ARTICULATION OF COMMUNITY ENGAGEMENT: A COLLABORATIVE RECOVERY MODEL (CEACRM)

by

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Abstract

This thesis is divided into five chapters. The first chapter consists of a two-part introduction. The first part of the introduction provides a critique of the prevailing diagnostic and medicalized worldview within our current mental health systems and presents evidence of a need to consider alternative approaches for understanding and working with human experiences of suffering within the field of mental health. The methodological approach for this thesis is discussed and an argument is provided for the necessity for further articulation of aspects of Community Engagement: A Collaborative Recovery Model (CEACRM). In the second part of the introduction an overview of CEACRM is provided. Chapters 2 to 4 focus on articulating important elements of CEACRM; specifically the absence of pathological labels, the presence of relational collaboration, and the presence of a naturalistic environment. Chapter 5 takes into account political considerations to provide a contextual framework for understanding potential challenges to working in nontraditional ways within the field of mental health, addresses potential implications for professionals, suggestions for future research, and concludes with reflections from the author.

Keywords: Community Engagement: A Collaborative Recovery Model, Susan Swim, Christopher Kinman, postmodern therapy, social construction theory, deconstructing diagnostic discourse, involuntary detention, relational collaboration, ecopsychology, ecotherapy, equine-assisted therapy, human rights, social justice.

(*Kadler, 2008)*

Dedication

To my loving family.

Acknowledgements

My heartfelt gratitude to Susan Swim for graciously and generously inspiring, validating, and deepening my learning and growth throughout this process. My sincere appreciation to Christopher Kinman for gently and empathically guiding and encouraging me along this writing journey. Thank you to David Abramovitch, David Nylund, and Chris Blantern for encouraging and generative conversations. Finally, a huge thank you to the community of folks at City University of Seattle.

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Part I: Introduction to Thesis

Since the first American Psychiatric Association's publication of the Diagnostic and Statistical Manual of Mental Disorders (DSM) in 1952 (APA, 1952) the number of psychiatric diagnoses has increased by over 400% (APA, 2013). The first American Psychiatric Association's publication of the Diagnostic and Statistical Manual of Mental Disorders in 1952 identified approximately 50-60 different psychogenic disturbances (APA, 1952). Twenty years later, in 1987, after three revisions the publication of DSM IIIR identified between 180-200 recognized illnesses; more than tripling the number of psychogenic disturbances (APA, 1987). Today, the most recent version of the DSM, the DSM-5 (APA, 2013) has upwards of 265 disorders depending on definitional boundaries (Gergen et al., 1996; Ghaemi, 2013).

Despite the dominance of DSM diagnostic criteria in thinking about mental disorders in clinical practice, research, treatment development and law, the classification system lacks validity (Hyman, 2010). In contrast to a disease where etiology or pathologic processes (pathophysiology) are known, a disorder is a word "generally used to describe a medical condition or abnormality conferring harm or risk of harm in which etiology or pathologic processes are unknown” (p. 156). A common language for communication is important, however if our language is lacking in terms of providing a useful explanation for the life struggles that clients are bringing forward what purpose is this ‘diagnostic reality’ serving and who is ultimately benefitting? (Gergen et al., 1996, p. 105). Given this current trend of increased expansion and intensification of both diagnosis and our system for classifying mental disorders within the field of mental health, it is ethically imperative for us to take a step back and consider how this diagnostic and medicalized worldview is experienced by people who seek the support of mental health professionals in managing the life challenges they face.

From a social constructionist perspective, diagnoses are understood as “socially constructed meanings put forward by the dominant professional culture” (Gergen et al., p. 105). Thus when we ascribe a diagnostic label to a person we are essentially agreeing to “make sense of some behavior or event in a certain way” (p. 105). By engaging in this process there is a danger for the professional and for the client in assuming that a diagnosis is true and valid. Hyman (2010) defines validity as meaning that “a diagnosis picks out a natural kind based on etiology or pathophysiology” (p. 158). A social constructionist perspective invites alternative questions for consideration surrounding diagnosis:

> What is the intent of a diagnosis?
>
> What questions are believed to be answered by diagnosis?
>
> What information is thought to be gained?
>
> What does one want a diagnosis to communicate and to whom?
>
> If there are many ways to think about, to describe what may be thought of as the same thing (i.e., behaviors, feeling), how can we respect and work within all realities?

Should we consider the possibility of multiple diagnoses?

How can we bring the client into the process?

How can, and is it possible, for a diagnosis to be meaningful for all involved?

How can it be collaborative, tailored to the individual, useful?

What other words can we use?

If we reject diagnostic terms, should we try to persuade the helping system to change its nosology?

How do we develop a way in which multiverses can co-exist?

(Gergen at al., 1996, p. 105).

In an invitational paper delivered in conjunction with a talk given at a Galveston Symposium in 1991, entitled *Dis-diseasing of Mental Health,* Harold Goolishian (2017) wrote about how our reliance and emphasis on psychiatric diagnoses and terminology over the last century within the field of mental health has contributed to a language of description that may be called 'deficiency language.' Essentially, we have created "a world of description that understands only through what is wrong, broken, absent, or insufficient" (p. 69). Goolishian, an American psychologist and co-developer of a postmodern collaborative approach to therapy, believed that "this deficiency language has created a world of mental health that can be compared to a black hole out of which there is little hope to escape whether we be clinician, theoretician, or researcher" (p. 69). Goolishian claimed that this deficiency language has become "a major impediment that prevents us from reaching those with whom we work" (p. 70).

Implications of this linguistic black hole extend beyond affecting mental health professionals working within the field to the creation of lasting impacts upon the people coming to the professional for support. Self-concept, self-identity and relationships with loved ones and the community are altered by diagnostic labels. In a 2010 article published in "The Annual Review of Clinical Psychology," former director of the National Institute of Mental Health, Steven Hyman (2010), writes about the problem of reification related to the diagnosis of mental disorders. He argues that cautionary statements within the DSM "provide little protection among many communities of users against reification of the disorders listed within" (p. 158). Hyman sees reification as problematic in that it impedes scientific progress by controlling and limiting the research questions investigators ask or imagine asking. From my perspective, reification is concerning because diagnostic labels may contribute to the creation of a phenomenological reality of entrapment within "an unintended epistemic prison" (Hyman, 2010, p. 157) for people labeled within the diagnostic categories outlined in the *International Classification of Diseases and Related Health Problems* (ICD) and *Diagnostic and Statistical Manual of Mental Disorders* (DSM). Rather than being treated as heuristic, disorders may be conceptualized as real entities from which there is no cure nor hope for escape.

Language of deficiency contributes to the creation of a social reality for a person that is accepted and reinforced as a part of the fabric of our entire social narrative, embedded within "our universities, our public language, our legal system, our educational systems, and our economic system" (Goolishian, 2017, p. 70). By engaging in discourse that pathologizes diverse responses to adversity as if they were medical conditions, mental health professionals disempower individuals and perpetuate social exclusion and stigma (Mad in America Editors, 2019). Social stigma associated with the objectification and categorization process of labeling contributes to demoralization and paralysis, undermining possibilities for constructive change in the lives of these people (Tomm, 1999). Impacts of diagnostic labels expand beyond the professional-client relationship to affect relationships that a person has with their own sense of self, with the loved ones in their life, with their community and with society at large.

Karl Tomm, a Canadian professor of psychiatry at the University of Calgary, noted "the effects of labelling persons as mentally ill can be devastating to their personal identity (as having legitimate worth) and to their place within the community (as having respectable status)" (1999, p. 2). Further, diagnostic labels hold weight in legal proceedings, custody hearings and in a person's prospects for obtaining employment, volunteer opportunities or travelling. Ultimately a diagnosis can mean the difference between a person's freedom and the same person being stripped of fundamental human rights and experiencing the trauma of involuntary detainment within a psychiatric institution. Research suggests that "excessive reliance on certain biomedical interventions, including antidepressants and voluntary and involuntary hospitalization, may have a counterproductive effect and lead to increased suicide risk" (OHCHR, 2019, p. 2).

A Call for Change

Demands for alternative approaches for understanding and working with people outside of the prevailing diagnostic and medicalized worldview are increasingly being recognized and discussed (Community Legal Assistance Society [CLAS], 2017; OHCHR, 2019; Scottish Executive, 2006; Superior Health Council, 2019). A recent example comes from an Open Statement written by the United Nations Special Rapporteur on the right to health on October 10, 2019, World Mental Health Day. "In the face of staggering suicide rates, scaling up already-existing approaches that target individual brain chemistries risks exacerbating the vicious cycle of stigma and social exclusion that often aggravates loneliness and hopelessness" (OHCHR, 2019, p. 1). The statement outlines a need for a rights-based response to suicide prevention which "cannot be achieved through the excessive use of medication, nor through coercion and isolation, which remain stalwart features of mental health systems" (p. 1).

The Office of the High Commissioner for Human Rights (OHCHR) recommends that professionals within the health sector “seek solutions that both prevent the accumulation of trauma and desperation that leads to suicide and respond to those in crisis in a way that addresses the underlying issues that have so deeply affected them” (OHCHR, 2019, p. 4). Thus there is a call for a shift within the field of mental health from focusing solely on categorizing behaviors in pathological terms and prescribing psychiatric drugs, to seeking to understand with compassion how a person may be suffering and considering what we as professionals, and fellow human beings, can do to provide holistic support. Central to a holistic approach is an acknowledgement and addressing of “the structural and psychosocial determinants of distress, such as childhood trauma and abuse, social inequality and discrimination” (p. 1). Engagement needs to extend beyond the individual to encompass relationships and the broader environments in which a person lives, works, learns and plays.

Problem Statement

The current trend towards increased diagnosis and medicalization in our mental health systems is problematic to the extent that it labels and stigmatizes people without providing the respectful, compassionate and effective support that they need and deserve. In my opinion, it is tragic and unconscionable that people who seek support for life problems from mental health professionals and share vulnerable narratives of life struggles currently risk the potential harmful consequences of receiving not much more than a vague diagnostic label, a prescription and possible involuntary detainment in a psychiatric institution. Rather than meaningful support, consequences of treatment can result in a permanent shifting of how a person views themselves; negatively impacting their ability to move forward in life. This begs the question, which is riskier? To suffer in silence, in isolation? Or to seek support within a broken system, where a person may walk away with less hope and more problems than they faced when they originally sought help? There must be a way that we, as professionals within the field of mental health, can do better.

Purpose of this Thesis

The purpose of this thesis is to invite readers to consider alternative approaches for understanding and working with people who are experiencing suffering in their lives.

Outlining Methodology

In considering which methodological approach to take for this thesis, I found it helpful to consider the question “how might research be useful in my professional practice?” (McNamee, 2014, p. 87). My intent in writing this thesis is not to create a document producing “reliable and repeatable results that can be made accessible in some published form” subject to public critique and testing methods for the purpose of generalizability (Shotter, 2014, p. 9). Rather, I am interested in a method of inquiry that is practice-oriented and practice based. I am “concerned with our gaining a sense of *where we are* in relation to our immediate surroundings [within the broad field of mental health] and of the surrounding field or *landscape* of real possibilities open to us for our next steps” (p. 9).

My hope is that my process of inquiry will contribute to opening up space for thought and conversation surrounding how we might ‘go on together’ (Wittgenstein, 1953) in our efforts to understand and heal human experiences of pain and suffering in respectful and dignified ways. I am attempting to generate new possibilities and/or new forms of understanding (McNamee, 2014) for thought, for conversation and for therapeutic practice. These new forms of understanding and thought will be found beyond the realm of the current prevailing diagnostic and medicalized worldview of mental health. I will not be presenting any final answers, rather I am interested in sensing similarities (Shotter, 2014, p. 20) among various approaches within the field of mental health. I am curious about seeking out alternative options and/or perspectives to prevailing medicalized and diagnostic views and approaches for understanding human experiences of pain and suffering.

I want to make explicit that I am not proposing acceptance of one specific model or approach of therapy, nor am I proposing a solution for ways of addressing what Goolishian (2017) refers to as the 'black hole' of mental health created from our dependency and reliance on psychiatric terminology and deficiency language. Instead, this thesis aims to build on and bring to conscious awareness for the reader some of the transformative literature, knowledge and ideas that are already in practice and supported by evidence. As you read, I invite you to be curious about your own reactions. What intuitively makes sense? What is possible? I invite you to experiment with a sense of open-mindedness surrounding the possibility of moving beyond medicalized and diagnostic understandings of diverse human experiences of pain and suffering.

Articulation of CEACRM

This thesis examines three important aspects of a model that characterize a non-traditional way of working or being with human experiences of pain and suffering. Recognizing that our methods for scientific inquiry are informed by the world we are a part of, I have chosen to focus on aspects of Community Engagement: A Collaborative Recovery Model (CEACRM). By doing so I am sitting with the relations that I have (C. Kinman, personal communication, 2019). I was introduced to CEACRM and the work of Susan Swim and Now I See A Person Institute (NISAPI) by Christopher Kinman, a professor at City University of Seattle. I am deeply grateful to both Christopher Kinman and Susan Swim, who graciously hosted me as a learner at Now I See A Person Institute (NISAPI).

Through a process of engagement in what Shotter (2014) may consider orientational learning I continued leaning into “coming to a *sense* of, a *feel* for, the world” that I wanted to explore through my inquiry (p. 3). In the course of extensive involvement with others (Shotter, 2014, p. 3) through generative conversations, observations, reading, reflecting and writing I began noticing connections between academics, practitioners and philosophers who described ideas in alignment with my own interests, values, beliefs and life experiences. I began to consider that perhaps a re-envisioning of therapy is possible. Rather than understanding therapy as a medicalized, diagnostic, distant and individualistic process; perhaps opportunity exists for therapy to be conceptualized and experienced as human, relational and natural. Pivotal to this discovery was the ongoing support, nurturance, guidance and mentorship provided by both Christopher Kinman and Susan Swim.

With the foundation of CEACRM as a platform for my inquiry, I have connected elements of the model with ideas and practices from a variety of academics, professionals and philosophers. My aim in writing this thesis is to invite a gentle shift of perspective towards how we see and treat human beings in their experiences of pain and suffering within the field of mental health.

Acknowledging Language

In describing the methodology and structure of this thesis, it is important to acknowledge the role of language. French literary theorist Jacques Derrida views language as a system of differences (Gergen, 2015). For Derrida, “word meaning depends on differentiating between a presence (the word you have used) and an absence (those to which it is contrasted)” (p. 20). In an effort to write in a way that makes sense to the reader in this thesis, I will be following the theme of noticing both the presence and absence of elements I believe to be important to consider within an alternative philosophical framing of approaches for therapeutic practice. The three aspects of CEACRM that I focus on articulating in this thesis are:

1. Absence of pathological labels
2. Presence of relational collaboration
3. Presence of nature

Each of these aspects is addressed in detail in subsequent chapters of this thesis. The remainder of Chapter 1 will provide an overview of CEACRM.

Part II: Introduction to CEACRM

Community Engagement: A Collaborative Recovery Model (CEACRM) is an approach to couple and family therapy developed by Susan Swim and colleagues. The model is currently utilized at Now I See A Person Institute (NISAPI), a non-profit organization providing therapy for trauma, unresolved symptoms and severe family conflicts, family reunification and parental alienation services including monitoring, therapeutic visitation and supervised visitation, and family and individual life coaching services in a naturalistic environment in Los Angeles, California (Swim, n.d.). Swim et al. (2016) describe the cornerstone of CEACRM as providing "therapeutic services to establish collaborative, genuine, and caring relationships that foster conversations of hope and new possibilities for change, co-developed by the therapist and client in dialogue" (p. 1).

Purpose for Development

This therapeutic approach to working was developed with the intention:

1. To de-stigmatize those suffering from mental health and substance challenges.
2. To transcend diagnosis in lieu of seeing people as people who are suffering in life events and challenges.

3. To see people as people and not be limited to seeing them or their seeing themselves as a diagnosis, nor being bound to one.
4. For clients to see themselves through the strength-based lenses of a therapist.
5. To co-create strength-based client-led solutions and new possibilities (Swim et al., 2016, p. 2).

Central Tenets

The central tenets of CEACRM are:

1. Therapeutic normalcy with the use of horses and outdoor offices.
2. Multiplicity of individual and family needs and voices heard.
3. No strict time limits.
4. Narratives transforming problems and deficiencies into strength and hope.
5. Narratives of genuineness and transparency between therapist and client.
6. An atmosphere from the therapist of care and curiosity, rather than pre-knowing or therapist-led conversations, to produce sustainable change regardless of previous diagnosis, ethnicity, socio-economic status or age (Swim et al., 2016, p. 2).

Core Principles

The three core principles of CEACRM are:

1. Recovery focused care.
2. Collaborative practice.
3. Connection—collaboration—and—change (Swim et al., 2016, p. 2).

History and Development of CEACRM

An understanding of the history and development of CEACRM requires an appreciation for the various ideas and work that influenced its construction.

Collaborative Language Systems

CEACRM is based on the premises of the Collaborative Language Systems (CLS) theory developed by Harlene Anderson and Harold Goolishian in the 1980's (Swim, 2016; Prasad, 2017). CLS is a postmodern approach to therapy that "describes the process of change as the evolution of meaning through dialogue" (Gehart-Brooks & Lyle, 1999, p. 58). The emphasis when working in this way is on opening up space for conversation, rather than focusing on producing change (Anderson & Goolishian, 1992). Therapy and the therapeutic conversation are seen as "mechanisms through which the therapist and the client participate in the co-development of new meanings, new realities, and new narratives" (p. 29).

International Influences

In addition to honoring the practices of Collaborative Language Systems, CEACRM reflects the works and ideas of the Houston Galveston Institute (Texas, United States), Kanankil Institute (Merida, Mexico), Now I See A Person Institute (California, United States), work of Miller, Duncan, & Hubble (1997), Jaacko Seikkula (Finland), Tom Andersen (Norway) and the Rhizome Way of Christopher Kinman and Lynn Hoffman (Canada) (Swim, 2016, p. 1).

Formation of a Novel Approach

CEACRM was first introduced to the Marriage and Family Therapy field in 2008 at a American Association for Marriage and Family Therapy (AAMFT) pre-conference. Ideas for the development of CEACRM originated from collaborative, informal conversations between Susan Swim and two international colleagues, Christopher Kinman in Canada and Rocio Chaveste in Mexico. At the time of initial conceptualization, all three professionals were providing novel forms of therapy for populations and noticing positive changes where change had previously not occurred (Swim et al., 2016).

Christopher Kinman in his work with Indigenous peoples in Canada often provided therapy outdoors; walking alongside youth, families, and community members, immersed in 'relations with nature.' In his book *Pilgrimages of the Gift* (2011) Kinman describes therapy with a young man connected to a First Nation community school in British Columbia. During their time together, the two would walk in the forest around the young man's school. "We would find a log, we would sit and listen to the chickadees and the jays; we would notice the various forms of life in movement around us. Little was said, yet it felt like something good was occurring" (p. 31). Feedback from the young man's mother confirmed the helpfulness of Kinman's unique approach. "Clearly, something was happening [during therapy] that was perceived as helpful; but, it was happening within silences, within and through minimal talk. It happened as we walked together, as we looked at life in movement around us" (p. 32).

Rocio Chaveste, in Mexico, was involved with the opening of a client driven substance center where clients were in charge of their treatment and solutions.

In California Susan Swim involved her two horses as "co-therapists" providing therapeutic services on a naturalistic horse ranch for people who had not been assisted by traditional therapy at traditional venues or by institutionalization. Traditional venues are defined as "office settings, wrap around in-home therapy, or hospitalization" (Swim et al., 2016, p. 1). Swim found that working within a natural environment in sight of horses provided an atmosphere of safety, normalcy and nurturance for clients (p. 2).

Current Research

Since the initial launch of CEACRM in 2008, Swim and her colleagues at NISAPI have continued to refine the theoretical model. In collaboration with her team she continues to engage in participative research aimed at bringing in the voices of the Now I See A Person Institute

(NISAPI) community, involving clients and their family members, student learners and faculty and staff of the institute in continued efforts to demonstrate the effectiveness of CEACRM and to fundraise to promote expansion, sustainability and longevity of the non-profit organization (Myers et al., 2008; Swim et al., 2016; Swim, Abramovich, et al., 2018; Swim, Priest, et al., 2018; Swim, 2018, 2019a, 2019b).

Outline of the Remainder of Thesis

Chapter one provided a critique of the prevailing diagnostic and medicalized worldview within our current mental health systems and presented evidence of a need to consider alternative approaches for understanding and working with human experiences of suffering within the field of mental health. The methodological approach for this thesis was discussed and an argument was provided for the necessity for further articulation of aspects of Community Engagement: A Collaborative Recovery Model (CEACRM). In the second part of the chapter an overview of CEACRM was provided. Chapters 2 to 4 of this thesis will focus on articulating what I believe to be three important elements of CEACRM; specifically, the absence of pathological labels, the presence of relational collaboration, and the presence of a naturalistic environment. Chapter 5 will take into account political considerations, with the intention of providing a contextual framework for understanding potential challenges in working in non-traditional or innovative ways within the field of mental health, address potential implications for professionals, suggestions for future research and conclude with reflections from the author.

Chapter 2: Absence of Pathological Labels

> What does it mean to see a person?
>
> To SEE a person means to enter each session with your true self, leaving your personal agenda at the door. To see the client, you understand that you do not know who they are, as you have never walked in their shoes—you just have to see who they are—the person sitting in front of you" (Swim, 2016, p. 12).

The purpose of this chapter is to further articulate and provide evidence for the first of three aspects of a way of working with, or of being with, human experiences of pain and suffering that I believe to be critically important. The focus of this chapter is on the absence of pathological labels. As outlined in chapter 1, this notion of suspending judgment of people based on categories of deficiency outlined in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) or *International Classification of Diseases and Related Health Problems* (ICD), is in alignment with the second and third purposes of the development of Community Engagement: A Collaborative Recovery Model (CEACRM); "to transcend diagnosis in lieu of seeing people as people who are suffering in life events and challenges" and "to see people as people and not be limited to seeing them or their seeing themselves as a diagnosis, nor being bound to one" (Swim et al., 2016, p. 2).

In my opinion, diagnostic labels and pathological language get in the way of a professional's ability to truly see a person. Instead of relying on the language of deficiency provided by the DSM or ICD, CEACRM supports a recognition of human experiences of suffering and a compassion for and recognition of the symptoms that often result from the social and environmental conditions in which a person lives. Too often, therapy offers diagnoses and labels for problems without the possibility of solutions. People come to mental health professionals seeking support; hoping for a sense of alleviation or some degree of relief from the distress they are experiencing. In a place of vulnerability, these people offer their narratives to a stranger, opening up and revealing difficult, painful, tender and private parts of themselves that haven't previously had a voice, parts of themselves that may not have been expressed or heard in the past. A diagnostic and medicalized worldview limits our capacity as professionals to listen, to really hear and endeavor to understand another person's lived experience.

Diagnostic Discourse

Professionals caught up in diagnostic discourse create a "limited field of possible actions and responses" within their interactions with clients (Simblett, 2013, p. 118). Working within a system of care dominated by deficiency language, mental health professionals may find themselves constrained to listening only for narratives falling within the binaries of disorder/normality, pathology/health, personality disorder/fixed, singular personality, functional disability/functional ability. Information falling outside of the frameworks provided by the DSM, may be ignored, deemed irrelevant, and not further pursued (Simblett, 2013). Once a categorization is made or a deficiency is found that may foreclose any further discussion of opportunities, alternate possibilities and hope for sustainable change. A diagnosis could effectively displace the opportunity for a person to share who they are and for the mental health professional to seek understanding about how a person's life came to be how it is now.

In his clinical work with children diagnosed with attention deficit hyperactivity disorder (ADHD), author and renowned therapist David Nylund engages with clients and their families in a non-pathologizing, non-reductionist framework. In an interview with a doctoral candidate discussing his novel, *Treating Huckleberry Finn: A Narrative Approach to Working With Kids Diagnosed with ADD/ADHD,* Dr. Nylund explains how he has found pathologizing language to "interfere with the bringing forth of the inherent skills, knowledge, and talents that parents, teachers, and children might otherwise adopt in coping with the problems associated with ADHD" (Kindsvatter, 2005, p. 503). If a mental health professional limits conversations to pathology and medicalized terminology, then that limits the opportunity for consideration of alternative and creative ways for solving problems that the child is experiencing. Further, "one of the unfortunate consequences of the diagnosing of ADHD is that it tends to cement for parents a totalizing deficit-based description of their child" (p. 504).

In addition to impacting relationships with other people in a client's life, diagnostic discourse has implications for self-concept, self-identity, and pragmatic consequences for future personal development. O'Connor et al. (2018) conducted a systematic review collating, evaluating, and synthesizing 38 qualitative research studies exploring how psychiatric diagnosis interacts with young people's self-concept and self-identity. Impacts of receiving a diagnosis include a sense of being marked as flawed or deficient. Pragmatically, "young people in 11 studies stated that receiving the diagnosis had restricted their opportunities in education, career, and relationships" (p. 101). A recurrent finding amongst the qualitative research was that after a diagnosis "young people's expectations and aspirations for the future were revised downwards (p. 101)." The acceptance of a psychiatric diagnosis in some cases "lead to anxiety about future prospects and realignment to less ambitious career and educational plans" (p. 101).

From the moment a client enters the therapy room, their appearance, their utterances, their expressions, their communications, are filtered through the theoretical framework and philosophical lens held by the professional. If this framework is embedded with language of deficiency, of searching only for what is "wrong, broken, absent, or insufficient" (Goolishian, 2017, p. 69) then new or increased knowledge of these deficiencies and problems is all that a person will gain from the interaction. A belief in individualized deficiency and reinforcement of deficit-based descriptions from mental health professionals have the potential to forever impact how a person sees themselves and the choices they make throughout their life.

Subject Positioning Theory

Subject positioning theory offers a theoretical framework for further conceptualizing the dynamics present within interpersonal encounters between mental health professionals and people seeking support. Positioning theory proposes "people are positioned or position themselves with respect to rights and duties to act within evolving storylines, and on the basis of claims about relevant personal attributes, the discursive process of prepositioning" (Harrè et al., 2009, p. 5). By bestowing diagnostic labels and utilizing pathological language to describe the cause of a person's struggles, mental health professionals are contributing to a storyline that constrains opportunities for action (C. Blantern, personal communication, 2019).

A person who is categorized as mentally ill by virtue of receiving a diagnostic label is cast into a position of abnormality. The socially constructed meaning of a diagnosis, influenced by relational, cultural, interpersonal and intrapersonal factors, frames the way a person carries on within their life, "thinking, feeling, acting, and perceiving – against standards of correctness" (Harrè et al., 2009, p. 9). Bound within an identity of abnormal and categorized as mentally ill, a person can become trapped within a storyline of deficiency; a narrative whereby they are doomed to fall short of meeting socially constructed notions of normality in all aspects of their life. When problems are individualized, diagnostic symptoms may be accepted and understood as personal attributes contributing to a phenomenological experience of imprisonment within "diagnosis created unworkable problems" (Gergen et al., 1996, p. 106). Once a person is diagnosed, every move they make is potentially dysfunctionalized, internally and/or externally, a process described by Kenneth Gergen as “the tyranny of diagnosis” (p. 106).

Walking through life with the belief that one is marked as permanently flawed or deficient constrains a person in terms of what they can say or do and influences their chances of leading a meaningful and fulfilling life. Deficiency language has become so engrained and accepted within our society that diagnostic labels are essentially a part of our “prevailing normal conversational architecture” (Anderson-Wallace et al., 2001, p. 415). Within the field of mental health, discursive processes between professionals and people seeking support predominantly reinforce a working frame based on deficiency, brokenness, and helplessness. This working frame becomes the lens through which a person sees themselves, influencing how a person positions themselves in relations to others and how they are responded and related to by other people as they move through the world.

Power Imbalance

A person who carries a pathological label is re-positioned as a member of an oppressed and marginalized group within society vulnerable to experiences of social isolation, stigmatization, power imbalances and inequality. Subject positioning theory posits that through the discursive process of social interactions a person “may be implicitly positioned as a particular kind of person” (Burr, 2002, as cited in Harrè et al., 2009, p. 19). When a person’s identity includes a diagnostic label, assumptions are made consciously and/or unconsciously about the meaning of diagnosis and the meaning of mental illness. Repeated exposure to harmful and stigmatizing assumptions can translate to a sense of powerlessness, a loss of personal agency and ultimately limit a person’s capacity and hope for change.

Within our mental health system “the biomedical understanding of mental health problems can be seen as a form of authorities’ knowledge, which organizes power relations during the treatment process" (Sercu & Bracke, 2017, p. 1251). Knowledge is disseminated in a top-down fashion by experts in a hierarchical position of power above clients. This psychiatric approach is "a reflection of the culturally dominant, middle-class approach to psychiatric problems" (1255) and in my opinion, discounts the unique life experiences, circumstances and situations that encompass a person. Within this medicalized model, compassion, understanding, and the provision of dignified treatment and care rank below economically driven systems of classification and categorization. In contrast, a postmodern social constructionist perspective offers an alternative way of conceptualizing diagnosis.

> Thinking of therapy and diagnosis from a postmodern social constructionist perspective redefines the therapist-client relationship and challenges professional knowledge. It moves therapy from a relationship between a knower and one who is ignorant to a collaborative partnership in which the deciding of, the exploring of, and the "solving" of problems is a process of shared inquiry in which the diagnosis is not fixed and the problem may shift and dissolve over time (Gergen et al., 1996, p. 106).

Honoring and Valuing the Client

Principles of respect and humility are essential for honoring and valuing people seeking support from mental health professionals. Embracing this stance may involve a deliberate decision to step away from deficiency language. As outlined in Chapter 1, the history of the development of CEACRM was influenced by the works and ideas of the Houston Galveston Institute (HGI). The following quote, in a paper representing an externship training program at HGI, eloquently describes a collaborative postmodern theoretical orientation embraced by the Institute:

> We [Susan Swim and Harlene Anderson] believe that it is essential to have respect and

> humility for ourselves and for those with whom we work. This must be protected and cherished. To access and maintain this stance it has become important for us to give up the notion of pathology and of ourselves as healers, and to re-examine our thinking and values regarding power, hierarchy, and technical expertise. We believe in the capacity of humans to manage their own lives (Swim et al, 1998, p. 75).

From an ethical standpoint, recognizing the power differential that inherently exists between a person seeking support and a professional within the field of mental health is essential. As professionals and as fellow human beings, the words we choose to relate to or describe the people we are engaged with have tremendous impact. A social constructionist perspective recognizes language as “not simply a tool or vehicle used to transmit or exchange information about reality, rather language is seen as constructing reality” (McNamee, 2014, p. 74). From this view, it is understood that language holds power. The words we use as professionals can contribute to the co-generation of new possibilities, recognition of unique gifts, engender hope, and sustainable change; or they can contribute to the stigmatization and imprisonment of people within a downward spiral of deficiency, infirmity, and chronicity (Goolishian, 2017).

Sensitivity to language is incredibly important if we want to avoid further “marginalizing and objectifying people who seek help” (White, 1995). Instead of relying on pathological terminology and focusing solely on labelled diagnoses, therapists can seek to respond to individuals “in a way that sees symptoms or problem behavior as making sense or ‘natural’ responses to difficult situations” (Olson et al., 2014, p. 22). For example, in a group facilitated by Vassallo (1998) members with a history of psychosis understood the pathological term “withdrawal” not as a symptom but as a social consequence of stigma. This group discovery led Vassallo (1998) to argue that “it is subjugating for ‘withdrawal’ to be defined as a pathological feature of illness when it is clearly a legitimate and reasonable response to a deleterious judgmental social context" (p. 21). Regardless of our intention when using language, it is important to remember that we can only know the impact of our words by listening and paying attention to the response of the other (Gehart, 2018).

Hope for Recovery

A deliberate step away from the use of pathological labels and deficiency language promotes a different sort of positioning, both for mental health professionals and for people seeking support. When the rules of engagement shift there is potential for long-term outcomes to shift as well. Within the CEACRM model the purpose of each therapeutic action is to promote recovery. There is a fundamental belief that each person has the inherent strengths and self-agency to transcend diagnosis, symptoms and trauma (Swim et al., 2016, p. 3). This belief is in alignment with the first core principle of the model, recovery focused care. The idea behind this core principle is that by working with therapists who genuinely embrace the belief that people can and will recover, clients begin to see themselves through the lens of the therapist as the "heroes and heroines" of their own journey (Swim et al., 1998).

Therapists working from a recovery focused care perspective understand and genuinely believe that people have the possibility of recovering their own agency, of deciding for themselves the best solutions for their own life situation and of empowering themselves to design possibilities to live in a better way (Myers et al., 2008; Swim et al., 2018). Recovery is conceptualized as achievable and therapist and client work collaboratively towards constructing new relations to problems. Achievable recovery is based on the idea of "human diversity as multiple possibilities" (Swim, 2016, p. 3).

Recovery Focused Care

The term *recovery* has increasingly been incorporated into research literature surrounding topics of mental health resulting in discourse surrounding "what recovery means, how it is experienced, measured, and how professionals and services can deliver recovery-oriented support in practice" (Forrest, 2014, p. 29). In terms of consensus about the definition of recovery, literature in the field "has repeatedly suggested that there is no consensus, and there is commonly confusion and ambiguity around the concept" (p. 29). In my opinion it seems counterintuitive that within a professional field dedicated to promoting the health and well-being there is no lack of research and academic writing surrounding theoretical perspectives explaining individualized problems, deficiencies and chronic disorders; yet this notion of *recovery* is so poorly understood.

Despite the debate in the literature surrounding a semantic definition for the term recovery, the idea of recovery focused care within the field of mental health is not new, nor is it bound by international borders. In 2006 the Scottish Government published a Report of the National Review of Mental Health Nursing in Scotland entitled *Rights, Relationships and Recovery* (Scottish Executive, 2006). Key messages framed as foundations for action in the report outline a need for continued development of rights-based and person-focused mental health care and a recommendation for the recovery approach to "be adopted as the model for mental health nursing care and intervention, particularly in supporting people with long-standing mental health problems" (p. 2).

A 2019 scientific advisory report published by the Superior Health Council of Belgium recommends recovery-based approaches as useful alternatives to diagnostic classifications arguing that "it is more useful to understand the combination of factors causing and maintaining symptoms than to identify a DSM or ICD category" (Superior Health Council, 2019, p. 1). The report is based on an evaluation of peer-reviewed scientific literature, reports from national and international organizations and opinions of experts. Authors of the report consist of a working group including experts from a broad range of areas of expertise with backgrounds in psychiatry, lived-experience expertise, psychology, sociology and philosophy. The Superior Health Council of Belgium views recovery-based approaches (clinical, personal and social) as a way to "better contextualize and adapt interventions according to patients' values, affinities and goals" (p. 1).

Justice in Listening

The act of listening and truly being present with another person is an act of social justice (C. Kinman, personal communication, 2018). To genuinely be with a person, to attempt to understand their struggle with life's burdens and to form a meaningful relationship are experiential processes that take time, open-mindedness and patience. Witnessing as someone shares their story can be healing and transformative for everyone involved. Thinking deeply and taking the time to consider another person's perspective before responding is a demonstration of care and respect. How we as professionals listen to the people coming to us for support is impacted by underlying philosophies, theoretical frameworks, personal beliefs, values and our own lived experiences. How can we support a person to recover if we do not believe in the capacity of human beings to manage their own lives, to heal, to transcend pathological labels and reliance on pharmaceutical medications to manage symptoms of suffering?

Instead of focusing on diagnostic criteria and psychological jargon therapists working from a CEACRM model consider questions like: Who is this person sitting in front of me now? Why do they believe they are feeling the way that they do? What do they want or envision for themselves in the future? How can we collaboratively work together to move towards that vision becoming a reality? And, who are the people in this person's life that need to be brought into the conversation for sustainable and meaningful change to occur? Additional adaptations within CEACRM include extended sessions, conjoint and individual therapy, and collaboration through continuous conversation with members of a client's system or community (Swim et al., 2016). There is an emphasis within the model on taking the time necessary to listen, being available and responsive and checking in with clients between sessions. There is an ethic of flexibility and generosity with time, whereby therapists are truly endeavoring to understand the complexities of each person's situation and remaining open about communication throughout the process (Swim, 2016).

Conclusion

In concluding this chapter I want to be clear that I am not proposing an abandonment or outright radical rejection of diagnostic classifications. Instead my intent within this chapter is to provide evidence surrounding the need for consideration and implementation of alternative approaches for understanding and working with human experiences of pain and suffering within the field of mental health. Ethically it is essential to respect each client's frame of reference. If embracing a diagnostic label is beneficial, meaningful and helpful for a person; then as mental health professionals this is not something to challenge. Rather, in acknowledging the evidence provided in this chapter surrounding potential harmful implications of diagnosis for clients and the need for alternative approaches within the field of mental health care, my hope is that the reader considers ways of looking beyond diagnostic labels and pathological language in seeking to understand the life struggles of people who access support services. Although economical and time-efficient, diagnostic classifications do not provide an accurate, fair or just explanation for diverse human behaviors. Harold Goolishian (2017) also believed a broader perspective is necessary:

> We simply cannot understand human behavior independent of the social context, the historically situated narratives of identity of the concerned actors, the intentions and agency of the individuals concerned, and the broader socioeconomic and historical setting in which the behavior occurs" (Goolishian, 2017, p. 70).

Chapter 3: Presence of Relational Collaboration

> I feel a never ending challenge to create communities where those who suffer can take charge of their lives and be seen by their strengths, where weakness is not the dominant reality (Swim, 2016, p. 2).

The purpose of this chapter is to further articulate and provide evidence for the need for the second of three aspects of working with, or of being with, human experiences of pain and suffering that I believe to be critically important. The focus of this chapter is on the presence of relational collaboration. Within the Community Engagement: A Collaborative Recovery Model (CEACRM) relational collaboration is defined as "the completely shared and egalitarian experience of defining the focus and direction of therapy and community services" (Swim et al., 2016, p. 4). Within the therapist-client relationship "conversations are client driven and all clients have ownership in their conversations for change" (p. 4). In my opinion, relational collaboration is critical because it protects and preserves the dignity of people seeking support from mental health professionals. Ethically it is imperative that people have a voice in the way they are treated and that they maintain a sense of agency in the decisions that are being made regarding treatment and care.

Demands for change within current systems of mental health service delivery are increasingly being discussed in the literature. In an article reviewing the introduction of recovery focused training for mental health nurses in Scotland, Cambers (2016) describes current catalysts for change as arising from "the emergence of mental health survivor groups and disability groups, the growing political voice of service users in the United States in the late 1970s and 1980s, and the civil rights movement" (Shepherd et al. 2008; Stickley & Wright, 2011; as cited in Cambers, 2016, p. 27). Collaborative therapy can be understood as one way of potentially meeting demands for change within mental health service delivery. Recognizing, respecting and upholding social justice and fundamental human rights addresses issues that are current and relevant on both global and local levels within the field of mental health.

A 2014 literature review exploring how mental health issues affect the rights of individuals diagnosed with mental illness globally concluded that “family members with mental health issues continue to be marginalized, medicalized and ostracized, hence exposing them to human rights abuses” (Mfoafo-M’Carthy & Huls, 2014, p. 8). Examples of human rights abuses are evident in cases where individuals experience a loss of liberty and are subject to detention and involuntary psychiatric treatment within institutions. “Individuals with mental illness who are receiving care in psychiatric institutions suffer greater human rights violations than individuals who are in correctional facilities” (p. 3). Thomas Szasz, an influential critic of coercive psychiatric practices argued “involuntary institutionalization and treatment are crimes against humanity” (Spillane, 2018, p. 343). Rather than offering services that are client-driven and relationally based, in our current mental health systems people who are seeking support for dealing with life’s burdens risk involuntary imprisonment.

Involuntary Detention in British Columbia, Canada

In the last decade in the province of British Columbia (B.C.), Canada involuntary admission rates to psychiatric facilities have risen from at least 11,937 to 20,008 per year. In comparison, the number of voluntary admissions has remained virtually unchanged at a rate of 17,659 to 17,060 per year (Community Legal Aid Society [CLAS], 2017). The rising rates of involuntary admissions in B.C. indicate that “our mental health system predominantly interacts with people with mental health problems in an adversarial way, by removing their rights to make decisions” (p. 13). A 2017 research report published by the Community Legal Assistance Society

(CLAS), a non-governmental organization in B.C., recommends an overhaul of the system. The report, entitled *Operating in Darkness: BC's Mental Health Act Detention System,* highlights the fact that "B.C. is considered the most regressive jurisdiction in Canada for mental health detention and involuntary psychiatric treatment" (CLAS, 2017, p. 7).

Violations of the human rights of individuals experiencing mental health concerns are not a new phenomenon. Historical accounts document "cases of people being tied to logs far away from their communities for extensive periods of time and with inadequate food, shelter, or clothing" (World Health Organization, 2003, p. 12). The power held by mental health systems to involuntarily admit and detain people in facilities without access to legal representation "means that people can be locked away for extensive periods of time, sometimes even for life, despite having the capacity to decide their future and lead a life within their community" (p. 12). In B.C. between the time period of 2008 and 2016 detainees of the mental health system who were entitled to legal aid were refused representation 639 times (CLAS, 2017, p. 10).

The reality of involuntary commitment to mental health facilities is that "the loss of liberty is only the beginning of rights deprivations. Once detained in the B.C. mental health system, the detaining facility controls every aspect of your life and your body" (CLAS, 2017, p. 5). While other Canadian jurisdictions are engaged in conducting systematic reviews of their mental health systems "to evaluate whether their legal framework was functioning effectively to further legislative goals and fulfilling the rights guaranteed by the *Canadian Charter of Rights and Freedoms* and the *United Nations Convention on the Rights of Persons with Disabilities*, B.C. has neglected this critical engagement" (p. 6). Further, the B.C. Mental Health Review Board publishes no annual report. This means that our provincial mental health detention system is currently ‘Operating in Darkness’ with “people tucked out of sight with no monitoring, oversight or accountability” (p. 6).

Coercive practices which are inherently emotionally and/or physically abusive are frequently implemented in mental health systems. To coerce is to “achieve by force or threat; to restrain or dominate by force” (Coerce, n.d.). Common examples of coercion in mental health systems include restraints, “involuntary commitment, medication, seclusion, Swedish belts, and house rules and restrictions” (Larsen & Terkelsen, 2014, p. 427). The CLAS (2017) reported “at any point in time throughout the detention period, detainees can be subject to physical, mechanical, environmental and chemical restraints and placed in seclusion (solitary confinement in a small, locked room)” (p. 14). Furthermore, “there are no criteria in the B.C. *Mental Health Act* and its regulations that define, govern, or establish oversight of restraint and seclusion use” and “there is no legal requirement to document the restraints and seclusion” (p. 14).

Upon admittance to the psychiatric ward “detainees are generally required to remove their clothes and wear a hospital gown/pyjamas” (CLAS, 2017, p. 14). Throughout their confinement clothing is treated “not as a right, but as a privilege, and [detaining facilities] will often use access to clothing as a behavior modification method” (p. 14). There are no regulations in the *Mental Health Act* protecting an individual’s right to same sex clothing removal (p. 15). Thus, “the consequences to patients hospitalized in such an environment - the powerlessness, depersonalization, segregation, mortification, and self-labeling - seem undoubtedly counter therapeutic” (Rosenhan, 1973, p. 398). How can one reasonably expect a person to heal in an environment where despite the fact that no laws were broken, they are treated like a criminal? Separated, isolated and segregated from the rest of society? From family members, friends, loved ones and community at a time when natural systems of support are arguably most needed?

Depersonalization and Powerlessness

The power imbalance present in biomedical understandings and treatment of mental health concerns is perhaps most evident and even further accentuated in psychiatric institutions. A noteworthy experiment published in the Santa Clara Law Review in 1973 describes the experiences of 8 sane people who gained secret admission to psychiatric hospitals (Rosenhan, 1973). The study entitled *On Being Sane in Insane Places* questions the legitimacy of prevailing beliefs that presenting symptoms can be categorized and that “the sane are distinguishable from the insane” (p. 380). 8 pseudo-patients initially described vague symptoms of hearing unclear voices to admission staff at each hospital. Upon entry the pseudo-patients ceased any symptoms of abnormality. Disturbingly, there was a failure by professionals in detecting sanity in any of the cases and each pseudo-patient was eventually discharged with the chronic diagnosis of “schizophrenia in-remission” (p. 384). Central themes discussed in the pseudo-patient’s subjective experiences of time within psychiatric hospitals included depersonalization and powerlessness.

The origins of depersonalization are contributed to by “the hierarchical structure of the psychiatric hospital” (Rosenhan, 1973, p. 396). The professionals who are at the top of the hierarchy spend the least amount of time with patients. “Average daily contact with psychiatrists, psychologists, residents, and physicians combined ranged from 3.9 to 25.1 minutes, with an overall mean of 6.8” (p. 396). Psychiatric ward attendants opt to spend the majority of their time in the ‘cage,’ the glassed quarters that contain professional staff. “The average amount of time [daily] spent by attendants outside of the cage was 11.3%” (391). If patients are not spending time on the ward interacting with mental health professionals, this begs the question what comprises their daily life?

In a more recent study Radcliffe and Smith (2007) observed levels of social interaction and activity among in-patients on 16 acute psychiatric wards in 6 hospitals in a large mental health trust. In terms of daily life during detainment in psychiatric hospitals the study revealed that “despite the intense enclosed nature of the ward, 84% of time was spent interacting with no one at all.” Just a meagre “6% of the patients’ time was spent on what might loosely be termed therapeutic interactions” (p. 285). Results from the study clearly demonstrate how “the aims of improving acute care need to extend beyond looking after patients, keeping them safe and giving them medication, to what they actually do when they are in hospital to aid recovery and promote their mental health” (p. 169).

These facts highlight the harsh and tragic reality that exists within our current mental health systems, globally and locally. A person who seeks support for life struggles takes a risk that may result in demoralization, stigmatization and potentially the loss of the right to make any decisions regarding their treatment and care within the mental health system. Once detained, prisoners of the *Mental Health Act* detention system are subject to practices of coercion; violations that may further traumatize rather than heal initial presenting concerns. Once released, there is no way to overcome or detach from designated psychiatric label(s) and the associated personal, legal and social stigmas (Rosenhan, 1973). An alternative to dominant models of adversarial and hierarchical approaches to mental health care is collaborative practice, the second core principle of CEACRM.

Collaborative Practice

Collaborative therapy was initially developed by Harlene Anderson, Harold Goolishian and their colleagues at the University of Texas Medical Branch in the United States, later leading to the establishment of the Houston Galveston Institute in 1978 (Gehart, 2018; Houston

Galveston Institute, 2019). There are a number of philosophical assumptions that form a foundation for conceptualizing the purpose of and ethics for working collaboratively with people in therapy (Anderson, 2012). Included within these assumptions is an acknowledgement of the systemic and contextual circumstances in which we as human beings live:

> We live and practice surrounded by fast-changing global and local landscapes that reflect social, cultural, political, and economic transformations. Concomitantly, we witness a forceful swelling plea from all corners of the world for democracy, social justice, and human rights. People want to participate, contribute, and share ownership. They demand respectful listening, responsiveness to their expressed needs, and to make the decisions regarding their lives (Anderson, 2012, p. 9).

Practicing from a collaborative framework involves honoring the client's position as expert in his or her own life experiences. In contrast to traditional approaches where questions and interactions between client and therapist are predominantly influenced by the therapist's expertise of a "theoretical understanding and knowledge of psychological phenomenon and human behavior," in collaborative therapy the therapist is in a position of humility and flexibility, "always in the process of understanding, always on the way to understanding [the client] and always changing" (Anderson & Goolishian, 1992, p. 32).

> The therapist does not dominate the client with expert psychological knowledge so much as he or she is led by, and learns from the expertise of the client. The therapist's task, therefore, is not to analyze but to attempt to understand, to understand from the changing perspective of the client's life experience (Anderson & Goolishian, 1992, p. 32)

Collaborative Participation

Collaborative practice within the CEACRM model is viewed as a “reflective venue” inviting participation from the entire client system (Swim et al., 2018). At NISAPI the intention of therapists is to invite all that participate in the challenge at hand into the conversation. The team never offers who should come instead they “ask as a host would when inviting beloved guests” (p. 4). This practice in in alignment with influences from the pioneering work of Tom Andersen surrounding reflecting teams (Andersen, 1991). Reflective processes where more than two people are present offer unique opportunities for a variety of voices to be shared and considered. Tom Andersen “describes people experiencing problems as wanting an alternative understanding of self, which he believes is best promoted by allowing for as many perspectives as possible in the conversation” (Gehart, 2018, p. 390). Therefore opportunities to hear, reflect and consider a variety of perspectives can be conducive for healing.

Within the reflective space each person present will listen through their own filters based on their personal identity. Personal identities are complex and are composed of a multitude of selves—of historical events and experiences, of diverse connections and relations, of hopes for the future, and of failures and pain from the past. Thus when listening each person will be impacted in unique ways. For example, there will be a distinction in attentiveness to specific words and phrases, to what strikes or resonates for each person as they hear another speak. This diversity in listening translates to unique perspectives, reflections and the co-generation of new meanings, possible solutions, and generation of hope for the future.

Within CEACRM “the therapist’s position is to reflect clients’ dialogue back to them in a different enough manner that new possibilities arise” (Swim et al., 2018, p. 3). It is important that the evolving dialogue is not too unusual for the clients to hear (Andersen, 1991). “During the reflection the therapist alters the discussion through slight changes, similar to the differences between waves on the sea, and through these slight changes, the clients are able to steer a new course" (Swim et al., 2018, p. 3). An understanding of the complexity of dialogue re-enforces the importance of respecting where each person is at and recognizing that in any conversation there are multiple conversations co-occurring. There is the 'outer dialogue' between group members, and there are also 'inner dialogues' within each person as they speak and listen (Andersen, 1991). "When clients are speaking aloud, they are not only speaking to the listener but also to themselves" (Gehart, 2018, p. 389). Therefore, as therapists it is necessary to allow people to be present and understand that although they may not feel comfortable expressing themselves with outer dialogue they are likely engaging in processing and making sense of their own inner dialogue. Tom Andersen believed in respecting this inner world of clients and allowed the people he supported to "keep their inner dialogs private if they so choose" (p. 390). Thus, collaborative participation will be experienced, processed, and expressed differently for each person.

Reflective collaborative practice offers the opportunity for clients and members within their communities to interact, connect, comfort and potentially come to view one another in a renewed light. I believe that people seeking support from mental health professionals often have experienced a sense of disconnection from others in their life who may not understand their struggle, in part because their behaviors or life experiences fall outside of what is deemed "normal" by society or dominant culture (Glyde, 2014). Participating in a reflective collaborative practice has the potential to give voice back to people who have not felt heard or understood in the past. Within the context of a safe, respectful, reflective venue facilitated by therapists; clients and members of their community are able to listen, to hear each other and to potentially come to see one another through the eyes of the therapists – eyes reflecting strength and hope (Swim et al., 2016).

Connection—Collaboration—Change

Through the processes of connection and collaboration, change occurs. This section outlines the third core principle of CEACRM, connection—collaboration—change. Each component of the principle will be discussed for the purpose of providing a theoretical framework for conceptualizing how change occurs within the model.

Connection

The idea of connection is related to the concept of full presence (Swim et al., 2001) and is in alignment with the theory of process ethics (Swim, 2003). Swim et al. (2001) describe full presence as “a therapist’s position of honoring and valuing the client’s narratives by speaking honestly and caringly, opening the door to developing trust, and by staying humble (not claiming to know what is going on for a client or what may be the best opportunities for change)” (p. 16). Aspects of full presence, specifically the therapist’s position of “not-knowing,” builds on work from Harlene Anderson and Harold Goolishian (1992). From a not-knowing position “the therapist’s actions and attitudes express a need to know more about what has been said, rather than convey preconceived expectations about the client, the problem, or what must be changed” (p. 29). A therapist’s full presence is one of three critical components in process ethics.

Process ethics is a collaborative endeavor and can be conceptualized as “the respectful and meaningful interpersonal space between therapist and client” (Swim et al., 2001, p. 14). Swim et al. (2001) describes the guiding premise within process ethics as “the co-creation of ethics that occur within relational opportunities” (p. 15). Process ethics is differentiated from traditional content ethics or standards of practice published by psychotherapeutic organizations such as the Canadian Counselling and Psychotherapy Association, British Columbia Association of Clinical Counsellors or American Psychology Association. The intention behind process ethics is to both honor and also supplement standardized codes of ethics.

> Process ethics in large measure supports and reinforces the principles outlined in official [ethical] codes, but goes the next step to include the specific ways that such principles will be enacted in any given therapeutic relationship. The participants (client and therapist) define ethical partnership together and orchestrate therapeutic actions (Swim et al., 2001 p. 16; Swim, 2003).

Deliberately attending to the process ethics present within every relationship is a key foundational element for connection. Within this philosophical stance the client's view of the nature of the problem is privileged "while simultaneously valuing the therapist's experience as a practiced facilitator of therapeutic discourse" (Swim et al., 2001, p. 16). The focus during interactions "is on personal identity and not the diagnostic labels people have often been assigned" (Swim et al., 2016, p. 1). Therapists embrace the assumption that "each person has inherent strengths and self-agency to transcend diagnosis, symptoms, and trauma" (p. 1). Thus, clients are valued, honored, and respected. They are viewed as people who have the resources, the strength, the inner resiliency and the capacity to make the changes that are needed to lead a meaningful and fulfilling life.

Collaboration

Collaboration within CEACRM is envisioned as a relational process. As previously mentioned, relational collaboration is described as a "completely shared and egalitarian experience of defining the focus and direction of therapy and community services" (Swim et al., 2016, p. 4). The intention in working collaboratively is to honor clients' wishes and needs "to be in charge of their treatment and their lives." The focus is on creating a safe and respectful environment "where no one feels judged but, rather, is allowed a conversational space where the client leads 'the team' to what is important to talk about" (Myers et al., 2008, p. 2). Conversations are not centered around diagnostic discourse, rather the client decides what and how much they want to share within a space free from prejudice, psychological jargon and theoretical preconceived expectations.

Relational connectedness, a pivotal component of CEACRM, is ensured by offering both individual and relational sessions. "To establish a therapeutic relationship with the clients and their family members, all are assigned individual and family therapists" (Swim et al., 2016, p. 1). Therapists are generous with their time, allowing the space for relationships to develop naturally and in a meaningful way. "Sessions may last two to three hours and several times a week until the initial crisis has been transformed into narratives of hope, strength, and change." There is room for "each person in the client's community of support, to hear their needs as well as the clients, who previously had been defined as a problem" (p. 1).

Decades of empirical research consistently demonstrate that a positive relational alliance is one of the best predictors of outcome in therapy (Duncan et al., 2003; Lambert & Barley, 2001). Further, "client ratings of the alliance are far better predictors of outcome than therapist ratings" (Bachelor & Horvath, 1999, p. 4 as cited in Duncan et al., 2003). Therefore, providing the opportunity for immediate feedback from the client's perspective on the relational bond is an essential component of learning about what is working and identifying what needs to be changed to reach beneficial outcomes. Implementing reliable, clinically feasible instruments such as the Outcome Rating Scale (ORS) and Session Rating Scale (SRS) with the deliberate intention of engaging in collaborative discussions about results is a method whereby clients may experience more of a sense of having their voice heard and dignity respected (Hafkenscheid et al., 2010).

Change

Within CEACRM "each client is viewed as unique and a 'Person' whose challenges occur within individualized and relational contexts" (Myers et al., 2008, p. 4). For change to occur "clients need the freedom to express their thoughts in a manner that respects and hears their ideas for change" (p. 2). The goals for therapy are determined by clients and are "continuously changing and evolving until the challenges deconstruct" (Swim et al., 2016, p. 4). It is through the new meaning created in reflective, collaborative discourse that change is facilitated (p. 4). The effectiveness of CEACRM is evidenced by research that demonstrates meaningful, lasting, and sustainable change for clients and their families (Myers et al., 2008; Swim et al., 2016; Swim et al., 2018; Swim, 2018, 2019a, 2019b).

Conclusion

For sustainable changes to be maintained in a person's life, these changes need to be meaningful, realistic, and person-centered to the extent that they reflect and respect the unique life circumstances, preferences, beliefs, values and relational connections of the person seeking support. Amid a system dominated by the expansion and intensification of diagnostic classifications and psychiatric treatment facilities operating in ways that oppress and violate a person's sense of dignity and fundamental human rights, alternative approaches are desperately needed. Through the compassionate and caring lens of therapists working within the CEACRM framework, clients begin to believe that they do have the capacity to manage their lives. Through the nurturing, caring and hopeful eyes of therapists working from this approach, clients are positioned in a place of competence and proficiency equipped with the confidence needed to move forward within their life. This chapter defined the concept relational collaboration, provided evidence for the need for relationally based, collaborative approaches to treatment and further articulated the third core principle of CEACRM. The focus of chapter 4 will be the presence of nature.

Chapter 4: Presence of Nature

> The clients learn and live words of compassion, honesty, respect, choices, heart, and normalcy. These are words used with horses and in observing horses. Horses give and demand these words. In such, we create a relationship with new language and meaning (Myers et al., 2008, p. 14).

The purpose of this chapter is to further articulate and provide evidence for the third of three aspects of a way of working with, or of being with, human experiences of pain and suffering that I believe to be critically important. The focus of this chapter is on the presence of nature. Alternative settings for the provision of therapeutic services alter the context within which unique dialogues can naturally emerge. “If we alter the context, or way of doing conversation, a door opens for new feelings, thoughts, relationships, and change. This is inevitable. Conversations make us feel and do differently when we are free to speak” (Swim, 2016, p. 38). For clients who have had experiences of being harmed within traditional mental health services there may be a great deal of fear, shame and anger in seeking support from professionals. Natural environments that incorporate outdoor offices and offer opportunities for interaction with animals provide normalcy and create an atmosphere of safety and security where trust can potentially develop.

Immersion into a natural environment facilitates re-connection with nature. Stepping into a peaceful environment removed from the busyness of everyday life can offer an opportunity to engage safely within the present moment, creating distance from the fast-paced pressures and overstimulation of modern society. Nature reminds us as human beings that we are connected in intimate ways to the world around us. Qualitative research is beginning to emerge in the literature providing evidence of effectiveness of therapeutic practices that incorporate the resources of the natural environment for clients experiencing symptoms of anxiety, depression, stress and attention difficulties (Kamitsis & Simmonds, 2017). The connection between getting active outside and improved psychological health is consistently supported by research (Buzzell & Chalquist, 2009). Immersion in nature helps to diminish stress, anxiety, anger and gloom, creating space for the emergence of optimism, self-esteem and vitality (p. 71).

A 2018 article published in *Frontiers in Psychology* reviewed 123 studies examining the role of nature and its ecosystem services in ecotherapy. Evidence demonstrates that human interactions with nature are associated with enhancement of recovery from physical and mental illness, and are important for aspects of healthy development (Summers & Vivian, 2018). The presence of nature has proven positive impacts on general medical recovery, pain reduction, mood and stress, attention deficit attention deficit/hyperactivity disorder, dementia, obesity and general mental health issues. Developmentally, nature influences creativity, cognition, restoration, well-being and life satisfaction. As human beings, we “need interaction with nature and its ecosystems to enhance our cognitive, emotional, spiritual and aesthetic development” (p. 2).

Relational and Ecological Connections

In his 2019 doctoral dissertation *The River Carries that which the Mountains Cannot Hold: A Series of Geophilosophical Experiments with the Fraser River*, Christopher Kinman presents the argument that the ideas and practices informing life, education and work “must emerge from and find ways to return to the specific relational and ecological assemblages that include the land, air and water with which we live” (p. i). His thesis is dedicated to a young man and his mother, Mathew Hanusz and Jennifer Kettenacker. Kinman describes how Mathew’s situation of living with what is considered in psychiatric language, Tourette Syndrome, contributed to an experience of isolation or dislocation “from the lands, places and contexts that most of us take for granted” (p. 1). In their time together, Kinman and Mathew would find comfort walking, talking and watching the flow of the Fraser River.

Kinman often invited Mathew and his mother to workshops he was hosting. It was there that Kinman recognized “what we often think of as mental health or mental illness is undeniably tied to the relational/ecological contexts of the lands, waters and air that we all live and move within” (p. 2). Within a different ecological context, of being embraced within a community exuding attitudes of understanding and acceptance, significant and meaningful change occurred for Mathew. Instead of curse words, Mathew would sometimes blurt out “love you!” Within this renewed ecological context, Mathew “discovered that the situation he was in worked just fine in the context of stand-up comedy” (p. 2). Further, he became “a most lucid poet, having an ability to articulate the connection between our sufferings and the lands we move upon” (p. 2). Perhaps within this unique relational and ecological setting, Mathew experienced a sense of freedom or liberation from dominant individualized conceptualizations of mental health and mental health symptomology, thereby facilitating the emergence of a renewed narrative surrounding personal identity, belonging and connection.

Mathew passed away in the spring of 2017 from fentanyl poisoning. His influence and inspiration continue on, inviting us to turn our “eyes away from the internalized pathologies and remedies of mental health toward the living movements of the lands we jointly reside upon” (p. 2). Kinman writes of his gratitude to both Mathew and his mother for inspiring him and helping him to “see the relations between the movements of the lands and waters and our communal well-being, as well as relations between the land and waters and that which we call mental health” (p. 2). Like Kinman (2019), I wonder as mental health professionals do we need to locate ecological events, defined as events occurring in specific times and contexts, as existing inside an individual body or mind as *mental health concerns*? As separate entities from relational and ecological contexts? How might we ethically connect the concerns being brought forward by clients to broader ecological and relational contexts in respectful, reasonable and realistic ways?

Perhaps one way to facilitate re-connection with ecological relations is through immersion in the natural environment during therapeutic encounters. As mental health professionals, we are in a position of privilege, inviting clients to travel to meet us in our place of work, our own settings of familiarity and comfort created within our homes or located within institutional environments. What if instead the spaces we welcomed clients into were places located amongst peaceful, natural settings? Amid landscapes representing a sanctuary or safe refuge? Places in view of animals in their natural habitats, trees, plants and greenery, rivers, streams or creeks naturally flowing? Settings where we can see the sky, the clouds, the sunshine? Locations where we can hear raindrops falling to the ground or feel the heaviness of precipitation lingering in the air? Where we can view mountain ranges or gaze towards the vastness of the ocean? Where we can breathe in fresh air? Rather than restricting clients within spaces that are potentially experienced as artificial, constraining or oppressive; what if instead we met our clients in the middle, collectively embracing and appreciating aspects of our shared earth?

Ecopsychology

The field of ecopsychology acknowledges that biologically we are connected to a larger ecosystem and appreciates how the needs of the earth and the needs of the human individual are interwoven (Kamitsis & Simmonds, 2017). Theodore Roszak, who is credited with coining the term *ecopsychology* writes that the idea “proceeds from the assumption that at its deepest level the psyche remains sympathetically bonded to the earth that mothered us into existence”

(Roszak, 1995, p. 5 as cited in Kamitsis & Simmonds, 2017, p. 230; Bai, 2015). Inviting curiosity about who a person is, beyond their human relationships, is another opportunity for re-connection with diverse ecological relations. Dialogue can extend to inquiries and exploration of meaningful "bonds with the other-than-human world including a special attachment with an animal in childhood, a particular love of a beautiful place" or memories of comforting landscapes or settings (Buzzel & Chalquist, 2009, p. 37). The remembering and imagining of familiar and meaningful geographical locations can be soothing, potentially facilitating for clients an embodied experience of positive inner feelings of safety, strength, comfort and optimism (Payne et al., 2015).

By acknowledging the presence of nature within our lives, there is potential for an opening-up of "possible worlds in which those who recognize their relations with these geographies can learn to live and take action" (Kinman, 2019, p. i). By establishing or re-establishing connections to settings, landscapes and other sentient beings across time, we encounter, discover and re-discover parts of ourselves; parts of our identity that we may have lost sight of or may not have known existed. In my humble opinion, nature exists as a lifelong potential site of healing, representing ongoing sustenance and crude resiliency. Our shared natural environment is always present, even amid phenomenological human experiences of seemingly desolate and overwhelming aloneness. The enduring presence of nature reminds us of our interconnectedness as human beings with the evolutionary processes of nature and our intimate relationship with the earth. This relationship transcends materialist scientific knowledge and historical documentation, and surpasses verbal articulation.

If our intention within professional practice is to encourage sustainable, meaningful changes that a person can carry with them beyond the therapeutic setting to influence diverse aspects and dimensions of their life, then why not dedicate time to facilitating re-connection with a resource that is both cost-efficient and readily available? I invite you to consider what might emerge from gently inquiring about a person's relational connection with the natural environment? Perhaps inquiry opens up dialogue that incorporates values, passions and ideas related to spirituality.

Sacred Ideas

In terms of facilitating a context of safety and security within the therapeutic relationship for the exploration of spirituality, mental health professionals can be present in a way that invites sacred ideas into the room (Swim et al., n.d.). Swim et al. (n.d.) write about a "spirituality of welcoming" whereby "the faith, the beliefs, the theologies, the spiritualities, the theisms, or even the atheisms are able to find a warm and useful welcoming into the world of therapy" (p. 2). By remaining non-judgmental, open-minded and genuine, mental health professionals can embrace opportunities as they arise for engagement in collaborative discourse surrounding themes of sacred ideas. In my opinion the practice of a spirituality of welcoming is more complex than it may sound academically. The discussion of sacred ideas involves the use of careful, well-timed and skillfully chosen questions, offered within the context of a safe, trusting and genuine relationship.

In the interest of illustrating an example of sacred ideas related to nature being woven into therapeutic practice, I will describe an experience I had. I participated in a family therapy session with a young man in his teens and his primary caretaker, his grandmother. The conversation in the room during the session naturally began to shift towards the young man sharing how he missed his father who had passed away. When the topic of his deceased father arose, there was a moment of silence in the room. I remember feeling a sense of heaviness, a sadness and an unease. I was concerned that the mention of his father's death would be left hanging and that this young man would be abandoned in his pain. I recognize now that those fears come from my own history of interactions with mental health professionals in the past. After a pause one of the therapists gently, yet directly asked the young man "where do you believe your father is now?"

What I experienced in the room is difficult to articulate in words. From my perspective, that particular moment in time felt like a moment of healing. A bridge was created welcoming us all into sacred conversation. The young man's grandmother shared that she believed in heaven. The young man was quiet; after a few moments he was invited to share his voice. He shared that he believed in reincarnation. From there, he began to tell a story where he and his grandmother had recently noticed a beautiful bird outside. For this young man, during that moment of observation he had thought about his father as this bird. The idea of re-envisioning death, as the ending of one life and the beginning of another, was comforting for this young man. Because of the therapist's question and the safety this young man felt within the relationship, the narrative surrounding his father's death shifted. Rather than being 'lost forever,' dialogue shifted towards noticing how his father still existed as a presence on earth, albeit in a different life form.

Thus, in my opinion sacred ideas and the potential connection with our natural environment are another possible pathway for facilitating dialogue surrounding themes such as grief and loss and may provide comfort for some clients. Ethically it is essential that as mental health professionals we acknowledge and pay attention to our own spiritual identities and ensure that we are not pressing our own implicit or explicit beliefs upon others. An openness, a curiosity, a respect and appreciation for the diverse ways of conceptualizing existential questions and beliefs can be beneficial. While language gives us the words to be able to construct our experiences and to give meaning to our lives within relationships, exposure to different ideas and conceptualizations of our fundamental biological relationship with the earth may open up new worlds for clients. Perhaps novel therapeutic conversations will spark an awakened awareness of new ways of being in relationship with nature, of moving through and noticing the natural environment during activities of daily living. An integration of aspects of different belief systems within conversation may contribute to a recognition and acknowledgement of new possibilities for engagement with our shared earth.

Ecotherapy

Ecotherapy is defined as “a form of applied ecopsychology, with the process of forming a relationship with nature having two aspects: (i) a passive connecting with the aesthetic beauty of natural environments that in themselves become places of healing, and (ii) a more active engagement in which therapy is conducted using the resources of the natural environment” (Kamatsis & Simmonds, 2017, p. 230; Buzzell & Chalquist, 2009).

Healing with Horses

There are a number of organizations offering certifications, frameworks, and ethical guidelines for professional standards within the innovative and emerging field of equine-assisted psychotherapy (EAP) or equine-facilitated counselling (EFC). The American Hippotherapy Association (AHA), the Professional Association of Therapeutic Horsemanship International (PATH Intl.) and the Equine Assisted Growth and Learning Association (EAGALA) all originated in the USA where the field developed (Notgrass & Pettinelli, 2015; Lee et al., 2016). Although current research in the field has been criticized for lacking a common language (Notgrass & Pettinelli, 2015), peer-reviewed studies are continuing to emerge within the literature outlining the benefits of incorporating horses into therapeutic interactions (Burgon, 2011), documenting theoretical foundations for equine assisted interventions (Burgon et al., 2018) and applying novel methodologies to improve standardized protocols for animal assisted interventions (Scopa et al., 2019).

Clinical applications for equine-assisted therapy (EAP) are wide-reaching and evidence exists supporting effectiveness for a broad range of populations. Lee et al. (2016) conducted a narrative synthesis exploring the current state of knowledge and areas for future research in EAP. Included in the synthesis were 24 studies, four from peer-reviewed journals and 20 from master's thesis or doctoral dissertations during the time period of 1999 (when EAGALA was founded) and 2014 (when the search was conducted). The current knowledge base in EAP is heavily dependent on research presented in unpublished theses and dissertations which necessitates an acknowledgement of certain limitations including smaller sample sizes, less rigorous designs and absence of engagement within a double-blind, peer review process. The authors of the synthesis anticipate "that as EAP research develops, future literature reviews will focus more heavily on published research" (p. 228).

At Now I See A Person Institute (NISAPI) horses are therapeutic partners providing opportunities for clients to engage in relational connections that are relaxed and intimate. "Horses aid in helping one to understand and grasp such tenets as loyalty, love, nurturance and respect for others" (Myers et al., 2008, p. 13). In interactions with horses "an environment of healthy trust and attachment occurs without complex human requirements of judgments, expectations or prejudice" (p. 13). Horses naturally experience you as you are within the present moment through a lens of simple and genuine unconditional acceptance. Through the eyes of an animal there is no prejudice, no judgment, no psychological jargon nor psychiatric diagnoses. At NISAPI, clients who have experienced severe trauma report the presence of horses on the ranch as contributing to “a loving and nurturing environment that neutralizes pain and evolves conversations of hope and transformation” (Swim, 2016, p. 38). Susan Swim, executive director and founder of the institute, reports that the presence of horses on the ranch provide “a non-threatening buffer that promotes open dialogue” (p. 39).

Conclusion

In this chapter I further elaborated on ideas, theories, and practices related to the theme of the presence of nature. My intention was to briefly summarize relevant research on the health benefits of human interactions with nature and to add my thoughts to potential ways of expanding therapeutic work beyond individualized pathology to include consideration of relational and ecological connections. I shared an experience of sacred ideas being woven into therapeutic practice, briefly introduced the innovative and emerging field of EAP and ended with descriptions of the integration of horses as therapeutic partners at Now I See A Person Institute. The final chapter of this thesis takes into account political considerations to provide a contextual framework for understanding potential challenges to working in non-traditional ways within the field of mental health, addresses potential implications for professionals, suggests areas for further research and concludes with reflections from the author.

Chapter 5: Political Considerations

I have chosen to begin this chapter with a poem (Bueno de Mesquita, 2019) that poignantly illustrates the harsh reality that currently exists for people trapped within mental health systems that perpetuate practices of stigmatization, marginalization, and oppression.

Crisis by Amanda Bueno de Mesquita (2019)

I work within the crisis team,
Where the clients have no name.
As their label is diagnostic,
Hence their heads are hung in shame.
The workforce taps their notes up,
Feeding diagnostic lies the ink of truth.
And doctors look right through me,
When I ask them for some proof.
I work within the crisis team,
Who visit clients bearing meds.
Who have no homes or loved ones,
But have voices in their heads.
Who usually make such sense to me,
When I stop by just to listen.
And suddenly their saddened eyes,
Look up to me and glisten.
Through the haze of medication,
That Harmeceuticals create.

I pray my interventions,
Are not too little or too late.
As I gently tell those on my watch,
It makes sense to feel such pain.
As life has often been so cruel,
And there is no measure of sane.
I work within the crisis team,
Not to earn my living,
But to question all the methods,
And these stale ways of giving.
To try to make a difference,
In this world that's full of pain.
With meds as understanding.
And where no one seems to gain.

The final chapter of this thesis takes into account political considerations to provide a contextual framework for understanding potential challenges to working in nontraditional ways within the field of mental health, addresses potential implications for professionals, suggests areas for further research and concludes with reflections from the author. Environments like the one described in this poem can be experienced as traumatizing with the effect of haunting both service users and mental health professionals alike. The reality is that even the most well-intentioned person entering the field of mental health service, hoping to make a positive difference, will at some point come face-to-face with predominant models of mental health care based on the foundational assumption that people seeking support are in some way broken, lacking, deficient, or mad.

Non-pathologizing, collaborative approaches such as aspects of the Community Engagement: A Collaborative Recovery Model (CEACRM) described in this thesis face significant challenges in gaining traction, expansion and accessibility within a field dominated by forces of corporatization and medicalization. The field of mental health has increasingly been pushed towards "categorizing and pathologizing people, which is at the service of economic rationalization, whereby efficiency and economics have come to supplant creativity and caring" (Hibel et al., 2017, p. 28). Rather than focusing on providing dignified, client-centered, recovery-oriented support through meaningful relationally-based therapeutic services "those who operate mental health organizations are often far more concentrated on acquiring funding and on issues of liability" (p. 27). Mental health professionals working within current pathology-focused environments are reporting experiences of demoralization, describing practice in these toxic and oppressive environments as conflictual due to the lack of congruence with their personal values, philosophy or training (p. 28).

In her 2010 doctoral dissertation *Doing Justice as a Path to Sustainability in Community Work,* Vikki Reynolds uses the term "spiritual pain" to refer to the state that many mental health professionals experience in their efforts to provide compassionate care for clients entrenched within systems that perpetuate structural oppression, injustice and harm. Reynolds writes "our community and counselling work is often a frontline response to acts of violence, abuses of power and other acts of oppression that clients struggle against; it is part of our collective response to an unjust world" (p. 3). Reynolds believes that recognizing and explicitly naming the underlying social and institutional structures that promote, support or keep problems alive creates room for different meanings to be understood. Like Reynolds, I believe that there are potential ways of working where “together we are in unity with clients and with the broader community” (p. 15). My hope is that through continued interconnection we can continue as a field to move towards social justice.

Expectations of the Mental Health System in British Columbia

The Interior Health Authority, responsible for providing a wide range of health-care programs and services to residents across British Columbia’s Southern Interior region, assembled a document outlining what people can and should expect from the mental health system in BC. The document entitled *Survival Kit: Your Rights as a Person with Mental Illness* includes the following “rights” that are not currently legally guaranteed “but intended to help service providers, patients and family members to achieve the best of our mental health system” (Interior Health Authority, 2020, p. 1).

> The right to have your basic human rights respected.
>
> The right to services that promote mental wellness and recovery and positive attitudes towards mental illness.
>
> The right to have concerns listened to, heard and responded to with procedures that follow respectful process.
>
> The right to privacy.
>
> The right to access timely and relevant treatment and services.
>
> The right and responsibility to be a full partner in one’s care and to participate in the development, implementation and evaluation of one’s plan for recovery/rehabilitation.
>
> The right to the least restrictive environment possible when in an inpatient setting.

> The right to appropriate and comprehensive information, education and training, in plain language, about one’s mental health problems, their treatment and what recovery services and community supports are available to meet one’s needs.
>
> The right of access to a support person of one’s choice, which could include family, advocates or friends, or to exclude individuals whom the person feels would have a negative effect on their treatment/well-being at this time.
>
> The right to be included and involved at all levels of systemic mental health delivery and policy (Interior Health Authority, 2020, p. 1).

Given the power imbalances within the hierarchical system of top-down authoritative knowledge dissemination inherent within the medical model of mental health treatment, along with findings from the recent research project by the Community Legal Aid Society (CLAS) investigating the current state of British Columbia’s mental health detention system described in chapter 2, how are mental health service users being protected? If these basic rights are not a part of law, and if the “*BC Mental Health Act* and the *Mental Health Regulation* are outdated, deeply flawed, and inadequate to fulfill the rights guaranteed by the *Canadian Charter of Rights and Freedoms*” (Johnston, 2017, p. 7) what can we, as professionals and participants co-existing and working within these systems, do?

Upholding of Human Rights

In a 2014 article published in the *Journal of Mental Health Practice,* Ruth Forrest demonstrates that human rights are integral to the principles of recovery in mental health. She argues that professionals working from a recovery-oriented perspective need to first uphold people’s human rights. Her work provides further evidence to support ways of practicing therapy that embrace a non-pathologizing, non-reductionistic perspective. Forrest (2014) ties together articles 9 and 10 of the *European Convention of Human Rights* (ECHR, 2010) with examples of principles of recovery-oriented support relevant in the mental health system (p. 32).

> *Article 9: Freedom of thought, conscience and religion* By classifying a person's thoughts and belief systems as 'delusional' or 'paranoid', or even by reducing their experiences to 'symptoms' such as 'anxious' or 'depressed', mental health professionals can undermine a person's freedom of thought. This is not to say that we ought to 'collude' with every individual's belief system, but that we need to respect people's beliefs and work within their framework of understanding, rather than imposing our views or the views of our profession on them.
>
> *Article 10: Freedom of expression* Similarly, when professionals document a person's experiences using jargon, we also risk denying them freedom of expression. By translating a person's expression of their experiences into the language of diagnosis or symptoms we are changing their story. This is not to say that professionals should avoid contributing to a person's understanding of their experiences by working with them and making suggestions, but that psychological formulations should be written collaboratively and the professional should use the person's own language when documenting what they express (Forrest, 2014, p. 32).

Potential Implications for Professionals

At a bare minimum, my hope is to raise the consciousness of mental health professionals about the impacts that decisions, including the use of deficiency language and diagnostic labels, have on the long-term future of a person's life. In my opinion, there is a dire need within the field for further research that incorporates the voices of mental health service users, advocacy and legal representation to ensure that laws about fundamental human rights are upheld and a closer examination of the context in which mental health services are being provided. Opportunity exists for changes and improvements to be made in many areas, including within educational settings and professional regulating bodies. Pedagogical approaches to graduate student education and supervision of beginning therapists entering the field are essential and serve as important foundational bases for ethical practice.

How we treat people, the words that we use, the labels that we ascribe, all impact a person's sense of self. "Knowledge of the descriptions associated with a psychiatric disorder has an effect on those who are diagnosed with them" (Superior Health Council, 2019, p. 9). Harold Goolishian (2017) wondered whether our languages of description have "over the years, ended up forcing socially constructed self-narratives on our clients of uselessness and filth" resulting in the possibility of people selecting the option to 'go mad' (p. 111). Rather than further contributing to narratives of deficit, incompetence, inadequacy, and chronic pathology, as mental health professionals we are in a unique position with the privilege to make intentional decisions about how we engage with clients. A person who comes to a naturalistic horse ranch, surrounded by nature and normalcy; embraced within a caring, authentic relationship has a fighting chance for the development of a different kind of socially constructed narrative.

Reflections from the Author

This thesis is an invitation to professionals within the field of mental health to consider ways to transcend psychiatric labels and psychological terminology to endeavor to truly understand a person and their life experiences. It is important to recognize that the person in front of you is influenced by their family of origin, society, culture, historical events, relationships with others, thoughts, feelings, emotions, and sensations. In my opinion we must as human beings humbly embrace the reality that we don't hold all of the answers; that there isn’t one perfect one-size-fits-all framework, intervention or manualized strategy that will effectively and efficiently reduce, treat or ‘cure’ experiences of suffering. Rather, each relational interaction that we engage in is an opportunity to take the time to ask ourselves “what does this valued, treasured, and sacred human being need and want?” Embodying this stance requires full presence (Swim et al., 2001), empathic listening, checking for understanding, attentiveness, authenticity, humility, and care. I believe that we need more professionals willing and able to engage in normalizing rather than stigmatizing discourse; to provide compassionate, nurturing and ethical care, rather than defaulting to labelling clients with totalizing descriptions, dictating treatment and forcing hospitalization and medicalization.

My hope is that my writing will stimulate generative thought, reflection, discussion, and dialogue surrounding the fundamental purposes of human service provision and issues regarding the upholding of human rights and movement towards social justice. How can we ensure that at a bare minimum, the people seeking support from mental health professionals leave feeling heard, seen, and understood? That after sharing vulnerable, tender, and private parts of their existence they are able to carry on within their lives with a sense of hope and the knowledge that another human being in this world truly cares? Collectively, let’s progress in ways that recognize and respect the complexity of human life experiences, work together to proactively prevent the accumulation of trauma and painful experiences of overwhelming emotion in isolation, and facilitate re-connection with relational and ecological contexts.

(*Kadler, 2019*)

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