wounded Healers: A collective learning

Consent Form

I have read the explanation about this study. I have been given the opportunity to discuss it and my questions have been answered to my satisfaction. I hereby consent to take part in this study. I realize that my participation is voluntary and that I am free to withdraw from the study at any time.

I agree that data collected in this study may be used for subsequent research projects and publications of similar nature, conditional on approval by an ethics committee for research and respecting the same principles of confidentiality and protection of information ☐ yes ☐ no

I agree to be re-contacted in the future for related research ☐ yes ☐ no

I agree to have my interviews audio taped for data transcription ☐ yes ☐ no

Please send me e-copies of: thesis ________ articles arising from this study ______

Signature : ____ Date : __________________
Print Name : _______________________________________
Name that I wish be linked to my words in this study: _______________________________
email: ____

I declare that I have explained the purpose, nature, benefits, risks and drawbacks of the study and have responded to the best of my knowledge to the questions asked by the participant.

Researcher's signature__________________________________ Date : __________________
Print name: ____

Researcher's contact information

This study is being conducted by Piedad Martin-Calero Medrano, under the supervision of Professor Marion Brown, School of Social Work, Dalhousie University. If you have any questions regarding the study, or if you want to withdraw, please contact:

Piedad Martin-Calero at (902) xxx-xxxx or Piedad.martin@dal.ca
or supervisor
Marion Brown at (902) 494-1192 or Marion.Brown@dal.ca

Workplace experiences of Mental Health Wounded Healers: A collective learning

Following each interview you will be asked to review this form

Use of Quotations

Print Name: ______________________________________

Date: ______________________

Select the section of the research this form is referring to:

- Group Interview 1
- Group Interview 2
- Group Interview 3

I agree to anonymous direct quotations/segments from this interview being used in the written reports on this research	☐ yes	☐ no	
I request opportunity to compare my portions of the group interview transcripts with direct quotes being used in any articles or publications arising from this study	☐ yes	☐ no	
I agree to portions of my transcribed contributions (within the group interviews) being shared with another participant when these words are part of a conversation that may be included in the final research	☐ yes	☐ no	☐ n/a

<u>Researcher's contact information</u>

This study is being conducted by Piedad Martin-Calero Medrano, under the supervision of Professor Marion Brown, School of Social Work, Dalhousie University. If you have any questions regarding the study, or if you want to withdraw, please contact:

Piedad Martin-Calero at (902) xxx-xxxx or Piedad.martin@dal.ca
or supervisor
Marion Brown at (902) 494-1192 or Marion.Brown@dal.ca

Workplace experiences of Mental Health Wounded Healers: A collective learning

During Group Interview 3 you will be asked to review this form

Consent to collect Individual Reflection

Print Name: ____

Date: _______________________

I consent to having my individual reflection collected in this study	☐ yes	☐ no
I agree that my individual reflection collected in this study may be used for subsequent research projects and publications of similar nature, conditional on approval by an ethics committee for research and respecting the same principles of confidentiality and protection of information	☐ yes	☐ no

Researcher's contact information

This study is being conducted by Piedad Martin-Calero Medrano, under the supervision of Professor Marion Brown, School of Social Work, Dalhousie University. If you have any questions regarding the study, or if you want to withdraw, please contact:

Piedad Martin-Calero at (902) xxx-xxxx or Piedad.martin@dal.ca
or
Marion Brown at (902) 494-1192 or Marion.Brown@dal.ca

APPENDIX D.2 PHONE CONTACT AND OVERVIEW GUIDE

The purposes of this phone overview are to:

- ensure that you are fully informed about the study and have had any questions answered
- encourage reflection on your level comfort and sense of safety about engaging in this research
- discuss the terms of consent to participate

Questions:

- Have you read the Informed consent form?
- Would you like to read it together?
- Do you have any questions about the information on the form?
- Is there anything about you that you would like me to know prior to the beginning of the study?
- Do you have any worries or concerns regarding your wellbeing or safety if you decide to participate in this research?
- Could you rank from 1 to 10 how likely you think it is that being part of this research may be triggering for you?
- If you do feel triggered as a result of being part of this research, can you rate from 1 to 10 how serious or severe you think your response may be?
- Can you share with me any signs that would let me know that you may be having a difficult time being in this research?
- If, during the research, you find that you are having a hard time or if you feel triggered:
    - Is there a way that you may prefer to let me (or the group) know?
    - Is there something that you would like me (or the group) to do or say to you?
    - Is there something that you would like me (or the group) not to do or say to you?
    - Do you have a plan about how you would take care of yourself and access supports?

- Could you rank from 1 to 10 how comfortable and confident you are about being in this study and being ‘ok’?
- Do you have any other questions for me?

If during the research I feel that, according to what you have shared with me in this conversation, you are ‘not ok’ (or if you don’t come to one of our meetings and you don’t let me know that you will be absent) I will approach you in person or over the phone to talk with you about how you’re feeling. If it seems that your safety is at risk I will encourage you to contact your established support systems, Mobile Crisis, or to go to the nearest emergency room. I will also contact my supervisor, Marion Brown, to access support with any decision-making. I will only contact Mobile Crisis or the police as a last resort, if I perceive the situation is an emergency, and after exhausting all avenues at coming to a decision together.

APPENDIX E   RECRUITMENT NOTICE

Workplace Experiences of Mental Health Wounded Healers: A Collective Learning
Researcher: Piedad Martin-Calero, MSW student, Dalhousie University

Are you a university trained mental health worker living in the Halifax area (or within commuting distance) who identifies as someone living with mental health challenges?

Are you interested in and committed to using this lived experience and knowledge in your work?
Do you have experience attempting to practice this way?

If you answered yes to the questions the above, I invite you to participate in this MSW thesis research.

If you participate in this research, you will join other mental health workers living with mental health issues to discuss your experiences in a series of small group meetings, which will take place in the spring of 2015.

My own workplace experiences as someone living with mental health challenges, and as someone who believes in the value that my lived experiences can bring to my work, have been the inspiration for this research. My hope is this research will bring legitimacy to the knowledge of 'Mental Health Wounded Healers,' so that this knowledge will be considered in the future design of mental health practices, programs, and services.

Individuals with a range of experiences, professional backgrounds and theoretical orientations are encouraged to participate in this research.

Participation in this study is voluntary and participants have the right to withdraw at any time and without consequence.

Please contact me if you are interested in learning about the methods for this research and expectations of participants.

RESEARCHER
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