

ENVISIONING CHANGE  
PRINCE GEORGE WOMEN'S EXPERIENCES OF SUBSTANCE USE AND  
MENTAL HEALTH THROUGH PHOTOGRAPHY

by

Hilary McGregor

B.A., McGill University, 2004

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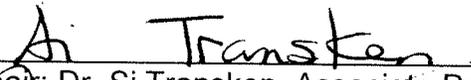
**APPROVAL**

Name: Hilary McGregor

Degree: Master of Science in Community Health Sciences

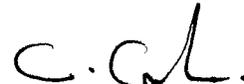
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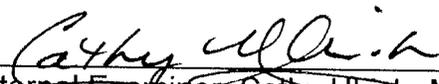
Examining  
Committee:

  
Chair: Dr. Si Transken, Associate Professor  
School of Social Work  
University of Northern British Columbia

  
Supervisor: Dr. Sarah de Leeuw, Associate Professor  
School of Health Sciences  
University of Northern British Columbia

  
Committee Member: Dr. Margot Parkes, Associate Professor  
School of Health Sciences  
University of Northern British Columbia

  
Committee Member: Dr. Candida Graham, Academic Physician –  
Psychiatry  
Northern Medical Program  
University of Northern British Columbia

  
External Examiner: Cathy Ulrich, MSc  
President and Chief Executive Officer  
Northern Health Authority

Date Approved:

August 6, 2013

## **Abstract**

This thesis documents a qualitative, community-based project called *Envisioning Change* that took place in Prince George, British Columbia in 2011-2012. The project engaged five women in the creative process of photography to explore their experiences of substance use and mental health. Based on the innovative method of Photovoice, women took photographs representing their experiences. Their photographs were subsequently used to guide in-depth interviews. Interviews were analyzed revealing five themes that highlight the importance of addressing women holistically within their particular contexts. One of the primary findings was of women's strength and resilience in coping with and recovering from mental health and substance use issues. The photographs were exhibited in Prince George and the project was presented at multiple conferences. Photographs are a unique and impactful approach for sharing research results to local, national, and international audiences. Feedback from participants indicated that the project was an empowering and transformative experience.

## Table of Contents

<b>Abstract.....</b>	<b>ii</b>
<b>Table of Contents .....</b>	<b>iii</b>
<b>List of Tables .....</b>	<b>v</b>
<b>List of Figures.....</b>	<b>vi</b>
<b>Acknowledgements .....</b>	<b>viii</b>
<b>Dedication .....</b>	<b>ix</b>
<b>CHAPTER 1 Introduction.....</b>	<b>1</b>
<b>1.1 Positionality .....</b>	<b>3</b>
<b>1.2 Thesis organization .....</b>	<b>6</b>
<b>CHAPTER 2 Project background .....</b>	<b>8</b>
<b>2.1 Mental health and substance use.....</b>	<b>8</b>
2.1.1 Definitions and language.....	9
2.1.2 Mental health and substance use in Canada .....	12
2.1.3 History of mental disorders and addiction treatment .....	14
<b>2.2 Prince George, BC: Location and demographics .....</b>	<b>16</b>
<b>2.3 Social and geographic determinants of mental health and substance use.....</b>	<b>20</b>
2.3.1 Sexism and gender discrimination .....	24
2.3.2 Colonialism and racism .....	29
2.3.3 Stigma and discrimination.....	38
2.3.4 Northern geographies .....	41
<b>2.4 Why this project?.....</b>	<b>43</b>
<b>CHAPTER 3 Methodologies.....</b>	<b>44</b>
<b>3.2 Research approach .....</b>	<b>45</b>
<b>3.3 Feminist methodologies and intersectionality .....</b>	<b>47</b>
<b>3.4 Review of additional informative methodologies.....</b>	<b>53</b>
3.4.1 Interpretive and critical phenomenology.....	53
3.4.2 Decolonizing and critical Indigenous methodologies .....	54
3.4.3 Community-based participatory research.....	55
<b>3.5 Photovoice: The theory behind the practice.....</b>	<b>57</b>
<b>CHAPTER 4 Methods.....</b>	<b>60</b>
<b>4.1 The project .....</b>	<b>60</b>
<b>4.2 Data collection .....</b>	<b>66</b>
<b>4.3 Data analysis.....</b>	<b>67</b>
<b>4.4 Knowledge for action.....</b>	<b>69</b>
4.4.1 Photography exhibitions and presentations .....	70

4.4.2	Project website .....	78
4.4.3	Summary report.....	78
<b>4.5</b>	<b>Research quality.....</b>	<b>79</b>
<b>4.6</b>	<b>Ethical considerations .....</b>	<b>83</b>
<b>CHAPTER 5</b>	<b>Results and discussion .....</b>	<b>94</b>
<b>5.1</b>	<b>Summary of participants .....</b>	<b>94</b>
<b>5.2</b>	<b>Interviews and participant photographs .....</b>	<b>95</b>
5.2.1	Place and space.....	97
5.2.2	Embodied realities.....	107
5.2.3	Power.....	115
5.2.4	Relationships .....	125
5.2.5	Resilience .....	143
<b>5.3</b>	<b>Exhibition questionnaires .....</b>	<b>157</b>
<b>5.4</b>	<b>Participant experience of the project.....</b>	<b>164</b>
<b>CHAPTER 6</b>	<b>Conclusions and reflections.....</b>	<b>169</b>
<b>6.1</b>	<b>Insights for individuals in policy and practice .....</b>	<b>176</b>
<b>6.2</b>	<b>Reflections .....</b>	<b>177</b>
<b>6.3</b>	<b>Limitations.....</b>	<b>179</b>
<b>6.4</b>	<b>Final word.....</b>	<b>180</b>
	<b>Bibliography .....</b>	<b>182</b>
	<b>Appendix I – Project Proposal Brief.....</b>	<b>194</b>
	<b>Appendix II – Recruitment Poster .....</b>	<b>196</b>
	<b>Appendix III – Informed Consent Form .....</b>	<b>197</b>
	<b>Appendix IV – Informed Consent Form Addendum .....</b>	<b>200</b>
	<b>Appendix V – Acknowledgement and Release Form.....</b>	<b>201</b>
	<b>Appendix VI – Confidentiality Agreement for Presenter .....</b>	<b>203</b>
	<b>Appendix VII – Project Experience Questionnaire .....</b>	<b>204</b>
	<b>Appendix VIII – ArtSpace Exhibition Media Coverage .....</b>	<b>205</b>
	<b>Appendix IX – Exhibition Questionnaire .....</b>	<b>206</b>
	<b>Appendix X – Community response: “What is mental health to you?” .....</b>	<b>207</b>
	<b>Appendix XI – Community response 2: “What is mental health to you?” .....</b>	<b>209</b>
	<b>Appendix XII – Community response: “What substances did/do you use. Why?” .....</b>	<b>210</b>
	<b>Appendix XIII – Project Presentations.....</b>	<b>212</b>
	<b>Appendix XIV – Ethics Approval Certificate .....</b>	<b>213</b>
	<b>Appendix XV - Informed Consent for Use of Photographs .....</b>	<b>214</b>
	<b>Appendix XVI - Acknowledgement and Release for Use of Photographs.....</b>	<b>217</b>

### **List of Tables**

Table 1	Research goals and corresponding data collected.....	3
Table 2	Selected population demographics compared regionally, provincially, and nationally.....	19
Table 3	Summary of SDOH statistics for Indigenous women and girls in Canada compared to their non-Indigenous counterparts .....	34
Table 4	Research framework .....	44
Table 5	Project Timeline.....	61
Table 6	Data sources .....	67

## List of Figures

Figure 1	Mental health continuum.....	10
Figure 2	Continuum of substance use.....	11
Figure 3	British Columbia Health Authorities.....	19
Figure 4	Cycle of Trauma and Addictions.....	28
Figure 5	Participant notebook with guiding questions and crisis resources.....	65
Figure 6	Project information at ArtSpace Photography Exhibition March 2012.....	72
Figure 7	Community response to “What is mental health to you?”.....	72
Figure 8	ArtSpace exhibition.....	72
Figure 9	ArtSpace exhibition.....	72
Figure 10	ArtSpace exhibition.....	73
Figure 11	ArtSpace exhibition.....	73
Figure 12	ArtSpace exhibition.....	73
Figure 13	Rotunda exhibition.....	75
Figure 14	Rotunda exhibition.....	75
Figure 15	Rotunda exhibition.....	76
Figure 16	Rotunda exhibition.....	76
Figure 17	Rotunda exhibition.....	77
Figure 18	Rotunda exhibition.....	77
Figure 19	Photograph of Joy (Rachel).....	99
Figure 20	Photograph “Bridge was suicide to me” (Lissie).....	102
Figure 21	Photograph “OCD has to be a certain way” (Lissie).....	102
Figure 22	Photograph “Jar of anxieties” (Lissie).....	109
Figure 23	Photograph “Child-like emotions sometimes” (Lissie).....	110
Figure 24	Photograph of eye (Jane).....	112
Figure 25	Photograph “My opinion didn’t matter” (Lissie).....	117
Figure 26	Photograph of moon and clouds (Roxy).....	120
Figure 27	Photograph of barriers (Roxy).....	121
Figure 28	Photograph of crows (Jane).....	122
Figure 29	Photograph of back of daisy (Ooleesia).....	123
Figure 30	Photograph of bug in daisy (Ooleesia).....	126
Figure 31	Photograph of “listen” (Ooleesia).....	127
Figure 32	Photograph of doorway (Ooleesia).....	127
Figure 33	Photograph of footprints (Ooleesia).....	128
Figure 34	Photograph of shadows (Ooleesia).....	130
Figure 35	Photograph of Mother (Rachel).....	130
Figure 36	Photograph of Grandfolks (Rachel).....	131
Figure 37	Photograph of Linda (Rachel).....	132
Figure 38	Photograph of Jean (Rachel).....	132
Figure 39	Photograph of Penny (Rachel).....	133
Figure 40	Photograph of Yvette (Rachel).....	134
Figure 41	Photograph of Susan (Rachel).....	134
Figure 42	Photograph of crows - 2 (Jane).....	135
Figure 43	Photograph of fence (Jane).....	136

Figure 44	Photograph of lake reflection (Jane).....	137
Figure 45	Photograph red berry (Jane) .....	138
Figure 46	Photograph self-portrait (Rachel).....	140
Figure 47	Photograph of pills (Jane).....	141
Figure 48	Photograph “Facing a bigger world” (Lissie).....	144
Figure 49	Photograph “Trapped behind bars” (Lissie).....	144
Figure 50	Photograph of feet (Roxy).....	145
Figure 51	Photograph of compost (Jane).....	145
Figure 52	Photograph of plant in concrete (Ooleesia).....	146
Figure 53	Photograph of footsteps (Jane).....	147
Figure 54	Photographs of dandelions (Jane).....	148
Figure 55	Photographs of damage (Ooleesia).....	149
Figure 56	Photographs of bridge (Ooleesia).....	150
Figure 57	Photograph of cross (Roxy).....	151
Figure 58	Photograph of little girl (Roxy).....	152
Figure 59	Photograph of sunset (Jane).....	153
Figure 60	Photograph of red sky (Roxy).....	154
Figure 61	Photograph “Rocks are hardship, hands are worth it” (Lissie).....	154
Figure 62	Photograph “Crow trapped in branches” (Lissie).....	155
Figure 63	Exhibition Questionnaire: 1) How did you hear about this exhibition?.....	158
Figure 64	Exhibition Questionnaire: 2) I am (please check all that apply).....	159
Figure 65	Exhibition Questionnaire: 3) Rate your understanding of women and substance use/mental health issues <i>before</i> attending the exhibition?.....	159
Figure 66	Exhibition Questionnaire: 4) Did the exhibition <i>change</i> your understanding and/or assumptions about women who live with substance use and mental health issues?.....	160
Figure 67	Wordle of exhibition questionnaire comments.....	163

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## **Dedication**

I dedicate this thesis to Jane, Lissie, Ooleesia, Rachel and Roxy – and to all of us who have experienced some aspect of mental health and substance use struggles.

## CHAPTER 1 Introduction

*“There can be no health without mental health.”*  
(Mental Health Commission of Canada, 2012, p.8)

This thesis documents a community-based project called *Envisioning Change*. The project engaged women in the creative process of photography to explore, conceptualize, visualize, and describe their lived experiences<sup>1</sup> with substance use<sup>2</sup> and mental health,<sup>3</sup> issues that frequently co-occur for people in complex and reinforcing ways. The purpose of this project was to investigate multiple interrelated factors<sup>4</sup> that contribute to northern<sup>5</sup> women’s experiences of substance use and mental health, including their successes and challenges accessing supportive services in Prince George, British Columbia (BC). New knowledge produced through this project was shared with people in the community and beyond to

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<sup>1</sup> Lived experience refers to embodied or subjective knowledge. Narratives of lived experience provide knowledge about the social location embodied by an individual or group (Dhamoon & Hankivsky, 2011). In exploring lived experiences, participants are considered experts and offer researchers an understanding of their thoughts, commitments and feelings through telling their own stories, in their own words, and in as much detail as possible (Reid, Flowers & Larkin, 2005). This “emphasizes and celebrates the voices, experiences, perspectives, and agency” of groups that are typically marginalized or excluded from academic literature and public policy (Dhamoon & Hankivsky, 2011, p. 21).

<sup>2</sup> For the purposes of this thesis, the phrase *substance use* was selected in order to be inclusive of the wide range of substances (commonly used, prescription, illicit) and experiences (use, abuse, misuse, reliance, addiction, etc) that people have with them, and also to avoid stigmatizing terminology and labels as much as possible (see Chapter 2).

<sup>3</sup> For the purposes of this thesis, the phrase *mental health* is used to encompass a wide range of experiences on a continuum, including: positive experiences of mental wellness on one end; commonly experienced issues such as mild anxiety and mild depression along the middle; and more severely disruptive mental illnesses or disorders on the other end. The phrase *mental health issue* is used in this thesis to encompass the portions of the mental health continuum that cause distress to the individual but may or may not include a diagnosed illness. I chose this terminology to be inclusive and allow women to self-identify with the project topic (see Chapter 2).

<sup>4</sup> The main interrelated factors discussed in this thesis are geographic and social determinants of health including: sexism and gender discrimination; racism and colonialism; stigma and discrimination; and northern geographies (see Chapter 2). I discuss and apply *intersectionality* as an analytical approach in this project (see Chapter 3).

<sup>5</sup> *Northern* refers to being of *the north*, a region identified by Thien & Hanlon (2009) as the remote, thinly populated and resource-dependent regions characterizing much of Canada beyond the more heavily populated strip bordering the United States (see section 2.3.4 for further discussion of northern geographies and their impact on health, specifically mental health).

promote awareness about mental health and substance use. Sharing the project in a variety of formats was intended to promote dialogue and understanding and contribute to reducing stigma. The project was meant to inform individuals in policy and practice towards improving services in northern BC. In addition, I wanted to learn about photography as a method for engaging people in research and for sharing results with diverse audiences. The outcomes of this project suggest that taking photographs, within this project context, was a powerful experience for some participants. In addition, viewing women's photographs combined with their narrative had an impact on the audience.

This project was grounded in feminist methodologies and intersectionality, a theoretical lens that endeavours to understand multiple and intersecting systems of oppression and privilege in order to better address health inequities (Hankivsky & Christoffersen, 2008). Based on the innovative method of Photovoice, women took photographs to represent aspects of their experiences living with mental health and substance use realities. Their photographs then provided the framework for individual interviews to explore the meaning and symbolism behind their images. The photographs provided a departure point for participants to share additional experiences not represented in the photographs.

The research goals are presented in Table 1 along with the types of data that were collected in the project. The main data source was interview narratives that were thematically analyzed resulting in five major themes. Additional data was collected in two questionnaires to provide feedback on the project. These were completed by attendees at the photography exhibitions, and by participants at the end of the project.

Table 1 Research goals and corresponding data collected

<b>Primary research goal</b>		<b>Data collected</b>
1	To investigate and produce new knowledge of Prince George women’s lived experiences of substance use and mental health.	Interview narratives based on participant photographs; Participant feedback
<b>Secondary research goals</b>		
2	To promote dialogue and understanding of substance use and mental health issues among the community and the public, thereby contributing to reducing stigma and discrimination.	Exhibition questionnaire
3	To learn about photography as a method for sharing research results in a meaningful way.	Exhibition questionnaire
4	To inform individuals in policy and practice for improved services in northern BC.	Exhibition questionnaire
5	To learn about photography as a method for engaging women in research.	Participant questionnaire

Two public exhibitions were installed in Prince George. I presented the project to several local, provincial, national and international conferences, and I built and promoted a project website ([www.envisioningchange.ca](http://www.envisioningchange.ca)). The exhibitions were both a powerful experience for the women and for the audience. This is reflected in the results presented in Chapter 5, and also in the comments that I received personally at the exhibition. The exhibitions, presentations, and the website offer a visual and narrative ‘snapshot’ of the lives and experiences of women struggling with stigmatized realities.

### 1.1 Positionality

Before I further introduce this project and the contents of the following chapters, I will position myself in relation to this research. This act of self-reflexivity, or positionality, is a critical part of quality in qualitative research, and is especially important to feminist researchers. Self-reflexivity offers the reader information about a researcher’s worldview through which a project was conceptualized, conducted, and the data interpreted. Throughout the project, I reflected on ways that my particular histories and worldviews might influence

the research, primarily through discussions with my supervisor and in field notes. Further discussion of reflexivity is provided in Chapter 4 under research quality.

Who I am, my histories, experiences, motivations, and values have contributed to shaping all aspects of this project. I chose this thesis topic for several reasons. First, I am a woman and have a longstanding interest in mental health and substance use issues based on personal experiences and educational background. I have come to realize in recent years that I, and several people close to me, have struggled to live with full emotional and mental wellness. I have also witnessed and experienced substance use in response to emotional distress. As an undergraduate student, I studied psychology at McGill University and became very interested in the multi-disciplinary minor of Social Studies of Medicine. Combining these two program backgrounds, I chose community health as a graduate discipline in part because it incorporates broader conceptualizations of health, such as the social, economic and political factors that contribute to experiences of wellness and un-wellness.

Second, I have roots in Prince George and the north<sup>6</sup> and wanted to build connections here and contribute to the community. Prior to coming to Prince George, my family lived for a year in a First Nations community on the north west coast of British Columbia where I was one of the few white kids on the reserve. At the time of writing this thesis, I am in my mid-thirties and building a life in Prince George. I have long-term connections to this community because my family moved here when I was 12, I attended high school here, and my mother has lived here ever since. All three of my siblings now live here and I have remained connected to Prince George through frequent visits over the years. In 2010 I returned to live,

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<sup>6</sup> For me, feeling connected to the north has to do with feeling comfortable in the landscape and geography of the region, recognizing the architecture of resource-based towns, and being familiar with some of the social issues that accompany them. It means feeling at home in the climate and context of Prince George with knowledge of it as a distinct place, unique in many ways from the urban centers in the south.

work, and study after spending the better part of my adult life in Montréal, Toronto and Ottawa. After so many formative years in large urban centres, and at the same time feeling connected to the smaller city of Prince George and the north, I am aware of the influence of geography on my own life and especially of Prince George as a particular place in comparison to other cities.

Third, I have a strong interest in social justice and a desire to make a positive impact in my community and beyond. I want to engage critically in concepts of structural power that contribute to marginalization<sup>7</sup> and inequities in health. Social justice became important to me in my mid-twenties, in part through many of the social and academic experiences I had at McGill University. These heightened my awareness of the many ways that the normative majority represses and discriminates against behaviours, experiences and/or realities that differ from it (such as sexuality and gender, different health statuses, mental health issues, substance use problems, etc, etc). These personal experiences translated to an awareness of inequities and injustice on a societal level and an interest in making a positive contribution.

Finally, I value creativity and unique approaches that disrupt traditionally white male-dominated institutions such as research. My interest in photography began when I inherited an old Nikon camera in my early 20s. I remember how differently I engaged with my surroundings when I had it with me – the familiar became new again. As a creative art, I appreciate how accessible photography is, both for the one taking photos and for those viewing them. In September 2010 when I began my graduate studies and was

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<sup>7</sup> According to the International Consultative Forum on Education for All (EFA Forum), UNESCO, *Status and Trends*, 2000, marginalization occurs when “people are systematically excluded from meaningful participation in economic, social, political, cultural and other forms of human activity in their communities and thus are denied the opportunity to fulfill [sic] themselves as human beings” (Canadian policy Research Networks, Inc. [CPRN], 2000, p.1).

conceptualizing a thesis project, I heard a CBC Radio show<sup>8</sup> on the power of creativity that provided the inspiration to include photography in my thesis and led me to discover Photovoice. To conclude, who I am, my personal life experiences, my educational background, and the place I have chosen to live, have all coalesced into the formulation of this project.

## **1.2 Thesis organization**

This thesis is organized in six chapters. Chapter 2 follows this introductory chapter and contextualizes the project topic, providing information on mental health and substance use in Canada, current statistics and demographics, and information on the project location of Prince George, BC. Specific social and geographic determinants of health are introduced, laying the groundwork for the discussion presented in Chapter 3 on the methodologies underlying the project.

Several methodologies are presented in Chapter 3 that informed this project. Feminist methodologies and intersectionality are the main foundations of this project. I was also informed by, and include a discussion of, interpretive and critical phenomenology, decolonizing and critical Indigenous methodologies, and community-based participatory research. This chapter also includes a discussion of the philosophical and methodological foundations of Photovoice.

Chapter 4 presents the research methods. These include how data was collected and analyzed, and what activities I undertook to promote positive action and change, such as

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<sup>8</sup> CBC Ideas: *Beauty will save the world* <http://www.cbc.ca/ideas/episodes/2010/06/10/beauty-will-save-the-world/>

photography exhibitions, a project website, and conference presentations. Chapter 4 also includes a discussion of how quality was achieved in the research methods along with some of the ethical considerations of the project.

Chapter 5 presents the results of the main data from the interviews and includes many examples of women's photographs and narratives to support the emergent themes.

Discussion of the results is woven throughout this chapter. Chapter 5 also includes the results of two questionnaires that provide information on the impact of the project for participants and exhibition audiences.

This thesis concludes in Chapter 6 with a summary of the results, implications of the findings, additional reflections on the project, and identification of project limitations.

## CHAPTER 2 Project background

This chapter provides a review of relevant literature to frame the context of this research project. It begins with definitions and discussion of mental health and substance use, followed by an overview of the city and demographics of Prince George, BC where the research took place. This is followed by an introduction to the concepts of social and geographic determinants of health, a framework for understanding the many structural and socially based factors that impact individual, community, and population health including mental health and risks for substance use issues. Within this section, several specific social determinants of health that have particular significance for this project are explored. These include gender-related factors, colonization and racism, and stigma and discrimination. The relationship between geographic location and substance use and mental health issues are also discussed. Throughout, relevant examples and statistics are included to emphasize the importance of specific topics.

### 2.1 Mental health and substance use

*“Mental illness and substance use problems affect people of all ages from all walks of life. They are your family, your friends and your neighbours.”*  
(BC Ministry of Health Services, 2010, p.11)

Mental health problems affect an estimated one in five Canadians in any given year with an economic cost over \$50 billion (Mental Health Commission of Canada [MHCC], 2012). In British Columbia, the provincial government spent over \$1.3 billion in the 2008/09 year on services that directly address mental health and substance use (BC Ministry of Health Services, 2010). This number includes spending by only three of the six main ministries

involved in mental health and substance use<sup>9</sup> and does not include indirect costs related to lost productivity, which is estimated at \$6.6 billion annually for the province of BC (BC Ministry of Health Services, 2010). Mental health and substance use issues have a significant impact on the health care system and economy, not to mention on the mental, social, and financial well being of individuals, families and communities.

### ***2.1.1 Definitions and language***

This project explored women's experiences of *mental health* and *substance use*. It is thus worthwhile to begin with a discussion of what is meant by these two phrases in the context of this research. First, I will differentiate between the concepts of mental health and mental health issues. For the purposes of this thesis, *mental health* is a general term that encompasses a wide range of experiences on a continuum, including: positive experiences of mental wellness on one end; commonly experienced issues such as mild anxiety and mild depression along the middle; and more severe and disruptive mental illnesses or disorders on the other end. This continuum is depicted in Figure 1. On one end is *mental wellness*, which is "a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community" (WHO, 2007, par.1). In contrast, *mental illness* includes the conditions that are described in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR) (American Psychiatric Association [APA], 2000). *Mental health issue* is used in this thesis to encompass the portions of the mental health continuum that

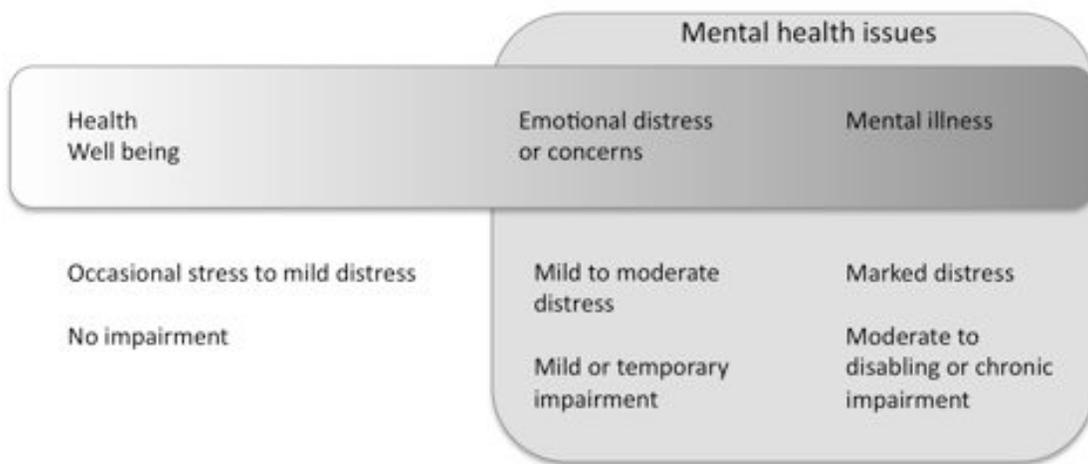
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<sup>9</sup> The six main ministries involved that provided input into this plan and that have specific actions linked to mental health and substance use in BC are the Ministry of Health; Children and Family Development; Healthy Living and Sport (former); Education; Social Development; and Justice. Additional ministries included in mental health and substance use since the development of the plan are the Ministry of Energy and Mines and the Ministry of Aboriginal Relations and Reconciliation (T. Collins, personal communication, March 19, 2013).

cause distress to the individual but may or may not include a diagnosed illness. In other words, mental health issues include “the full range of patterns of behaviour, thinking or emotions that bring some level of distress, suffering or impairment in areas such as school, work, social and family interactions or the ability to live independently” (MHCC, 2012, p.14).

Figure 1 Mental health continuum

(Adapted and reprinted with permission from University of Michigan Human Resources, 2012)



*Substance use* also exists on a continuum, with safe use on one end and problematic use on the other. This continuum is depicted in Figure 2. Substances can range from legally obtainable and commonly used caffeine, tobacco and alcohol, to prescription medication, to illicit substances such as marijuana, psilocybin, cocaine, heroine, crystal methamphetamine and other ‘street drugs.’ The potential of harm from substance use can occur for all of these categories of substances and at many points along the continuum of use; for example health problems, accidents, or physiological dependence (The Standing Senate Committee on Social Affairs, Science and Technology [The Standing Senate Committee], 2006).

Figure 2 Continuum of substance use

(Adapted and reprinted with permission from BC Ministry of Health Services, 2010, p.16)



Many different terms are used to describe substance use in the literature. Some of the terms are: problematic substance use, substance misuse, substance abuse, substance dependence, and drug addiction. Some substances that are commonly ‘abused’ induce physiological addiction characterized by tolerance to the effects of the substance and withdrawal symptoms upon sudden cessation (Sussman & Ames, 2002). In contrast, habituation refers to the psychological reliance on a substance without the physiological aspect (Sussman & Ames, 2002). Some substances, like caffeine and nicotine are physiologically addictive but are not generally considered substances of abuse. Substance misuse is the use of a drug “for a purpose or in a manner in which it was not intended or prescribed” (Sussman & Ames, 2002, par.6). Substance use becomes abuse when negative consequences result, such as social or legal problems (Sussman & Ames, 2002). *Substance-related disorders* are categorized in the DSM-IV-TR as mental health conditions and include a variety of classifications resulting in specific diagnoses (APA, 2000). According to Sussman and Ames (2002), there is no universally accepted definition of addiction. For the purposes of this thesis, the phrase *substance use* was selected to be inclusive of the wide

range of substances (commonly used, prescription, illicit) and experiences (use, abuse, misuse, reliance, addiction, etc) that people have with them. The term was also meant to avoid medicalizing and stigmatizing terminology as much as possible. The word ‘use’ is value-neutral and refers to behaviour, while terms such as abuse, misuse, and addiction imply an evaluation or judgment of that behaviour. As well, the terms addiction, disorder, and dependence indicate conditions identified and treated within the medical system, hence these terms function to medicalize the behaviour of substance use. While I have opted to use the phrase *substance use*, other terms may be included throughout this thesis to maintain consistency with the original source.

It is common for individuals to experience both substance use (problematic and non-problematic) *and* mental health issues. Research indicates that over 50% of people who abuse drugs and almost 40% of those who abuse alcohol also have a mental illness, rates of almost four times and two times respectively than for people without a history of substance use disorder (Skinner, O’Grady, Bartha & Parker, 2004). Approached from the other direction, an estimated 30% of people with a diagnosed mental illness will also experience a substance abuse problem during their lifetime, close to twice the rate of people without a history of mental health disorder (Skinner et al., 2004). There is also a relationship between mental health and use of substances such as nicotine. People with mental illness are almost twice as likely to smoke cigarettes as people without a mental illness (Lasser, Boyd, Woolhandler, Himmelstein & Bor, 2000).

### ***2.1.2 Mental health and substance use in Canada***

Since the beginning of this thesis project in 2010, awareness of mental health in Canada has shifted, partly due to reports released in recent years and the resulting increased

visibility of mental health in the media. Mental health and addiction issues have gained visibility, recognition, and increasing priority in public health and other areas in recent years. This began with the first-ever national Canadian study of mental health, illness and addiction released in 2006 by The Standing Senate Committee on Social Affairs, Science and Technology [The Standing Senate Committee] chaired by The Honourable Michael Kirby. The report *Out of the shadows at last: Transforming mental health, mental illness and addiction services in Canada*, revealed an alarming number of challenges facing Canadians with mental health issues. Along with several findings, the report recommended the creation of a mental health commission that would provide a needed national focus for mental health issues in Canada. Canada has been the only G8 country without a national mental health strategy for some years (Picard, 2011). The Mental Health Commission of Canada (MHCC) was established the following year. In 2009, the MHCC released a document *Toward recovery and wellbeing: A framework for a mental health strategy in Canada* (MHCC, 2009). This was followed by the release of the first-ever mental health strategy for Canada, *Changing directions, changing lives*, in May 2012. With a national spotlight on mental health and increasing dialogue in the media, there is hope for ongoing improvement of services and supports for people struggling with these issues.<sup>10</sup> There is also increased potential for improved societal perceptions and reduced stigma and discrimination of mental health and substance use difficulties.

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<sup>10</sup> The first Standing Senate Committee report in 2006, *Out of the Shadows at Last: Transforming mental health, mental illness, and addiction services in Canada*, included addictions explicitly in its title and content. However, subsequent documents by the Mental Health Commission of Canada have not been able to sustain a focus on substance use and addiction, something that the Mental Health Commission acknowledges in their report *Changing directions, changing lives*.

While these national initiatives are very important and worth celebrating, several reports have criticized the 2006 Standing Senate Committee report for “failing to account for the sex and gender differences linked to mental health” (Stout, 2010; Ad Hoc Working Group, 2006; Salmon, Poole, Morrow, Greaves, Ingram & Pederson, 2006). These challenges point to a need for further research in the area of gender and mental health/substance use. In part, this thesis has taken up the work of gendering mental health and substance use research by focusing on women’s experiences and voices.

### ***2.1.3 History of mental disorders and addiction treatment***

Treatment for mental disorders and addiction evolved separately, resulting in two distinct systems of care and support (The Standing Senate Committee, 2004). Prior to the 1900s, virtually no psychiatric services existed in Canada. People with mental illness were either jailed or cared for by families or religious institutions (The Standing Senate Committee, 2004). An era of institutionalization in Canada from 1900 to 1960 saw the establishment of several large ‘insane asylums’ that primarily utilized crude and ineffective treatments (The Standing Senate Committee, 2004). Due in part to burgeoning human and civil rights movements and the advent of more effective pharmacological treatments, the long process of deinstitutionalization began in the 1960s and continues in the present. Three distinct stages of deinstitutionalization came into being. The movement of people from psychiatric institutions to psychiatric wards of general hospitals took place. This was followed by an expansion of mental health care into communities (The Standing Senate Committee, 2004). Community mental health care focuses on meeting health needs at the

community and primary care level, instead of within institutional facilities.<sup>11</sup> For example, in the Northern Health Authority that serves Prince George, BC and region,<sup>12</sup> the Mental Health and Addictions teams work in partnership with many community services to offer “wrap-around” services that are client focused and provide a continuum of care options (Northern Health, n.d.-a).

Addiction treatment in Canada was virtually non-existent prior to the 1940s. The prevailing societal attitude ‘blamed the victim’ for having a weakness of will or defective personality (The Standing Senate Committee, 2004). Starting in the 1940s and continuing through the mid-1960s, attitudes towards alcoholism began to shift due in part to the development of Alcoholics Anonymous (AA) and to the advancement of a disease model of alcoholism that shifted responsibility away from the individual (The Standing Senate Committee, 2004). During this time, most provincial governments established addiction-related agencies to provide or coordinate services whose mandates expanded from a focus on alcoholism to include other drugs, although illegal drug-use treatment continued to be overshadowed by a legal and punitive approach (The Standing Senate Committee, 2004). In the 1960s and 70s, the proliferation of drug-use was paralleled by an increase of treatment centres and approaches and increased governmental spending (The Standing Senate Committee, 2004). Integration of addiction treatment services with other health and social services did not occur until the 1980s, becoming more fully integrated with the mental health system and larger social welfare policy and social support systems as a result of major health

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<sup>11</sup> For more on the history of mental health services in Canada, see Chapter 7 of *The Standing Senate Committee*, 2004).

<sup>12</sup> For more information on the Northern Health Authority and services in Prince George, BC, see section 2.2 in this chapter.

reform in the 1990s<sup>13</sup> (The Standing Senate Committee, 2004).

Despite the amalgamation of mental health and addictions services in most provinces, as recently as the 2006 Standing Senate Committee report, many people continued to experience exclusion from one or the other service stream if they admitted to concurrent issues. For example, if one admitted to substance use problems, they may be excluded from mental health services, or conversely from addiction treatment programs if they disclosed use of medications for mental health issues (The Standing Senate Committee, 2006). The Standing Senate Committee report (2006), based on extensive engagement and consultation, concluded that people were frustrated trying to access assistance from either the mental health *or* addictions service systems, but that trying to deal with both issues at the same time resulted in additional barriers. As one anonymous contributor to the report described:

I've gotten help for each individual thing but to get help for (both), like at the same time, you fall between the cracks and if one of your disorders is worse than another and then one doctor thinks you're seeing somebody else, basically nobody's helping you, nobody follows up, you kind of disappear. (The Standing Senate Committee, 2006, p. 206)

While changes have hopefully occurred in the years since this report, the finding suggests that continued improvements are needed in the coordination of services for mental health and substance use related issues.

## **2.2 Prince George, BC: Location and demographics**

This study took place in Prince George, British Columbia (BC), a northern city with particular geographic, economic, and social conditions, as well as unique demographics. The

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<sup>13</sup> Canadian health care reform in the 1990s involved the following main themes: decentralization of authority to Regional Health Authorities; emphasis on evidence-based decision-making, cost-effectiveness, and accountability; a shift from institutional care with an illness focus to community-based services with a focus on wellness; integration; and an emphasis on client-centered services (Thomas, 2005). In BC, the current regionalization arrangement in place since 2002, divides the province into five geographical health authorities and one provincial health authority for province-wide services (Figure 3 in section 2.2).

city is situated on the traditional territory of the Lheidli T'enneh<sup>14</sup> in the central interior of the province 800 km north of Vancouver.<sup>15</sup> Self-proclaimed the northern capital of BC, Prince George has a population of just over 70,000 (over 84,000 in the census agglomeration) (Statistics Canada, 2011a). It has a burgeoning service industry to complement its resource-based economic foundations. Prince George is home to the newest Canadian university (University of Northern British Columbia), which opened its doors in 1994, a community college (College of New Caledonia), and a regional hospital (University Hospital of Northern British Columbia).

Prince George is a great city that many of us are happy to call home. However, it also has its share of social issues. *Maclean's* ranked Prince George the most dangerous city in the country for three years in a row (2010 to 2012).<sup>16</sup> Contributing to this ranking was increased gang and drug-related crime as well as a string of homicides during that time (MacQueen & Treble, 2011). Based on Statistics Canada data, Prince George had seven murders in 2010, placing it highest per-capita in the country, 486% above the national average (MacQueen & Treble, 2011). In a *Maclean's* article, the Prince George RCMP Superintendent accounted for the significant share of the crime to "turf wars over the drug trade, and related addiction issues" (MacQueen & Treble, 2011, par.7). The city is also located on one end of a notorious section of Highway 16 labeled the "Highway of Tears." A large number of women, most of whom were Indigenous, have gone missing or been found murdered along this stretch of highway between the years of 1969 and 2006 (MacQueen & Treble, 2011).<sup>17</sup> Sharron Hurd of

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<sup>14</sup> For more information on the Lheidli T'enneh First Nation, visit their website at <http://www.lheidli.ca/>

<sup>15</sup> To provide some reference point, Vancouver is the largest urban center in the province and is located on the southwest corner of the mainland. The population of Metro Vancouver is over 2.3 million, more than half the population of British Columbia (Statistics Canada, 2011b).

<sup>16</sup> See *MacClean's* 2011 Crime Chart here <http://www2.macleans.ca/crime-chart/>

<sup>17</sup> To learn more about The Highway of Tears, visit <http://www.highwayoftears.ca/> and read the Highway of Tears Symposium Report from 2006 found here <http://www.ubcic.bc.ca/files/PDF/highwayoftearsfinal.pdf>

the Phoenix Transition House in Prince George acknowledged in the Maclean's article that the city remains a dangerous place for vulnerable women (MacQueen & Treble, 2011). Mental health and addiction services in Prince George are provided for the most part by the Northern Health Authority [Northern Health] in concert with a variety of community organizations. Northern Health provides youth and adult community programs, as well as inpatient and intensive services that include a psychiatric assessment unit, youth treatment center, adult psychiatric inpatient unit, and a withdrawal management unit (detox), and several residential service locations.<sup>18</sup> In 2002, the province of BC was divided into five geographically defined health authorities,<sup>19</sup> with Prince George located in the largest (Figure 3) (Thomas, 2005). The Northern Health Authority is divided into three service delivery areas, with Prince George located in the Northern Interior Service Delivery Area.

Northern Health serves about 300,000 people of which 13% is Aboriginal,<sup>20</sup> the highest proportion in any health authority across the province (Northern Health, n.d.-b). Aboriginal people make up approximately 3.8% of the overall population in Canada, about 5% in the province of BC, and 11% in the city of Prince George (Milligan, n.d.). In contrast, the immigrant<sup>21</sup> population in Prince George is less than 10%, which is low compared to the

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<sup>18</sup> For more information on the mental health and addictions services offered by Northern Health, visit <http://www.northernhealth.ca/YourHealth/MentalHealthAddictions/CommunityContacts/NorthernInterior/PrinceGeorge.aspx>

<sup>19</sup> The First Nations Nisga'a Health Council remains an independent health authority (<https://sites.google.com/a/nvha.ca/main/>) and a province-wide First Nations Health Authority was established in 2012 under the Tripartite Health Plan to govern health services for First Nations in the province (<http://www.fnhc.ca/index.php/iFNHA/>).

<sup>20</sup> The term *Aboriginal*, as stated in Canada's 1982 *Constitution Act*, is inclusive of First Nations, Inuit, and Métis peoples. These three populations are diverse both between and within groups in socio-linguistic, cultural and geographic aspects. The terms *Aboriginal* and *Indigenous* are used in this thesis to refer collectively to the original inhabitants of the land now known as Canada: First Nations, Inuit, and Métis.

<sup>21</sup> According to Statistics Canada, the definition of immigrant persons are those "who are, or have ever been, landed immigrants in Canada. This person has been granted the right to live in Canada permanently by immigration authorities. Some immigrants have resided in Canada for a number of years, while others are more recent arrivals." (Statistics Canada, 2013a).

province (almost 28%) and across Canada (almost 20%) (BC Stats, n.d.-b; Chui, Tran & Maheux, 2009; Statistics Canada, 2007). Additionally, the population considered to be ‘visible minority’ is low in Prince George at just under 6% compared to almost 25% in BC, and just over 16 % across the country (BC Stats, n.d.-a; Statistics Canada, 2010). See Table 2 for a summary of these numbers.

Figure 3 British Columbia Health Authorities

(Reprinted with permission from the content owner, BC Ministry of Health, and the map source BC Association of Community Response Networks [BCCRN], 2010)



Table 2 Selected population demographics compared regionally, provincially, and nationally

	<b>Prince George</b>	<b>British Columbia</b>	<b>Canada</b>
Aboriginal <sup>22</sup>	11.3%	5%	3.8%
Immigrant <sup>23</sup>	9.6%	27.5%	19.8%
Visible minority <sup>24</sup>	5.9%	24.8%	16.2%

<sup>22</sup> All Indigenous Aboriginal statistics in this table are from Milligan, n.d. (2006 Census data)

<sup>23</sup> Immigrant statistics in this table are from BC Stats, n.d.-b and Statistics Canada, 2007 (both 2006 Census data)

<sup>24</sup> Visible minority statistics in this table are from BC Stats, n.d.-a and Statistics Canada, 2010 (both 2006 Census data).

Prince George has particular demographic make-up in which Indigenous peoples represent an important minority population compared to others in Prince George and across the province. Indigenous people are over-represented in the areas of mental health and substance use issues, a situation that cannot be understood outside the context of colonialism. Not only have colonial policies and practices had a resounding impact on Indigenous peoples' vulnerability to mental health and substance use issues, but they also continue to reduce access to resources required to maintain health and mental wellbeing. Additionally, the health care system in Canada is borne of a colonial history and is therefore limited in its ability to meet the needs of Indigenous individuals (Nelson, 2012). Colonialism and its repercussions on Indigenous peoples' mental health and substance use are discussed in greater depth later in this chapter.

### **2.3 Social and geographic determinants of mental health and substance use**

Mental health and substance use issues are extremely complex and interrelated. They do not stem from one cause, but rather result from “a complex combination of social, economic, psychological, biological, and genetic factors that influence our overall mental health and well-being” (MHCC, 2012, p.14). The biomedical<sup>25</sup> understanding and approach to health and illness has dominated for many decades, but in recent years a population health approach is gaining traction in health prevention, policy and education. This approach brings an understanding of the broader context of socially and environmentally mediated realities in which people live their lives, and how these impact health outcomes.

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<sup>25</sup> The biomedical model of medicine focuses on the physical processes of illness and does not account for social, economic, and individual contributing factors.

The social determinants of health (SDOH) approach to population health takes into consideration how multiple societal processes (such as sexism, racism, heterosexism, colonialism, and others related to gender, health status, and migration status), differentially moderate access to resources (such as food, education, employment, and housing) (Smylie, 2009). Restricted access to resources is directly linked to lower educational attainment, poverty, poor housing, community disadvantage, and ultimately inequities in health outcomes (Smylie, 2009). The World Health Organization (WHO) offers this definition of social determinants of health, stating that they:

...are the conditions in which people are born, grow, live, work and age, including the health system. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels, which are themselves influenced by policy choices. The social determinants of health are mostly responsible for health inequities – the unfair and avoidable differences in health status seen within and between countries (WHO, 2012a).

Social determinants interact in complex ways to influence individual mental health and substance use risks and experiences. Stable employment is often more difficult to obtain when struggling with mental health and substance use problems. This can result in a lack of financial independence, which in turn impacts one's ability to access regular healthy meals and stable housing. Unfortunately, conditions of unemployment and poverty reciprocally contribute to experiences of mental health and substance use issues thereby creating a cyclical and reinforcing pattern. In addition, stigma and discrimination can make it more difficult to obtain important resources such as employment and housing. The Standing Senate Committee (2006) undertook extensive consultation and recorded the input from over two thousand Canadians in the report *Out of the Shadows at Last*. The report described ways that the "social determinants of mental health have largely been overlooked despite their importance in preventing and in treating mental illness" (p.6).

Reading and Wien (2009) identify different levels of social determinants that operate proximally, intermediately, and distally. For example, proximal SDOH are “the conditions that have a direct impact on physical, emotional, mental or spiritual health” (Reading & Wien, 2009). These may include unstable, crowded, or unhealthy housing; lack of food availability and quality; barriers to education and employment; individual health behaviours; and family violence and other forms of trauma. While Reading and Wien (2009) acknowledge the uncertain processes of how proximal SDOH work, they suggest that in many cases, these conditions make it harder to meet basic survival needs, and act as stressors increasing the likelihood of behavioural and learning difficulties in children and adolescents, and substance abuse and other social problems among adults.

Intermediate social determinants operate at a level slightly removed from the individual and “can be thought of as the origin of those proximal determinants” (Reading & Wien, 2009, p.16). For example, the health care and education systems mediate the availability and accessibility of education and health care. Community infrastructure and resources mediate an individual’s experience of their physical environment. Specifically for Indigenous peoples, cultural continuity is an intermediate determinant of health (Reading & Wien, 2009).

Within this framework, “[d]istal determinants have the most profound influence on the health of populations because they represent political, economic, and social contexts that construct both intermediate and proximal determinants” (Reading & Wien, 2009, p.20). These have also been called the *causes of the causes* (Marmot, 2005). Writing specifically in the context of Indigenous health, the authors identify distal determinants of health as: colonialism; racism and social exclusion; and, self-determination. Extending this framework

beyond the Indigenous context to this project and based on my readings of the literature, this thesis expands upon several distal social determinants relevant to mental health and substance use: sexism and gender discrimination; colonization and racism; and, stigma and discrimination. Each of these distal health determinants mediates access to resources that influence mental health and substance use risks and experiences.

In addition to the social determinants, geography has a significant impact on health and wellbeing. There is a distinction between rural and urban geographies when looking at access to health care and health outcomes. As well, there are often differences in access to resources for health, such as the proximal social determinants already discussed, and different levels and types of stressors (Thien & Hanlon, 2009). Often discounted as a static backdrop or container for health statistics, geographies actually have a dynamic role in shaping our experiences of health and wellness. For example, concerns for confidentiality within a small community will influence individuals differently depending on many different factors. Spaces, places and geographies are experienced differently by gendered and racialized subjects and are always the outcome of those who hold power and produce the landscapes. Not only is it important to incorporate gender in health research, policy, and practice, but these also need to be responsive to women within their particular geographic *context* (Northern Secretariat of the BC Centre of Excellence for Women's Health [Northern Secretariat], n.d.). The importance of northern geographies on mental health and substance use is discussed in section 2.3.4.

### 2.3.1 *Sexism and gender discrimination*

*“The complex interconnections of sex and gender affect who we are, what we do, and how we are treated, and have profound effects on our health”*

(Johnson, Greaves & Repta, 2007, p.4)

Sex and gender are terms often used interchangeably in research. They are, however, distinct though related concepts. *Sex* is a multi-dimensional biological construct that includes anatomy, physiology, genes, and hormones. Sex plays an important role in health because biology influences many processes. For example, one’s response to alcohol and drugs depends in part on physiology, metabolism, and hormones (Johnson, Greaves & Repta, 2007). *Gender* is the socially prescribed and experienced dimensions of “femaleness” or “maleness” that is in constant flux based on cultural and temporal realities (Johnson, Greaves & Repta, 2007).

Sex and gender are both increasingly recognized as important determinants of health and necessary to incorporate into health research. Historically though, much health research has been undertaken with a ‘gender-neutral’ assumption (the neutral being male) (Johnson, Greaves & Repta, 2007). This project explored the experiences of mental health and substance use for *women*, a categorization that includes aspects of both gender *and* sex. In this project, the focus was on the socially constructed and mediated aspect of gender. I chose to identify gender *discrimination* as a determinant of health instead of simply *gender* to highlight the role of inequitable power distribution that implicates gender as a mediating factor for accessing resources required for health and wellness.

Gender is intimately connected to social and economic status because maleness is almost universally valued over femaleness (Johnson, Greaves & Repta, 2007). According to the World Health Organization (n.d.-a), “gender determines the differential power and

control men and women have over the socioeconomic determinants of their mental health and lives, their social position, status and treatment in society and their susceptibility and exposure to specific mental health risks” (par.7). Women in Canada are differentially affected by several social determinants of health compared to men, including: greater likelihood of heading a single-parent household; greater amount of time spent on unpaid care giving; and, lower average incomes. These factors increase the likelihood of experiencing higher stress and lower levels of self-rated mental health.

In 2006, there were about four times as many female lone-parent families (1.1 million) as male lone-parent families (281,800), a ratio that has remained fairly consistent over several decades (Milan, Keown & Urquijo, 2011). Women spend more than double (50.1 hours/week) the average time spent by men (24.4 hours/week) on unpaid childcare (Milan, Keown & Urquijo, 2011). In addition, 49% of women provide care to a senior compared to 25% of men (Milan, Keown & Urquijo, 2011). Canadian women earned an average total income of \$30,100 in 2008 compared to \$47,000 for men (Williams, 2011). In 2008, women earned approximately 65% of what men earned (\$30,200 and \$46,900 annually) in part because women are less likely to work full-time (Williams, 2011). Considering that lone-parent families are generally more likely to have low income, that women earn less on average than men, and that women spend significantly more time on unpaid childcare, it is not surprising that 21% of lone-parent families headed by a female are low-income compared to 7% for those that are headed by a male (Williams, 2011). Race intersects with gender for Indigenous women and results in disproportionate burden of many social determinants of health. This is discussed in more detail in section 2.3.2.

In the same way that economics contributes to overall health, mental health is linked to income gradient (Turcotte, 2011). Family situation impacts women's self-reported stress levels. For women aged 35-45, 41% of those heading a lone-parent household reported their days were "quite a bit or extremely stressful," compared to 38% of those living alone and 28% for women living with a spouse and children (Turcotte, 2011). In 2009, 6% of Canadians reported a mood disorder diagnosed by a professional, nearly two-thirds of which were reported by women (Turcotte, 2011). Prevalence of anxiety disorders is highest among women aged 45 to 64 (6.8% with a diagnosis) compared to 3.9% of men in this age group (Turcotte, 2011). This gender difference may partly be explained by differences in help-seeking behaviour. Women are more likely than men to seek help when experiencing a mental health concern, so they are more likely to be diagnosed (Turcotte, 2011). In 2009, 17% of women who described their mental health as fair to poor had seen a psychologist in the prior year as compared with 11% of men (Turcotte, 2011). Women's disproportionate role in unpaid care giving results in an increased burden of stress and mental health repercussions for women. For example, one-third of women caregivers for individuals with multiple sclerosis are distressed to the point that they have a clinical disorder themselves (Pakenham, 2005) and over 50% of female caregivers of individuals with Alzheimer's suffer from clinical depression (Cohen & Eisdorfer, 1988).

Survivors of violence, trauma and abuse often experience mental health and substance use issues in complex, indirect, and mutually reinforcing ways (Ad Hoc Working Group, 2006). The literature often uses the terms 'violence,' 'abuse,' and 'trauma' in overlapping ways, however the terms often mean something different when speaking about interpersonal trauma versus the kind of trauma experienced on a societal scale such as war or

environmental disaster. For the purposes of this thesis I use the terms to mean the various forms of interpersonal trauma – physical, sexual, emotional and verbal abuse – that women can experience either as children or adults (Morrow, 2002). The United Nation’s 1993 *Declaration on the Elimination of Violence against Women*, which was signed by Canada, defines violence against women as:

Any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life. (WHO, 2012b, p.1)

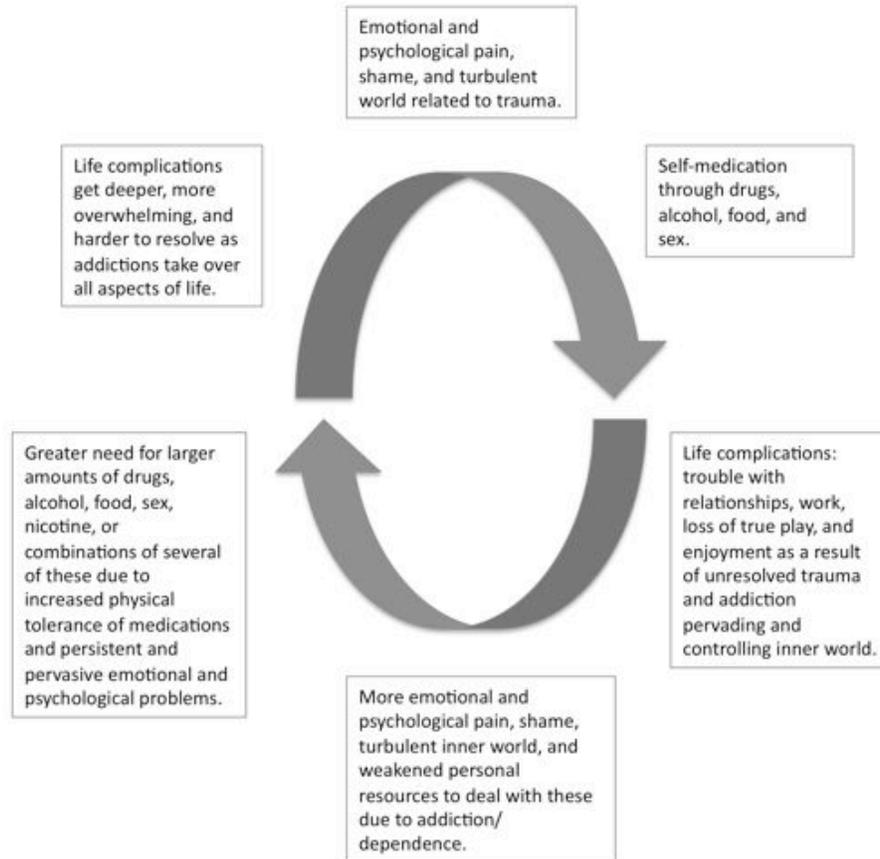
Police data indicates that while the most frequent violent offences against both women and men include common assault, uttering threats, and serious assault, in 2011 women were eleven times more likely than men to be a victim of sexual offences and three times as likely to be the victim of criminal harassment (stalking) (Sinha, 2013). 45% of violence against women is perpetrated by an intimate partner, compared to just 12% of violence against men (Sinha, 2013). Trauma is intimately interrelated with mental health and substance use issues for women. Emotional and psychological pain related to trauma is often self-medicated with substances such as drugs, alcohol, and food. This can create a negative cycle of distress, substance use, and life complications. Figure 4 depicts an example of how trauma, mental distress, and addictions interact.

Women who use substances and also access anti-violence services report using substances to cope with the impacts of violence on their physical and mental health (Cory, Godard, Abi-Jaoudé, & Wallace, 2010). Indigenous women may be more severely impacted by violence and trauma, which occurs within a context of historical traumas that have strong intergenerational transmission and are linked to substance abuse and psychological distress (Adelson, 2005). There is a general lack of recognition in health policies and service delivery

of the ways trauma is connected to substance use and mental health issues, resulting in inadequate services for women (Ad Hoc Working Group, 2006).

Figure 4 Cycle of Trauma and Addictions

(Adapted and reprinted with permission from Health Communications Inc. Source: Dayton, 2000, p.19)



At the same time, several resource and toolkits have been published<sup>26</sup> that target health sector providers and identify key approaches for supporting women and collaborating across sectors in regards to violence, mental health and substance use (Haskell, n.d.). A recent initiative

<sup>26</sup> As identified by Haskell (n.d.), see *Freedom from Violence: Tools for Working with Trauma, Mental Health and Substance Use* from Ending Violence Association of BC <http://www.endingviolence.org/node/459>; *Building Bridges: Linking Woman Abuse, Substance Use and Mental Ill Health* from BC Women's Hospital and Health Centre <http://www.bcwomens.ca/Services/HealthServices/WomanAbuseResponse/Building+Bridges.htm>; and *Coalescing on Women and Substance Use* from BC Centre of Excellence for Women's Health <http://www.coalescing-vc.org/virtualLearning/section1/default.htm>

undertaken in British Columbia and the Yukon by the BC Society of Transition Houses reviewed the interrelatedness of violence against women, mental health and substance use. The review included consultations with women with lived experience, service providers, and representatives from several federal ministries (BC Society of Transition Houses, 2011). Salmon et al. (2006) advocate for funding and evaluation of gender-specific, culturally responsive, trauma-informed care based on antiracist principles and that contribute to larger decolonization and self-determination efforts.

To conclude, there are several reasons why *Envisioning Change* focused on the gendered category of women. First, differential valuation of men over women in society has disadvantaged us in securing resources that contribute to mental wellness. Second, women's prescribed gender roles make us more vulnerable to certain stressors, including violence and trauma. Third, we are under-represented and historically excluded from research (Johnson, Greaves & Repta, 2007). Gender intersects with other social identities and differences such as race, ethnicity, class, sexuality, and ability, that should also be taken into consideration within research, programs, policy and service delivery for mental health (Salmon et al., 2006). In addition to the social determinants that impact on women as a broad group, Indigenous women may experience the intersecting oppressions of sexism, racism, and the impacts of colonialism.

### ***2.3.2 Colonialism and racism***

*“The oppression of Aboriginal peoples within Canadian society has resulted in social inequities that are at the heart of many mental health issues.”*  
(Nelson, 2012, p.3)

As we have seen in the discussion of gender discrimination, social determinants of health (SDOH) can stem from deeper social structures and processes that operate at national

and global levels (Czyzewski, 2011). Colonialism and racism are distal determinants of Indigenous health and operate on a broad systemic level with ripple down effects through intermediate and proximal determinants such as family violence and access to employment, education, housing, and health care (Reading & Wein, 2009). Colonialism and racism impact mental health at a variety of levels, including: embodied trauma from direct experience of colonial policies and practices and its intergenerational transmission; restriction of access to proximal SDOH such as education, employment, housing, etc; and health services that are inaccessible and not culturally safe for Indigenous people. The following discussions also include analysis of the intersecting impacts of gender.

I begin by defining the terms. *Colonialism* is: “i) the control or governing influence of a nation over a dependent country, territory or people; ii) the system or policy by which a nation maintains or advocates such control or influence (Random House, 2010 in Czyzewski, 2011, p.1). In this thesis, I use the term *colonialism* to encompass “the political, social, and ideological aspects” of *colonization*, which refers more specifically to “the geographic and economic processes of incursion” (Nelson, 2012, p.4). While First Nations, Inuit, and Métis are diverse peoples differing between and within groups by socio-linguistic, cultural, and geographic aspects, most groups share a common social, economic, and political predicament as a result of colonialism (Kirmayer, Brass, & Tate, 2000).

*Racism* is “any action, practice, or belief that reflects the racial [...] ideology that humans are divided into separate and exclusive biological entities called ‘races’ [...] and that some races are innately superior to others” (Smedley, n.d., par.1). A racist worldview assumes there is a “causal link between inherited physical traits and traits of personality, intellect, morality and other cultural behavioral features” (Smedley, n.d., par.1). Racism and

colonialism are inextricably linked because colonial policies and practices are driven by a racial worldview and devaluation of colonized peoples (Kobayashi & de Leeuw, 2010). As one of the characteristics of colonization, racism and the resulting oppression and discrimination have negatively impacted Indigenous peoples' economic, political, cultural and social wellbeing (Czyzewski, 2011).

The history of European colonization of North America includes “decimation by infectious disease, warfare, and active suppression of culture and identity that was tantamount to genocide” (Kirmayer et al., 2000, p. 608). Systematic cultural assimilation continued throughout recent decades with Government policies that forced sedenterization, created reserves, relocated communities to remote regions, established residential schools, removed children from families, and imposed bureaucratic controls (Kirmayer et al., 2000). Residential schools operated from 1831 to 1998 and forcibly removed Aboriginal children from their families and communities to attend missionary or government operated schools with the intention of destroying Aboriginal social and cultural identity (Wesley-Esquimaux & Smolewski, 2004). The stated purpose of residential schools was to provide education to Aboriginal children but the reality was that students were “subjected to continual, relentless denigration in order to assimilate them into mainstream culture” (Chansonneuve, 2007, p.10).

Psychological, physical, sexual and spiritual abuses were common in residential schools and as more people who spent their childhoods in these institutional environments returned to their homes, “communities became inundated with people suffering from unhealed trauma, grief, and rage” (Chansonneuve, 2007, p.12; Kirmayer et al., 2000). Negative ways of coping with this grief and pain include addictive behaviours and lateral violence directed towards family and community members, thereby “creating

intergenerational cycles of unhealthy relationships mirroring those in residential schools” (Chansonneuve, 2007, p.12). As a result of these experiences, Indigenous cultural identities have been described as “reeling with what can be regarded as an endemic and complex form of post-traumatic stress disorder (PTSD) (Wesley-Esquimaux & Smolewski, 2004, p.1). This has been described as a “soul wound” in which “an entire population is affected for generations by the experience of systematic violence, oppression, and widespread grief” (Duran & Duran, 1995 quoted in Nelson, 2012, p.12, p.24).

One of the impacts of colonialism is a disproportionate burden of mental health and substance use issues for Indigenous populations (Kirmayer et al., 2000). The high levels of social and psychological problems in Aboriginal communities (including depression, family violence and breakdown, mental health issues, and self-destructive behaviours such as suicide) are argued to be the direct result of abuse experienced in the residential school system (Grant, 1996 in Corrado & Cohen, 2003). An estimated 85% of Aboriginal clientele in drug and alcohol treatment programs attended residential schools (Corrado & Cohen, 2003).

The 2002/2003 Aboriginal Peoples Survey found that of First Nations women 18 years and older living on-reserve, 20% had attended residential school, while in 2006, 12% of First Nations women 25 years or older and living off reserve had attended (O’Donnell & Wallace, 2011). The numbers were markedly higher for women aged 55 and over, with one in five having attended residential school (O’Donnell & Wallace, 2011). A comparatively small number of Métis women (3%) and larger number of Inuit women (19%) also reported having attended a residential school (O’Donnell & Wallace, 2011). Recognizing the impact of intergenerational transmission of trauma discussed earlier, the numbers of women with

parents or grandparents who attended residential school was higher (34% of First Nations women living off-reserve, 15% of Métis women, 21% of Inuit women) (O'Donnell & Wallace, 2011). O'Donnell and Wallace (2011) make note that many women did not know if their parents or grandparents had attended a residential school, and so it is possible that the percentage of women with this familial history is actually higher than reported.

In addition to sexism and gender discrimination, Indigenous women in Canada face the many detrimental impacts of colonialism (direct embodied trauma, transmission of historic trauma, domestic violence, childhood abuse), racism, and classism (Stout, 2010). These distal determinants of health have resulted in “social norms, policies and practices that tolerate or actually promote unfair distribution of and access to power, wealth and other necessary social resources” (Czyzewski, 2011, p.1). The following statistics help to frame some aspects of Indigenous women's lives in terms of proximal determinants and access to resources for health and wellbeing. These are summarized in Table 3.

Family status influences women's access to education, employment, income, housing, food, and also stress levels. In 2006, 18% of Aboriginal women over the age of 15 were single parents compared to just 8% for non-Aboriginal women (O'Donnell & Wallace, 2011). In addition, these families tended to be larger (22% with three or more children) than lone-parent families headed by non-Aboriginal women (10% with three or more children) (O'Donnell & Wallace, 2011). 8% of Aboriginal teenage girls aged 15-19 were parents in contrast to 1.3% of non-Aboriginal teens (O'Donnell & Wallace, 2011).

Housing has an impact on women's health and safety. Crowded housing is defined as more than one person per room, and has been linked to several health and social issues, including mental health problems and family violence (Health Canada, 1999 in O'Donnell &

Wallace, 2011). In 2006, 26% of First Nations women and girls in reserve communities and 6% off reserve were living in crowded conditions compared to 3% of non-Aboriginal women and girls (O'Donnell & Wallace, 2011). More Aboriginal women and girls live in homes requiring major repairs (28% of Inuit, 44% of First Nations on-reserve and 16% off-reserve, and 14% of Métis) than non-Aboriginal women and girls (7%) (O'Donnell & Wallace, 2011).

Table 3 Summary of SDOH statistics for Indigenous women and girls in Canada compared to their non-Indigenous counterparts

(O'Donnell & Wallace, 2011; Brennan, 2011)

<b>SDOH</b>	<b>Indigenous women</b>	<b>Non-Indigenous women</b>
Single parent	18%	8%
Teen parent	8%	1.3%
Crowded housing	26% on-reserve 6% off-reserve	3%
Homes in need of major repairs	Inuit 28% FN on-reserve 44% FN off-reserve 16% Métis 14%	7%
Labour force participation	59.1%	61.7%
Average annual earnings	\$15.6K	\$20.6K
Unemployment rate	13.5%	6.4%
Education – less than high school	53% Inuit 39% FN 27% Métis	20%
Education – university degree	9%	20%
Education – community college diploma or certificate	21%	20%
Attended residential school	19% Inuit 20% FN on-reserve 12% FN off-reserve 3% Métis	n/a
Parent or grandparent attended residential school	21% Inuit 34% FN off-reserve 15% Métis	n/a
Violent victimization <sup>27</sup>	28%	11%

<sup>27</sup> Rates of violent victimization, including spousal violence, of the female population in the provinces age 15 or older in 2009 (Brennan, 2011).

Employment impacts women's income and independence. Labour force participation rates for Aboriginal women (59.1%) are similar to their non-Aboriginal counterparts (61.7%), however, Aboriginal women's average annual earnings are notably lower at \$15.6K compared to \$20.6K for non-Aboriginal women (O'Donnell & Wallace, 2011).

Unemployment rates<sup>28</sup> for Aboriginal women were twice as high in 2006 at 13.5% as that of non-Aboriginal women (6.4%) (O'Donnell & Wallace, 2011).

Education influences health outcomes and is related to employment, income, and family status. In 2006, 35% of Aboriginal women compared to 20% of non-Aboriginal women over the age of 25 had not graduated from high school (O'Donnell & Wallace, 2011). The Aboriginal Peoples Survey asked why respondents had not completed elementary or secondary school, and about one in five Aboriginal women between the ages of 15 to 34 said the reason was 'pregnancy or to take care of children' (O'Donnell & Wallace, 2011). There was also a notably smaller proportion of Aboriginal women aged 25 and older with a university degree compared to their non-Aboriginal counterparts (9% and 20% respectively), however, Aboriginal women are as likely as non-Aboriginal women to have a diploma or certificate from a community college (O'Donnell & Wallace, 2011). Respondents of the Aboriginal Peoples Survey who had some postsecondary studies cited the following reasons for not completing: 'financial reasons' (15%), 'wanted to work' (14%), 'to care for their own child or pregnancy' (11%), and 'other family responsibilities (13%) (O'Donnell & Wallace, 2011).

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<sup>28</sup> Unemployment rates differ by location. Generally speaking, the gap between the unemployment rates of Aboriginal and non-Aboriginal women is smaller among those with higher levels of education. See O'Donnell & Wallace (2011) for more information.

Violent victimization of Indigenous women in Canada is estimated at close to triple that of non-Indigenous women (Brennan, 2011). Many Indigenous women who are victims of violence are young, two-thirds of whom are between the ages of 15-34 (Brennan, 2011). Women in the arctic are significantly more likely to be victimized. Violent crimes against women in Nunavut were nearly 13 times the rate for Canada (Statistics Canada, 2013b). The Native Women's Association of Canada has documented more than 500 Aboriginal women and girls missing or found murdered in the past 30 years (The Standing Senate Committee on the Status of Women, 2011). As with all social determinants of health, violence is connected in complex and mutually reinforcing ways. As part of information gathering process, an interim parliamentary report on violence against Aboriginal women was urged by 'witnesses' to "take a comprehensive approach to the problem of violence against Aboriginal women, an approach which takes into consideration larger systemic issues such as poverty, housing, and racism" (The Standing Committee on the Status of Women, 2011, p.6).

Lack of culturally competent and safe care is an additional barrier for some Indigenous women seeking mental health and substance use services. *Culturally safe care* "involves building trust with Aboriginal patients and recognizing the role of socioeconomic conditions, history, and politics in health; requires communicating respect for a patient's beliefs, behaviours, and values; and, ensures the client or patient is a partner in decision-making" (Health Council of Canada, 2012, p.5). *Cultural competence* is the knowledge, skills, and attitudes of practitioners that allow them to meet the social, cultural, and sometimes linguistic needs of Indigenous patients by adapting the way they deliver health care services (National Collaborating Centre for Aboriginal Health [NCCA], 2013). In fact, a recent report from the Health Council of Canada (2012) summarized that,

Many Aboriginal people don't trust – and therefore don't use – mainstream health care services because they don't feel safe from stereotyping and racism, and because the Western approaches to health care can feel alienating and intimidating. (p.4)

While the *cultural safety* of mental health and addiction services remains an issue, changes are being made in the way these services are provided to Indigenous peoples and communities (Nelson, 2012). In Prince George, there are several options for culturally based services related to mental health and substance use, including the Central Interior Native Health Society (CINH). CINH is “a not-for-profit society dedicated to Aboriginal health” (CINH, n.d.-a). This primary health care clinic provides “inclusive, accessible and safe health care” with a holistic approach that promotes “physical, spiritual, emotional, and cultural harmony within all Aboriginal Peoples who reside in North Central British Columbia” (CINH, n.d.-a). The range of programs offered at CINH include addiction services that explicitly incorporates the understanding that the root causes of addiction issues are anchored in the trauma resulting from colonialism:

The Aboriginal values of kindness, honesty, sharing and strength are most important in approaching addiction issues because the symptoms appearing as addiction have root causes in the loss of land, culture, and language experienced by Aboriginal people in Canada. These losses were compounded by residential school experiences and other racist policies that systematically discriminated against Aboriginal peoples. The loss of traditional ways of living that fostered community health and individual well being has resulted in health concerns including abuse of alcohol and drugs and mental health concerns. (CINH, n.d.-b, par.1)

Services include referral to external resources and working with patients through their healing.

As summarized in this section on colonialism and racism, Indigenous women may face multiple impacts of individual and institutional discrimination and disadvantage based on race, gender and class (Browne & Fiske, 2001). It is fundamental to include a discussion of this country's colonial history and resulting ongoing repercussions to contextualize the

disproportionate burden of mental health and substance use issues for Indigenous women. It is an ethical imperative to recognize and include a discussion of our shared colonial history in research, policy, programming and service delivery, which I have tried to do here.

### **2.3.3 *Stigma and discrimination***

*“When we do speak, please do not avoid us. What we have is not contagious.”*  
(Sheila Hayes Wallace quoted in The Standing Senate Committee, 2006, p.18)

The World Health Organization (2001) notes that the care and treatment of “people with mental and behavioural disorders has always reflected prevailing social values related to the social perception of mental illness” (p. 49). Historically, people with mental illness were labeled ‘idiots’, ‘imbiciles’, and ‘lunatics’ and addiction problems were perceived as a sign of personal weakness (The Standing Senate Committee, 2004). Negative perception, fear, and stigma still persist today, despite many advances in service models, policies, and legislation (The Standing Senate Committee, 2004). Individuals face discrimination on personal and structural levels with negative impacts on the ability to seek support, access services, and maintain secure employment and housing, factors that are so fundamental to recovery (The Standing Senate Committee, 2004). For women in particular, their overrepresentation in caregiver roles places them under even greater scrutiny and puts them at risk of losing their children to a system that discriminates against their struggles instead of providing support (BC Centre of Excellence for Women’s Health, 2010).

Stories of stigma and discrimination told in the consultation process for The Standing Senate Committee report *Out of the Shadows at Last* leave no doubt that this is a significant aspect in many people’s daily realities living with mental health and substance use issues. The report included stories about how stigma and discrimination made finding safe and

adequate housing difficult for people living with mental illness. For example,

Nobody has a right to prevent us from living in their neighbourhood. This is a blatant discrimination and flagrant violation of human rights. [...] Nobody is criticizing us because of anything we have done wrong. They are criticizing us out of fear and ignorance. (Phillip Dufresne quoted in The Standing Senate Committee, 2006, p.11-12)

The process of finding and securing stable employment also reveals stigma and

discrimination as described by this witness in *Out of the Shadows at Last*:

...because I had been so open about my illness, it took me a number of years to find decent, secure employment. I felt that people now saw me as a gamble. If I had survived cancer, diabetes or high cholesterol, I'm not sure I would have faced the same challenges. (Karen quoted in The Standing Senate Committee, 2006, p.7)

Another witness said, "I cannot tell you how profound an impact a psychiatric label makes on our life. I mean, I lost my job and I lost my means for getting another job because I had been in the hospital" (Francesca Allan quoted in The Standing Senate Committee, 2006, p.14).

Further challenges of navigating the mental health care system were identified by the Standing Senate Committee (2006), including lack of information, a convoluted health care system, and long waiting lists that make seeking assistance very difficult. A family member quoted in the report described it as:

...a frustrating, lonely journey. Most people make many, many calls in an effort to get help. When you finally find something that looks hopeful, you get on a ten month waiting list...it is like showing up in emergency with a broken bone and being told, yes, it is really broken, so try and do what you can with it and we will see you in ten months. (Healthy Dowling quoted in The Standing Senate, 2006, p.24)

Many other levels of discrimination towards mental health and substance use issues occur within society at large. For example, one woman described how disclosing that she is a recovering addict results in a drop in her credibility despite also being a retired teacher and a member of a Board of Trustees (Patricia Commins quoted in The Standing Senate Committee, 2006). This quote by a young woman battling depression expresses the

additional challenge of facing stigma on top of the difficulty of a mental illness:

Broken. Lonely. Hopeless. Ashamed. Rejected. Isolated. Afraid. Unsupported. Lost. Anxious. Disbelieved. Overwhelmed. Embarrassed. Dark. Pained. Desperate. Fading. I'm a 31-year-old Canadian woman who has been fighting the disease of Depression since my late teenage years. The words above are words that come to my mind when I think of what it's like to live as a Canadian in Canada with Mental Illness. It's pretty sad when you sit around wishing you had any (literally ANY) other disease other than a Mental Illness. There is so much shame, stigma and disbelief that accompany a diagnosis of a mental illness. It's the constant justification that you're actually sick. Why do we who suffer with this debilitating disease have to suffer socially as well? (Kim quoted in *The Standing Senate*, 2006, p.15).

Salmon et al. (2006) suggest that stigma, marginalization, and discrimination have particular impacts on women's mental health and substance use realities. While mental health and substance use problems remain highly stigmatized in Canadian society for both men and women, as is evidenced in the previous paragraphs, due to women's greater responsibility for childcare, women's "substance use and mental health concerns become differently scrutinized by authorities than men's and carry an elevated and different level of stigma and societal concern" (Greaves, 2006, p.1). Women who are pregnant or mothering report difficulty accessing care because of the increased stigma (Greaves, 2006). Many women who are pregnant or mothers and who are using substances or dealing with addiction, fear disclosing because of the shaming and blaming public discourse towards mothers who use substances (BC Centre of Excellence for Women's Health, 2010).

Barriers to mental health and substance use services exist on multiple levels. On a systematic level "punitive mothering policies, fragmented services, and narrow service mandates" are significant barriers (BC Centre of Excellence for Women's Health, 2010, p.3). Fear of losing their children is one of the most significant barriers to treatment. This is an issue echoed by women in this project as well. On a program level, "admission criteria and wait lists are common barriers" (BC Centre of Excellence for Women's Health, 2010, p.3).

And on a personal level, women may face various situations that make it difficult to seek treatment, including violent partners or lack of alternatives for leaving their children in the care of others (BC Centre of Excellence for Women's Health, 2010). A woman/mother-centred, harm reduction, and collaborative approach to practice, programs and policies is recommended by the BC Centre of Excellence for Women's Health (2010).

The Standing Senate Committee report (2006) demonstrates the deep divide between policy and lived experience due to ongoing stigma and discrimination towards women with mental health and substance use issues. Women too often fall through the gaps and are left struggling in the most adverse of situations. This was echoed in some of the stories from this project.

#### **2.3.4 Northern geographies**

Northern geographies influence women's health and can contribute to experiences of marginalization characterized by isolation, limited options, limited power, and being silenced (Leipert & Reutter, 2005). *The north* has been identified as the remote, thinly populated and resource-dependent regions characterizing much of Canada beyond the more heavily populated strip bordering the United States (Thien & Hanlon, 2009). Although Prince George is an urban centre with a regional hospital and university, it is distinct from southern cities by its relative isolation from other cities and its role as a service centre for a large rural region. Rural, remote and northern regions and centres are all different, but they often share certain characteristics such as economic uncertainty, feeling ignored and misunderstood by urban regions where decisions are made, and concerns about access to quality health care. In addition to individual and socio-cultural factors, health care practice and policy must attend to contextual factors of northern settings (Leipert & Reutter, 2005). A report analyzing the

2006 Standing Senate Committee report *Out of the Shadows at Last* through a gender-place lens, recommended that gender, place, and culture be factored into all health care policy (Whyte & Havelock, 2007).

Although the material entity of place has recently begun to be taken seriously in understandings about public health, place often remains a static, passive, and empty backdrop for other processes known to influence health such as income, education, and demographics (Thien & Hanlon, 2009). In other words, geography is viewed merely as a container for health statistics, while the way that place actively contributes to experiences is overlooked. Valentine (2007) provides a powerful example of how varying places and spaces, which are constituted by those who hold power, cause one woman's lived experiences of various social identities to either emerge to the forefront or recede to the background. Valentine (2007) highlighted "the significance of space in processes of subject formation" and suggested that intersectionality offers "a theoretical framework in which to develop geographical thinking about the relationship between multiple categories" (p.18). Parr (2000), writing specifically about the "geographies of mental health" post-institutionalization, shows how places act as "arenas of identity formation" and shows that "post-asylum geographies are complicated landscapes of inclusion and exclusion, something that we are only just beginning to understand (p.226, 236). In addition, Curtis (2010) argues that context matters for social relationships and the "interactions between individual people show variability from one setting to another, generating geographies of social relations (p.95). While some scholars are taking up this discourse, much work remains to understand how place is an important and active context for health experiences. This project attempts to incorporate an understanding

of the interactive influence of place and space on women's experiences of mental health and substance use.

#### **2.4 Why this project?**

Improvements in health inequities in Canada have lagged in part because the complex interactions between social (and geographic) determinants of health have not been sufficiently explored and incorporated into policy and practice (Hankivsky & Christoffersen, 2008). Gender is an important factor in addiction and mental health risks and experiences (Salmon et al., 2006). Women are over represented in certain mental illness diagnoses and are at higher risk of interpersonal victimization including childhood abuse, sexual abuse, and intimate partner violence; traumas that often co-occur with substance use and mental health problems (Ad Hoc Working Group, 2006). Indigenous women are burdened with a disproportionate amount of mental health and substance use issues, a health inequity that needs to be understood within the context of historic and ongoing colonialism and intergenerational trauma (Kirmayer et al., 2000). There are gaps in knowledge about women's experiences of mental health and substance use that have not been fully accounted for in research, health promotion, and treatment (Ad Hoc Working Group, 2006; Salmon et al., 2006). Additionally, many mental health policies and practices have neglected to address rural and northern community needs (Leipert & Reutter, 2005). Several reports acknowledge these gaps and call for research on women's experiences of mental health and substance use issues in order to support better policies, programs and service delivery (Ad Hoc Working Group, 2006; Salmon et al., 2006). This project is in part a response to these calls.

### CHAPTER 3 Methodologies

This chapter reviews and describes the methodologies underlying *Envisioning Change*. I begin with several key definitions of the terms and how they are used in this thesis. Then I provide an overview of qualitative, quantitative, and mixed-methods approaches and their fundamental knowledge claims. Following this, I engage with feminist and intersectionality methodologies and explain how they have shaped and influenced my research. I then introduce three other methodological approaches that have informed the project. Finally, I introduce Photovoice and discuss its underlying philosophies, how they align with the methodologies used in this project, and why I have chosen to use Photovoice. All combined, this chapter outlines the research framework for *Envisioning Change*, summarized in Table 4.

Table 4 Research framework

<b>Approach</b>	<b>Knowledge Claims</b>	<b>Methodologies</b>	<b>Research Design</b>	<b>Methods</b>
•Qualitative	•Social constructivism •Advocacy/participatory	•Feminist •Intersectionality  <i>Also informed by:</i> •Phenomenology •Critical Indigenous methodologies •CBPR	•Photovoice	•Purposeful sampling •Participant photography •In-depth interviews •Content analysis & phenomenography •Photography exhibitions •Questionnaires

There exists in the literature a wide range of overlapping uses and definitions for the key terms related to the overall process of research. In order to minimize confusion and misunderstanding, here are the definitions I used in this thesis. There are three main *research approaches* and these are quantitative, qualitative and mixed-methods (Creswell, 2003). *Knowledge claims* are broad assumptions about how a researcher will learn and what they

will learn during a research inquiry (Creswell, 2003). *Methodologies* provide a “philosophical framework” and general strategy of inquiry that informs the research procedures (Creswell & Plano Clark, 2007, p.4; Creswell, 2003). A *research design* is the plan of action linking philosophical assumptions (methodologies) with specific methods (Creswell & Plano Clark, 2007). *Methods* are specific techniques employed to collect and analyze data (Creswell & Plano Clark, 2007).

### **3.2 Research approach**

The practice of research involves combining philosophical assumptions with a research design and then implementing these through specific methods (Creswell, 2003; Creswell & Plano Clark, 2007). Philosophical assumptions about the nature of reality underlie all research designs (Creswell, 2003). Approaches to research are shaped by the assumptions we have about human behaviour, social processes, and political/economic realities. These assumptions in turn shape and frame the questions we ask, the types of data collected, and how results are interpreted.

Broadly speaking, the three main research approaches are quantitative, qualitative, and mixed methods. Each is based in different philosophies. *Quantitative* research is fundamentally premised on positivist and post-positivist assumptions that knowledge grows from careful observation and measurement of an objective reality that exists out in the world separate from ourselves (Creswell, 2003). In contrast, *qualitative* research is based on knowledge claims of social constructivism and advocacy or participatory approaches, which assume reality is subjective and reflects history and context<sup>29</sup> (Creswell, 2003). Social constructivism posits that knowledge is produced through social interactions, located within a

historical and spatial context. Within this knowledge claim, meaning from field data is generated through the researcher's analysis (as opposed to objective observation, as in quantitative research) (Creswell, 2003). Advocacy/participatory knowledge claims take constructivism further, adding social justice concerns. Research based in this philosophy is collaborative, includes the voices of people who experience various marginalizations, and strives for emancipatory action (Creswell, 2003). *Mixed methods* research is based in pragmatic knowledge claims with a focus on solutions to a research problem by using whatever methods work (Creswell, 2003). Some writers highlight the underlying philosophical assumptions of mixed methods, while others emphasize the techniques of collecting and analyzing data (Creswell & Plano Clark, 2007). Mixed methods research incorporates a combination of both qualitative and quantitative methods in one study, the results of which are combined using one of several procedures (Creswell, 2003; Creswell & Plano Clark, 2007).

My decision to undertake a qualitative research project is rooted in my own worldviews that align with social constructivism. From my perspective, reality is highly subjective. It is always shaped by one's experiences and context. I also have a strong interest in social justice and the multiple layers of marginalization and inequity that unfolds in the realms of health and wellness. A qualitative approach prioritizes the exploration and investigation of lived experiences through creative and narrative methods. Since qualitative research approaches accept that the researcher's analysis is influenced by her worldviews, histories, and experiences, I have provided a short self-reflexive piece as part of the introduction to this thesis. This project was based in two qualitative methodologies and

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<sup>29</sup> Additional comparison of quantitative and qualitative approaches relating to research quality, generalizability, reliability and reproducibility is provided in Chapter 4.

informed by several additional ones. Each are presented and discussed in the following section.

### **3.3 Feminist methodologies and intersectionality**

Broadly located in an interest in health inequities and structural power differentials that impact women and their risks for and experiences of substance use and mental health issues, my thesis was based primarily in feminist methodologies. I also applied the analytical lens of intersectionality, a recent theoretical innovation that moves beyond essentialized gender categories to include multiple social identities and systems of oppression in understanding gendered experiences.

Feminist methodologies broadly seek “to develop an account of the world that places women’s lives, experiences, and perspectives at the centre of analysis” in order to correct biased androcentric accounts (Hawkesworth, 2006, p. 3). Often characterized as “oppositional research,” feminist methodologies challenge the right of the powerful across diverse disciplines to (re)define realities (Hawkesworth, 2006). Feminist theories often apply a gender perspective, privilege women’s experiences, use participatory methods, and are concerned with social justice (Taylor, 1998). As Landman (2006) explains, “feminists are concerned with the implications of excluding women’s knowledge and experience within the traditional male constructions of knowledge” (p. 430). Essentially, feminist methodologies aim to inform an approach that challenges gender inequality and that empowers women (Taylor, 1998). In-depth interviews are a valuable way of engaging in feminist research and is the primary data gathering method used in this project. In my experience in this project, in-depth interviews created a space for women to tell their stories in a way that privileged their experiences and knowledge. Centering the interviews on women’s photographs not only

permitted women to choose their photography subjects, and therefore the topics they wanted to discuss in the interview, but it also encouraged a conversational quality to the interview and allowed me to share some information as well. In contrast, more structured and classically designed research interviews might take a more didactic approach, seeking answers to specific questions that may inhibit a level of familiarity and trust to develop which encourages spontaneous sharing.

In a 1981 article, Oakley highlighted several aspects of feminist interview approaches, all of which I employed in *Envisioning Change*. These included the interviewer sharing knowledge along with asking questions, using participatory approaches that challenge the power relationships between researcher and researched, and also working to challenge stereotypes and the relationship between the researcher and the researched. I was able to incorporate each of these feminist interview approaches by using participant photography in the project. Women in the project took photographs that symbolized for them important aspects of living with substance use and mental health issues. Their photographs then provided the focus for in-depth interviews. In this way, women's role in the research process shifted. They chose, through their photographs, the messages they decided were most important to convey. This acted to disrupt the typical power dynamic in a research relationship, shifting it in favour of participants (see Chapter 4 for more on the application of Photovoice in this project).

Experiences of gender can be intensified and structured by many other social dimensions and there is widespread agreement within sociology and feminist literature that “the concept of gender needs to be specified and contextualized” (Siltanen & Doucet, 2008, p. 175). Despite agreement that gender is a multifaceted phenomenon, and while its

complexities need to be considered, there remain questions about how exactly this complexity should be addressed to create useful knowledge (Siltanen & Doucet, 2008). One analytical strategy to address this is the theoretical innovation of *intersectionality*, which grew out of criticisms of second wave feminism that prioritized gender to the exclusion of other oppressions. The term was first coined in the 1980s by critical legal theorist and feminist Kimberle Crenshaw in her theorizing about the multidimensionality of Black women's experiences and their erasure within "single-axis" analyses of gender and race discourses (Crenshaw, 1989, p.57; see also Crenshaw, 1991). Intersectionality examines the complexity of social identities and inequities based on gender, race, class, disability, and sexuality (Bilge, 2010). It can be applied to a wide range of social science disciplines, including health research and policy.

Significant gaps remain in our understanding about the root causes of health inequities and consequently academics are beginning to apply intersectionality analysis to this problem (Hankivsky & Christoffersen, 2008). For example, while the social determinants of health approach (see Chapter 2) acknowledges differential access to resources by some groups due to societal processes linked to poverty, under employment, poor housing, community disadvantage, and ultimately inequities in health, the complex ways that the social determinants intersect and mutually reinforce one another are not fully understood (Smylie, 2009). Intersectionality strives to understand multiple and intersecting systems of oppression and privilege in order to better address health inequities (Hankivsky & Christoffersen, 2008). Instead of focusing on one aspect of identity, intersectionality is a tool to investigate experiences in terms of complexities and multiplicities.

As discussed in Chapter 2, gender is a widely recognized social determinant of health, resulting in what some consider ‘the mainstreaming’ of gender-based analysis (GBA) in health policy and research. GBA brings a much-needed focus on gender inequities, but has been critiqued for prioritizing gender and failing to account for complex interactions between multiple determinants (Kazanjian & Hankivsky, 2008; Paterson, 2010). GBA in practice is typically limited to comparisons of inequalities between women and men with little attention to the diversity and heterogeneity within these categories (Siltanen & Doucet, 2008). For example, within the category of women, there are great health disparities between Indigenous women and non-Indigenous women (see Chapter 2). Diversity *within* the gender categories of women or men includes race and ethnicity, class, ability, age, sexuality, and geography, to name a few.<sup>30</sup> The gap between the theoretical understanding of gender, which acknowledges diversity within gender categories, and the methodological practices of gender-based analysis, means that gender continues to be prioritized to the exclusion of other social identity categories (Siltanen & Doucet, 2008). This has excluded the issues and priorities of many vulnerable women from mainstream women’s health research, including Indigenous, ethnic minority, and low-income women (Hankivsky et al., 2010). For example, applying intersectionality to the social determinants affecting Indigenous peoples’ health allows for understandings of the effects of history, discourse, and power (de Leeuw & Greenwood, 2011).

Relevant to the location-specific nature of this research project, intersectionality analysis can inform policy implementation strategies for specific jurisdictions and locales

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<sup>30</sup> My project focuses on women, just one of many possible gender identities. It was beyond the scope of this project to engage with trans-identified people, however there is a need for research exploring differently gendered people and their experiences of mental health and substance use. Many of the issues resulting from marginalization and discrimination that are discussed in this thesis may apply to other populations as well.

(Siltanen & Doucet, 2008). The need for specific and contextualized policy has been argued in the Status of Women papers produced for the *Integration of Diversity* initiative (Siltanen & Doucet, 2008). These papers call for the recognition of diversity within gender categories and for contextualized policy and delivery mechanisms (Siltanen & Doucet, 2008).

The analytical lens of intersectionality is still very much in development and there is ongoing discussion and debate about how to apply it to analyze the everyday lives of women (Siltanen & Doucet, 2008). One approach is to assume the importance of gender in people's lives. However, most authors investigate rather than assume the significance of gender and other social identity categories. The approach to research questions of assuming little about the significance of categories of difference allows it to become known through the investigative process (Siltanen & Doucet, 2008). This approach strengthens interpretive value through being open to those theoretical categories that may be analytically relevant (Siltanen & Doucet, 2008).

A related consideration for the application of intersectionality is if some dimensions are more important than others (Siltanen & Doucet, 2008). Valentine (2007) shows that space and context are significant in bringing certain dimensions to the fore or to the background depending on how individuals experience themselves in different contexts. She notes that specific spaces are produced and stabilized by the dominant groups who occupy them and thereby highlight different oppressions (Valentine, 2007). Although there continues to be much debate about the ways that multiple inequalities intersect and even matter, agreement is developing that "grand generalizations about the nature of relationships between categories of experience are of little use" (Siltanen & Doucet, 2008, p.184). This points towards "seeking answers in the specifics of people's everyday lives" (Siltanen & Doucet, 2008,

p.184). Oppression is located at the structural social institutional level and it can also be analyzed at the individual experiential level (Siltanen & Doucet, 2008). *Envisioning Change* undertook to investigate intersecting oppressions within a particular geographic locale via women's lived experiences of substance use and mental health in their everyday lives.

Intersectionality analysis developed as a theoretical argument, but there has been limited discussion about its application to inform methodology, or how to put it into practice (Siltanen & Doucet, 2008; McCall, 2005). McCall (2005) proposes three approaches to intersectionality that differ in their understanding and use of analytical categories: *anticategorical complexity*, *intercategorical complexity*, and *intracategorical complexity*. Intracategorical complexity falls conceptually between the other two approaches and was the inaugural approach to the study of intersectionality (McCall, 2005). Similar to anticategorical complexity, the intracategorical approach "interrogates the boundary-making and boundary-defining process itself" but "acknowledges the stable and durable relationships that social categories represent" (McCall, 2005, p. 1773-4).

I applied the intracategorical approach in my research because it permits the focus on a particular social group at neglected points of intersection in order to reveal the complexity of lived experiences within that group (McCall, 2005). This approach, according to McCall (2005), neglects to analyze differences *between* groups. This would be an intercategorical approach and is beyond the scope of my research because it would require comparisons between each category of diversity. For example, it would be necessary to compare the experiences of men and women within each category of visible minority status, as well as contrast the experiences of all visible minority groups within each gender category (McCall, 2005). While this approach lends itself to quantitative or mixed methods designs, the

intracategorical approach is well suited to in-depth qualitative methods such as narrative, case study or ethnography (McCall, 2005). These methods permit the identification of new or invisible groups at the intersection of multiple categories and the in-depth investigation of lived experience. This is at the heart of what my project undertakes.

Intracategorical complexity begins by acknowledging broad structures of inequality, such as gender, ethnicity, and class. It remains skeptical, however, of categories as “misleading constructs that do not readily allow for the diversity and heterogeneity of experience to be represented” (McCall, 2005, p. 1783). Social groups that are subjects of analysis are investigated in detail and complexity, although in the end some generalizations about the group must be made (McCall, 2005). While not fully rejecting or deconstructing categorizations, overall intracategorical studies remain deeply skeptical about homogenizing generalizations that occur with classification and categorization (McCall, 2005). As McCall summarizes, “the point is not to deny the importance – both material and discursive – of categories but to focus on the process by which they are produced, experienced, reproduced, and resisted in everyday life” (p. 1783).

### **3.4 Review of additional informative methodologies**

Feminist methodologies and intersectionality shaped the design of this project, but it was also informed by other methodological approaches. These are briefly discussed below.

#### ***3.4.1 Interpretive and critical phenomenology***

In contrast to descriptive phenomenology, which views reality as objective and independent of history and context (a methodology that would fit within a quantitative project), interpretive and critical phenomenological methodologies consider subjective experiences to be “inextricably linked with social, cultural, and political contexts (Lopez &

Willis, 2004, p. 729). Within this orientation, the researcher is viewed as having expert knowledge, which guides the research process, in contrast to the descriptive practice of “bracketing” one’s preconceptions and personal knowledge (Lopez & Willis, 2004). Critical phenomenology is an emancipatory application of the interpretive approach that acknowledges the effect of dominant worldviews in silencing marginalized individuals and groups (Lopez & Willis, 2004). The researcher “teases out how dominant belief systems serve to mask, gloss over, ignore, or trivialize the realities of the participants” (Lopez & Willis, 2004, p. 731). Aspects of interpretive and critical phenomenology that I applied in my project included the social constructivist worldview and the importance of structural power in silencing certain voices. However, intersectionality takes these concepts further by specifically addressing the complexity of multiple oppressions and identities while acknowledging the socially constructed nature of our worlds. Colonialism, for instance, is a powerful social construct impacting lived realities especially for Indigenous women and especially in northern geographies like Prince George, BC.

### ***3.4.2 Decolonizing and critical Indigenous methodologies***

When initially conceptualizing this project, I was conscious that based on the research topic and the location of the study, it may be disproportionately relevant to Indigenous women. I argue that any project on mental health and substance use in northern BC could not be ethically undertaken without consideration of the deep impacts of colonialism on Indigenous peoples and its implications for research. Both Indigenous and critical methodologies acknowledge that all inquiry is both political and moral and that research is inextricably linked to European imperialism and colonialism (Denzin & Lincoln, 2008). Smith (1999) describes how the term ‘research’ can conjure deep distrust by Indigenous

communities since it “is implicated in the worst excesses of colonialism [and] remains a powerful remembered history for many of the world’s colonized peoples” (p.1). Indigenous inquiry is distinct from other methodologies by the explicit inclusion of cultural protocols, values, and behaviours in the research (Smith, 1999). I approached this project committed to engaging with themes related to the impacts of colonization that arose in the course of the project. However, since this project was not undertaken in an Indigenous context or community in which cultural protocols would be appropriate, these strategies were not explicitly incorporated.

Recognizing that knowledge is power, Smith (1999) has identified several questions that Indigenous communities often want to know about research. These questions can and should be considered in non-Indigenous contexts as well, since they fuel ethical thinking and decision making related to research projects. These questions include: Whose research is it? Who owns the research? Whose interests does it serve? Who will benefit from it? How will its results be disseminated? These questions are important in community based participatory research as well. I have attempted to respond to each of these questions in various discussions throughout this thesis. For example, questions of ownership are discussed in relation to ethical considerations in Chapter 4. Questions of who benefits and dissemination of results are discussed in Chapter 4 within the section on knowledge for action.

### ***3.4.3 Community-based participatory research***

Community based participatory research (CBPR) is a methodology that focuses on shifting the locus of control towards a community of interest by involving diverse partners in all aspects of the research design and implementation, and conducting research that benefits the communities involved (Israel, Eng, Schulz & Parker, 2005). Most CBPR seeks

knowledge for action and includes either direct interventions or initiatives to influence policy (Israel et al., 2005). What distinguishes participatory approaches from other methodologies are not the methods, which are often used within different paradigms as well, but the methodological contexts of their application that shifts the “location of power” at all stages of research (Cornwall & Jewkes, 1995). These ideas are particularly compatible with *Envisioning Change*. Indeed, I drew extensively on the broad methodological concepts of CBPR and yet chose not to carry out such a project for several reasons.

While this project shares some similarities with CBPR, it differs in important ways as well. Challenges to CBPR as a methodology include a number of critiques. First, CBPR approaches may overlook power differentials within a community by engaging community leaders to help set research priorities and goals (Canadian Institutes of Health Research, 2007). Those less empowered in a community may not have their needs and priorities represented by leaders who may even block research projects desired by marginalized members (Canadian Institutes of Health Research, 2007; Cornwall & Jewkes, 1995). Second, it can be difficult to identify a distinct community or the most appropriate representatives to engage and consult with (Cornwall & Jewkes, 1995). Third, there can sometimes be a mismatch between a researcher’s need to consult and engage community members and the community’s resources and priorities to fulfill consultation requirements (de Leeuw, Cameron & Greenwood, 2012). In addition, marginalized populations may be struggling with basic needs and lack the resources and energy to engage in the research process (Cornwall & Jewkes, 1995). Fourth, and as Pain (2004) suggests, despite the intent to balance power through CBPR, there may be an implied paternalistic relationship that overlooks how communities are able to empower themselves. Despite the claim of developing shared

research questions, CBPR projects are often top-down and driven by academic and funding priorities. Finally, CBPR requires a long-term commitment by the researcher to follow-through on relationships developed throughout a CBPR project. This may exceed realistic capabilities of a Master's thesis. Although I did not conduct a CBPR study, I employed Photovoice, a procedure often identified as a CBPR methodology.

### **3.5 Photovoice: The theory behind the practice**

Often described in the literature as a CBPR methodology, I used Photovoice as a research design because it provides a link between methodologies and methods. The specific methods of *participant photography* and *photo-elicited interviews* are described in Chapter 4, but here I will introduce the three key theoretical frameworks underlying Photovoice as founders Wang and Burris originally conceived it. This discussion shows how well Photovoice aligns with feminist and intersectionality methodologies.

The first theoretical framework is Paulo Freire's approach to critical education. Freire understood that every person is capable of perceiving and dealing critically with the world if given the right tools (Wang & Redwood-Jones, 2001). Freire proposed that the visual image in particular is a powerful tool for critical engagement (Wang & Redwood-Jones, 2001). The second framework underlying Photovoice is feminist theory, in which power accrues to "those who have voice, set language, make history and participate in decisions" (Wang & Redwood-Jones, 2001, p. 561). Photovoice empowers by bringing "seldom-heard ideas, images, conversations, and voices into the public forum (Wang & Redwood-Jones, 2001, p. 561). And finally, Photovoice has been informed by a community-based approach to

photography<sup>31</sup> as a way for ordinary people to use cameras for social change (Wang & Redwood-Jones, 2001). With roots in feminist inquiry, Photovoice values the experiences of women. Photovoice provides an alternative to positivist ways of knowing and conceptualizing the world. Photovoice asks women to photograph representations of their lived realities that then bring to life the depth and breadth of our lives and challenges (Wang, 1999). Wang (1999) suggests Photovoice to explore health concerns that have been overlooked, unconceptualized, or ignored but are central to women's experience. This may include investigating the relationship between multiple social identities, which is also something intersectionality explicitly strives to do. In addition, both Photovoice and intersectionality require constant interpretation and analysis of power and the conscious intent to improve inequities through analysis of lived experiences of those who exist on the margins of mainstream society. This was something that I focused on throughout the research.

A key for disrupting the typical power dynamic between researcher and interviewee is the use of participant photographs to guide group discussions and individual interviews. Not only does this allow for participants to determine what is of meaning and importance to them by the subject of their photographs, but also through the analysis and interpretation of meaning. Participant analysis of images through the identification of meaning and themes is critical to the Photovoice method. Although in some circumstances, researchers engage in analysis of the images (for example Poudrier & Mac-Lean, 2009), Wang (1999) asserts that

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<sup>31</sup> Jo Spence, a British photographer, provided cameras to in order to take pictures of topics that included illness, social injustice, sexuality, and joyful events (Wang & Redwood-Jones, 2001). Photovoice has also been informed by the work and teachings of other community-involved photographers including Wendy Ewald, who taught photography to children around the world; Jim Hubbard, who originated the "Shooting Back" projects with homeless children; and Alex Harris, who co-founded Duke University's Center for Documentary Studies (Wang & Redwood-Jones, 2001).

in order to maintain an empowering and participatory approach, it is important that participants analyze and identify the meaning of images (Wang, 1999).

Chapter 3 has presented an in-depth discussion and explanation of the philosophical assumptions and methodologies behind *Envisioning Change*. In Chapter 4 that follows, the specific methods used to operationalize the project are presented in detail.

## CHAPTER 4    Methods

Research methods are the *who, what, when, where* and *how* of a project. In this chapter, I describe the practical implementation and some of the underlying considerations of conducting this research project. I begin with an overview of the project, a description of the connections I made in the community, and the sampling and recruitment processes used. I then review the group orientation session that initiated the data-collection portion of the project. Section 4.2 outlines the methods used to collect data and the different types of data that were gathered. Following this, I explain the methods used to thematically analyze the interview data. The two concluding sections provide discussions about research quality and ethical considerations for this project.

### 4.1    The project

*Envisioning Change* was launched with six participants in August 2011 after recruitment with the assistance of several community organizations. Data was collected using an adaptation of the Photovoice method. Women took photographs guided by questions about their daily lives, the challenges and strength they find living with mental health and substance use issues, and their experiences accessing services in a comparatively small northern community. Their photographs were then used to guide individual, in-depth, qualitative interviews. Interviews were recorded and I transcribed them to produce interview transcripts, which were analyzed for themes. The women participated in several group sessions over the months to coordinate the project and we all worked together to organize a photography exhibition that was installed at *ArtSpace* in downtown Prince George in March 2012.

Table 5 Project Timeline

2011	May	• Developed connections with community organizations
	June	
	July	• Recruitment • Individual meetings with potential participants • Project orientation
	August	
	September	
	October	• Participant photography
	November	
	December	• Individual interviews • Transcribed interviews
2012	January	
February	• Planned photography exhibition	
March	• Data analysis • Photography exhibition at <i>ArtSpace</i>	
April	• Follow-up group session to present results to participants	
September	• Website launched	
2013	January	• Photography exhibition at Rotunda Gallery
	August	• Thesis defence
	September	• Project summary

As a project undertaken at the community level, I began by contacting several organizations in Prince George that provide services to the population I sought to reach. The purpose of contact was multi-fold. First, as an information exchange process, I wanted to inform organizations of my planned project and learn from these service-provision organizations what I could about the context of women’s mental health and substance use services in Prince George. Second, I hoped to find assistance in the form of letters of support (for the ethics approval process), with recruitment, and meeting space.

After identifying key organizations with the assistance of my supervisor, I made email contact and followed with phone calls to 10 organizations. In my initial e-mail introduction, I provided a project proposal brief (see Appendix I). I met with individuals from nine organizations.<sup>32</sup> The meetings ranged from brief exchanges to several hours of

<sup>32</sup> Central Interior Native Health, Elizabeth Fry Society, AWAC, Phoenix Transition House, The Native Friendship Centre, Canadian Mental Health Association – PG Branch, Positive Living North, Youth Around PG (YAP), and Future Cents.

discussion about the issues of substance use and mental health in the community. I learned a great deal through these meetings and they helped me shape the direction of the project. For example, through discussions, it became very clear that there is a wide range of realities along the mental health and substance use spectrums and that, in order to keep the project within a manageable and safe zone for everyone involved, I should take this into consideration for recruitment. Two organizations provided letters of support for the project and several assisted with recruitment and offered space for group meetings and individual interviews. I am very grateful to have undertaken my project in a city and within a community that is so supportive of student projects.

Purposeful sampling was used to recruit participants who self-identified with the topic of the study. As a qualitative sampling technique, purposeful sampling is intended to provide a view into a specific situation or phenomenon (Koerber & McMichael, 2008). Sample size has implications for a research project and its outcomes. For example, larger sample sizes typically provide more generalizable results. Those results, however, may be unmanageable, too resource-intensive (time and money), or reduce the depth and breadth of data. This project sought richness and depth of data instead of generalizability,<sup>33</sup> so the target number of participants was 8-10 women. As well, Photovoice projects ideally include 7-10 participants to allow for practical ease and in-depth discussion (Wang, 1999).

I recruited with the assistance of several community level organizations that I met with (as opposed to the Northern Health Authority) in part because I did not want to exclude women who may experience substance use and mental health issues but who have not accessed 'formal' services (such as psychiatric assessment, support groups through the hospital, etc). Accessing a population that has not necessarily entered the institutionalized

mental health and addictions system was an effort to prioritize women's understandings of themselves and their own realities, instead of their learned understandings through institutional contact.<sup>34</sup>

I provided a recruitment poster (see Appendix II) to four organizations that I had made contact with and asked that they post it in a visible location and inform any clients who they thought may be interested. Participation was completely voluntary. I considered placing posters in public spaces around Prince George, although decided to recruit exclusively through community organizations to ensure that participants were connected to supportive services. Inclusion criteria were: women, 19 years and older, who self-identified as having experienced substance use issues and emotional distress,<sup>35</sup> and who were living in Prince George, BC.

Over the course of three months during which I was actively recruiting, twelve women contacted me interested in participating in the project. After first contact, I met individually with each potential participant at a local café to talk about the project generally, to review the informed consent form (see Appendix III and IV), answer any questions, and to establish a few baselines. The questions covered in the initial meeting included their motivation for participating, any expectations they had of the project, and their past experience taking photographs (I made it clear that experience was not required). I also asked about the supports women had in their lives and if there were any barriers to their participation in the project. Access to established supportive resources was an important

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<sup>33</sup> Generalizability is the ability to extend the results of a study to a broader group.

<sup>34</sup> As it turned out, all of the women in the project had some level of interaction and service utilization from the Northern Health Authority.

<sup>35</sup> In the recruitment poster, I chose to use the words 'emotional distress' instead of 'mental health issue' because I wanted to use words that were more inclusive of a variety of mental health experiences. 'Emotional distress' is also a phrase that I thought participants might more readily identify with and not feel labeled or stigmatized by.

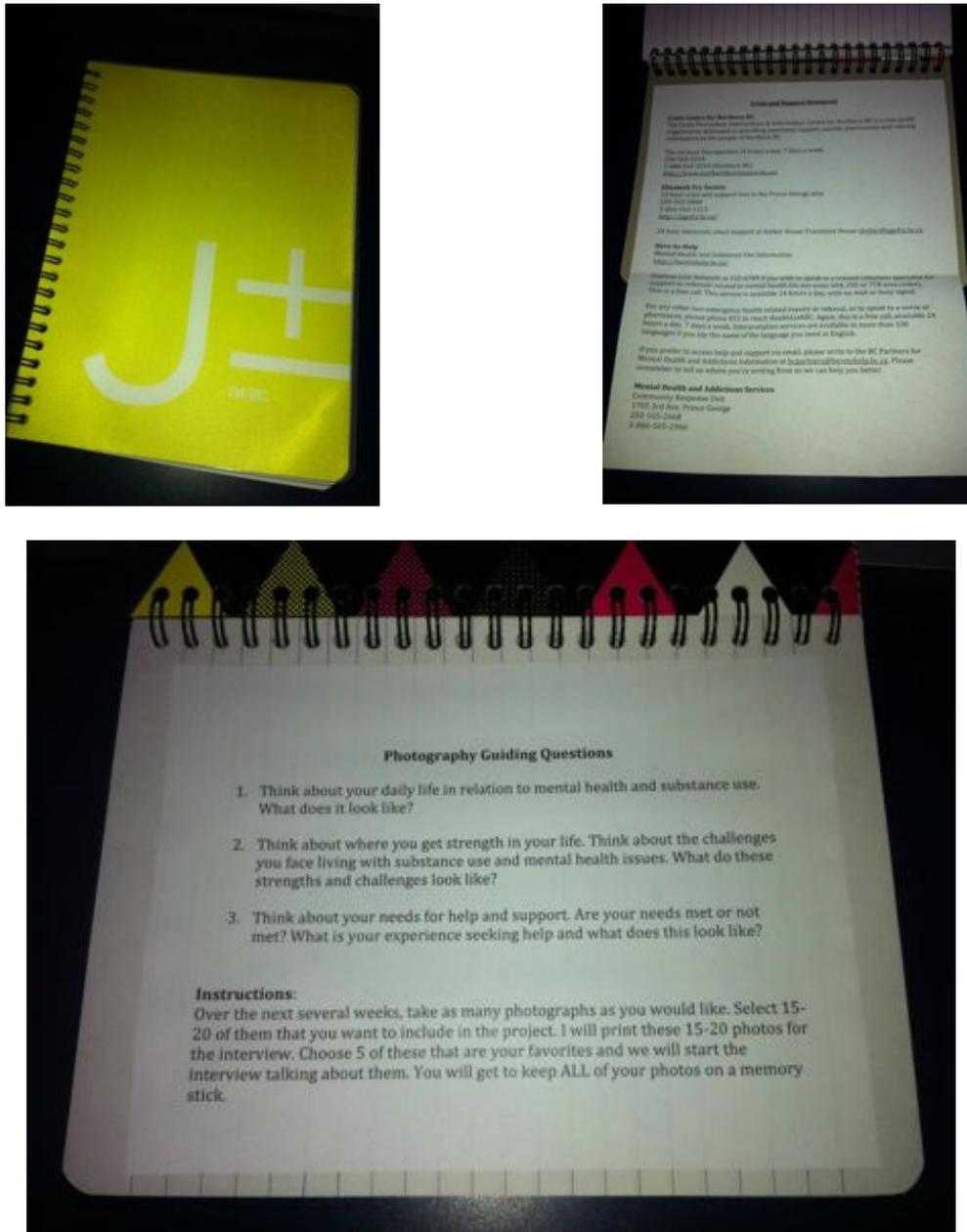
consideration for women's participation to assist them maintaining emotional and mental safety throughout the project.

I met with eleven women overall and maintained contact with nine by the time of the project orientation meeting. Of the nine women I expected at the orientation, six women attended. Six participants began the project at the end of August 2011. Because this number was smaller than I hoped for, and because I expected some dropout over the course of the project, I continued to follow leads on possible participants. In the end, no new women joined the group. Over the first few months of the project, one woman returned to treatment and fell out of contact.

The purpose of a first group meeting was to orient participants to the project and to facilitate a discussion related to ethics and safety when taking photographs for the project, an important step in any Photovoice project according to Wang and Burris (1997). We explored ideas about authority and responsibility when taking photographs, and about potential risks and safety issues, both emotional and physical. At this meeting I introduced a second consent form titled "Acknowledgement and Release" (see Appendix V), which required participants to obtain the consent of anyone they included as a recognizable subject in their photographs.

Each participant was loaned an entry-level digital camera and asked to take 15-20 photographs over several weeks. I provided participants with a notebook for their personal use in the project. I encouraged them to record their thoughts about the photographs they took in order to help them remember for the interviews, but made it clear that the notebooks would not be submitted for the project. The notebook also included basic instructions, guiding questions for their photography, and a list of crisis resources in the community if they found themselves needing additional support (Figure 5).

Figure 5 Participant notebook with guiding questions and crisis resources



At the end of the orientation, a photographer from the community joined the group to provide an introduction to the cameras and some photography tips. This person signed a confidentiality agreement in advance of the meeting and each participant was informed that he would attend to ensure that all were comfortable with this approach (see Appendix VI).

Photovoice projects require significant investment of time and commitment from participants. This particular project unfolded over the course of eight months. In recognition of their contributions, participants received an honorarium of a \$75 gift certificate at the end of the study. In addition, I put together small albums of their photographs and several pictures of their photographs at the *ArtSpace* exhibition. Participants also kept their individual guest book that contained comments from exhibition attendees. While these small tokens could never fully represent my appreciation for the participant's dedication and contributions to the project, I hope that they understand my gratitude and indebtedness to them.

#### **4.2 Data collection**

The main source of data in this project was photo-elicited, in-depth interviews that took place after the participant photography phase. Some women needed more time for the photography phase than others, so as participants completed their photography and were ready, we met individually for an interview. Their photographs were used as a departure point for the interviews, which were three hours long on average. They were conducted in a private room at one of two community organization locations chosen by the participant. Interviews were digitally recorded for later transcription. A key feature of Photovoice is participant analysis, a process by which participants select, contextualize and code their photographs through interviews or group discussion (Wang & Burris, 1997). I did not engage in any formal analysis of the photographs myself.

Three additional sources of data were collected to enrich the project. In order to gain some insight into the potential impact of the photography exhibitions, a brief questionnaire was available to exhibition attendees (which will be discussed in the following section). At a

concluding group session, I presented the preliminary analysis of the interviews to participants and asked for their feedback. This discussion was recorded and transcribed (results are included in Chapter 5). At the end of the project, participants completed a brief questionnaire about their experiences participating (see Appendix VII). In sum, the interview narratives provide the basis of my research findings and three additional sources of data were collected to provide information on the project’s impact and to deepen the qualitative interview analysis.

Table 6 Data sources

Main Data	Individual interviews
	Participant feedback on preliminary interview data analysis
Additional Data	Exhibition attendee questionnaire
	Participant experience questionnaire

### 4.3 Data analysis

Qualitative research can be quite diverse in the methodologies and methods used. A literature review on qualitative data analysis that included grounded theory, content analysis, and phenomenography informed my thematic analysis of the interview data. My analytic approach was primarily based on phenomenographic methods and a qualitative content analysis method described by Graneheim and Lundman in a 2004 health research article. The first step I undertook was to identify *content areas*. I used the questions that guided participant photography to identify the basic content areas as: experiences of substance use and mental health; strengths and challenges; and accessing services (see Figure 5 for the questions that guided participant photography). I then identified *meaning units*, or pieces of relevant text, within the transcripts. I began by closely reading the interviews and populating a table with meaning units to be condensed and abstracted into codes. This approach to analysis relates specifically to the *manifest* content of the transcripts, or the “visible, obvious

components” (Graneheim & Lundman, 2004, p.106). My experience of this method was as a very bottom-up approach to data analysis. While useful in providing an initial structure, it left me overwhelmed by detail and lacking a clear sense of the larger themes.

In consultation with my supervisor and another academic advisor, Dr. Neil Hanlon, I began to simultaneously approach the data with a wider perspective. This involved identifying broad themes that emerged across interviews, then populating the themes with evidence from the transcripts. This process initially began during transcription, when I took note of repeating concepts, similarities, and differences between the interviews. As opposed to manifest content, this aspect of data analysis deals with the *latent* content, or “interpretation of the underlying meaning of the text,” which is parsed out as themes (Graneheim & Lundman, 2004, p.106). This process is similar to phenomenographic methods of analysis. These approaches undertake to describe experiences through repeated rounds of analysis of in-depth interview transcripts that are viewed holistically, not individually (Marton, 1994).

Throughout the analysis, I incorporated the analytical lens of intersectionality, a methodology outlined in detail in Chapter 3. I approached the data with an awareness of the whole person and the multiplicity of social identities, including gender, culture, racialization, socio-economic position, health status, and others. I remained aware that each of these might have interacting impacts on participant’s experiences of mental health and substance use. I also tried not to assume primacy of any one category of identity, and indeed, in line with intracategorical complexity, I viewed social categories as a useful conceptualization while attempting to not reify them through my analysis.

This project utilized two questionnaires. One was an open-ended questionnaire asking participants about their overall experience in the project (Appendix VII). The other gathered information on attendees of the photography exhibitions (Appendix IX). The exhibition questionnaire asked two rating scale questions.<sup>36</sup> One question asked about attendees' self-rated knowledge of the subject prior to the exhibition, the other was a follow-up question to assess any self-rated change in attendees' understandings or assumptions about women with mental health and substance use issues after the exhibition. This data provides descriptive information based on a count of responses and resulting percentages for each category. The open-ended qualitative comments from attendees added depth and nuance to the findings.

#### **4.4 Knowledge for action**

Informed and motivated by the theoretical approaches of feminism, social justice, and community-based research, this research was conceived as ideally being an *exchange* that benefits both the researcher and the participants/communities who participated. *Knowledge translation*, also known in Canada by the terms knowledge exchange and knowledge transfer (Straus, Tetroe & Graham, 2009), is “a dynamic and iterative process that includes the synthesis, dissemination, exchange and ethically sound application of knowledge to improve health, provide more effective health services and products, and strengthen the health care system” (CIHR, 2013, par.1). Knowledge translation is about moving “beyond the simple dissemination of knowledge into actual use of knowledge” (Straus et al., 2009). I wanted not only to be the *recipient* of information, but also to *return* outcomes of the project to participants and communities in a meaningful way. Providing *deliverables* to participants and the broader community is an important ethical consideration in all research (Israel et al.,

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<sup>36</sup> Rating scale questions ask respondents to rate a particular issue on a scale.

2005). It is also an important part of CBPR projects (see section 3.4.3). I undertook to give back to the women and the community in a number of ways throughout this project.

Additionally, the specific actions outlined below are linked to the goals of the project to promote dialogue and understanding of substance use and mental health issues among the community and the public, and to inform individuals in policy and practice for improved services in northern BC (see Table 1 for project goals).

#### ***4.4.1 Photography exhibitions and presentations***

From the beginning of the project, I suggested that if the group so chose, we could exhibit their work in a public format. The women unanimously agreed they wanted to display their work, so together we organized a photography exhibition that was installed at a local venue called *ArtSpace* in downtown Prince George in March 2012. The exhibition highlighted a selection of women's photographs that were accompanied by their words. Each participant chose which photographs they wanted to display and the words to accompany them. An email invitation to the exhibition was sent to a long list of community organizations, individuals, local legal and political offices, clinics, hospital contacts, list-serves, educational institutions and departments, and more. The exhibition was viewed by a wide range of people and received local media attention, including a radio interview aired on CBC Daybreak North, a radio clip played on 94X The Wolf, a front page photograph in The Free Press, and website coverage by Prince George Tourism (see Appendix VIII). The exhibition provided an opportunity for the work to be exhibited in a semi-professional

format<sup>37</sup> and for the community to learn about and interact with the project.

The wall used to display information about the overall project is shown in Figure 6. I included a poster that was presented at the Public Health Association of British Columbia conference in November 2011. The recruitment poster and posters advertising the exhibition were included, as well as a tri-fold pamphlet on the project for people to take away. A one-page questionnaire and a box to submit the questionnaires were provided (see Appendix IX). To encourage completion of the questionnaires, those who provided their name and contact were entered in a draw for a digital photo frame.<sup>38</sup> Part of the purpose of exhibiting the project publicly was to increase dialogue about mental health and substance use issues to support understanding, emotional connection with those struggling, and to reduce misunderstanding and stigma. I placed blank paper on the wall with the question “What is mental health to you?” as an invitation to further engage in the topic (Figure 7). Responses to this question are summarized in Appendix XI for interest, but do not form part of the data for this project.

Working with the women to plan the exhibition, I provided some guidelines based on budget and size of the room. For each participant, four to five images were enlarged to 16” x 20”, mounted on foam core and laminated. One participant chose to display more images at a smaller size of 8” x 10”. The women decided they wanted to present their photographs grouped by individual and to have a guest book for each so they could keep the comments from attendees. Two women were able to assist with the actual installation of the exhibition

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<sup>37</sup> Several women commented on what a powerful experience it was to have their photographs enlarged and exhibited in a public art gallery space for others to see and interact with. This was a unique experience for all of the women and I was told made them feel like their realities were valued in a way that they were not typically. Additional feedback from participants on the project experience is presented in section 5.4.

<sup>38</sup> The draw was only for the March 2012 exhibition and not the January 2013 exhibition. Submission of name and contact was completely voluntary and were detached from the questionnaires in order to maintain anonymity of respondents.

and helped make decisions about where and how the images would be installed. Pictures of the photographs displayed at *ArtSpace* are represented in Figures 8-12. One woman expressed a strong sense of how she wanted her images displayed, and Figure 10 shows her photographs connected with a geometric web of yarn.

Figure 6 Project information at ArtSpace Photography Exhibition March 2012



Figure 7 Community response to "What is mental health to you?"



Figure 8 ArtSpace exhibition

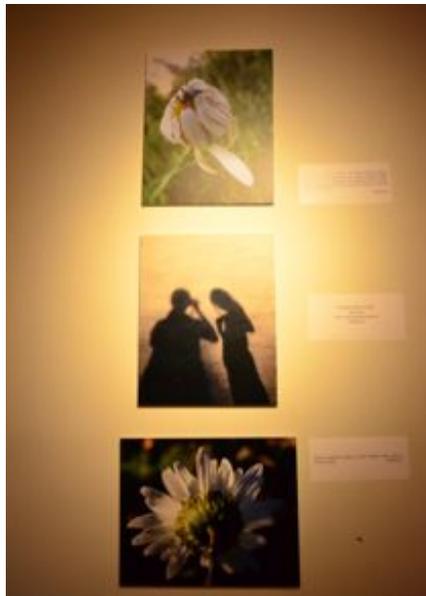


Figure 9 ArtSpace exhibition



Figure 10 ArtSpace exhibition



Figure 11 ArtSpace exhibition



Figure 12 ArtSpace exhibition



Another exhibition was held in January 2013 at the University of Northern British Columbia Rotunda Gallery. Although not planned in collaboration with participants, each consented to the use of their photographs and narratives in additional exhibitions (Appendix XV). I was able to include additional images and several of larger size, thanks to a bigger gallery space, a financial contribution from the UNBC Arts Council, and funding from Dr. Sarah de Leeuw. For this exhibition, I placed two different questions on the wall as an invitation to engage in the topics: “What is mental health to you?” as well as, “What substances did/do you use. Why?” The community responses to these questions are shared in Appendix XI and XII for interest. It is worth noting that the space of the exhibition was located on campus at the university, so likely had quite different foot traffic than the downtown exhibition location.

This exhibition received less media attention, but was announced on CBC daybreak north the week of the opening. I sent an email invitation to the same list of contacts as the *ArtSpace* exhibition; however, a smaller number of people attended the opening night, approximately 25. Throughout the course of the month long installation, I received positive feedback and interest from several people at the university, including a professor who held a class in the space so that his students could engage with concepts related to mental health and substance use. Images of the exhibition are presented in Figures 13-18.

Figure 13 Rotunda exhibition



Figure 14 Rotunda exhibition



Figure 15 Rotunda exhibition



Figure 16 Rotunda exhibition



Figure 17 Rotunda exhibition



Figure 18 Rotunda exhibition



Women in the project were interested in their contributions having wide exposure for greater impact. The exhibitions were one way to accomplish this, as were the seven papers and two posters I presented at local, provincial, national, and international conferences over the course of the project (see Appendix XIII).

#### **4.4.2 *Project website***

I built a project website as a perpetual source of information on the project and to overcome the boundaries of place and time to make the project accessible to a global audience ([www.envisioningchange.ca](http://www.envisioningchange.ca)). The website went live in September 2012 and was distributed to participants for their comments before it was shared widely with local community organizations, national networks, and various email lists in December 2012. As of July 1, 2013, the site had received 825 visits from 362 people, mostly located in Canada. I shared the website via Twitter to specific organizations working in mental health, including the Canadian Mental Health Commission, Canadian Mental Health Association (CMHA) National, CMHA BC and Centre for Addiction and Mental Health (CAMH). It was re-Tweeted by CAMH to over 10,000 followers. There is a comments section of the website which has received several supportive posts, including one that speaks to the impact that this kind of project can have for individuals.<sup>39</sup>

#### **4.4.3 *Summary report***

After defending this thesis, I will finalize a summary report to provide an accessible documentation of the project and results. A thesis has a specific academic purpose and typically includes theory and language that may be less useful for those working at the

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<sup>39</sup> To view the comments on the project website, visit:  
[http://www.envisioningchange.ca/Envisioning\\_Change/Comments.html](http://www.envisioningchange.ca/Envisioning_Change/Comments.html)

community level. The design of the summary report will be much briefer and will focus on the project, the methods, and the results. This will hopefully be a more useable format for sharing the project in a meaningful way with participants and community members. The summary report will be sent by email to the community organizations that supported the project and will be available on the project website. Participants will each receive a hard copy of the summary report and thesis.

#### **4.5 Research quality**

Achieving quality in research is necessary if the results are to be used productively, as a basis for developing policy and legislation, or in guiding program development and implementation. Evaluating quality in qualitative research is a complex process. This project was designed to include measures of quality, the specifics of which are discussed in what follows.

The criteria used to evaluate quality depends on if the research is quantitative or qualitative. Within quantitative approaches, reliability, validity and generalizability<sup>40</sup> are the measures of quality, also known as objectivity and trustworthiness. These measures do not necessarily transfer adequately to qualitative research because of underlying philosophical differences.<sup>41</sup> There remains debate among scholars about how to evaluate quality in qualitative research (Mays & Pope, 2000). Some scholars, such as Collingridge and Gantt (2008), are willing to use the quantitative terms ‘reliability’ and ‘validity’ but suggest alternate ways they are achieved in qualitative research, for example by “selecting an

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<sup>40</sup> Validity is the extent to which what is *claimed* to be measured is *actually* measured and reliability is a measure of reproducibility given a similar context (Collingridge & Gantt, 2008). Generalizability is the ability to extend the results of a study to a broader group.

<sup>41</sup> External objective reality (quantitative approaches) versus socially constructed and historically contextualized reality (qualitative approaches). See Chapter 3.

appropriate method for a given question and applying that method in a coherent, justifiable, and rigorous manner” (p. 391). Others, such as Auerbach and Silverstein (2003), suggest *justifiability of interpretations* and *transferability of theoretical constructs* as replacement concepts for reliability, validity and generalizability. In order for research to be justifiable, it needs to be transparent (clear steps), communicable (understandable by others) and coherent (theoretical constructs fit to make a coherent story) (Auerbach & Silverstein, 2003). One of the challenges within qualitative research is that different measures of quality are often applied within different methodologies.

In response to this fragmentation and in an attempt to identify more generalized criteria to assess qualitative research, Tracy (2010) has proposed eight universal criteria: a worthy topic, rich rigor, sincerity, credibility, resonance, making a significant contribution, ethics, and meaningful coherence. I address quality in both the project design and the implementation of *Envisioning Change*, a process that involved a number of steps and which unfolded over the duration of the project.

As identified by Collingridge and Gantt (2008), Auerbach and Silverstein (2003), and Tracy (2010), a critical measure of quality in qualitative research is research design *coherence*. This is the alignment of the methodologies with the methods and analysis to tell a story that makes sense. This project begins with a social constructivist worldview and a concern with social justice. Feminist methodologies and intersectionality form the philosophical framework of the project, which is operationalized using Photovoice and specific methods compatible with all of the above. This research framework is summarized in Table 4. Photovoice seeks to empower those living on the margins of mainstream society by providing a platform for the exploration and depiction of their lived realities of a particular

phenomenon. It also seeks to make social change by presenting these often-unheard realities to a broader audience, particularly those in positions of social power to make changes. This project linked the methodologies to the methods with a Photovoice research design to achieve meaningful coherence.

Tracy (2010) proposes *crystallization* as an alternative to triangulation, which is the comparison of multiple methods, sources, theories, and/or investigators and is commonly used in qualitative research to increase the validity of results (Creswell & Miller, 2000). Crystallization is a concept that incorporates multiple data sources, researchers and lenses and allows “different facets of problems to be explored, increases scope, deepens understanding, and encourages consistent (re)interpretation” (Tracy, 2010, p.843). Tracy (2010) argues that triangulation is a concept arising from the assumption that there is one objective reality to be discovered. This does not fit with research that utilizes “interpretive, critical, or postmodern paradigms that view reality as multiple, fractured, contested or socially constructed” (Tracy, 2010, p.843). In my research design, I incorporated the feedback and input from several senior academics from different disciplines, including my supervisor, two thesis committee members, and a fourth professor. Each provided comment and guidance on my preliminary data analysis, resulting in a deeper and broader perspective. In addition, I have collected data from multiple sources in questionnaire format to broaden the meaning and applicability of the project. The additional data contributes to the quality of the overall research by providing information on the impact of the photography exhibition on viewers as well as the experience of participants in the project. I also asked for participant input on the preliminary results of the data analysis, a procedure discussed below.

Many qualitative researchers employ ‘participant checking’ to verify results with participants. Indeed, Creswell and Miller (2000) quote Lincoln and Guba (1985) in saying that member checks are “the most crucial technique for establishing credibility” (p.127). However, Tracy (2010) argues that member checking again assumes a single truth, and proposes instead *member reflections* to provide additional data and perspectives for a richer analysis without requiring alignment between researcher and participant views. I employed member checking/reflections in my research design and invited participants to gather as a group in order to respond to my preliminary findings. Two of the five women were able to attend and I recorded and transcribed the discussion. I met with the three remaining participants individually to share findings and provide them an opportunity to give me feedback. Participant feedback is incorporated into the results and discussion section where applicable, another effort to ensure research quality in this project.

Objectivity is a goal of quantitative research, evaluated through measures of reliability and validity (Auerbach & Silverstein, 2003). In contrast, qualitative research acknowledges the subjectivity of the researcher (Kvale & Brinkman, 2009). *Reflexivity*, or locating oneself in research, is a practice embedded in an understanding that objectivity and neutrality are not possible in research since it is always designed, conducted, and analyzed through the perspectives and biases of individuals (Absolon & Willet, 2005). Locating oneself in research enables the reader to interpret the results with an understanding of the researcher’s worldviews (Abolson & Willet, 2005). In addition, reflexivity is a component within Tracy’s (2010) proposed criteria of ‘sincerity’. Throughout the research project, I engaged in self-reflexivity by thinking through issues, in discussions with my supervisor and others, as well as in my field notes. In these ways, I considered how I specifically engaged in

the project and how my positionality might influence it. Kobayashi (2003) provides a critical analysis of self-reflexivity and cautions that, while it is an important aspect of identifying differences between the studier and the studied, it is useful only when it generates “sincere and engaged moral discussion that goes well beyond the confines of any individual” (Kobayashi, 2003, p.349). Kobayashi (2003) suggests that we use reflexivity as a peripheral rather than central part of research and that we consider the extent to which reflexivity needs to be shared to make a point. In Chapter 1, I provided a brief framing of myself in the context of this research along with my motivations for undertaking this project.

#### **4.6 Ethical considerations**

There are several levels of guidance and approvals for conducting ethical research. The *Tri-Council Policy Statement on the Ethical Conduct for Research Involving Human Subjects* (TCPS 2) guides research in Canada that involves human subjects. The core principles underlying the TCPS 2 are: respect for persons, concern for welfare, and justice (CIHR, NSERC & SSHRC, 2010). In preparation for undertaking *Envisioning Change*, I completed the online Tri-Council Policy Statement 2: CORE (Course on Research Ethics),<sup>42</sup> which provides an introduction to the TCPS 2. All research conducted under the auspices of the University of Northern British Columbia (UNBC) that involves the use of human subjects must conform to the *UNBC Policy on Research Involving Human Participants* and must have the prior approval of the UNBC Research Ethics Board (REB), composed of representatives from both UNBC faculty and community (University of Northern British Columbia [UNBC], n.d.).

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<sup>42</sup> The Tri-Council Policy Statement 2: CORE (Course on Research Ethics) was accessed from <http://www.pre.ethics.gc.ca/eng/education/tutorial-didacticiel/>

My experience with the UNBC REB offered unexpected insights into the research I undertook. My first submission to the REB was declined because the REB lacked confidence that the benefits of the study were worth the risks. Upon further inquiry and discussion with the REB Chair, I learned that their primary concerns centered on perceived risk to the target population<sup>43</sup> taking photographs of their daily realities. For example, if women were observed photographing ‘crack houses’ or active drug deals, that might be interpreted as a threat, with the potential for physical threat or harm. This concern revealed assumptions made by the REB about this population. I propose that these assumptions expose larger societal perceptions and judgments about people with mental health and substance use issues – that they have risky daily experiences compared to people who do not have these issues, for instance, street-level involvement in illicit drug use and the sex-trade. The assumptions that were made about women with substance use and mental health issues acted to ‘other’ them, creating an illusory boundary between those who do and those who do not experience mental health and substance use issues. In contrast, a great number of people, one in five in fact, struggle with some aspect of substance use and mental health concern over the course of their lifetime (MHCC, 2012). The stigmatization of mental health and substance use issues may contribute to rendering many of this 20% invisible. Only those people on the far side of the spectrum (those who are homeless, incarcerated, poor, etc) are made visible to society. While it is clear that people who live with substance use and mental health issues exist along a very broad continuum of experiences, the REB assumed that this study would encounter women in primarily active addiction and mental illness who face great risks in their everyday lives and might lack agency to participate safely in a research project. The process of achieving

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<sup>43</sup> Women who self-identified as experiencing substance use and mental health issues.

institutional ethics approval for *Envisioning Change* highlighted an aspect of societal expectations that, in fact, this study hoped to address.

The process of thinking through the REB's concerns for this project, and incorporating several adjustments to address these concerns, helped make the project design stronger and safer for everyone involved. I clarified the screening processes to include questions about potential participant's stability and support, and I prioritized a group discussion on safety to take place at the project orientation. The REB approved the project with additional information and the ethics approval certificate is provided in Appendix XIV.

The inclusion of participant photographs in this project raised specific ethical considerations. These additional considerations relate to the inclusion of identifiable subjects in the photographs, the authority and power that one has when taking photographs, and safety for all involved. To address the potentiality of participants including human subjects in their photography, I provided an Acknowledgement and Release form so participants could obtain signed permission from their photo subjects (Wang & Redwood-Jones, 2001). This form is provided in Appendix V. For simplicity and safety, I decided that no identifiable minor<sup>44</sup> could be included in project photographs. This was discussed in length at the project orientation session. Several women had children who they were planning to photograph for the project. We discussed the possible implications this might have and alternate ways to include images of children and symbolically represent the same ideas. In the end, three women included images of children, but did so in creative ways that protected the identity of the child. One woman included identifiable people in her photography and she obtained a signed Acknowledgement and Release from each subject.

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<sup>44</sup> The age of majority in British Columbia, at which the law considers individuals to be adult, is 19 years old.

Authority and power when taking photographs is a consideration in Photovoice research (Wang & Redwood-Jones, 2001). A photographer has the power to capture images that may negatively or inappropriately represent an individual or organization. In addition, the use of cameras can intrude on the privacy of others (Wang & Redwood-Jones, 2001). The group discussed these issues at the project orientation and considered how they would feel if they were not treated considerately and ethically in another's photographs. This helped them decide what kind of photographs would be appropriate for the project. For example, they considered possible implications of negatively portraying a service-provision organization, and agreed that it was important to not cause any harm in their photographic representations.

Finally, safety was discussed in depth at the project orientation session as a paramount concern. It was considered from multiple angles, including individual physical safety, emotional and mental safety, and the safety of those in close proximity. Regarding physical safety, especially as the primary concern for the REB, the group brainstormed about how the project might put their physical safety at risk. We then considered ways they could be sure to avoid such situations, for example, not going out alone at night to take photographs and not taking pictures of dangerous or illegal exchanges. Emotional and mental safety was a particular consideration in this project because I asked participants to think about potentially difficult or triggering experiences related to substance use and mental health. I found the group was well versed in ways they could take care of their mental and emotional wellbeing. They identified different ways this might unfold for them, for example, recognizing their own triggers and seeking support when needed. Finally, one woman recognized that her participation in the project might have an impact on her immediate family and others close to her. As a group, we discussed how to keep this in mind and how to talk about the project

with people in their lives. The purpose of these discussions was to encourage participants to think carefully about and prioritize their own physical and emotional safety, as well as the safety of those close to them, and to not compromise either for the sake of the project or a good photograph.

Knowing that the population I wanted to reach might face multiple barriers to participating, I made sure to ask at the very first screening meeting if they could think of anything that might make their participation difficult. Some women identified transportation and childcare as potential challenges. In order to reduce these barriers, I provided transportation and childcare options. The bus tickets I made available did not turn out to be utilized as expected, and unfortunately I was not able to reimburse for taxi fares.<sup>45</sup> I did my best to provide meeting places that were centrally located and close to public transit. It was important that I was able to provide support for childcare for the women who needed it so they could attend meetings without additional cost.<sup>46</sup> There are multiple ways that childcare can be addressed depending on resources and specifics of the situation. For example, providing a trained childcare provider on location for group meetings is one option. For several reasons, I preferred to reimburse participants for the cost of them hiring their own childcare provider.<sup>47, 48</sup> I recommend that childcare be regularly considered in research

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<sup>45</sup> Several central bus routes provide public transportation in Prince George. Public transportation in Prince George has improved significantly in the past decade; however, it has limited scheduling on weekends and evenings. It turned out to not be a preferred option for the women in the project who did not own a vehicle.

<sup>46</sup> I was interested to learn that the REB had not previously seen childcare addressed in project ethics applications. I think that ANY project that requests time outside the home of people of childbearing age should consider the provision of childcare. This is a basic ethical consideration to ensure that those who have children are not put at greater burden to participate in the project. It also helps to ensure that people with children will be included in research.

<sup>47</sup> Bringing children to the project meetings might have been distracting and it might have been even more challenging for women to travel to project meetings by public transportation with small children. It seemed the most logical and respectful to allow women to choose their own childcare provider and to reimburse them for this cost.

projects, whether a study includes women and/or men, so that having children and paying for childcare is not a barrier to participation.

*Consent* implies that individuals who participate in research do so freely, understanding the purpose, risks and benefits of the research as fully as reasonably possible (CIHR, NSERC & SSHRC, 2010). Consent can be regarded from both a legal and an ethical perspective. For the purposes of this project, I was not concerned with the legal implications because I included only women 19 years and older, the age of majority in British Columbia at which the law considers individuals to be adult. For consent to be meaningful, it needs to be informed and freely given. At the beginning of the project, I explained to each person that their participation was voluntary and they were free to withdraw at any time without negative consequence if they so chose. If they decided to withdraw from the project, the information they had provided for the project up until that point would be removed from the project and destroyed. To be informed, participants must receive accurate and understandable information on what participation in the project will involve and the potential benefits and risks of doing so. The consent form is an important way to impart this information and document a participant's agreement. However, assuming that participants read and understand consent forms undervalues this important ethical step in research, so I verbally reviewed all information in the consent form with each participant and answered any questions they had. In order to assess participant comprehension of the information provided in consent forms, I asked each person to tell me in their own words what they had understood. I then documented that participants were able to express in their own words the

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<sup>48</sup> I applied for and received a UNBC Graduate Research Award that provided reimbursement for specific project expenses. I was reimbursed for most of the project costs incurred from November 2011 – March 2012 from this award.

key points of the consent form. Some women were a little taken off guard by this process; however, it allowed me to see parts of the project that needed further clarification. Sometimes people are not comfortable asking questions because it suggests a lack of understanding.

*Capacity* is the ability of participants to understand relevant information about a research project and to appreciate the potential consequences of their decision to participate or not participate (CIHR, NSERC & SSHRC, 2010). Some projects need to consider the capacity of participants to provide consent. For example, projects that include children or people with cognitive impairments have to carefully account for the ability of participants to understand what they are consenting to (CIHR, NSERC & SSHRC, 2010). For the purposes of this study, asking participants to rephrase information was a way of establishing and documenting capacity. Capacity is not a static determination but rather can change over time depending on several factors, including any changes in a participant's condition. It may vary depending on the complexity of the choice being made, the circumstances surrounding the decision, and/or the time that consent is sought (CIHR, NSERC & SSHRC, 2010). In other words, consent and capacity to consent must be an *ongoing* process. Throughout the project I made sure to check back on relevant aspects of the project to make sure participants were still in agreement. Prior to conducting each interview, I asked if it was still okay for me to record the discussion. This reminded participants of what they had originally agreed to and allowed them to re-assess their decision within the current context. I think it was a useful way to keep the reality of the project and their decisions about participating in the project at the fore.

Other questions about capacity arose during the project. One woman experienced a mental illness relapse and spent time in the hospital. During this time, I postponed any

project decisions related to the use of her photographs until she was well again. This was a decision I made based on believing it safer to err on the side of caution and out of concern for her capacity to consent at the time.

Near the end of the project, it became clear that I had not considered all the possible uses of the photographs, such as posting PowerPoint presentations to conference websites, including photographs on a project website, use in additional exhibitions, and possible additional uses such as a book. The original consent form did not adequately cover these uses so I created a second consent form specifically for the use of photographs (see Appendix XV). I reviewed the form with each participant and they selected the uses they consented to. A parallel Acknowledgement and Release form was also created for the subjects of photographs to document their consent to the use of their photograph in these additional ways (see Appendix XVI).

The right to control information about oneself is an important aspect of *privacy* and is related to the concept of consent (CIHR, NSERC & SSHRC, 2010). In research, an individual's privacy is respected by providing the opportunity to consent or withhold consent to the collection, use and/or disclosure of one's information (CIHR, NSERC & SSHRC, 2010). Privacy risks in research relate to the identifiability of participants, and any harms they, or groups to which they belong, may experience from the collection, use and disclosure of personal information (CIHR, NSERC & SSHRC, 2010). Privacy risks are present at all stages of research, including collection of information, analysis, dissemination, storage and retention, and disposal of records or devices on which information is stored (CIHR, NSERC & SSHRC, 2010). My research project was no exception.

The informed consent process I went through with participants provided the women the opportunity to give (or withhold) consent about the use of their personal information provided in the project. Throughout the project, I undertook safeguards to minimize privacy risks, including omitting individual names when typing interview transcripts, assigning a numeric code to transcripts, and printing transcripts on a private printer. During the project, all information (such as the interview audio, photographs, and transcripts) was stored on a personal laptop protected by password. All project materials, electronic and hard copy, will be stored in a locked cabinet in an office on the UNBC campus for a minimum of five years.

*Confidentiality* is the ethical obligation to safeguard entrusted information by protecting it from unauthorized access, use, disclosure, modification, loss or theft (CIHR, NSERC & SSHRC, 2010). Confidentiality is essential to maintaining the trust between researcher and participant as well as the integrity of the project (CIHR, NSERC & SSHRC, 2010). Trust is built over time as relationships are established. For this reason and because of the nature of this research, the project design unfolded over an entire year with multiple contacts both with individual women and in a group context. Actions on my part that indicated my attentiveness to issues of confidentiality and privacy hopefully helped establish and maintain the important trust between researcher and participant. Near the end of the project when I presented the consent form for the use of photographs, all the women selected the option that permitted me to use any of their photographs and words in any format in activities that aligned with the project goals and intentions. I was honoured by this permission because I interpreted it as a high level of trust they placed in me to present their photographs and stories in a thoughtful and ethical way.

Confidentiality in the project was addressed in several ways. In order to safeguard participant's confidentiality, they were asked if they would like to be identified by their name, and if not, were asked to select a pseudonym. Several women chose to use their own name in the project and two women chose to include self-portraits in their photographs. This raised some concern for unforeseen future implications of self-exposure for participants. I checked periodically throughout the project to make sure they were still comfortable with their choices. I decided it was important that I help them understand possible impacts, but ultimately respect their decision. Generally, all the women were passionate about sharing their stories and hoped to help others through sharing their experiences. All of the women considered using their real name in the project, but several decided for a variety of reasons that it was better for them not to.

At the beginning of the project, I asked a community member to present a photography workshop for the group as part of the project orientation. This person signed a confidentiality agreement prior to meeting with the group and the women were informed of this as well (see Appendix VI). The project design included group meetings, which meant that I could not guarantee confidentiality of the information that was shared in the group context. To address this, I informed participants of this limitation during the consent process. I also led a discussion about safe space and confidentiality at the first orientation session.

In Photovoice projects, participants produce knowledge through their photography and the information shared in interviews. This raises important ethical questions about *ownership*. Following the recommendations of Photovoice projects, I positioned myself expressly as not owning the photographs, although women provided consent for specific uses of their photographs and narratives. Each individual contribution to the project remains that

of the contributor. However, through the course of the project that was devised and implemented, new knowledge was produced. This new knowledge is more than the sum of the individual women's contributions because it has been distilled through an overarching analytic process.

A concern about the control of photograph use arose in the context of the project website. The use of information and images posted on the Internet becomes very difficult to control. I researched the topic of safeguarding images on websites and learned that it is impossible to completely prevent unwanted downloading and use. Participants were made aware of this and other risks in the *Informed Consent For Use of Participant Photographs* (Appendix XV). In an effort to safeguard the images from unregulated use by the public, I placed a copyright notice on each page of the site and implemented a feature in the site design to make it less easy to download images.

To conclude, this Chapter has described the methods of *Envisioning Change* – how participants were recruited, what the project involved, how and when the project was initiated and unfolded, and how data was collected and analyzed. It also provided a discussion of quality and ethical considerations specific to the operationalization of the project. The next chapter presents the outcomes and a discussion of the results.

## CHAPTER 5 Results and discussion

*Envisioning Change* is anchored in the data from in-depth interviews and is augmented by additional data from questionnaires and participant feedback. The bulk of this chapter focuses on the presentation and discussion of results from the qualitative interview analysis. Along with these results are examples of women's photographs and accompanying narratives. Participant reflections on the preliminary analysis of the interviews are incorporated throughout.<sup>49</sup> Following presentation of the interview analysis outcomes, results from the questionnaires collected from exhibition attendees are discussed. The chapter concludes with the results from a participant questionnaire about their experience of the project. A brief summary of the five women who participated in the project introduces the discussion of data.

### 5.1 Summary of participants

Five women completed the project. They ranged in age from 22-35. Three were mothers and one of these three had custody of her children. Two women were of Aboriginal decent; one of First Nations/Métis ancestry, the other Inuit. Although the group was small, two of five represents 40%, a percentage much higher than the general population and closer to the documented over-representation of Aboriginal women with mental health and substance use issues. Two women did not finish high school and two had either graduated from college or were currently attending college. Financial stability had been a challenge for all of the participants, several of whom had been or were currently on disability or social

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<sup>49</sup> As discussed in Chapter 4, participant reflections are an important way to provide additional data and perspectives for a richer analysis (Tracy, 2010, p.843).

assistance. Housing had subsequently been a challenge for all of the women at some point in their lives. The mental health issues described by this group<sup>50</sup> ranged from major, chronic and treatment-resistant depression, suicide attempts, cutting, anorexia, obsessive-compulsive disorder (OCD), generalized anxiety, and post-traumatic stress disorder (PTSD). Substance use issues were primarily related to alcohol, pot and cigarettes but also included cocaine and other drugs. Four of the women indicated early childhood experiences of emotional trauma or physical/sexual abuse.

## **5.2 Interviews and participant photographs**

I was honoured to hear deeply personal stories of struggle and triumph in these interviews, and as I write this thesis, it is critical that I find a careful balance between sharing these stories (something these women wanted and felt compelled to do) and protecting their privacy. My decision was to include the participant's chosen name (some women chose a pseudonym to protect their identity) for photographs and accompanying narrative, but to use anonymous quotes throughout the text without identifying the speaker. In some cases, the text refers to a photograph and so identifies the participant in this way. As well, it is important to note that it was not possible to include in this thesis all of the important, resonant, and impactful information shared with me throughout this project. I have done my best to identify some of the major themes that emerged; however these could never encompass the breadth of the stories and experiences that women shared with me.<sup>51</sup>

Individual interviews were conducted with each of the five women. Interviews were recorded, transcribed, and analyzed as a whole body of data. I looked for common themes

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<sup>50</sup> These are terms that were used by women in interviews.

<sup>51</sup> For more examples of women's photographs and words, please visit the project website at [www.envisioningchange.ca](http://www.envisioningchange.ca)

and differences between all of the interviews and identified five major themes. The first one relates to how women experience space and place as active features in their lives instead of as merely static backdrops for life. Different examples of this were shared throughout the interviews, highlighting the impact of space and place on women's experiences of mental health and substance use. The second theme identifies how deeply embodied mental health and substance use issues were for these women. They described again and again how symptoms and realities were located in their body. This theme highlights the conflict between the common perception that what is 'all in your head' is somehow less important than physical ailments.

The third theme is about power. Power is a huge topic that receives much attention in a range of disciplinary literatures. It unsurprisingly emerged in these interviews, highlighting the multiple ways and levels in which power impacts women's realities related to mental health and substance use. A fourth theme centered on the complexity and importance of varied and multiple relationships for women's health and healing. It highlights the role that both negative and positive relationships have for women's mental health and substance use issues and for our wellbeing and recovery. This theme includes examples of relationships with ourselves, with others, with society, and with substances.

The theme I discuss last was the most pervasive and resonated positively throughout the interviews. Women's strength and resilience in the face of multiple levels of challenge and opposition shone through each interview and was evidenced in many of the photographs. Indeed, this was the first theme that became apparent as I transcribed the recorded interviews. I hope that ending the results from interviews on this theme allows it to sink deep into reader's understandings of women who struggle with mental health and substance use

experiences. Each of the five themes is expanded below with examples from women's photography and narrative quotes from interviews.

### **5.2.1 Place and space**

*"[...] what happens if people don't want to go downtown because it's a trigger and they'll be offered drugs?"  
(Participant)*

The idea that material space is not a neutral backdrop that we act out our lives upon, but rather has an active influence on our experiences and how we understand the world and ourselves, was discussed in Chapter 2. And indeed, the active nature of place and space emerged on multiple levels in the interview data and related to country, city, neighborhood, room and even more specifically than that. For example, brought to Prince George by her mother as a teenager, one woman felt torn between here where her daughter is and the American city where her father lives. She described feeling heartbroken no matter which city she is in because of the deep longing for either her father or her daughter:

When I'm here I'm always missing my dad. My heart's broken because I'm missing my dad. We call each other all the time. [...] I'll go there and see him, but I'm missing my daughter so much my heart is breaking there.

At the level of city, another woman described finding it a challenge to go out in Prince George knowing that she may run into people from her past life that could trigger her post traumatic stress disorder (PTSD):

[...] there's a lot of PTSD stuff that has to do with abusive relationships and sexual abuse and all that sort of thing. I was so fucking scared every time I left the house I didn't want to see anybody, you know, that had any part in any of it, you know?

Now that she is clean and sober, it poses challenges for being in a city where she has lived her whole life:

Like here I can't leave the house without seeing people that I know. I don't know how to put that, but I see people every time I go out of the house, well not just people, but people I know and don't want to associate with anymore because I'm clean and sober and trying to live a good life and they're not.

Also at the level of a community, but providing an example of how we are actively shaped by space, one woman spoke about how alcohol use and resulting physical abuse she experienced in her family was normalized because of its frequency in other families in her small northern community:

When I was younger he [her father] would binge once in a while. There were quite a number of years where he didn't drink at all. Then he started drinking again. [...] There was a lot of... a lot of physical abuse. [...] Not at me actually. At my siblings and my mom. [...] Just seemed normal because I'd seen it in other families too, so it wasn't...it just was.

This example speaks to how the places we inhabit actively shape what we are able to accept and understand as 'normal.' Describing the differences between Prince George and her hometown, she spoke of the freedom children had because of the smallness of the town where everyone knew each other: "We never told our parents where we were going or what we were doing. It just never crossed our mind to and they never asked. And because it was so small a community, they probably would have known where we were anyways." One participant made the connection between what was socially acceptable and normalized in her neighborhood and her use of drugs while she lived there.

The photographs that represent the theme of space and place are representative of a smaller scale. For example, in relation to her home, one woman spoke about having a Life Skills<sup>52</sup> worker spend time in her living space as a rare and positive thing, "she is my only

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<sup>52</sup> Individuals who work in Life Skills Support Services with the Canadian Mental Health Association assist individuals with serious and persistent mental illnesses. They assist with areas such as budgeting, cooking, meal planning, home maintenance, medication management, socialization, and appointments. To learn more, visit <http://www.princegeorge.cmha.bc.ca/how-we-can-help/community-outreach>.

visitor in my safe zone, usually.” This comment highlights the active and impactful nature of her home, her personal space, and the significance of having friendly company within it (Figure 19).

Figure 19 Photograph of Joy (Rachel)



“I look forward to being around her. She offers to help around the house or take me out and about. Yet more often than not I like her to have a seat with me and chill out once a week. I don’t get that from anyone else, only from her [...] She has her chair in front of mine and we have a chit-chat sit down. We visit once a week, and she is my only visitor in my safe zone, usually.”

Speaking more generally about Life Skills workers, she expanded that:

Quite often, the Life Skills Workers that I have had the chance of getting to know, were the most frequent company, that would come into my home for a visit. This may be a little sad, yet, I was at ease with them and I am happy to know them. I would gladly welcome them into my home. I find them to be more of a friend and a lighthearted confidante.

In other words, for this participant, the importance of relationships, and relationships that unfolded specifically within a particular space, were deeply impactful. This is further expanded upon within the theme on relationships (section 5.2.4).

Highlighting the meaning of space on emotional and mental wellbeing, one woman described the material space of the seclusion rooms on the ‘3<sup>rd</sup> floor’<sup>53</sup> of the hospital:

[...] there’s two rooms just cement, no bed. They give you one yellow blanket and whatever you want to call it, a padded thing you sleep on. And I really think the ones that have no sunlight, I don’t like the chicken scratch on the plexiglass. [...]

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<sup>53</sup> The ‘3<sup>rd</sup> floor’ was a familiar way women in the project referred to the Adult Psychiatric Inpatient Unit (PIU) of the Prince George hospital.

plexiglass scratched up with people who had some kind of object. You know. It's disgusting.

Speaking about being “locked” in the seclusion rooms, she described it as “inhumane.” As a specific example of the active impact of space on our experiences of mental health and wellness, she told about her “totally harmless friend” that “was in the back for 11 days” (more than twice the five day limit that she identified). Finishing the story, she asked,

Do you think that helped her any? [...] You know...it shouldn't have happened like that. That probably set her back and set her whole treatment back. She went in voluntary most of the time for readjustments or just 'cause she wasn't feeling well. [...] Now she's in the only existing institution [...].

For the participant, then, the actual trajectory of mental health programming is related to *where* treatment is taking place. This underscores the inseparability of location from treatment, something many of the women observed. Expressing her opinion about the seclusion rooms one woman said, “I wish they'd tear them two no-window rooms out of there.” These statements about the seclusion rooms of the psychiatric unit reflect the potential negative impact material space can have on mental wellbeing.<sup>54</sup>

Places can have a healing impact on women's lives as well. One participant experienced a women's shelter as more than just a static site. Instead it was a space of deep healing through the community of other women she found there and the resulting realization that she was not alone in her struggles:

Being at the shelter was probably one of the most healing things that I've done for myself in a long time. [...] being in the house was a way for me to let down a lot of the sheaths and to say, 'Here's my brokenness.' And I was accepted, and that felt good.

The site of a women's shelter is formed in part by the occupants, highlighting the social and interactive nature of human wellness and material location.

One participant spoke at length about a proposed location for a downtown drop-in centre in a basement with no windows. She was opposed to this and described how important it was that an environment is bright and welcoming, especially for people suffering from mental health issues:

[...] its about having a safe place. It needs to be bright and spacious, if people want to hang there for any length of time. Sure they could walk into a dark corridor and have a meal and maybe sit down with someone for a tea or coffee but they'll want to leave right away. [...] who would want to spend 2 or 3 hours in a dark dungeon-ey place?

Not only that, but “what happens if people don't want to go downtown because it's a trigger and they'll be offered drugs?” These observations highlight a realization I had through the course of the project: that spaces and places could be very triggering and anxiety producing for some people. I took this into consideration when I arranged to meet women for the project, individually or as a group, and tried to balance accessibility of the location with limiting the potential trigger of the downtown core. As much as possible I tried to give a few options for locations, particularly for the individual interviews.

The dynamic and impactful nature of material or built environments was evident in women's images as well as their interviews. An example of how meaning is assigned to place and space by a person's inner emotional and mental health realities can be seen in Figure 20. For this participant, the different meanings a bridge could have depended on her level of wellness or suicidality. It is a powerful reminder of the different meanings that places can have for each of us. Constructions of place, in other words, are never static but are instead always in flux, co-produced by the people who live in them and experience them.

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<sup>54</sup> This participant noted that she had participated in a consumer consultation process related to Mental Health and Addictions services and had provided her views on the seclusion rooms through this process.

Figure 20 Photograph “Bridge was suicide to me” (Lissie)



“You know, whenever I go by a bridge these days, I don’t always think of it anymore, but whenever I used to go by any bridge when I was suicidal, I used to think, ‘Hunh, I could jump over that.’ I was always thinking of ways that I could die. It is not a good way to walk through life...very dark [...] I had many plans for suicide and some of them involved bridges and the best ways to ensure that you die in case just falling over the bridge doesn’t kill you. [...] It’s nice now to look over and see a nice view and not see a potential death [...] even further, to not see a potential death that I want.”

On a smaller scale, one woman described the space of her table in relation to obsessive compulsive disorder that requires her to keep it organized in precisely the right way, with “everything in it’s place” (Figure 21).

Figure 21 Photograph “OCD has to be a certain way” (Lissie)



“This is my table. The only table that I have. Everything placed on this table has its proper place that it is returned to each time that I pick it up. It has to be this way. I cannot help it. I wish I could change the need to make this exactness exist, but I cannot. I have obsessive-compulsive disorder. This is just one example of what it looks like for me.”

This exemplifies one way that an experience of a mental illness can interact with and be expressed through space.

### *Discussion*

The examples offered by participants in this research demonstrate the depth and variety of meaning that space and place can have for women with substance use and mental health issues. Understanding that women actively interact with and are influenced by space and place, could have importance at multiple levels of service delivery. For example: Life Skills workers visiting client homes; practitioners understanding the stressors and inner conflicts that women may experience within their sense of space and place; and in the selection and design of buildings and rooms for psychiatric units and drop-in centres. It is imperative that women are approached as whole people with complex and interacting issues within their specific context. These themes align with some of the literature cited in Chapter 2 that point to the impact of geography, place, and space on mental health (Valentine, 2007; Thien & Hanlon, 2009, Whyte & Havelock, 2007; Northern Secretariat of the BC Centre of Excellence for Women's Health, n.d.; Curtis, 2010).

Participants spoke about both the positive and negative influences of particular spaces. The concepts of 'therapeutic landscapes' and 'landscapes of risk' discussed by Curtis (2010), locates the findings of this project within a broader health geography literature. Therapeutic landscapes are spaces that are "conducive to physical, mental, spiritual, emotional, and social healing" (Gesler, 2003 in Curtis, 2010, p.36). 'Healing places' often incorporate natural landscapes and the "association with health depends on their *social* and *symbolic* importance, as well as their direct *physical* effect on the human mind and body" (Curtis, 2010, p.36). It is interesting to note the number of photographs that women took of nature in this project. In contrast, 'landscapes of risk' may lack material elements that support 'healing' or they might include "stressors which undermine and damage mental

health and may cause, or at least exacerbate, mental illness” (Curtis, 2010, p.37). When one woman spoke about the potential of a new drop-in centre and how important it was that the space is bright and inviting, she was effectively talking about the difference between a therapeutic landscape and a landscape of risk.

Various community, social, and health services are often siloed and disconnected physically and geographically from each other. Some women described a long road to finding the right supportive services for their needs. Some also spoke about how difficult it was to find services that could address their situation holistically, instead of focusing on just one aspect of their life. For example, one woman told me she felt ostracized for wanting to talk about her eating disorder at Alcoholics Anonymous (AA) meetings. Spaces are actively constituted by the people who inhabit them, and this was the case for one participant and her experience there. The feeling of exclusion led her to seek support elsewhere. Spaces that are focused on isolated issues force women to fragment their deeply interconnected realities in order to access specific locations, programming, and resources (for example, mental health counseling, addiction services, housing resources, social assistance, employment support, trauma counseling, etc). One woman suggested more liaisons and advocates to bridge the gaps in services for women. She found that availability of advocates was limited for individuals not identified as high-risk or unless you happen to connect with the right person in one particular area.

Integrated and collaborative care is an approach to try to bridge the segregated specialized services some individuals face. The provincial Ministry of Health is working towards integrating primary and community health services in BC by 2015, with the aim of improving the coordination of care for people with chronic and/or severe illness (BC

Ministry of Health, 2012). The scientific literature shows that people with mental health and/or substance use problems “significantly benefit from holistic health care that coordinates the variety of providers and ensures consistency and collaboration between providers” (BC Ministry of Health, 2012, p.20). In collaborative care approaches, various providers work together to provide services in ways that support a holistic care plan. This approach is often applied in the treatment of chronic conditions. Integrated care models are usually employed for individuals with “complex health and social needs that require specialists, various health providers and support workers to work as a team to address and improve the determinants of health for these individuals” (BC Ministry of Health, 2012, p.21).

I suggest this approach could be taken further by locating services in the same place. Complex illnesses may require many different specialists, for example, family doctor, psychiatrist, psychologist, eating disorder counselor, dentist, osteopathologist, etc. Women confirmed in the participant validation session that the segregation of various services geographically around the city has a significant and very real impact on their ability to access those services. It is costly and time consuming to travel between locations for appointments and resources. A few women confirmed that it was exhausting, in fact “a full-time job,” to travel to and from multiple appointments, especially without a vehicle. Combining several specialist services in one physical location would make it much easier, more efficient, and more cost effective for many women to attend to their health.

As discussed in Chapter 2, one of the geographic determinants of health relates to access to services. I was surprised to learn that while there is a men’s residential treatment

centre (Baldy Hughes Therapeutic Community), one does not exist yet for women.<sup>55</sup> Without question, a residential addictions recovery centre for women in the Prince George region is needed, something that was corroborated by the women in this project. For several years, a local non-profit group, the Hutda Lake Wellness Centre for Women, has been advocating for a harm-reduction-focused<sup>56</sup> centre at Hutda Lake, a former corrections facility 30km outside the city (Ewart, 2013). In the spring of 2011, another non-profit group announced plans for a Northern Supportive Recovery Centre for Women at a vacant school in the Haldi Road neighborhood just west of the city (Ewart, 2013). This proposed centre would be based on an abstinence model. There continues to be controversy surrounding both proposals and concerns over limited funds.<sup>57</sup> As the northern capital and health services centre of the northern half of the province, the Prince George community needs to continue working towards establishing the services needed.

In their feedback on the preliminary analysis, women were strongly supportive of the theme of space and place, and were also surprised by how obvious it was and how easily and commonly it is overlooked. This may be due, in part, to how immersed we are in our environments without necessarily being consciously aware of their impact on us. One woman suggested how a greater awareness of space and place among service providers could

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<sup>55</sup> The Prince George Mental Health and Addictions Unit offers an in-patient detox unit with wrap-around, integrated community follow-up services. This is a different type of service than a residential therapeutic community (sometimes referred to as residential treatment centre).

<sup>56</sup> Harm reduction focuses on reducing the harmful consequences associated with drug use and other risky health behaviours while respecting an individual's right to decide. Rooted in social justice framework, harm reduction addressing the inequalities of health and wellbeing in the drug using community (Ontario Harm Reduction Distribution Program, 2013).

<sup>57</sup> Baldy Hughes is operated by the BC New Hope Recovery Society and was opened in 2007. In December 2010 the Province of BC purchased the property to provide stability and long-term security to the program. Under this agreement, the BC New Hope Recovery Society receives annual operating funding through BC Housing as well as support recovery funding from the Ministry of Social Development for each resident who qualifies. Support is also provided from the Province through gaming and capital improvement grants and revenue generating initiatives from the community (Baldy Hughes Therapeutic Community, 2013).

improve their interactions, particularly with youth. She has found that many mental health and addictions practitioners focus on negative symptoms when initiating a conversation, for example, asking about suicidal thoughts. As an alternate approach, she suggested practitioners pay attention to a client's expressions of self in their surroundings. For example, personal posters on hospital room walls or the writing on one's hand. These expressions of self in a spatial (and sometimes embodied) way provide an opportunity to engage youth in a strengths-based and holistic manner. Support for this concept can be found in Curtis (2010), who acknowledges that 'social spaces' occur not only at the community and societal level, but also the micro-level of individual rooms and buildings, and also the human body.

### **5.2.2 Embodied realities**

*"I still do get anxious, but not full blown panic attack like I'm going to die. I would get them so bad that my whole left arm would do numb and tingly and my teeth would go tingly. It was weird. And I couldn't breath."*  
(Participant)

The interviews revealed that mental health and substance use issues are embodied realities experienced in a physical way, not just in the mind. *Embodiment* is the expression of, or tangible or visible form of, an idea, quality, or feeling (Oxford Dictionaries Online, 2013). In relation to my analysis of women's stories, I use the term to refer more specifically to the physical manifestation of emotional or psychological states. While only a few photographs represent this theme, the link between psychological and physical experiences for women with mental health and substance use issues was very evident in interview narratives.

Participants spoke about the intense physical sensations that accompany psychological states such as anxiety and manic episodes. Describing the physical expression

of an intense manic episode, one woman said “[...] manic is high energy and they can have lows of depression, and also they can cry and laugh within the same moment, within a minute, within a few seconds. Like, cry to tears and gut laugh. I’ve done it.” Speaking about how she has learned to manage her anxiety, another woman described the physical sensation of how her heart would feel like it was about to explode, “that’s the very first thing my mind goes to, ‘I’m going to have a heart attack, my heart is going to pop.’” She also described panic attacks as feeling like she was going to die, “I would get them so bad that my whole left arm would go numb and tingly and my teeth would go tingly. It was weird. And I couldn’t breath.” Another woman spoke about one of her more prevalent compulsive behaviours that involves putting chap stick on her lips, a behaviour she views as originating from an early behavioural response to anxiety:

[...] one of the things that I did, because I had so much turmoil and anxiety in me, was I’d lick my lips all the time. [...] I’d lick all the way around so that I had angry red crusty chapped (lips)...so painful.

For her, that painful sensation remains and prompts an unwelcome compulsive response:

But that feeling, that’s how bad my lips hurt now when I need to put it on (chap stick). And at night, when I’m at home alone, I put it on all around my lips still, because it still hurts all the way around.

Speaking about some of her obsessive-compulsive behaviours, she described them as “a tick going through your mind”:

I can’t tell you how terrible it is when in the middle of the night, or when I’m trying to get to sleep, when my OCD is terribly bad, when I’m just trying to get to sleep and I’m so tired but every time I lay down under the covers, there it is again, and the tick goes through. And I have to get out of bed again [...] and again, and again [...] because you can’t ignore it. It’s literally like a tick. [...] There’s no waiting, you have to get up and do that. It’s horrible because that’s the last thing you want to do at that minute. You just want to sleep.

As a young child one woman's anxiety manifested in "a lot of really terrible stomach aches. They thought at one point I might have an ulcer." Trying to seek medical help for her situation, she was often dismissed by medical practitioners, "'What, you have a stomach ache? Who doesn't some times?'" But it wasn't just a stomachache though. It was a terrible horrible feeling about myself. It was self hatred, it was self loathing, it was...depression."

Many women repress or 'bottle-up' their emotions so as not to intrude on others, and one woman represented this visually with an image of an actual bottle with the word 'Anxieties' written on it. For her, this physical repression of feelings resulted in a deep and lasting depression (Figure 22). The theme of self-concept and self-esteem is discussed further in section 5.2.4 in the context of relationship with the self.

Figure 22 Photograph "Jar of anxieties" (Lissie)



"This picture is a metaphor for my depression. Many many times throughout my life I've bottled up every sadness, every hurt, every anxiety that I had. I kept them to myself as much as possible. I didn't want to bother other people with them. I didn't think other people would want to be bothered. These emotions tore me up inside and resulted in depression so deep that I was drowning."

The idea of holding feelings within the body and how this exacerbates mental health issues further exemplifies the embodiment of these realities:

I've talked to other people who have depression and they say the same thing. You keep it inside, you keep it inside. That's what *grows* depression. Because you don't release it. You don't let anybody know, so you keep it inside. What else can result from that but too much pressure, too much sadness in there that your brain can't handle it.

Such an observation clearly underscores that for some women, a mental state is not just a psychological experience separate from the physical, but instead a deeply embodied reality. Speaking about the impact of an early trauma, one woman described her response in embodied terms when she said, “something froze in me” (Figure 23).

Figure 23 Photograph “Child-like emotions sometimes” (Lissie)



“A child dressing up in adult shoes. [...] Sometimes [...] one doesn’t always grow up intellectually at the same speed as they grow emotionally. And there’s nothing they can do about it until their brain or their heart or a combination of both has subsided from a traumatic experience that caused the chasm to exist. [...] When I was 14, something so traumatic happened to me, I can’t remember what specifically, many bad things related to depression happened that year and the years since, that something froze in me. And part of me had to stop right there, stop developing, so it did. I grew in size, I learned new things, I got smarter, I wore bigger shoes. But inside I was still that little girl, so afraid to grow up and for so long I didn’t know why.”

Two women in this project struggled with eating disorders, primarily anorexia. One was fuelled from an early experience of ridicule about her appearance and resulted in a deep self-hatred focused on her physical self. Describing some of her thoughts as a young teenager, she said:

I thought I was so ugly and so fat. Like no one could be fatter than me. [...] I was so unhappy with how I looked that I couldn’t conceive of working with what I had. No, I want liposuction, I *need* liposuction, and I was just convinced. And I went through all of my teenage years hating how I looked and wishing that I could be anybody else. [...] I felt so hideous, so fat, so ugly and I just hated it. I just hated it.

Mental health and substance use issues, then, are embodied realities lived and experienced in and of the body. Her anxiety and concern for her self-worth became embodied on the level of weight and eating. Early on in response to deeply wounding ridicule, she:

... stopped eating so much and began eating just Raman noodles for dinner, as a rule, only 115 calories, and one piece of Bubalicious gum for the rest of the day. I'd chew it and the flavour would last for maybe 10 minutes, and then it would be like chewing a piece of paper, a wad of paper, and just chew chew chew chew.

Another woman described the height of her anorexia and cutting behaviour as a response to a very difficult relationship:

We would end up fighting, end up yelling, to say the least. [...] I didn't want to be yelling or screaming or anything like that [...] I did the majority of my cutting in that relationship. That was when my anorexia was at its height, I guess. I just could not cope, I didn't know what to do. [...] If I drank then I would not be able to see my daughter at all. And I was not going to let that happen.

For her, cutting was an alternative to being hurt by others and a way of coping with intense emotions:

I'd rather hurt myself than anyone else hurt me. I think the first time I cut or tried to cut [...] I'd had my last drink of alcohol and I was alone and [...] I just felt so hopeless. [...] I think the majority is not wanting to be hurt [...] It's easier for me to accept myself hurting myself than someone who says they love me hurt me.

These quotes also identify a relationship between different coping mechanisms. When drinking was no longer available, self-harm and restricted eating were alternatives. Perhaps the use of substances, the physical act of taking something into the body, is a way of embodying and therefore coping with overwhelming emotions and mental states. For example, another woman said, "I hated myself very much, so did horrible things to my body and stuff. Drugs drugs drugs drugs." Talking about her physical appearance when heavily involved in drug use, one participant remembered looking in the mirror: "[...] I didn't even look real. I didn't look alive. Especially when I was high I just looked like a ghoul...I was so

so skinny and the bags under my eyes were so deep and I was so pale [...].” For one woman, the following expression of fear and anxiety was embodied as a desire to die or “get loaded” in order to escape her inner conflict (Figure 24).

Figure 24 Photograph of eye (Jane)



“I was so afraid...I just wish I would die because I couldn't see any way out. And another way I was so afraid of dying. It was really polar opposite thinking. I wanted to die and I was afraid to die. I wanted to get loaded and then I didn't want to get loaded. I wanted to think clearly and then I didn't want to think at all. I didn't really know which way was up. I couldn't make up my mind. I was...tired of living, too afraid to die.”

In these examples, substance use is an embodied reality for the women in this project. Also evident are intersectional relationships between mental health and substance use enacted in and through the body (discussed further in section 5.2.4). In their feedback to the preliminary analysis of the interviews, one woman spoke about how some behaviours are driven not by a desire to hurt oneself, but by a drive to cope:

And it's not because, 'oh, jogging didn't work, so now I'm going to cut my arm,' right? It's not like you are choosing that particular coping mechanism, it's because you don't know what else to do. Because you've tried going here, and you try and you try and you try and you try and that is the end result after giving all you've got and you have nothing left to try. So, this is all I got. This is what my brain is saying will help me. Even though you know in your brain [...] that's the wrong thing to do, but it feels good because it's helping me cope.

In other words, embodied behaviours such as cutting and using substances can be viewed as adaptive approaches for coping with difficult realities. They are often perceived as the only available option: "...when I was cutting, it was like something to focus on, other than what is going on inside. Something physical, pain to focus on and you get that rush or whatever, but something to focus on outside what's going on in my heart." When asked what mental health means to her, one woman said, "Being able to cope with anything in a non-destructive way. Not having to resort to drinking or cutting or not eating or over eating or...anything detrimental."

### *Discussion*

Counter to the dismissive that "it's all in your head," recognizing just how deeply embodied these experiences are for women could inform the way that mental health and substance use is spoken about, understood, and even treated both by professionals and the public. For example, physical symptoms that might be dismissed as part of a mental health issue need to be taken seriously by health care professionals. As well, this could help to inform societal beliefs about mental health and substance use issues that fuel stigma and discrimination. A contributor to The Standing Senate Committee report (2006) highlights the importance of equal consideration for mental illnesses as physical illnesses:

Start treating mental illness as a biological illness the same as any physical disease. When we say that someone is sick we don't say "physically ill" so why do we say "mentally ill"? Mental illness is a physical illness, not some disease that enters the minds of the weak or characterless. Like cancer, it can happen to anyone. Let's start treating "mental" illnesses as what they are. Devastating diseases. (p.18)

Cartesian dualism, a deeply ingrained philosophy underlying western biomedical knowledge and culture, posits that the mind and the body are distinct – the body is a physical 'machine' and the mind an ethereal 'ghost in the machine' responsible for consciousness

(Mehta, 2011). Mind-body dualism is the basis of historical understandings of mental health and substance use as resulting from weakness of will or personality flaws (see Chapter 2).

These ideas remain in the collective consciousness and contribute to the dismissal and diminishing of mental health and substance use issues. I agree with author Mehta (2011) when she states,

...mind-body dualism is an example of a metaphysical stance that was once much needed to unshackle science and medicine from dogma, but which later had far reaching restrictive influence on the field of medicine, on its complete understanding of real health issues, and on developing effective interventions to deal with the same. (par.10)

In contrast to dualism is the conceptual framework of phenomenology (see Chapter 3), within which it is impossible to establish a distinction between our *perception* of phenomena and the actual *existence* of phenomena (Curtis, 2010). This renders it difficult to think about the mind and body as separate (Curtis, 2010). Evidence from research on psychosocial factors and physical health indicate that there is a strong link between states of mind and physical states (Curtis, 2010).<sup>58</sup> The theme of embodied realities from this project supports the need to treat women's mental health and substance use holistically.<sup>59</sup>

When I presented the preliminary analysis of interviews to participants, most participants were strongly supportive of this theme of embodied realities. Some women emphasized just how many times they have been given the message that because an experience has been identified as emotionally or psychologically based, it is something that is located in their head and can be 'overcome' with willpower. For example, one woman said,

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<sup>58</sup> For example, research on pain psychology show that a placebo can alleviate people's experience of pain with no biomedical basis (Curtis, 2010). As well, psychological distress can be manifested or expressed as physical symptoms, symptoms that vary between cultures (Curtis, 2010). We also know that an individual's psychological state (an individual response to phenomena) impacts physiological processes such as hormone levels (Curtis, 2010).

“I didn’t choose my mental illness. I didn’t choose that, it chose me. And that’s where it just pisses me off so much when I’ve been told so many times, ‘well it’s in your head, it’s up to you.’” In my own experience, I have seen the internalization of such dismissive, self-blaming rhetoric as a major challenge in identifying and treating mental health and substance use issues, particularly for women. We think that we should somehow be able to ‘overcome’ distressing feelings on our own – that what we experience does not warrant intervention. So many of us struggle alone and in silence believing ourselves not worthy of wellbeing. Part of this project is about countering these beliefs by creating positive and empowering space for women with mental health and substance use issues. The theme of embodiment has nudged up against the enactment of power, which is discussed further in the next theme.

### **5.2.3 Power**

*“Through mental illness I have felt at times that neither my voice  
nor my existence mattered.”  
(Participant)*

We live in a world in which there is structural and systemic power playing out in all of our lives. Some of us experience it more immediately than others. The manifestation of power and its impact on women’s mental health and substance use experiences emerged as a theme from this data in many ways.

One of the most obvious manifestations of power is the violence some women experience. Violence can be understood as the intentional use of power to cause injury, death, psychological harm, mal-development, or deprivation (WHO, 2013). Most of the

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<sup>59</sup> Holistic is a concept referenced throughout this thesis. The definition of holistic is “relating to or concerned with wholes or with complete systems rather than with the analysis of, treatment of, or dissection into parts.” (Merriam-Webster Online, 2013).

women in this project either spoke directly about experiences of trauma and violence, or alluded to it. Describing some of the early experiences of her father, one woman recounted:

I remember one of the times I did see my dad drunk, I was I don't know how old I was, but I remember. It was in the summer because it was quite late and it was still very very light out. And I looked out my bedroom window and saw him literally crawling home drunk (pause) I'd heard about how one of my brothers had been beaten with a skidoo belt. That was one of the times when I knew not to go home.

The statement in the above quote: “[t]hat was one of the times when I knew not to go home,” shows her understanding that her father had the power to cause pain, fear and distress. One woman alluded to traumatic experiences as she spoke about her mental health:

I definitely believe I have post traumatic stress disorder. There are some things that you can't deny when you've had a traumatic experience, or more than one in my case. Obviously that is going to affect you and it's going to affect how you act in the world. It's a survival mechanism.

A woman's experience at an addictions treatment centre corroborated the findings in the literature presented in Chapter 2. She found “every single person there had been sexually abused [...] men, women, everyone had been.” Early experiences of violence and trauma have deep impacts on a child. As discussed in Chapter 2, there is a strong link between experiences of trauma and violence and subsequent mental health and substance use issues for women.

Women in the project described several examples of social, clinical, and institutional power. For example, power manifested in women's lives as a differential between themselves and mental health practitioners. One woman spoke about trying to seek help as a deeply depressed and timid teen, and meeting with a psychiatrist who dismissed her and her pain as something to ‘just overcome.’ She described how she felt silenced and overlooked because of mental illness: “people kept trying to tell me that I didn't have reason to feel the way that I was feeling. But I couldn't just stop feeling the way that I was feeling. It was my legitimate

feelings.” Describing the impact these messages from the medical professionals had on her, she said:

[s]o, other people deserve help but I don't? There really must be something wrong with me. Just a horrible person. When you are 16 you are not even completely fully developed yet and this was how they were helping me develop my brain.

This quote identifies the social and institutional power that a psychiatrist can have in relation to a teenage girl. It can have a profound impact on someone in a vulnerable position to have someone in a position of power dismiss their concerns. For instance, one participant felt as if her very life was invalidated when she did not feel heard, as if her existence did not matter (Figure 25).

Figure 25 Photograph “My opinion didn't matter” (Lissie)



“The tape over my mouth represents the way my voice has been hushed, even silenced. I have felt ignored many times throughout my life. My eyes plead: to be heard, for someone to listen, to notice my pain, to notice me. Through mental illness I have felt at times that neither my voice nor my existence mattered.”

Clinical power was manifested within the particular space of the psychiatric unit at the hospital. Three women in the project disclosed in their interviews that they had spent time there. While one participant described accessing the ‘3rd floor’<sup>60</sup> if needed, others felt as though they were held there without choice or adequate information on how long their stay

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<sup>60</sup> ‘The 3<sup>rd</sup> floor’ was a familiar way women in the project referred to the Adult Psychiatric Inpatient Unit (PIU) of the Prince George hospital.

would be. Social and clinical power, then, were literally expressed through access to or denial of certain spaces. Two of the three women who had experience on ‘the 3<sup>rd</sup> floor’ spoke about the way they or others were treated by ward nurses. They described the treatment as sometimes manipulative, undermining, and sabotaging. For example, a participant perceived it as a ‘power play’ when nurses turned off the water to the seclusion rooms: “why would you ever have a button or a switch to shut someone’s water off unless you like playing head games?” Here, power was expressed in the nurse’s ability to control a necessary resource. Another observed that if a patient was feeling better, the nurses dismissed this as a manic episode. In this way, power to the participant was seen as the ability to determine another’s mental status for them. Speaking about the vulnerability of people who need to spend time on the ward, one woman described the impact of the way people are treated in this type of environment, “it takes a very special person to work with people that are kind of down and out. And that could kind of make or break a person sometimes if somebody’s in a really bad space in their head.” A few participants agreed that the only way to leave ‘the 3<sup>rd</sup> floor’ was to learn how to act in an ‘acceptable way,’ regardless of being well or not: “They don’t want to fix the problem, they just want you to pretend that you don’t have one.” This provides another example of perceived institutional power exercised over the lives of women seeking help.

Institutional power was enacted through the power of labeling women. Seeking help for mental health and substance use issues often leads to a diagnosis label. Two women explained how diagnoses and labeling by the mental health system resulted in the operationalization of power by medical professionals that had very real impacts on their

health. One found her physical complaints were dismissed as symptoms of her mental health labels:

I spent some time on the 3<sup>rd</sup> floor, and I find it really unfortunate that I did that because now I do have a label on me. [...] I've had really bad stomach issues for quite a while now and nobody listens to me anymore, 'Oh it's just your nerves.'

For this participant, the dismissal of her physical symptoms by a physician is a manifestation of power held by physicians to decide the legitimacy of a symptom. Another woman found that she couldn't trust her doctor with information about her mental health because of the possible role that information could play in a custody case. Describing how she feels about the power her doctor has in her life, she said:

[...] I'll do whatever it takes to appease him because I know that at any minute he can crush me, he can crush my life. [...] see that's the tricky thing about the systems. Any information that is provided from any source can be twisted.

These are strong words to describe a woman's experience of the power held over her life by a medical practitioner. The literature presented in Chapter 2 on stigma and mothering corroborates this participant's experience. Mothers with substance use and mental health issues are at risk of greater scrutiny and judgement from service providers (BC Centre of Excellence for Women's Health, 2010). Fear of having their children removed is a significant barrier to services (BC Centre of Excellence for Women's Health, 2010).

When women seek assistance from various social institutions, they often feel as though they are giving up their own autonomy and control over their lives. Some women in the project expressed significant dissatisfaction with social assistance because of the minimal financial support and the convoluted rules that restrict employment earnings. This functions as a disincentive for people to return to work when able. One woman described a situation in which she tried to get support while pregnant with her second child, but through several steps

required by the Ministry, found herself out of a job, without social assistance, and her employment insurance being reclaimed by the Ministry. This left her with no alternative but to return to an abusive partner. This situation highlights in several ways some of the problems inherent in a social system that attempts to assist women without taking their real lives into consideration. This terrible experience led this participant to conclude:

I will go out and sleep with a man who pays me money before I ever walk into that welfare office again, god honest truth. Because at least that man isn't going to turn around, beat the shit out of me and take my money like welfare does!

This is a very strong expression of her desire to maintain autonomy and control over her life, and to do so she must avoid social assistance institutions.

Women in the project spoke about their experiences of turning to the 'appropriate' systems for support and assistance and finding those very systems turning against them in a way that further disempowered and complicated their lives. One woman had extremely frustrated and devastating interactions with the legal, health, and child welfare systems that left her feeling defeated and disempowered in her attempts to protect herself and her children (Figure 26).

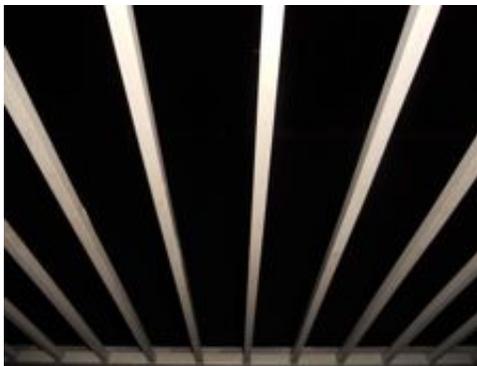
Figure 26 Photograph of moon and clouds (Roxy)



"I'm the moon, and this is all the support people (clouds). It's there and you can see it, but you can't touch it and you can't really go close to it. Because if you go close to that support, what's going to happen? You can't see the moon anymore, all you can see is the clouds. That's what happens."

She found there was a limit to the trust she could place in supportive resources such as the legal or medical systems. This situation resulted in increased feelings of anxiety and helplessness without the hope of help. The institutional power held by doctors and medical professionals makes it very risky for some women to actually find the support and help that they need dealing with their mental health and substance use issues. Lack of support leaves women without adequate care and struggling to cope on their own. A disproportionate number of women are single parents and caregivers, and at risk of interpersonal violence, putting more women than men into situations of needing support from social systems. These women are under greater scrutiny and therefore diminished autonomy and control over their own lives (see Chapter 2). One woman's photographs symbolize, in simple and powerful imagery a feeling of disempowerment because of the multiple barriers she faces (Figure 27).

Figure 27 Photograph of barriers (Roxy)



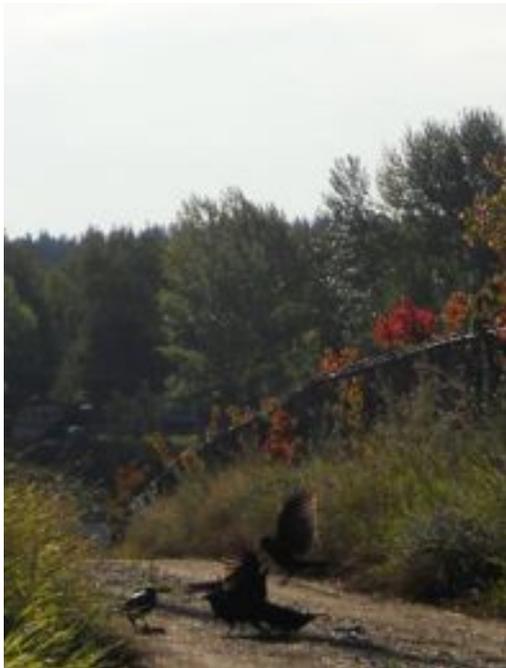
“The darkness is like life... and these are always our barriers. And even though it seems like you can just go strait through your barriers, as a whole you can't. It seems so dark because it is so unknown. And barriers are always so apparent, they are so bright and in our way and recognizable...that sometimes it seems so hard to get through them...even though there can be a lot of space and at first you think it's going to be so easy to get through those barriers, but when you try going through one, you realize there's so many more to go through. And it's just about looking upward through those barriers.”

Stigma and the resulting discrimination towards people with mental health and substance use issues are one way that the social power of normativity is materially expressed. One woman described how societal power plays out in the way that stigma literally inscribes itself in her ability to live life:

[S]ometimes I think because of the stigma associated with mental illness, and society has come a long way, certainly, but still when I say that I have a mental illness, people will assume that it means [...] there is something wrong with me in a way that means I don't deserve to be treated as others are treated.

Power, as expressed in stigmatization, functions to alienate people with mental illness and substance use issues. For example, one woman described how it felt to be spoken about as if not in the room. It was a disempowering experience because it removed her personhood and autonomy, contributing to a negative cycle of 'othering,' and of not being treated as a competent person. Another woman spoke about the impact of being judged based on only some parts of her identity. She said, "[i]t's hard when people make preconceived judgments about you without even getting to know you" (Figure 28).

Figure 28 Photograph of crows (Jane)



"In many different cultures, crows symbolize polar opposites...it was really hard to decipher what a crow is and you've got to make up your own opinion about it. I find it interesting that in some cultures they are really good and in some cultures they are really bad. I find it interesting because it seems like the world as a whole doesn't really know what to think about them...Some people think that drug addicts and people with mental disabilities and people that are just altogether different, independent thinkers even...they don't really know what to think of them...It's hard when people make preconceived judgments about you without even getting to know you."

An image accompanied by a similar message suggests that instead of judging people, we should “look at the back too” because we don’t know what has occurred to make people who they are (Figure 29). In other words, the face that we present to the world often hides the experiences and histories that have shaped our current situation in life. Negative judgments contribute to discrimination and stigmatization that reinforces disempowerment.

Figure 29 Photograph of back of daisy (Ooleesia)



“...everyone looks at the front. Why not look at the back too and see how just as interesting it is as the front. [...] I try not to judge others harshly because I don’t know what it’s like to be someone else, just like they don’t know what it’s like to be me. So why bother judging? The front is very different from what makes it up.”

Power also manifests in language. As many of us know intrinsically, words have the power to make us feel certain ways. The same held true for participants. The common usage of terms related to mental health in disparaging or misinformed ways (eg. “crazy”, “schizo”, “psycho”) perpetuates the diminishment of individuals living with mental health and substance use issues. One participant said:

I feel offended when people use that word (crazy) [...] because... people call me crazy. [...] I think it’s a misunderstood thing. People can joke around and stuff, but I think it can just be so largely misused in a negative connotation sort of way. And it’s just sad that... stigma is a big issue for me.

Describing an incident of overhearing people making fun of mental illness, she said, "... I know people with those mental illnesses. I know of the suffering. This isn't funny. It's not funny. This is suffering. This is intense suffering."

### *Discussion*

Structural and systemic power is an important and significant topic. The experiences of participants in this study clearly indicate that power is playing out at multiple levels for women who live with mental health and substance use issues. A greater awareness of systemic power and the many ways it could and does impact women will likely broaden the understanding of mental health and substance use issues, perhaps contributing to an approach of addressing women's disempowerment as a way to support mental health and healing.

While there are many inconsistent conceptualizations of recovery, the following suggests the importance of social and systemic power structures as key components: "Recovery recognizes the fact that an individual cannot fully heal in an environment that supports racism, homophobia, sexism, and colonization. Developing a healthy society can be seen as recovery on a collective scale" (Ida, 2007, p.52 in Weisser, Morrow & Jamer, 2011, p.8). This resonates with the findings from this project. The distress of disempowerment resulting from multiple systems of oppression contributes to women's experiences of mental health and substance use issues.

When women are in a position of needing assistance from certain systems (legal, medical, social services), they are required to relinquish their own autonomy and power over their lives and leave it in the hands of the authorities to make decisions that deeply impact them. This relinquishing of personal power over their own lives can have a deep impact on women's mental health. One woman spoke about a response to her perceived helplessness:

she disconnected from her reality and just went “through the motions” of her life. This was her way of coping, of holding things together for her children. In other words, a very real lack of power to control one’s own life can lead to anxiety and negative coping mechanisms and ultimately to mental health and substance use issues. This can lead to a reinforcing negative cycle. In order to holistically address mental health and substance use issues for women, policies and programs must take into account how experiences of empowerment and disempowerment are manifested in women’s lives. Policy and programs that support women’s autonomy and empowerment might include: safe, affordable, and accessible childcare so that women can work; safe, healthy, subsidized housing and transportation; affordable and culturally safe health care and counseling that allows women to disclose openly.

#### **5.2.4 Relationships**

*“A clinician is someone who I feel is a must to get to know on a more deep level. We must interact with ease and communicate with respect. I feel it is necessary to become friends with them and I would not have it any other way.”*  
(Participant)

Relationships play a significant role in all of our lives. They act on many levels and across multiple times and places. To be healthy, we need an integrated sense of ourselves within, and in relation to others and the world around us. Through all of the interviews, women spoke about their relationships – with themselves, with others (family members, partners, children, service providers, etc), with society at large, and with substances. Multiple and dynamic relationships contribute to our mental wellbeing or our mental un-wellness, as the case may be. Examples of each of these types of relationships and how they interface with mental health and substance use were evident in women’s photographs and interviews.

### *Relationship to self*

One's relationship with self can also be understood as self-concept, self-evaluation, or self-esteem. This sense of self, constructed through relationships with others over the course of a lifetime, contributes to how we move through the world and how we engage in relationships with others. In an image of a spider peaking out of a closed daisy, one woman spoke about the feeling that there was something terrible inside of her that she needed to hide from other people (Figure 30). This feeling mediates the way she interacts with and relates to others.

Figure 30 Photograph of bug in daisy (Ooleesia)



“For years I've loved daisies - for their simple, unfussy beauty. There is an ugliness I have inside me that I don't want others to see. Sometimes, the ugliness likes to come out just a little bit and I have to keep it in check, I can't let all of it out at once.”

Mann et al. (2004) stress the importance of one's self-concept for mental and social wellbeing because it influences our goals and aspirations, as well as the way we interact with others. An image and accompanying narrative from the project portrays one woman's growing sense of self-confidence in sharing some of her painful early life experiences. She

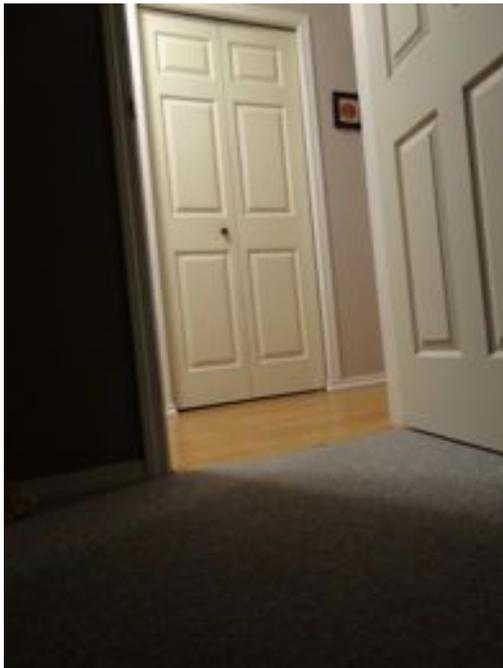
took a picture of a bird saying ‘listen’ symbolizing a transition in her relationship with herself that also influences her expectations of others to hear her story (Figure 31).

Figure 31 Photograph of “listen” (Ooleesia)



“Maybe finding that I can talk about stuff that has hurt and just not realizing that I could do that before.”

Figure 32 Photograph of doorway (Ooleesia)



“Having been closed in the past and now becoming more open. [...] Not sharing a lot of stuff. [...] I pretended like none of that had happened from my childhood. And now not being able to ignore any of that, or to bring myself some more understanding about why or how I think or act goes back to my childhood and how I grew up. Like starting to make those connections. [...] being able to give myself some flexibility...it’s okay to not have to be a certain way.”

Expanding on this idea of self-acceptance, she says, “it’s okay not to have to be a certain way” (Figure 32). In other words, her relationship with herself is becoming more forgiving and understanding, allowing her to make certain connections between her past and her present.

### *Relationships with others*

Relationships with others, especially those close to us, can support us living our full potential. They can also subtly, or not so subtly, undermine us. One woman was emphatic that her current partner keeps them safe and without him, she and her children would be vulnerable to further abuse from her ex partner. Relationships can also be abusive and controlling, as several women in the project experienced. Or, they can be a complex combination of both. One woman described a relationship with her adoptive father who would return from drinking binges and physically abuse her siblings and mother, but would take her out hunting, fishing and dog sledding. She cherishes her memories with her father despite the pain and fear that he brought to the family. An image representing one woman’s notion about the way that men can change and “turn into dogs” is captured in Figure 33.

Figure 33 Photograph of footprints (Ooleesia)



“At the time, this was perfect for what I was going through. I still hold onto hope that not all men turn into dogs.”

In the interview, she spoke about her experience of controlling and emotionally abusive behaviour in a primary relationship. There were significant impacts of this relationship experience on her mental health, illustrating the powerful link between relationships and wellbeing or lack thereof.

Women's roles in families (both families of origin and those established as adults), and indeed their relationships as mothers and partners, are central and play a significant role in their risks for, and experiences of, mental health and substance use issues. This is supported by the literature presented in Chapter 2 on social determinants of health and the additional stressors many women are under because of poverty, unstable housing, and their role as primary caregivers. One woman described how important it was in her family that she does not break down under stress and pressure. In her reality, she needs to hold it together and put the needs of others before her own. A mother's desire to protect her daughter from intergenerational trauma<sup>61</sup> is symbolized in Figure 34. There is a strong protective message towards her daughter in this image, a desire to ensure her daughter does not go through the same "pain and fear" that she herself did. This nurturing parental relationship could provide strong motivation in a woman's life to quit drinking, to make positive changes, or alternatively to put herself under additional stressors in order to protect her children.

Women's relationships with family members were complex and involved deep caring, as one woman verbalized in her photograph of her mother, "I will shelter you and protect you by loving you and being there for you whole-heartedly" (Figure 35).

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<sup>61</sup> See Chapter 2 for a discussion of intergenerational trauma and its effect on mental health and substance use.

Figure 34 Photograph of shadows (Ooleesia)



“Precious shadow of mine, steer clear of my ancestral pain and fear.”

Figure 35 Photograph of Mother (Rachel)



“Dear Mom, I love you like a daughter. I will shelter you and protect you by loving you and being there for you wholeheartedly. There may come a time when you are gracefully aging that I may become the one to take care of you. I must have you know, no fears, I am here for you too.”

Speaking about her grandparents, the same participant highlights their caring and present relationship in her life and the support she receives from them (Figure 36). The quote identifies the importance for women of safe and supportive family as they go through different mental health issues and experiences. It is also evident that being able to reciprocate

and care for others is an important part of mental wellness. Without these important relationships in our lives, the struggle is that much more difficult and challenging.

Figure 36 Photograph of Grandfolks (Rachel)



“I call them often...from home in the morning if I’m having a tough time my grandpa is very calm, peaceful [...] a few times she’s been able to calm me down. Go outside, sit down against a tree and lean on it, put my bare feet on the grass. I’ll talk with them for as long as it takes, really. And it’s like, thank you so much. I think I’ll be able to carry on with my day.”

One woman focused her photography for the project almost exclusively on the people in her life with whom she had important relationships with and that she wanted to honour. It is striking that she chose to use the project to bring to light the people and relationships that contribute to her life and her wellbeing. She shared her eloquent and personable writing about a range of community and mental health workers who had important positive impacts on her life. Describing a public health nurse she prefers to see instead of her doctor, she said, “I like to go see Linda, the public health nurse, for familiarity, consistency, and comfort level” (Figure 37). Women in the project described positive relationships as having the qualities of open communication, as being non-judgmental and accepting. They were described as empathic, compassionate, with the ability to listen and to understand. People able to build strong, positive, and therapeutic relationships with women were described as happy, joking, smiling, and genuinely loved their work. Thus, the depth and strength of

relationships and social connectedness is shown to contribute to women’s mental health and wellbeing. Pity was contrasted to compassion as a very different and undermining quality.

Figure 37 Photograph of Linda (Rachel)



“I would not go to my previous medical doctor, unless I was bleeding out, per se. I like to go see Linda, the public health nurse, for familiarity, consistency and comfort level. I look to her for acceptance and to confide in her a few of my personal stories to cover a brief history.”

The importance of each person along women’s journeys is evident in the following image and accompanying narrative (Figure 38). Jean is a secretary with the Community Outreach and Assertive Services Team (COAST) of Northern Health. For one participant, knowing that “a sweet and pleasant professional lady is a phone call away” makes a big impact on her experiences accessing mental health services.

Figure 38 Photograph of Jean (Rachel)



“I feel comfort in knowing that a sweet and pleasant professional lady is a phone call away. Jean is a fantastic secretary who works with the C.O.A.S.T. team for Northern Health. She knows me so well that when I reach out for her helping hand, she knows that I mean serious business.”

Of her relationships with various professionals in her life, one woman said:

I like to become friends with the professionals, in which whom, we need to work together to build a respectful rapport and trust. A comfortability level is one key to opening up and feeling that you are being heard. Open communication consists of, expressing how you think and feel freely, stating what is on your mind, and sharing what is playing on your heart.

The importance of trust, developed over time, in these caring and supportive relationships is clearly of utmost importance. These are *real* relationships, ones that have significant impact on women's ability to heal and achieve wellness. The image and narrative of Figure 39 highlight the importance for this participant of establishing mutually respectful friendships with caregivers. Establishing egalitarian-type friendships with professionals in the mental health and addictions field may not be the right approach for all, but it is clear that for her, it has been an important part of establishing a network of care and support that helps her achieve her goals.

Figure 39 Photograph of Penny (Rachel)



“Penny is a wonderfully funny woman. She is a friend that I confide in. She accepts me and respects me. I believe in her to be a gracious lady whom I care about and has taken me under her care.”

Speaking about the importance of trust in caring relationships and about the role of respect in building trust, one woman said, “I build up faith and trust by telling more and more of the truth. When, I find that I am being upheld with high regard, through the course of time, I am then an open book.” Being able to rely on a clinician “like a counsellor or even like a

mother” has been hugely beneficial for one participant, “When I need to lean on someone, they are there to be a strong, solid hand to guide me and lead me through” (Figure 40).

Figure 40 Photograph of Yvette (Rachel)



I hope they are personable and approachable first of all. Then there is being comfortable, which plays an integral part in someone expressing honestly and communicating openly. With this, trust is built.

A clinician is someone who I feel is a must to get to know on a more deep level. We must interact with ease and communicate with respect. I feel it is necessary to become friends with them and I would not have it any other way.

Once the trust is there, which is a must, I permit myself to speak to the Clinician like a counsellor or even like a mother, whom would shelter me from the storm. I feel it is natural that their maternal instincts kick in. When I need to lean on someone, they are there to be a strong, solid hand to guide me and lead me through. I am eternally grateful. I do not know what I would do without a bridge, an advocate, and a friend on the inside that is on my side.

Not only do positive relationships provide supportive listening and encouragement, but they also allow service providers to “tactfully use tough love to keep you on your toes, and to bring you back from crossing the line or having your wires crossed” (Figure 41).

Figure 41 Photograph of Susan (Rachel)



“Susan is all smiles. She is caring and sharing. She is well liked and well loved. She chooses her words carefully. She speaks from experience, she personalizes her teaching tactics. She is sharp under pressure and in being put on the spot. She is respectful in approaching people. She uses gentle persuasion to get you to open up. She, also, will tactfully use tough love to keep you on your toes, and to bring you back from crossing the line or having your wires crossed. She will make sure you are drawing boundaries to keep yourself safe and protected.”

The following quote highlights the importance for some women who are navigating the mental health system to develop a strong relationship with someone in a clinician capacity.

Someone who can advocate for them and help them to work out the best options and decisions within the particular context of their lives:

When I have major concerns that require discussing serious matters. This may require some expertise and stature, in order to be taken seriously immediately and for an agreed upon course of action to be taken promptly. I develop a strong bond with my Clinician, which allows my word and my story to be carried a long way by them. I may ask them to accompany me to an appointment with a psychiatrist or a physician. I may even have a discrepancy with someone in the professional field, perhaps in government, non-profit, and/or Mental Health, where I would talk it over with a few people who I can bounce it off of, and bring it to the attention of my Clinician to see what choices I have and "how to" or "how not to" go about it. I have the backbone to discuss serious issues with family, friends, and professional support people, as well.

Figure 42 Photograph of crows - 2 (Jane)



“...this is kind of where my life is now, I have to confront all these people from my past. It’s almost like they gang up on me and try to pull me down and I just have to stand my ground (like the one with wings up). And it’s really difficult when you have a whole slew of individuals, in this case crows, trying to talk you into doing what they are doing. But you just have to stay strong and make yourself big...kind of like a defense mechanism...a natural defense mechanism, make yourself big. Act like you are real strong even if you are not, you gotta just act that way.”

A variety of complex relationships in women’s lives can enhance or undermine one’s quest for wellness. One woman described how people from her past can pull her down into negative behaviours (Figure 42). In this way, relationships with people can be a negative

influence on women's healing process and may need to be let go as women grow. The need to let go of relationships from the past was mentioned by several women in the project

*Relationships with a larger society*

Another kind of relationship emerged from interviews that related to women's perception of themselves within a larger society. A pervasive sense of alienation and isolation from mainstream society was evident for many of the women. For example, describing how diminished she felt within a larger world, one woman said, "I was a low piece of shit and everybody was so much better than me" (Figure 43). While some women felt alienated, their relationships with a larger society were dynamic and changing as is evident in the quote, "I find it absolutely absurd the way I used to think."

Figure 43 Photograph of fence (Jane)



"I was in this big world and I felt really little. Like really low, like I was a low piece of shit and everybody was so much better than me...I think of it now and I find it absolutely absurd the way I used to think, and the way I sometimes still do think. I just felt like everyone was so much better and bigger and stronger...just better than me. I feel like sometimes...I'm still a little kid...just in a bigger body...I felt trapped in too. Like everything was really unreachable for me...and there's just no way out."

As we have seen throughout this section, relationships can impact upon our mental health and subsequent use of substances to cope with uncomfortable emotions. This sense of being small and vulnerable may contribute to an individual turning to drugs for a boost of

confidence and self-assurance. One's relationship with a larger society can manifest in a sense of being treated differently, as one woman described. She felt alienated and separate from the "9-5 mainstream world" because of how differently people are treated when they don't fit into it. She said of mainstream society, "this world seemed so strange to me, so foreign and I didn't understand any of it" (Figure 44). This speaks to a deep sense of disconnection in her relationship with broader society, something that is likely linked to experiences of mental health issues such as anxiety and depression, as well as other types of relationships.

Figure 44 Photograph of lake reflection (Jane)



"Here it's like the outside world [above horizon] and the world that I was living [reflection in the lake]. It seemed real to me but it was all just distorted. Just a haze. The real world didn't seem logical to me. [...] This world seemed so strange to me, so foreign and I didn't understand any of it."

The depth of disconnection from life in general that can result from depression is beautifully depicted in the following image in which one participant describes the surrealism of such a state (Figure 45).

Figure 45 Photograph red berry (Jane)



“This one is kind of like life and death. Dead and alive. Like at times, even when I’m in really bad depression, I find it kind of difficult to determine... whether I’m really alive or not. Sometimes everything just feels like a dream, especially when I was using... Like this is just some... world that death had made me believe was real life. Some sort of purgatory type thing. It’s weird. Life just felt so surreal sometimes...”

In this instance, the interconnectedness of depression with one’s relationship with society at large is highlighted. Depression clearly impacts upon, not only our relationships with ourselves and with others, but also on our sense of self in the world to an often significant degree.

#### *Relationships with substances*

Most women talked about substances in relational terms. In many instances, substances provided a sense of companionship. They also played an important role in social connections, especially early in life. For example, smoking a cigarette or joint could provide both a sense of companionship when alone or a moment of escape from the pressures of family life. Many women described early experiences of smoking pot as linked to spending time with friends. It provided the focal point of being in a group. For instance, one woman noted, “I had to quit the smoking because it would be too easy to smoke more and pick up that joint, and it’s just, I thought pot was my best friend.” There was this sense, then, of a

relationship with the substance itself and an aspect of maintaining a relationship with the self through substance use. Not only that, but it was evident that experiences of mental health were related to substance use, often in mutually reinforcing ways.

Relationships are dynamic and ever changing. Different levels of relationships interact and influence each other. For example, one woman felt that after a year of being clean and sober, she was finally becoming herself. In other words, through abstaining from drugs and alcohol, she has found a clearer sense of self than was previously possible. This speaks to the interactions between women's relationships with themselves and with substances. Another example of this is from a participant who spoke about how low self-esteem contributed to her dropping out of high school and turning to habitual pot smoking. Another woman found that doing drugs was an alternative to "lying in bed wanting to die." She highlighted how drugs gave her an escape from the agony of her inner self-hatred. Some women spoke about the importance of their relationship with cigarettes to the point that it influenced their decision-making about residential treatment locations. Some services do not permit smoking, which could be a barrier for many who are not willing or ready to give it up.

The narrative accompanying Figure 46 speaks to many different intersecting relationships. First, the use of a substance to "relive my past without feeling much emotion" and to "disregard getting attached to people." In these ways, marijuana was a way of mediating and making bearable her relationship with herself and her past, as well as keeping distance from relationships with other people. For many of us, this distancing feels like safety. Realizing how pot was impacting her ability to have relationships with others, she said, "I figured it was more healthy to be around a friend, or two, or three, and not totally isolated into an ignorant bliss by cutting myself off from human interaction." Here we see

how substance use is related to her past, but results in impacting her present relationships as well. This functional and important social role of drugs could be informative when addressing substance use for women and also prevention with youth.

Figure 46 Photograph self-portrait (Rachel)



“I did not like myself very much and I was lost in my own world of reminiscence. Where, I would delve into pivotal monumental moments and then dwell into deep dark depths of placidity. To take the time to encompass all of this in to full consideration, I would numb myself by smoking marijuana where I was able to relive my past without feeling much emotion, I was numbed. Somehow, I could and/or would disregard getting attached to people and would be discredited accountability for my actions. My state of mind, my headspace and/or the environment I was existing in was a hindrance and dragging

me down because the most important necessity I felt was that I wanted and needed pot. This became more and more prevalent as my pot expense was, all my money up in smoke.

I would at times feel used for smoking a lot of pot with friends. I almost preferred to smoke alone, yet I figured it was more healthy to be around a friend, or two, or three, and not totally isolated into an ignorant bliss by cutting myself off from human interaction. I was most happy in the company of only one other person at a time. One on one is preferable company for me still, to this day.

Another woman described her conflicting relationship with both street drugs and pharmaceutical medications as barriers to her feeling “normal” (Figure 47). Speaking specifically about the relationship between mental health and substance use, one woman said, “I seriously doubt I would have done any type of drug or anything alcoholic if my mental illness/depression had not gotten that severe. Peer pressure or not.” It was apparent that relationships exist between women and substances, relationships that were often mediated or complicated by relationships with themselves and others.

Figure 47 Photograph of pills (Jane)



“...(I would) go from this one to that one and this one to that one until suddenly I’m this monster and I don’t know how to survive without all of these drugs! And (now)...there’s all these (prescription) drugs and I don’t want to take any of them. And I feel like a monster because I don’t feel normal. But...I don’t want to take any of them.”

### *Discussion*

This theme encompassed many different types of complex and interrelated relationships. For clarity, they were presented in four sub-themes: relationships with the self, with others, with society at large, and with substances. As was amply evidenced in the many examples, multiple and dynamic relationships can contribute to our mental wellbeing in either positive or negative ways.

It has long been recognized that social isolation contributes to reduced psychological wellbeing (Kawachi & Berkman, 2001). As well, social connectedness is generally understood to play a positive role in mental wellbeing. According to a summary of various discourses by Curtis (2010), the processes by which social relationships may influence both psychological and physical health include: by encouraging positive health behaviour; discouraging unhealthy behaviour; provision of emotional and practical help; reducing anxiety and fear because of increased trust; and enhanced self-esteem through social activities (Curtis, 2010). To make this more complex, however, the results from this project

show that social relationships can in fact encourage unhealthy behaviours, including substance use and misuse.

Mental health and substance use are interconnected in very complex ways, a finding in this project that is supported by the literature discussed in Chapter 2. Substances can be an initiating event of mental health issues and also be used for self-medicating emotional states. For example, one woman traced her anxiety to an early experience smoking pot that she thinks was laced with methamphetamine, while another woman used pot because it had a calming effect on her anxieties. Many people turn to substances to cope with emotional discomfort and pain. This was discussed at length in Chapter 2 in relation to trauma.

Acknowledging that many different kinds of relationships can play a complex and important role in women's vulnerability to and healing from mental health and substance use issues is very important. There is great potential in positive relationships to reduce women's experiences of stigmatization, alienation, and isolation, thereby improving overall mental wellbeing, as summarized below by one woman:

[...] now that I am treated differently, at least, I mean some people still do treat me that way as I've told you, but my friends who know that I have these mental illnesses, and the wonderful health team that I've found now, that treat me very much like a person, like any other individual...I feel empowered. It's wonderful to feel just as strong a woman as anybody else. My opinion does matter, and most of the time my opinion is able to matter, and I know that. [...] I don't feel separate. I don't feel like 'here are the normal people, and here you are with the screw-ups.' Which none of us are. 'Here you are with the wrong people.' Which none of us are. I don't feel like people are looking at me or thinking, 'There's something wrong with you.' Because there's not, it's just illnesses I have. Doesn't mean there's something wrong with me. It took me so long to figure that out and it wasn't helpful, it was harmful before. Now I'm able to have confidence in myself and see that there's nothing wrong with me. Which is good.

When participants were presented with the preliminary analysis of the interviews, they supported the importance of the theme of relationships. They recognized the significant

role different relationships play in their experiences and risks for mental health and substance use issues.

### **5.2.5 Resilience**

*“I would not be anywhere without my feet.  
And as hard as that road is to walk sometimes, it’s all I’ve got.”  
(Participant)*

Woven throughout all the interviews was evidence of women’s incredible strength and resilience in the face of multiple levels of difficulty and challenge. Resilience is the ability to go through hardship and adversity and continue on the other side as a stronger person. Many of their photographs were representative of their strength, which took several forms including agency, voice, responsibility, determination, hope and tenacity. As they spoke about their photos, some participants expressed surprise at realizing how far they had come.

Women in the project expressed many forms of personal strength and resilience in their images and words. One woman described herself as a “fighter” in relation to her mental illnesses, and her determination is evident in her comeback from severe depression and anorexia that threatened her life. She speaks of her qualities of “grit and determination” that carry her through her challenging days (Figure 48). Taking responsibility for her mental illnesses helped her progress, however she still feels “trapped behind bars” (Figure 49). Despite “being kept behind the crowd” by her mental illnesses she expresses great determination in a self-portrait representing both the challenges and successes she encounters.

Figure 48 Photograph “Facing a bigger world” (Lissie)



“Dealing with mental illness, day in and day out, takes a toll no matter what I say, *even to myself*. The difficulty of it can make me feel overwhelmed and so small—not in stature, but in significance—relative to what’s around me. Grit and determination are qualities that I carry with me always. And still I have to *force myself* some days to pull through and face a bigger world.”

Figure 49 Photograph “Trapped behind bars” (Lissie)



“Mental illness can make me feel trapped from many things, as if kept behind some barrier that makes it very difficult to cross. [...] I take care of my illnesses much better now because I’m able to be responsible for them, but even so, there are times when I still have relapses and it’s frustrating because I’m kept behind the crowd who are able to excel in ways that I’m not there yet.”

Using her own feet as a symbol of her strength, one woman said, “I have to use them and make the best of them if I want to get anywhere,” another expression of autonomy and responsibility (Figure 50).

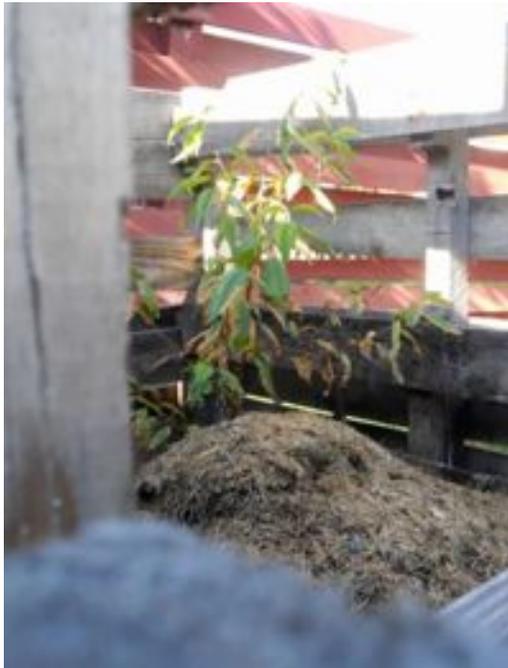
Figure 50 Photograph of feet (Roxy)



“I would not be anywhere without my feet. And as hard as that road is to walk sometimes, it’s all I’ve got. And I have to use them and make the best of them if I want to get anywhere.”

Women’s strength resonated in expressions of agency and self-awareness. Many participants’ narratives spoke both to the challenges they face and also the accomplishments they have made. One woman spoke about how at one point she never thought she would get to where she is now. She never thought things could change, but they have.

Figure 51 Photograph of compost (Jane)



“...even though everything can just kind of be a pile of shit...good can come out of it. You can still grow even though your foundation is a pile of shit...the compost will take garbage and make it into something that can flourish, can grow, can become beautiful.”

She summarized that good things can grow out of difficult beginnings and forge out of hard places. Her analogy of compost being a “pile of shit” that provides a fertile place of growth highlights her ability to transform difficulty into personal strength, the very definition of resilience (Figure 51). This was not the only example depicting growth despite an inhospitable environment. A similar symbol of resilience shows a plant growing out of asphalt (Figure 52).

Figure 52 Photograph of plant in concrete (Ooleesia)



“Something so fresh and fertile growing out of something so dry and hard. [...] I’ve been told a while ago that I should be meaner or negative or have like a hard edge to myself with what I’ve been through.”

This participant describes her image as “(s)omething so fresh and fertile growing out of something so dry and hard.” Women’s ability to find positives in their challenges shows great strength and perseverance. For example, one woman commented, “there’s always something good that comes out of something bad” (Figure 53). Messages such as these highlight women’s ability to transform their own lives through perspectives that allow them to understand and make sense of hardship.

Figure 53 Photograph of footsteps (Jane)



“This one is kind of like stepping out of the darkness into the light. There’s a faint little footprint there. There’s pieces of me that will remain permanently broken. There’s nothing I can do to change it. No matter how much I do, it just happened and it’s going to remain permanently broken, which this crack here kind of represents and the old tar...no matter how much I try to patch it up it just doesn’t work. But even though those pieces are permanently broken, it is possible to move forward. Those scars may never fully heal, but it is possible to move past them. The green grass growing through it represents the knowledge and the lessons that I’ve learned from the breakage, from the damage. That there’s always something good that comes out of something bad, no matter how deep the scar. There’s always something you can learn from it and take from it and there will always be something good. Just kind of moving forward with the knowledge that I wouldn’t have had without this...deep scar...in that deep scar, there’s a

huge piece missing, a bunch missing in there, which is why it’s a hole. And filling it with the good, filling it with the lessons. Because I believe that even when I’m changing my thoughts, I can’t just take the negative thought out because then there’s something that’s kind of missing. I need to replace it with a positive.”

For one woman, dandelions were “the perfect symbol for persistence” because of their ability to survive and thrive regardless of how hard people try to destroy them (Figure 54). Using this analogy she said, “year after year the dandelion blooms even breaking through barriers such as this concrete...” Also evident in this narrative is her sense of responsibility and hope. She said, “I have faith that one day I will be thriving with hard work.” This statement is filled with such self-possessed determination. Of course we all go through times when this optimism is not at the forefront, but seeing again and again in women’s images and words their commitment to making the most of their lives despite adverse conditions is really remarkable.

Figure 54 Photographs of dandelions (Jane)



“...the perfect symbol for persistence... It kind of symbolizes me, I suppose. Having pieces ripped off of me. The world can be pretty harsh. Especially when you are a kid and you are kind of just thrown out there. Piece by piece leaving it behind...or people are taking them...No matter how many petals and pieces are shed along the way, it continues to thrive. Year after year the dandelions bloom even breaking through barriers such as this concrete in the picture... This symbolizes to me my life has been broken time and time again but against the odds I have picked up the pieces, broken through the barriers of my addictions, my past, my mentality and although I am not thriving, I have faith that one day I will be thriving with hard work. And I also believe the dandelion is pretty strong willed to keep coming back, and it all comes down to choice with thriving. If I want to thrive or not it's going to be my choice...”

Another woman took several photographs representing something's existence despite its damaged shell (Figure 55). To her this resonated with her own ability to still be here despite all the hardship she has experienced. In relation to these images, she said, “you can beat me down but here I am still.” Again we see women recognizing and representing their own perseverance.

Figure 55 Photographs of damage (Ooleesia)



“Just having felt beaten down and again, thinking back to that last relationship. You know, you think you can beat me down but here I still am. Quite crumpled, but I’m still here.”

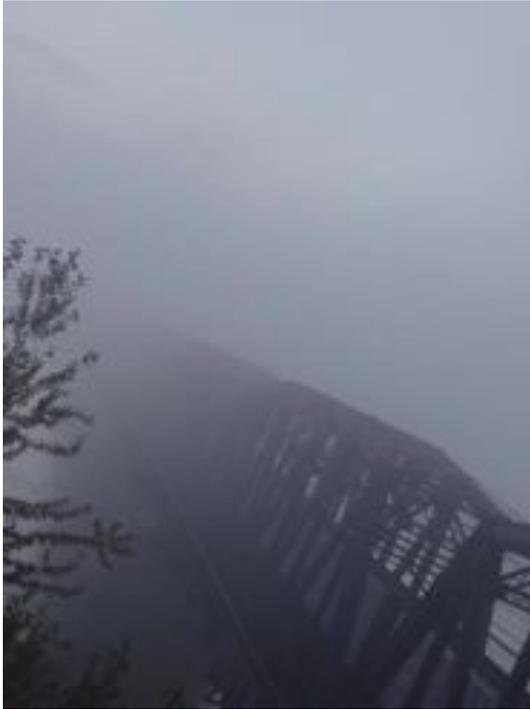
“...you can see what it is...the form is still whole, but look at all the different (holes) ...and it’s still there [...] still being strong”

“You can see it’s there, so kind of camouflaged [...] it’s dead but it’s still there”



Another symbol portraying resilience and strength was that of a bridge shrouded in mist (Figure 56). Describing these images the participant noted that one “cannot hide how strong I am, how strong I can be.”

Figure 56 Photographs of bridge (Ooleesia)



“I was trying to illustrate how structured and how solid and then you see the mist kind of starting to go that way towards it, maybe hide it [...] Cannot hide how strong I am, how strong I can be [...] No matter how hard someone tried to cover it up or I try to cover it up or pretend that it’s not there, that it really is if you look, if you look closely.”

At times, it seemed that participants were surprised to recognize their own strength through describing their photographs to me. This was expressed in a variety of ways, but typically through a verbal comment about it being a new perspective. The opportunity to reflect and review their life allowed them to recognize how far they have come. It leaves me to think that perhaps the opportunity to reflect on their realities through photography might in part be a process that provides one with a more holistic view of oneself, one that allows for strength to shine through.

Spirituality resonated for each woman as a place of strength. In identifying its importance in their lives, each woman differentiated between religion and their

understanding of spirituality. One woman turned to a spiritual perspective in order to rise above her difficulties and see the bigger picture, to trust in the process, and know that there is a purpose to all suffering. She showed profound strength and forgiveness of a former abusive partner in her efforts to remember both the positive and negative aspects of the relationship. One woman spoke about the place of spirituality and the conflict between it and the practical requirements of everyday life (Figure 57).

Figure 57 Photograph of cross (Roxy)



“I think when we go through this life we are often taught that if we are going to make it in this life you need to believe in the tangible. If you want to be successful, you have to grab what you can actually hold. You work hard, you go to school, you do these things, you gain employment, you have a house. Those are the terms of being successful in this life. And I think while everybody is growing up we get so...desensitized from what has actually brought us here and why we are here...And the reason why it is so hard is because you can't hold it, you can't see it or touch it or taste it or anything [...] I think that spirituality is considered such a thing of an older time. Its not modern...people don't believe in anything anymore.”

Another woman acknowledged, “I like to pray and I know that I wouldn't be here now if there weren't a god. I don't know where I'd be now. It's nice to have some faith in something other.” Articulating the importance of spirituality in her life and the ongoing quest for deeper connections, one woman noted that:

... something that is lacking in my life is spirituality. And I find that spirituality and religion are very different. I still don't know where I stand with any of it but, I think it's definitely a huge part of my life ...I know I'd be a lot more happier if I knew where my faith lied and I felt strong in my faith. And I don't mean faith in religion because I don't think I could ever be part of an organized religion, but just to be more spiritual.

An image that speaks to the search many of us experience for spiritual meaning in life is depicted in Figure 58. This image shows a little girl in a park looking away from the image focal point of a large tree. For this participant, the object of the search is apparent, but we often overlook it anyways.

Figure 58 Photograph of little girl (Roxy)



“... we are children, no matter how old we get or whatever happens, we are always children searching and...the thing about this picture is...this is usually what we are searching for [large tree in background] and it’s so strong and solid and apparent and it’s there, but we are always just a ways off in the shadows searching, even though it’s usually right there. [...] lots of people call it god, but whatever it is to you, that’s what it’s supposed to be.”

One woman described the “overwhelming calm” she feels when she finds one of her “perfect moments” (Figure 59). For her, the sunset represents the “positive endings” in her life, such as “choosing to end my substance abuse, choosing to end my self-defeating thoughts and behaviours, and choosing to end relationships with the people that no longer coincide with my life anymore.” While this narrative does not explicitly speak of spirituality, there are many aspects of it that indicate a spiritual approach to her life, including having “faith” that a perfect moment will come again no matter how long it takes. As well, she summarized her belief that, “Every night our lives end with the sunset and we are reborn by the sunrise.” Such a statement resonates with depth, hope, and perspective that highlight her strength and resilience and their connection to a form of spirituality.

Figure 59 Photograph of sunset (Jane)



“The lake was rather calm that day. This moment felt ‘right’ to me. When I was in the heat of a binge or in the midst of a mental episode I was so blind to the natural beauty that this life has to offer. Blind to the reasons that life is truly worth living. The only thing keeping me holding on sometimes is the knowledge that every so often, through the constant struggle, which is sometimes my daily life, a perfect moment will come along, a moment embodying overwhelming calm and beauty. I mean, sometimes I just wake up, survive, sleep, repeat. These times may last days, weeks, months, but keeping faith that my perfect moment could be just around the corner inspires me to keep going. I think one of the reasons that the sunset touches my heart so much is that it represents an end. Naturally, it is common to believe an end is a negative thing, but when the sun goes down and saturates the skies, the waters and the earth in such radiant colours, it is near impossible for me to feel anything but supreme peace. The sunset reminds me everyday of the positive endings in my life. The endings I have

chosen, such as choosing to end my substance abuse, choosing to end my self-defeating thoughts and behaviours, and choosing to end relationships with the people that no longer coincide with my life anymore, to name a few. Every night our lives end with the sunset and we are reborn by the sunrise, that is what I believe.”

Spirituality holds a place of importance for many people who are seeking mental wellness or overcoming unhealthy substance use issues. For each person, this is an individual process of discovery and learning, but it is important that service providers and professionals take this into consideration along with other holistic aspects. In Chapter 2, I presented some information on culturally safe health care. A growing recognition about the importance of culturally safe mental health and addictions services for Indigenous people is reflected in the initiatives being undertaken in Canada (Nelson, 2012). These approaches are holistic and incorporate an understanding of spirituality along with physical, emotional and mental wellbeing.

Women also spoke about hope, about how even though they struggle, there is reason to feel like things will continue to change. They felt it was important to know there was a

different view beyond their experiences of mental un-wellness. Referring to an image of a red sky, one woman spoke about how fire causes damage but leaves room for new growth. She said, “whenever it happens it will be such a beautiful thing” (Figure 60). Her ability to recognize possibility from something as destructive as fire is a display of her inner strength and resilience, as well as her hope and optimism for the future.

Figure 60 Photograph of red sky (Roxy)



“A lot of times we just stand alone [like the tree silhouettes] and we are surrounded by the fire...after the fire there is always the burnt...And that burnt-ness is always what gives way to new life...that means we only have to wait a little while...there will be the burnt parts and that will bring new growth... whenever it happens it will be such a beautiful thing...”

The following image of hands holding stones is an expression of hope and a perspective that despite the hardship of mental illnesses, “the warmth of life” remains (Figure 61).

Figure 61 Photograph “Rocks are hardship, hands are worth it” (Lissie)



“The rocks represent the hardship of mental illness: the hands represent the warmth of life surrounding the hardship. I can get so caught up in my mental illnesses that it’s hard to know, hard to see, or even remember in those times that there is more to the world around me... There is love around me, but it can be hard to notice. However unfortunate this may be, the world and its love is still there, and there’s hope in that.”

The perspective expressed in this photograph resonates with hope and renewal.

One woman spoke about a pivotal moment of change in her life. A shift happened inside of her that allowed her to take responsibility for her illnesses and start making choices in support of her wellness. She described how she changed and “before then I couldn’t open my eyes and then I did. And then I did. And then I really saw things” (Figure 62). This expression of responsibility and empowerment depicts women’s innate potential for profound transformation, an inexplicable moment of readiness that each of us arrives at in our own time.

Figure 62 Photograph “Crow trapped in branches” (Lissie)



“[...] the Beatles [...] blackbird song [...] it’s very much been a narrative for my life. Blackbird singing in the dead of night [take these broken wings] and learn to fly, all your life, you were only waiting for this moment to arrive. And later when it says take these sunken eyes and learn to see, all your life, you’ve only been waiting for this moment to arrive. When I changed, that became very much real...only been waiting for this moment to arrive. Before then I couldn’t open my eyes and then I did. And then I did. And then I really saw things. I saw things again as if for the

first time. [...] And [...] now I look up and I see things that I always missed before when I was so depressed and just looking at my feet. [...] And flying is a good metaphor because I just had such low self-esteem. I had no confidence by the time I reached even 17. It was all gone, absolutely all gone. And I mean now I’ve done so many things that I had given up on doing anything in my life. And I realized I can start my life now.”

### *Discussion*

Acknowledging women’s innate strength and resilience is fundamental to providing appropriate and supportive resources. This might translate into service providers asking women what they need to validate and respect that women seeking help may know more than expected. It is important that service providers remember that, despite mental health or

substance use, women have the capacity to heal from unthinkable experiences if given the appropriate support and patience to arrive at their own readiness. In response to this finding, one woman confirmed, “plant the seed and it will grow.” She explained that we have all lead different lives and it takes some people longer than others to reach a place of readiness. It is important that women are supported and allowed to progress at their own pace.

The strengths perspective or approach in social work requires that practitioners view individuals, families, and communities in light of their “capacities, talents, competencies, possibilities, visions, values, and hopes, however dashed and distorted these may have become through circumstance, oppression, and trauma” (Saleebey, 1996, p.297). A statement from Saleebey (1996) confirms what was expressed by women in this project; “[t]oo often practitioners are unprepared to hear and believe what clients tell them, what their particular stories might be, especially if they have engaged in abusive, destructive, addictive [...] behavior” (p.297).

Throughout the interviews, women mentioned things from which they found strength, things that helped them cope in positive ways. Some of these included writing in journals, talking to someone, and rational self-talk for anxiety and panic attacks. Some women described trying to stay present and moving out of the thinking mind. In fact, one participant said, “I think that’s one of the reasons why I like photography, so that I can just not think about anything but just focus on what I’m doing.” Part of being present can involve noticing warning signs. For example, one woman said that “the moment that I let that awareness slip, that’s the moment that I’m back in there and I don’t know how the hell I ended up on a seven day binge, or how I ended up not getting out of my bed for a month.” For some, “just letting myself feel is the best thing that I can possibly do for myself.” One woman spoke about how

her job is really positive, “I have a lot of great people that I work with, and that has saved me so much. To be able to look forward to work and know that they value me and they appreciate me and it builds my confidence.”

### **5.3 Exhibition questionnaires**

An important part of the Photovoice method is sharing participant images and narratives with communities in order to promote engagement and positive social change. In order to do this, we held two public exhibitions in Prince George, one at a downtown location in March 2012 and another at the University of Northern BC campus art gallery in January 2013. A brief questionnaire was collected from attendees at both exhibitions in order to gather information on the impact of the exhibitions on those who attended (see Appendix IX). The purpose of this questionnaire was to provide some information on three secondary project goals that are evaluative in nature (goals 2-4 in Table 1).<sup>62</sup> The results provide preliminary descriptive insight into attendees’ response to the exhibitions. This questionnaire is precursory and exploratory with limited reliability and generalizability. It is limited in part because results come from a self-selected sample of people who chose to attend the exhibition and who then chose to fill out the questionnaire.

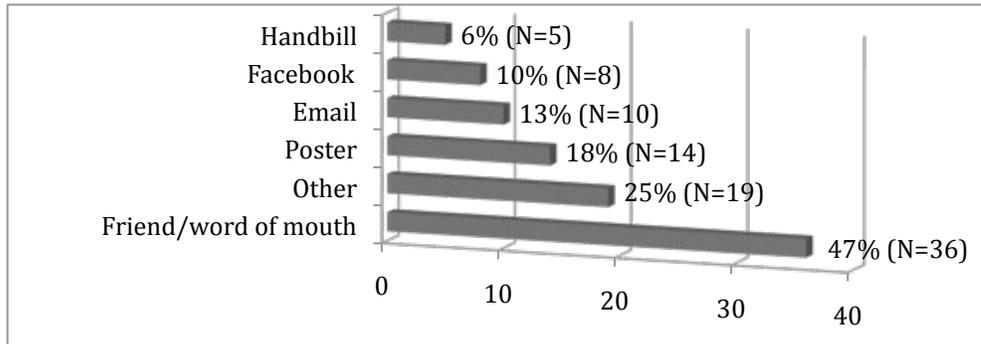
An estimated 80 people attended the ArtSpace opening night with a total of 69 questionnaires collected over the course of the month-long installation. Approximately 25 people attended the Rotunda opening night and 8 questionnaires were collected (total questionnaires from both exhibitions: T=77). The results of the questionnaires were compiled

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<sup>62</sup> As summarized in Table 1, project goals 2-4 were: 2) to promote dialogue and understanding of substance use and mental health issues among the community and the public, thereby contributing to reducing stigma and discrimination; 3) to learn about photography as a method for sharing research results in a meaningful way; and 4) to inform individuals in policy and practice for improved services in the north.

and revealed that the majority of people heard about the exhibit through friends or word of mouth (47%) (Figure 63). This information could be useful for other similar projects in the community.

Figure 63 Exhibition Questionnaire: 1) How did you hear about this exhibition?<sup>63</sup>



The second question asked about people's occupation and their connection to the topic of mental health and substance use. Many attendees were students (40%) and many identified as someone with a substance use and/or mental health issue and/or a family member of someone struggling with these issues (42%) (Figure 64). Question 3 and 4 were rating scale questions. The first asked about self-rated understanding of the project subject. Most people attending the exhibition rated their understanding of women's mental health and substance use issues as 'average' (48%) or 'higher than average' (36%) (Figure 65). I think this means that most people attended because they had an interest in and a certain amount of knowledge of the topic. The next question asked if the exhibition had changed<sup>64</sup> attendees' understanding and/or assumptions about women who live with substance use and mental health issues (Figure 66). Despite the generally high level of self-rated understanding, over

<sup>63</sup> Responses add up to more than 77 (100%) because some people gave more than one response. Percentages were calculated using T=77 as the denominator because that is how many unique questionnaires were collected.

<sup>64</sup> Based on feedback and upon further consideration, instead of the word *change* I used the word *impact* in the second questionnaire used at the Rotunda exhibition. I did not find that this change of wording made much difference in responses.

70% said that the exhibition changed their understanding and/or assumptions about women living with substance use and mental health issues ‘somewhat’ (29%) or ‘more than they thought’ it would (43%).

Figure 64 Exhibition Questionnaire: 2) I am (please check all that apply)<sup>65</sup>

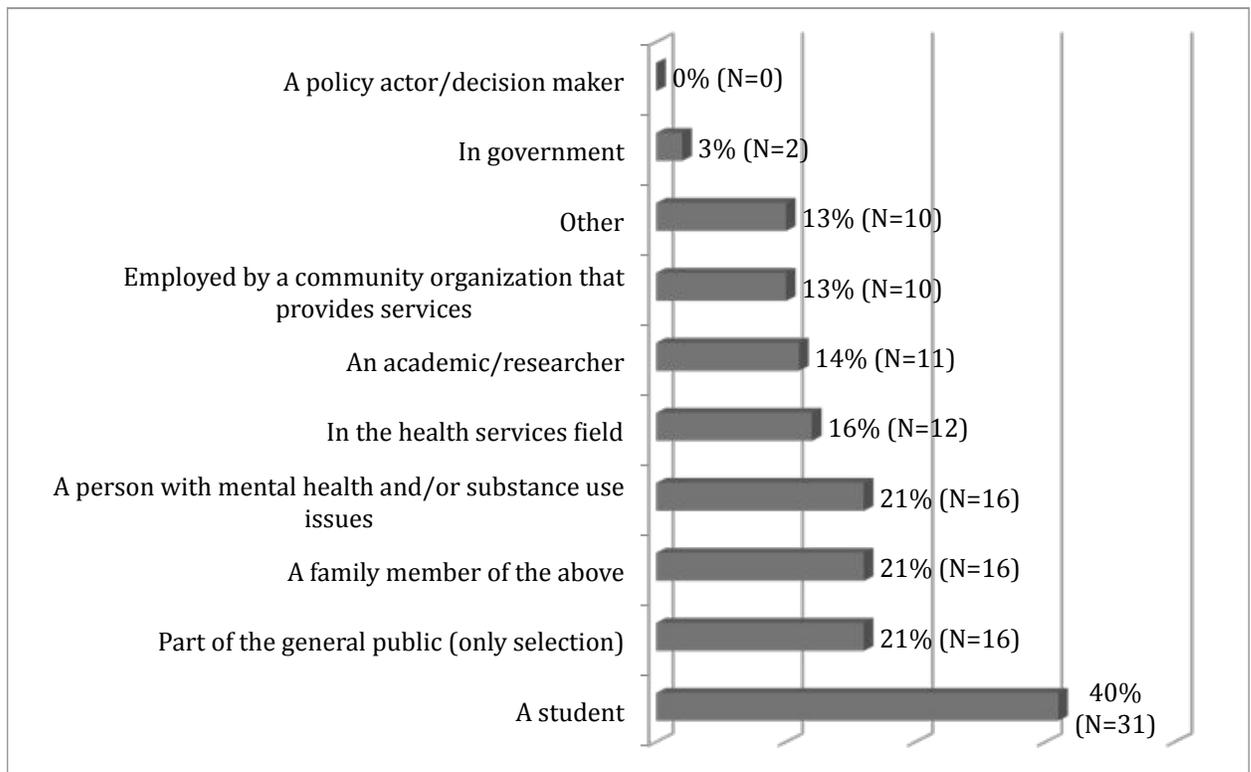
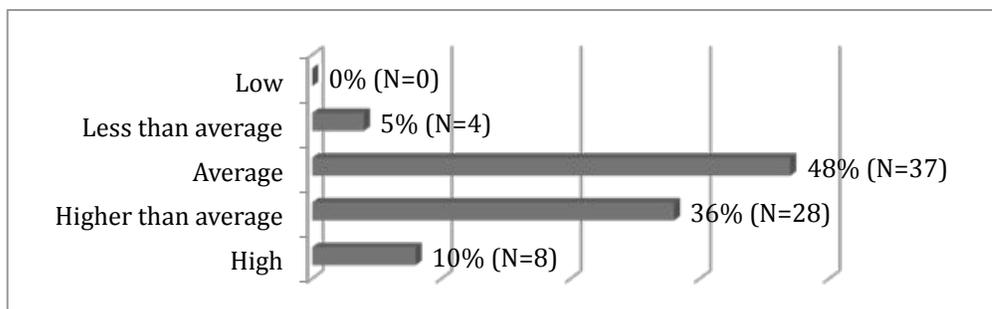


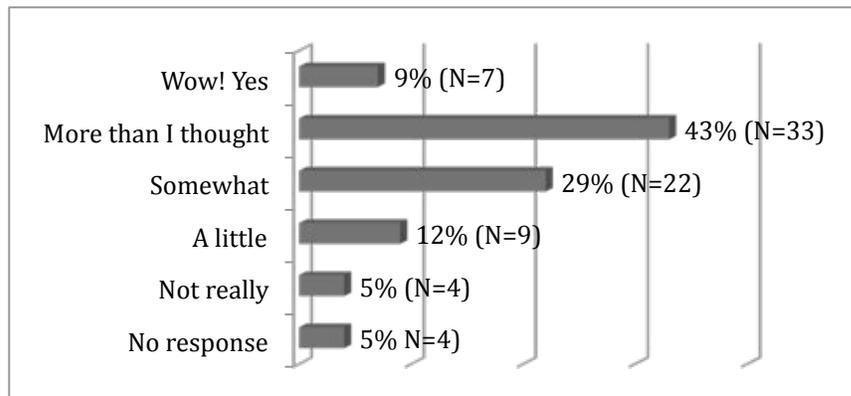
Figure 65 Exhibition Questionnaire: 3) Rate your understanding of women and substance use/mental health issues *before* attending the exhibition?<sup>66</sup>



<sup>65</sup> Responses add up to more than 77 (100%) because some people gave more than one response. Percentages were calculated using T=77 as the denominator because that is how many unique questionnaires were collected.

<sup>66</sup> Percentages calculated using T=77.

Figure 66 Exhibition Questionnaire: 4) Did the exhibition *change* your understanding and/or assumptions about women who live with substance use and mental health issues?



Comments from the questionnaires further articulate the impact the exhibition had on audience members and support the findings from the questions above.

Very positive feedback was received in the open-ended comments section of the questionnaire (69 comments received out of 77 questionnaires). Some comments pointed to the importance of this project for bringing these topics into the spotlight, for encouraging dialogue, increasing understanding, and addressing stigma. These comments relate to the second project goal of promoting dialogue and understanding of substance use and mental health issues among the community and the public. For example, one attendee said, “[m]ental health and substance abuse are usually kept in the dark, but this project did an excellent job putting it in the light!” Another commented that the exhibition was a “[g]reat way to see what is so often unseen.” Some people mentioned photography specifically, as this attendee did, “I think that photography is a great medium [...] to open up dialogue with others and new ideas for yourself.” In terms of addressing stigma, one attendee said that “[i]t is important that mental health issues are as accepted/understood as much/equally as physical health issues. It is still seen as a stigma in our society. This is an important exhibit – help build awareness/acceptance through photos/stories.”

The third goal of the project was to learn if photography was an effective method for sharing research results in a meaningful way. Many exhibition attendees made exclamations of the exhibition as “powerful” and “amazing.” For example, one comment was, “[v]ery powerful voices and images.” Several comments specifically mentioned the impact of the use of photography, such as this comment, “I love the fact you used the photographs to give these women their voices and for them to express themselves in a creative way.” Of the photographs, one attendee said that they “...were so revealing and told stories about these women’s lives so clearly.” Another attendee said that “[t]he photo’s actually surprised me a lot. It was not what I expected but it was very real.” I suspected that the visual nature of photographs would impact people in a more emotional and visceral way than words alone, which was expressed by one attendee’s comment, “I can’t explain why but I’m feeling very emotional! Amazing work – you and the women!”

The fourth goal of the project was to inform and influence individuals in policy and practice for improved services in the north. In order to assess the questionnaire results that speak to this goal, I isolated the respondents that identified as a policy actor/decision-maker (n=0), in government (n=2), employed by a community organization that provides services (n=10), or in the health services field (n=12).<sup>67</sup> The total number of individuals that selected at least one of these categories was n=21. There was a higher level of self-rated understanding of the project subject among this sub-group. 67% rated their understanding “higher than average” or “high” compared to 47% for the total attendee population. 29% of the sub-group said the exhibition changed their understanding/assumptions about the exhibition subject “more than I thought” compared to 43% of the total attendee population.

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<sup>67</sup> It is important to note again that people were asked to check all that apply from the list of options. This means that any one person may have identified themselves as more than one of these categories.

However, the comments from this sub-group added much nuance to these findings. A nursing student focusing on the area of mental health said, “[w]hat a wonderful way to show the stories and give these women a voice.” Another attendee who works at a women’s shelter said, “I see many women who struggle with substance use and mental health issues. I am glad that this exhibition is bringing to the forefront these issues that affect us all.” Another attendee who acknowledged their high level of knowledge of the project’s subject said that their, “...awareness/understanding did not necessarily change, but certainly deepened.” Interestingly, one attendee commented about the lack of time people generally have to really listen, and that this exhibit allowed the attendee to be “a voyeur into their [women’s] thoughts.” Another attendee called the exhibition “...very thought-provoking both professionally and personally. It helped me gain insight into the struggles everyday.”

As a way of visually representing all of the comments collected on all of the exhibition questionnaires, I created a *wordle*<sup>68</sup> in which higher frequency words and phrases from the comments are represented with greater size and prominence (Figure 67).

### *Discussion*

The use of questionnaires in this project was part of an overall qualitative inquiry. The purpose was not to gather data on an objective, measurable, reality, or to establish reproduceable factual information, but instead to explore the impact of exhibitions on attendees through a qualitative interpretation of responses. The results of the questionnaire suggest that additional inquiry is worth considering to learn more about the impact and utility of Photovoice projects for influencing policy and practice and initiating change.

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<sup>68</sup> A *wordle* is a ‘word cloud’ or visual representation of text. See <http://www.wordle.net/>.

Figure 67 Wordle of exhibition questionnaire comments



One of the audiences we hoped to reach and who were sent invitations, were people in policy, government, and health care. However, there was only minimal attendance by these groups. It is possible that these individuals would be more effectively reached through other methods or venues. One of the options the women suggested, and I considered, was to try and have their photos displayed in various locations in town such as City Hall, the Courthouse, the Police station, etc. I think this is an amazing suggestion and I would really like to see this happen. Unfortunately, I was not able to accomplish this prior to writing this thesis, but may consider it in future. Another option is to disseminate the summary report to individuals involved in local health policy and government.

While the results from the rating scale questions were not strongly supportive of the exhibition's impact on the sub-group representing individuals in policy and practice,<sup>69</sup> the comments from this sub-group of attendees added support for the potential of such work. In

addition, this project goal could be impacted in a variety of ways aside from the exhibitions, including through conference presentations, the project website, and the project summary report that will be completed and shared after the thesis is defended.

Despite the limitations of the exhibition questionnaire, the precursory results of this group of self-selected subjects suggest that photography and narrative could be a strong method for sharing lesser-known realities. However, as previously mentioned, this may not be the most effective method to disseminate research to individuals in policy and practice positions. I recommend for others undertaking similar arts-based or Photovoice projects to consider alternate approaches for engaging individuals with less personal stake in the topic but who may be in positions of power to make change.

Finally, I would like to highlight another benefit of the exhibition questionnaires. I was able to present the results of the questionnaire to participants at a final group meeting. It turned out to be a meaningful way for them to receive feedback on the impact of sharing their stories with the community. I think it provided a sense of reciprocity for them to hear back from those who came to see their work. This was a way for women to see how their work had impacted others and to see tangibly an outcome of their participation in the project.

#### **5.4 Participant experience of the project**

The fifth goal of the project was to learn about the experience of participating in the project, if it was positive or not, what might have improved the experience, and how meaningful the different aspects of the project were. At the end of the participant portion of the project (March 2012), I asked women to respond to a questionnaire in order to capture

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<sup>69</sup> The sub-group of attendees identified as a policy actor/decision-maker, in government, employed by a community organization that provides services, or in the health services field.

their feedback (see Appendix VII). In addition, some women made comments throughout the project, at the exhibition, and at the final group meeting. Below is a summary of their responses.

Participants generally found the project a positive experience. A few mentioned how they had never been part of something like this before. Some words used to describe their overall experience were: gratifying, humbling, wonderful, precious experience, an honour, closure, acceptance, relief, perspective, understanding. Speaking about photography specifically, women referenced the therapeutic aspect of it:

Taking photographs was a new sort of "therapy" for me. It was definitely a different avenue as opposed to the "same ol' same" writing and talk-therapy. It was possibly my favorite part of the whole project...[...] I enjoyed it thoroughly.

Another woman described how “It brought more substance to what was going on in the past few years.” Indeed, the process of capturing a still image seemed to provide a perspective to some participants, for example:

Seeing my issues and problems through a picture at a separate time from when I took the picture and feeling the emotions about why I took the picture during the time the photo was taken compared to months later was one of the most self-empowering experience and gaining that knowledge was priceless.

The act of taking photographs of important people was meaningful for another woman, because she “got to put faces and names to the people I care about and who have taught me, people I’ve learned from.” And for another, “Taking the photos gave me a sense of control that I didn’t have previously.” Indeed, the actual process of participating in this project was different for each person depending on how they chose to engage in it, but it involved real actions on the part of participants in their everyday worlds. This is distinct from projects that focus on interviews alone and corroborates the transformative potential of this type of project as an intervention. As one woman noted:

What the project has brought me, aside from clearer focus, is a new outlet to express myself, and the reassurance (which I need on a regular basis) to know I am not alone in dealing with my trials, tribulations, struggles, and heartache. I still struggle very deeply with the loneliness aspect of life, and the isolation that comes with that.

Participants found the photography exhibition at ArtSpace to be a significant part of the project. In response to the exhibition, one woman said,

...it was a very neat part of the project. I was pleasantly surprised with the amount of people who attended the opening night, and it was kind of nifty to sit in the shadows and observe without people knowing that it was, in fact, my photographs they were staring at.

Another woman described how she “was moved to tears more than once by being there, watching the way people took in my photographs, and the photographs of other participants.” Being able to see responses to photographs provided a sense of connection and belonging for some women and a sense of the impact their work had on others. This was described in one woman’s words, “The final product being presented to the public gave a deeper sense of how powerful a reaction the photos gave...” Described in another woman’s words, “Seeing what other people thought, I never thought other people understood or were able to relate. Usually I just think I’m the only one that feels this way, but really no.” Describing how she spent the evening of the opening night standing near her photos in order to be approachable, one woman spoke about the impact of connecting with others who were viewing her images:

This sort of bonding over hardship and struggle and the determination to keep going because there is nothing else is an amazing thing to share with a human being that you have never met before but suddenly feel like you know completely because you both stand in front of a picture that expresses it so neither of you have to. The power of that moved me so completely. I am grateful. I am amazed. I am humbled. I am honored. I am one of many. And I have hope.

Most of the participants found it positive to have group work included in the project, although for some it was frustrating to work with others and to find that not everyone was

always able to attend. One woman said, “having had a small group made it more comfortable, not so intimidating.”

While some women did not find that their participation in the project changed their understanding of themselves and mental health and substance use, they still found it impactful. For example, one woman said:

I’m not sure that I would use the word ‘changed,’ for what my understanding of myself and mental health and substance use has done through this project. Rather, I think my understanding has been ‘enriched.’

Another woman said her understanding of herself did change and that “I can accept myself and my faults easier and I have been able to let go and finally move on from a lot of issues that I felt were chaining me up.”

I asked all of the women if they had felt their voice and story had been heard in this project. Some of the responses were:

I feel very valued and very heard.

I felt at all times that what I chose to share about my personal life was being honored and respected, which I have so seldom felt in my life.

I think for any person struggling it only takes a true heart to listen and care but once you have been able to accept the different choices you can make you realize again you are a person and that you can make choices and have control. In the end we all struggle for control of our hearts.

I found that participants were describing a sense of belonging and connection through the project, specifically through sharing their photographs and seeing other people’s responses to them. For example, one woman said, “And what touched me the most was hearing from other people – as they looked at a photo of mine, for instance – tell me that they could relate, because they felt exactly the same way.” As evidenced in the following two quotes, being “witnessed” can have a powerful and transformative effect:

I realize [...] it's really done a lot of healing for me. A lot. And they say that the healing can only begin when someone bears witness, and I think a lot of people beared witness to a lot of things that were really deep inside, and that really really healed a lot, and it kind of restored something in there. And I was looking for that for a long time. So, honestly, words can't really express how much progress or anything that's been done, but it's amazing. It's really amazing.

I'm getting it out there. In my heart I was really fighting, I really wanted that because to me that was really really important, for certain people to bear witness to this.

To conclude, the project was a positive and sometimes transformative and even healing experience for the women who participated. Being able to share their realities with a larger community and see in various ways the impact this had on others was an impotent part of the overall project experience for them.

## CHAPTER 6      Conclusions and reflections

*“Thank you for the powerful work – a great glimpse at the minds and the creativity of women that we may not otherwise have heard from.”*

(Photography exhibition attendee)

This thesis documented a community-based project called *Envisioning Change* that took place in Prince George, BC from September 2011 to April 2012. The project engaged five women in the creative process of photography to explore, conceptualize, visualize, and describe their lived experiences with substance use and mental health. This project, instead of providing a description of verifiable truths, represents the potentiality of women’s experiences through insight into several individual realities. In this chapter, the main findings of the project are summarized and revisited in relation to the research goals identified in Table 1 (copied below for convenience).

<b>Primary research goal</b>		<b>Data collected</b>
1	To investigate and produce new knowledge of Prince George women’s lived experiences of substance use and mental health.	Interview narratives based on participant photographs; Participant feedback
<b>Secondary research goals</b>		
2	To promote dialogue and understanding of substance use and mental health issues among the community and the public, thereby contributing to reducing stigma and discrimination.	Exhibition questionnaire
3	To learn about photography as a method for sharing research results in a meaningful way.	Exhibition questionnaire
4	To inform individuals in policy and practice for improved services in northern BC.	Exhibition questionnaire
5	To learn about photography as a method for engaging women in research.	Participant questionnaire

This is followed by a summary of some insights that arose from this project that are of particular relevance for individuals in policy and practice. I provide a few reflections on the

project overall, including potential research topics that could follow. Finally, I discuss some of the limitations of *Envisioning Change*.

The primary goal of this project was to investigate multiple interrelated factors that contribute to northern women's experiences of substance use and mental health, including their successes and challenges accessing supportive services in Prince George, BC. This was investigated using participant photography and in-depth interviews. The findings of a thematic analysis of the interview data revealed five interconnected themes that are related to material space and place, embodiment, power, relationships, and resilience. While these five themes do not have distinct boundaries and they interact and overlap with each other, they represent one way of grouping the significant content of the interview data.

The first theme relates to the active nature of space and place. The project revealed that women are both creators and recipients of spaces. They experienced them on both the macro and micro levels. Several findings in this theme relate specifically to services in Prince George, BC and perhaps in other locations. First, actual material spaces, such as treatment centres, hospital wards, and drop-in centres, have an influence on mental health. Secondly, the geographic location of services spread throughout a city can make it financially and practically difficult for women to access the treatments they need. Finally, while Prince George is working on establishing a residential rehabilitation treatment centre for women, it still does not have one available. This means that women seeking longer-term residential treatment and rehabilitation for substance use problems need to leave their city in order to access it.<sup>70</sup>

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<sup>70</sup> The Prince George Mental Health and Addictions Unit offers an in-patient detox unit with wrap-around, integrated community follow-up services. This is a different type of service than a residential therapeutic community (sometimes referred to as residential treatment centre).

The second theme identified mental health and substance use experiences as deeply embodied realities. This has implications for supportive services at the community, clinical, and institutional levels. Women described sometimes feeling dismissed when seeking support for mental health issues. They found their mental health concerns were sometimes perceived by health care providers as something to overcome with will power. I think this is an artifact of Cartesian dualism in biomedicine in which the mind and body are viewed as distinct. Mental illness is easily characterized as a personality flaw within this dualistic framework. Dualistic thinking is evident in the way that many women felt undermined and dismissed when seeking support for mental health concerns. Unfortunately, there continues to be a differentiation between mental and physical health that is coupled with differential valuation of each. This contributes to the ongoing stigmatization and discrimination that exists for people who experience mental health and substance use issues.

The third theme in the interview data was about the manifestation of power and its impacts on women's experiences of mental health and substance use. Trauma and abuse are manifestations of power that are deeply connected with mental health and substance use issues. Chapter 2 provided a review of the literature on this topic, which was corroborated by participants in this project. Many of them spoke or alluded to traumatic experiences in their lives and of their use of substances or self-harming behaviours to manage the resulting emotional distress. There is growing acceptance of the role of trauma in mental health and addiction treatment. The results of this project support the need for trauma-informed care as part of a holistic approach to supporting women on their healing processes. In addition, the interviews revealed that *dis*-empowerment contributes to poor mental health and to the use of substances. Finding ways to build on women's innate strengths and support their autonomy

and control in their lives is an important part of improving wellness. Women in this project spoke about how having a psychiatric label shaped their experiences with the health care system, connecting their stories to those told in The Standing Senate Committee report about experiences of discrimination from within the health care system (Chapter 2). These included feelings of belittlement by doctors in the mental health system and lack of responsiveness to suicidal states in Emergency Wards.

The fourth theme revealed the centrality and dynamism of many kinds of relationships in women's lives and how these can support or undermine individuals in ways that contribute to mental health and substance use experiences. Abusive relationships in adulthood and early experiences of neglect or violence in the family can have profound implications for women's mental health and resulting use of substances. Some women spoke about the importance of supportive relationships with friends, family members, partners, and service providers for their mental wellbeing. I think that some service providers might find insight and reassurance from hearing about how important their caring and down-to-earth approaches are for women.

The fifth and final theme was the most pervasive throughout all of the interviews and brings to the fore women's innate strength and resilience in coping with adverse life experiences and mental health and substance use issues. It is important that mental health and addiction providers hold in the forefront women's strength and resilience. Women have the capacity to heal from unthinkable experiences when given the appropriate support. A key message is that women reach a place of readiness for positive change in their own time, and each step along the way contributes to this. As well, this theme supports a strengths-based approach to programming and services for women with substance use and mental health

issues. Focusing on the resources and skills women have instead of on deficiencies could go a long way to improving wellbeing.

Directly addressing the primary research goal, the five themes are a way of broadly grouping the significant content of the interviews thereby producing new knowledge on the multiple, interrelated factors contributing to Prince George women's lived experiences of substance use and mental health. Instead of being independent of each other, the themes interact and link with each other. Interaction between themes is evidenced in many ways throughout the data. This is typically the case when attempting to reduce complex qualitative data into categories. Indeed, when I presented the preliminary analysis to participants, one of them summarized the interaction and interrelatedness of all the themes when she said:

... these are not compartmentalized things, right? All six<sup>71</sup> of those issues are one and the same. Because your strength and resilience comes from saving your space and your place. And your space and place can create your embodied experiences, and the power imbalances also relate to the isolation and alienation. The relationships go back to the power imbalances. And this is the thing that nobody understands. They are all one and the same even though they are totally different fucking things.

Participants in the project validated the complexity and interrelatedness of each of the themes.

The themes that emerged from participant interviews in *Envisioning Change* indicate the imperative of treating women with substance use and mental health issues in a holistic manner, as complex and strong individuals within a particular context of space and place. All of the women in this project reached a point in their lives where they were ready to make a change. Prior to that, availability of resources was not enough. It was clear, however, that all

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<sup>71</sup> My preliminary data analysis had six themes: space and place, embodied realities, power, isolation and alienation, relationships, and resilience. During the writing of this thesis, I collapsed *isolation and alienation* into the theme of relationships because it related to women's relationship with themselves and with society at large.

the steps along the way and each interaction with supportive resources, planted seeds that grew into a readiness for positive change.

One of the secondary goals of *Envisioning Change* was to promote awareness and dialogue about mental health and substance use, with the intention of contributing to reducing stigmatization and discrimination. Women's experiences with these issues was shared with people in the community and beyond in a variety of formats. We held two local, public photography exhibitions (see Chapter 4 for details and images and Chapter 5 for results). Comments from a questionnaire completed by attendees indicate the importance of putting these topics in the spotlight and creating such spaces for dialogue, reflection, and learning about issues that are not typically spoken about because they remain shrouded in stigma. I really believe that demystification and personal/emotional connections are powerful ways to change attitudes and reduce discrimination. This project accomplished a bit of this in its own small way by sharing women's powerful images and words with diverse audiences in a variety of publications, presentations and exhibitions.

Another secondary goal of this project was to learn about photography as a method for sharing research results with diverse audiences. I have presented results on attendee responses to the photography exhibitions. They anecdotally suggest that there is a strong potential for the use of photography paired with narrative for sharing marginalized realities. Further research is needed with stronger methodological grounding. As a graduate student researcher, I found the use of photography in the project made it easier to share with people and gain their interest in the subject. Photography made the project much more accessible for people and interested an audience who may not have any prior knowledge of mental health and substance use issues. One of the big challenges of research is making the results

accessible to a broader audience, and I think that photography is one way of accomplishing this.

A third goal of the project was to inform individuals in policy and practice for improved services in the north. This was an ambitious goal and one that is difficult to measure. Any changes that occur in health promotion, policy or practice would be through increased awareness and compassionate decision-making at an individual level in people's capacity as practitioners and citizens. As a real-world example of how informing and influencing individuals in policy and practice might work, one of the committee members for this thesis works with Northern Health and was working on renewing a mental health and addictions intake form. After hearing the preliminary analysis of these interviews, she realized that the form asked about challenges and difficulties, but not about strengths and resources. She took this perspective back to make changes to the form. In ways like this, interactions with this project in its multiple formats, be it the exhibitions, a conference presentation, or the project website, contains the potential to make change at an individual level that ripples out through broader mechanisms.

The fourth and final research goal was to learn about photography as a method for engaging women in research. The results of the participant questionnaire suggest that taking photographs within the project context was a powerful experience for some participants. The opportunity to reflect on aspects of their lives and histories through a creative and visual process brought a new perspective of themselves and their realities through a lens of strength and resilience. Some women found the experience healing, suggesting the potential of similar projects for therapeutic purposes. I found that participant photography deepened the level of self-reflection and engagement with the research questions on the part of participants, it

changed the interview dynamic between researcher and participant by focusing on participant photographs, and it broadened the scope and formats for sharing women's lived realities and experiences because of the images.

## **6.1 Insights for individuals in policy and practice**

This project was limited in its ability to make policy and practice recommendations because of the small number of self-selected participants. However, the results can offer insights for individuals working within policy and practice in the mental health and addictions fields. It can also inform further studies. The following summarizes key results of interest to people involved in mental health and substance use policy and practice:

Considerations for community infrastructure and resources:

- Continue the process of establishing a women's residential therapeutic community or addiction treatment centre(s) in or near Prince George. Address other service gaps.
- Increased availability of liaisons and advocates would help women to bridge service gaps.
- Centralization of multiple specializations of physical and mental health care would increase feasibility for women to access services.

Considerations for therapeutic relationships and interactions:

- Approach women's treatment from a holistic framework taking into account the impact of larger societal processes such as sexism, racism, classism, homophobia and colonialism.
- Pay attention to how women express themselves in their spaces and places.
- Take women seriously. Do not use mental health or substance use status as a reason to dismiss women's experiences and symptoms.
- Remember that women possess great strength and resilience to survive and overcome adversity. Support their resilience from a strength-based perspective.

- Recognize the inherent power differential between practitioners and women seeking support and how this may contribute to therapeutic interactions.
- Supportive, trusting, respectful relationships with key practitioners and providers can be a powerful aspect to women's recovery and healing from mental health and substance use issues.
- Support women's autonomy and empowerment as a critical part of healing.

Considerations for program development:

- Particular spaces and places can be emotionally triggering for women. This should be considered when planning the location of programs.
- Consider spaces and places as having either therapeutic or detrimental potentiality on women's experiences of mental health and substance use.
- Photovoice projects and other creative approaches to engaging people in exploring and sharing marginalized realities have great potential to be meaningful, positive, and unique experiences for participants.

Considerations for policy development:

- Incorporate a trauma-informed approach for mental health and substance use.
- Recognize that women may internalize self-blaming ideas about mental health and substance use issues. Counteract this with an understanding of systemic oppressions operating at a societal and institutional level.
- Policy and programs that support women's autonomy and empowerment might include: safe, affordable, and accessible childcare so that women can work; safe, healthy, subsidized housing and transportation; affordable and culturally safe health care, and counseling that allows women to disclose openly.

## **6.2 Reflections**

Throughout the data analysis process, I made an effort to be aware of my preconceived expectations. I tried to engage the material in an open and receptive fashion. I acknowledge, however, that the researcher is an active factor in all aspects of research, including data analysis. The very asking of these research questions is driven from a personal

place and from my own life experience. In fact, some argue that without a personal investment in a research topic, it is less sincere and trustworthy. In order for the analysis to be transparent and open to further analysis by others, I have made an attempt to locate myself with a brief history of my interest and experience with the topic.

In part, because of my preconceived ideas of what would be most ‘noteworthy’ within the academic domain and deficit model, I found myself spending more effort identifying struggles women may have had in accessing services rather than positive experiences. However, recognizing this tendency in myself, I made a significant effort to present a balanced perspective and acknowledge the diversity of experiences the five participants represent. Indeed, because the project unfolded over many months and required ongoing participation, the women who were able to engage required a level of stability and support in their lives. This speaks to their eventual successes in building and sustaining a supportive network of resources.

It became apparent to me through this research project that the women I worked with had incredible power and agency and did not require someone such as myself, an external researcher, to ‘give voice’ to their experiences. Rather, I came to understand my role as being able to create a space for dialogue. Through my privileged position as someone able to invest the time and money into a master’s degree, I was able to create an opportunity, a space for women to express themselves and share their stories. These realities and stories exist regardless of this project and there are many ways they could come to light, including the exponentially growing online world in which individuals can find innumerable ways to share with others.

Out of this project have arisen several potential directions for further research. Some of these could be questions related to gender. For example, what are men's experiences of substance use and mental health and how do these differ from women's? What are transgender or genderqueer people's experiences? One could also investigate some of the themes in greater depth, for example, what are youth perspectives of space and place in relation to substance use and mental health? The possibility of photography as a therapeutic approach could be further investigated. As well, the importance of sharing one's story with a broader audience, of being witnessed, and its role in a sense of empowerment and wellbeing could be developed further. On noting that many of the photographs were of natural landscapes, another potential for future exploration might be the theme of nature and living landscapes and their potential relationship to mental wellness and/or healing.

### **6.3 Limitations**

Some limitations of the project are that it included a very small sample of women. As discussed in Chapter 4, this means that the results cannot necessarily be generalized to a broader population. However, the themes that resulted from the interviews are very broad and could inform others in multiple contexts. It is apparent that what is presented in this thesis are individual experiences and stories, but certain similarities are likely to exist across geographies and populations. Depth and richness of data are achieved despite the small number of participants through lengthy in-depth interviews, multiple sources of data, participant reflections, and incorporation of both visual and narrative content.

Not only was the number of participants small, it was also self-selected, which could introduce a self-selection bias. Participants chose to be involved in the project, which means there may be some commonality about them as a group that makes the results less

generalizable to the broader population. For example, the project was one that involved photography, so people with an interest in creative approaches may have self-selected to participate. As discussed in section 5.3, the results from the exhibition questionnaires are limited in their generalizability as well because they resulted from a self-selected group of people who chose to attend the exhibitions and who also chose to fill out the survey.

Another limitation is the lack of comprehensiveness. I approached this project from a feminist perspective and used a method that encouraged participants to direct the interviews. This was an important part of shifting the balance of power towards the women in the project by allowing them to decide what topics they wanted to share. However, this means that some topics may not have been covered if they chose not to bring them up. I may not have been told the whole context of a circumstance or story that was shared. This does not diminish the results of this project, however, it is important to note that not all topics of relevance to mental health and substance use arose. For example, we know that a disproportionate number of people with mental health and substance use issues are in the justice system, but incarceration did not come up within the interviews.

#### **6.4 Final word**

This was a large and ambitious project from the start, and ultimately there was not enough time to do everything that I would have dreamed of doing with this project. There are very real constraints on a master's level project related to time and funding. *Envisioning Change* is, however, one small contribution to the domain of experiential knowledge related to women's mental health and substance use, located in the particular geography and context of the northern city of Prince George, British Columbia. The collective results of this project not only achieved my primary research goal of investigating and producing new knowledge

of northern women's lived experiences of substance use and mental health, they also provide a strong basis of support for additional community-level projects that engage individuals to explore and share their marginalized realities through photography. I am very honoured to have had the opportunity and support to implement this project.

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## **Appendix I – Project Proposal Brief**

### **Contact information:**

#### **Title of proposed project:**

Envisioning Change: women's lived experiences of substance use and mental health in northern BC through photography

#### **Purpose of this research project:**

To understand northern women's experiences with substance use and mental health issues. I am interested in learning about factors related to accessing help and that contribute to women's experiences with substance use and mental health. One of the goals of this research is to inform health promotion and services to better meet the needs of northern women struggling with substance use and mental health issues.

#### **Why is this project important?**

- Mental illness and addiction are often overlooked yet significant public health concerns, directly affecting one in five Canadians over the span of a lifetime, resulting in serious social and economic impacts, and costing Canada more than \$14 billion annually.
- Women are over represented in mental illness diagnoses and are at higher risk of interpersonal victimization including childhood abuse, sexual abuse, and intimate partner violence; traumas that often co-occur with substance use and mental health concerns.
- Indigenous women, who represent a significant portion of the population in the Northern Health Authority as compared with other jurisdictions, are particularly over represented in the areas of mental illness and addictions, a health inequity that must be understood within the context of historic and ongoing colonization and intergenerational traumas.
- Mainstream addictions and mental health research, promotion and treatment have yet to fully account for women's experiences and have neglected to address rural and northern community needs.
- 

#### **Research Questions:**

- What are northern women's experiences of substance use and mental health?
- How do gender, culture, ethnicity, social class, geography, and other factors interact with and impact experiences of substance use and mental health?
- What are women's experiences accessing services in Prince George, BC?
- What are the implications of women's experiences for mental health promotion and service delivery in northern geographies such as Prince George, BC?

#### **Participants:**

Women, 19 years and older, who identify as having experienced substance use and mental health issues and who are currently living in Prince George, BC.

**Methods:**

We will start with a group orientation session. Then participants will photograph representative aspects of their experiences with substance use and mental health over several weeks. Using their photographs as a guide, I will conduct individual interviews with participants. The resulting narrative data will be analyzed for themes and verified with participants.

**Time-line:**

- Research proposal and ethics approval – June 2011
- Recruit 8-10 participants – July-September 2011
- Group orientation and participant photography – October 2011
- Individual interviews – November 2011
- Follow-up group session – March 2012

**Deliverables:**

- Summary Report
- Thesis
- Possibly an exhibition of the project and participant work (depending on interest)

## Appendix II – Recruitment Poster

# Share Your Story!!

## Envisioning Change Women's lived experiences of substance use and mental health in northern BC through photography

Are you a woman at least 19 years old living in Prince George who has struggled with substance use and emotional distress?

Would you like to share your story using photography?

### The Project

The purpose of this project is to learn about your everyday realities through photography, interviews and group discussions. What gives you strength? What are the challenges you face? What impacts your experiences with substance use and emotional distress? Have you found the support you need?



One of the goals of the research is to inform health promotion and services to better meet the needs of women in Prince George.

### What is involved?

You will take photographs (cameras will be provided) and participate in an individual interview and two group discussions. If the group wants to share their photography and stories with the community, we may consider an art exhibition. At the end of the study you will receive an honorarium in recognition of your time and contribution.

Participation in this research project is COMPLETELY VOLUNTARY and you may withdraw at any time. This research is part of a UNBC Community Health Science master's thesis.

### Contact Information:

The principal researcher for this project is Hilary McGregor, master's student at UNBC in Community Health Science.

Please contact me if you would like more information or are interested in participating at 250-617-9629 or e-mail at [mcgreg4@unbc.ca](mailto:mcgreg4@unbc.ca).

## **Appendix III – Informed Consent Form**

### **Envisioning Change: women’s lived experiences of substance use and mental health in northern BC through photography**

#### **PURPOSE**

This research is a Master’s thesis that is looking at northern women’s lived experiences of substance use and mental health in Prince George, BC using participant photography. It will ask questions about your every day experiences with substance use and mental health, your strengths and challenges, and the factors that contribute to your experiences. It will ask questions about accessing services in the area. One of the goals of the project is to inform health promotion and services to better meet the needs of women in Prince George.

#### **PROCEDURES**

Participation in this study will involve two group sessions, an individual interview, and taking photographs. The first group session will be an orientation to the project and to using a camera. I will take notes on this session and may analyze it as data. A photographer from the community, who will have signed a confidentiality agreement, may be invited to give a workshop on photography skills and camera use as part of this first group session. You will be given a camera to take photographs over several weeks. We will then meet for the individual interview that will take approximately 2 hours. You can choose the time and location of the interview from several options and I will audio record the interview. A follow-up group session that will take approximately 2 hours will be organized several months later to allow you to provide your input and feedback on the research results. I will record and analyze this group session. Participants may wish to present their work at a community exhibit. This option will also be discussed at the final group session. You will receive an honorarium at this final group session in recognition of your time and contribution to the research.

Working in a group means that you may hear personal stories and share your own stories with other participants. You understand and agree to not share personal stories or information revealed to you about other participants to anyone else. You understand that because of this, your confidentiality cannot be fully guaranteed.

#### **RISKS AND BENEFITS**

By participating in this study you will be contributing to a better understanding of the complex factors that impact northern women’s substance use and mental health experiences. Potential benefits to you as an individual may include the opportunity to engage in self-reflection and creative photography.

While taking photographs, it is important that you prioritize your own safety and not take unnecessary risks. Participation in this project may cause emotional distress as a result of exploring and sharing personal and sensitive life experiences. I will provide a list of crisis and support resources and contacts. There are no other known risks associated with participating in this study.

### **VOLUNTARY PARTICIPATION**

You were selected based on your expressed interest in participating in the project. Your participation in the research project is entirely voluntary. If you agree to participate, you are free not to answer any questions and to withdraw at any time without penalty or consequences. If you choose to withdraw, any information you have provided will be destroyed and excluded from the research.

### **RESEARCH RESULTS**

The only people who will see the information you provide me are myself and my thesis supervisor, Dr. Sarah de Leeuw of the Community Health Science Program at UNBC. I plan to personally transcribe your interviews, however if I am able to hire a transcriber, they will not be provided your name and they will also sign a confidentiality agreement in order to maintain your anonymity. Transcribed interviews and audiotapes along with your photographs will be stored for a minimum of five years in Dr. de Leeuw's locked cabinet at UNBC.

### **DISSEMINATION AND ANONYMITY**

The information you provide, including reproductions of photographs and portions of narrative, may be used in the researcher's thesis, future publications and presentations. You will remain anonymous unless you provide consent to reveal your name. If you wish to remain anonymous, I will not reveal your name or any identifying features or speech patterns in research reports or presentations. I will use a pseudonym to protect your identity. At the end of the study, a summary report and my thesis will be available to you on request.

### **QUESTIONS OR CONCERNS**

If you have any questions please do not hesitate to contact me. I appreciate your time and thank you in advance for your participation in this project.

Hilary McGregor, Master's candidate  
Community Health Science Program  
Tel: 250-617-9629  
E-mail: [mgreg4@unbc.ca](mailto:mgreg4@unbc.ca)

Dr. Sarah de Leeuw, Supervisor  
University of Northern British Columbia  
Tel: 250-960-5993  
E-mail: [deleeuws@unbc.ca](mailto:deleeuws@unbc.ca)

Any concerns about the project or questions about your rights as a research participant in this study should be directed to UNBC's Office of Research, 250-960-6735 or by email: [reb@unbc.ca](mailto:reb@unbc.ca)

**CONDITIONS OF PARTICIPATION**

I have received and read the information above and I agree to participate in this project.

\_\_\_\_\_  
Signature of research participant

Date: \_\_\_\_\_

\_\_\_\_\_  
Printed name of research participant

I believe that the person signing this form understands what is involved in the study and voluntarily agrees to participate.

\_\_\_\_\_  
Signature of investigator

Date: \_\_\_\_\_

\_\_\_\_\_  
Printed name of investigator

May I use your name?  Yes  No

If not, please provide below the pseudonym that you would like used when I use quotes from your interview:

\_\_\_\_\_

I would like to receive a copy of the:

- Summary Report
- Thesis

My contact information is:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## **Appendix IV – Informed Consent Form Addendum**

This form is to provide additional information about the project and to augment the full Informed Consent Form.

### **ASSISTANCE**

Local transportation and childcare assistance will be provided for those participants who require this support in order to attend project-related sessions and interviews.

### **QUESTIONS OR CONCERNS**

If you have any questions please do not hesitate to contact me. I appreciate your time and thank you in advance for your participation in this project.

Hilary McGregor, Master's candidate  
Community Health Science Program  
Tel: 250-617-9629  
E-mail: [mcgreg4@unbc.ca](mailto:mcgreg4@unbc.ca)

Dr. Sarah de Leeuw, Supervisor  
University of Northern British Columbia  
Tel: 250-960-5993  
E-mail: [deleeuws@unbc.ca](mailto:deleeuws@unbc.ca)

Any concerns about the project or questions about your rights as a research participant in this study should be directed to UNBC's Office of Research, 250-960-6735 or by email: [reb@unbc.ca](mailto:reb@unbc.ca)

### **ACKNOWLEDGEMENT**

I have received and read the information above and I agree to participate in this project.

\_\_\_\_\_  
Signature of research participant

Date: \_\_\_\_\_

\_\_\_\_\_  
Printed name of research participant

## Appendix V – Acknowledgement and Release Form

### **Envisioning Change: women’s lived experiences of substance use and mental health in northern BC through photography**

#### **PURPOSE**

This is a research project that explores women’s experiences of substance use and mental health. I understand that the purpose of this project is for people to photograph their everyday realities, explore strengths and challenges, and the factors that contribute to experiences of substance use and mental health. Participants take photos of their lives, and through interviews with the researcher, share their stories and the reasons for taking their photos. I understand that one of the goals of the research is to inform health promotion and services to better meet the needs of women in Prince George.

I am aware that the person requesting to take my photo is a participant of this research project being conducted by Hilary McGregor for the UNBC Community Health Science Master’s Program. I understand that photographs of me may be included in Hilary McGregor’s thesis, the project summary report, and in subsequent publications and presentations. In addition, the project, including photos and portions of participant narratives or stories, may be presented at a public exhibition. I understand that photographs will be accompanied by written narrative from the research participant that will describe their personal reflections, whether they are positive or negative in nature.

#### **AUTHORIZATION**

I hereby authorize \_\_\_\_\_ (research participant name) to take photographs of me to be used for purposes related to the “Envisioning Change” Research Project and that my name will not be used. I understand that the photographer has the right to use photographs taken of me, in whole or in part, ONLY as part of the above identified project. This agreement does NOT obligate this photographer to use photographs taken of me.

I agree to have photographs of me included in Hilary McGregor’s master’s thesis, summary report, and publications and presentations related to this research project.  YES  NO

I agree to have photographs of me included in a public photo exhibition.  YES  NO

I understand that my participation as an individual being photographed for this research project is voluntary and that I may choose to withdraw the photo of myself from the project up until **December 31, 2011** by contacting Hilary McGregor at 250-617-9629, or [mcgreg4@unbc.ca](mailto:mcgreg4@unbc.ca).

I have read and understand all of the above.

\_\_\_\_\_  
Signature of photo subject

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name of photo subject

\_\_\_\_\_  
Signature of photographer (research participant)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name of photographer (research participant)

***As the photograph subject, please keep one signed copy of this form for your records.***

For more information, please contact:

Hilary McGregor, Master's candidate  
Community Health Science Program  
Tel: 250-617-9629  
E-mail: [mcgreg4@unbc.ca](mailto:mcgreg4@unbc.ca)

Any concerns about the project should be directed to:  
UNBC's Office of Research  
Tel: 250-960-6735  
E-mail: [reb@unbc.ca](mailto:reb@unbc.ca)

## Appendix VI – Confidentiality Agreement for Presenter

This project is being undertaken by Hilary McGregor as part of a Master's degree in Community Health Science at the University of Northern British Columbia. The research has the following objectives:

1. To better understand northern women's experiences with substance use and mental health.
2. To examine factors related to accessing help and that contribute to women's experiences with substance use and mental health.
3. To inform health promotion and services to better meet the needs of northern women struggling with substance use and mental health issues.

The photography workshop will be part of a group project orientation session and is intended to build participant's skills and comfort with photography and camera use.

I, \_\_\_\_\_, agree to:

1. Keep all project information shared with me confidential by not discussing or sharing it in any form or format with anyone other than the Principal Investigator;
2. Keep the identity and names of participants confidential by not sharing with anyone outside the project any information that is learned in the photography workshop.

Photography Workshop Presenter:

\_\_\_\_\_  
(print name)                      (signature)                      (date)

Principal Investigator:

\_\_\_\_\_  
(print name)                      (signature)                      (date)

If you have any questions or concerns about this study, please contact:

Hilary McGregor  
[mgreg4@unbc.ca](mailto:mgreg4@unbc.ca)  
250-961-4976

This study has been reviewed and approved by the Research Ethics Board at the University of Northern British Columbia. For questions regarding participants rights and ethical conduct of research, please contact the UNBC Office of Research at 250.960.6735

## **Appendix VII – Project Experience Questionnaire**

Thank you so much for participating in this project. Your feedback on your experience of participating in the project is greatly appreciated and will help assess the value of using photography in research projects.

1. What has been your overall experience participating in this project?
2. Was taking photographs a significant or meaningful part of your experience?
3. Was the exhibition at ArtSpace a significant or meaningful part of your experience?
4. Was the group work a significant or meaningful part of your experience?
5. Has your understanding of yourself and mental health and substance use changed throughout this project?
6. Do you feel like your voice and story was heard in this project? Why or why not?
7. Is there anything that could have improved your experience with the project?
8. Any other comments?

## Appendix VIII – ArtSpace Exhibition Media Coverage



# Envisioning Change

**A unique and impactful photography exhibition!**

**Envisioning Change**  
 Photography Exhibition  
 Prince George artists share their experiences of substance use and mental health.

We are all intimately touched by mental health and substance use at some point in our lives. Come and learn from this exhibition and support the women in our community.

Prince George women share their experiences of substance use and mental health through photographs and words. In sharing these realities we hope to inform health care providers, policy makers, and everyone in the community for the betterment of services, support and opportunities for the people in our lives affected most.

**Opening night**  
**March 9, 2012**  
 7:00 – 9:00 pm

Photography Exhibition  
 March 7 - 10, 2012  
 Opening Night  
 March 9, 2012  
 7:00 - 9:00 pm  
 ArtSpace and Company  
 1845 3rd Ave  
 Prince George, BC V2L 3C6  
 Phone: (250) 563-9817  
 Email: [bookandcompanyevents@gmail.com](mailto:bookandcompanyevents@gmail.com)  
 Book and Company

This exhibition is part of a master's thesis project by Miya M...

**PRINCE GEORGE**

**Envisioning Change Photography Exhibition**

Prince George women share their experiences of substance use and mental health in this photography exhibition. Opening night on Friday, March 9th at 7:00pm. The exhibit runs until March 10th in ArtSpace.

**Location**  
 Book and Company  
 1845 3rd Ave  
 Prince George, BC V2L 3C6  
 Phone: (250) 563-9817  
 Email: [bookandcompanyevents@gmail.com](mailto:bookandcompanyevents@gmail.com)  
 Book and Company

**ABOUT PRINCE GEORGE | ACCOMMODATIONS | RESTAURANTS | ACTIVITIES | EVENTS | MAP**

**Find an Event**  
 Start date: 2012-04-04  
 End date: 2012-04-18  
 Category: Arts and Culture

## Appendix IX – Exhibition Questionnaire

**Thank you** for filling out this brief questionnaire. As part of a master’s thesis project, this questionnaire will help to assess the impact of the project and the utility of similar photo-based projects for engaging people and sharing results.

1. How did you hear about this exhibition?

- |   |   |
|---|---|
| <input type="checkbox"/> Poster: where? _____   | <input type="checkbox"/> Friend/word of mouth |
| <input type="checkbox"/> Handbill: Where? _____ | <input type="checkbox"/> Facebook             |
| <input type="checkbox"/> Email                  | <input type="checkbox"/> Other _____          |

2. I am: (please check all that apply)

- |  |  |
|--|--|
| <input type="checkbox"/> Part of the general public                                  | <input type="checkbox"/> In government   |
| <input type="checkbox"/> An academic/researcher                                      | <input type="checkbox"/> In the health services field                            |
| <input type="checkbox"/> A student   | <input type="checkbox"/> A person with mental health and/or substance use issues |
| <input type="checkbox"/> Employed by a community organization that provides services | <input type="checkbox"/> A family member of the above                            |
| <input type="checkbox"/> A policy actor/decision maker                               | <input type="checkbox"/> Other _____   |

3. Rate your understanding of women and substance use/mental health issues *before* attending the exhibition?

Low	Less than Average	Average	Higher than Average	High
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4. Did the exhibition *change* your understanding and/or assumptions about women who live with substance use and mental health issues?

Not Really	A Little	Somewhat	More than I thought	Wow! Yes
------------	----------	----------	---------------------	----------

5. Comments: \_\_\_\_\_

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## Appendix X – Community response: “What is mental health to you?”

At the exhibition of *Envisioning Change* that was installed at ArtSpace in March 2012, I posted blank paper along with a pen and the question “What is mental health to you?” These are the written responses over the course of the month.

- To accept yourself
- Being able to be yourself!!
- Appreciating life!
- Peace
- Balance
- Feeling at peace with yourself
- A healthy earth
- Holistic wellness
- We are human too.
- To feel normal
- I don't know!!!
- Inner strength
- Stability
- Open minded
- Loving yourself and knowing yourself
- Great question:  
Sometimes I feel if I knew, I would be more healthy
- The confidence to make decisions which have positive outcomes for yourself. The ability to rise above the confusion and voices which push a person beyond what they can comfortably bear.
- Freedom to realize your potential as a human
- I have lost hope I will ever know mental “health”
- To embrace, accept and love oneself, in spite of or through, mental illness
- The ability to face the world and see it the way other people do
- Being able to eat and sleep regularly and naturally
- Being loved, loving, feeling gratitude, having some luck
- Having healthy, supportive relationships
- Knowing who and what you are and never letting anyone tell you differently!
- Knowing you can never know
- Thriving instead of barely surviving
- For others to accept my differences and appreciate them as I have



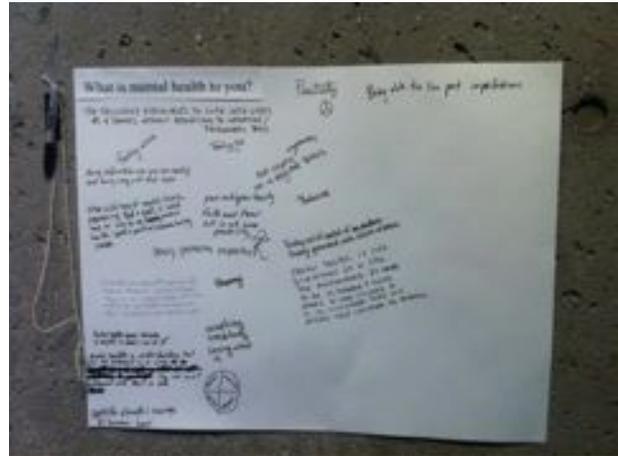
learned to do for myself

- The ability to keep reaching towards the light!
- Not doing the same thing over and over again expecting a different result!
- The confluence of self, spirit, nature, community and art!
- Having a hopeful positive perspective on self and life
- Knowing that I am ever growing and allowing that to both empower me and give me a sense of peace.
- A balance of brain chemistry and environment and support network.
- A cure for sanity
- The confidence that you are loved and have the capacity to love in return.
- Being able to cope with life's challenges without turning to destructive behaviours.
- Trauma + genetics + environment + brain chemistry = bipolar disorder? Loving family + friends + mental health workers = a chance for quality of life, mental well being.

## Appendix XI – Community response 2: “What is mental health to you?”

At the exhibition of *Envisioning Change* that was installed at the *Rotunda Gallery* in January 2013, I posted two blank sheets along with a pen and the questions “What is mental health to you?” and “What substances did/do you use. Why?” These are the written responses to the first question over the course of the month.

- Feeling whole
- Not crying vigorously on a regular basis.
- Positivity
- Being able to live past imperfections
- Balance
- Being perfectly imperfect
- Accepting uncertainty, loving what is.
- The resilience and resources to cope with life’s ups and downs without resorting to negative/problematic behaviours.
- Being different (or who you are really) and being okay with that. Value.
- After a life time of mental illness, experiencing bad and good, I would have to say for me mental health (as a positive) means being stable.
- It includes all aspects of a persons life. Physical, emotional, spiritual and mental. They are all interconnected not only within the individual but also with their environment and society as well.
- Mental health means believing in myself. It means I am ok.
- Mental health is understanding that you are different in a way. To be different and that is ok.
- Having the strength and courage to bounce back.
- Pain and opportunity. Faith and fear all in all one possibility.
- Feeling out of control of my emotions. Feeling grounded, safe, secure, at peace.
- Mental health is not guaranteed. It is like the environment. It needs to be in balance and have others to care and nurture it. To be sustainable. There are poisons that can erode its balance.





- Nothing but up and down quarks.
- Acid, mushrooms, pot, caffeine, MDMA, alcohol. Caffeine to focus and be energetic. Alcohol to forget my fear. Pot to relax and think. MDMA to feel love. Acid to see the world in detail and feeling. Mushrooms to see the level of complexity in the form of the world. They are tools that can teach us. Sometimes they can be an escape.
- If you need all this to feel, etc, then you have a problem...
- Sleep, for freakin' everything
- Cocaine, weed, ecstasy, alcohol. To make my mind stop.
- Why would you want your mind to stop?...
- Alcohol for depression, love for everything else.
- Alcohol is a depressant, a 'downer', makes depression worse.
- Love
- We all have areas that feel out of control. We all use ways to numb, cope, escape. These ways can be substances, habits, people, jobs – addiction to anything is unhealthy, in varying degrees.
- We all need help. Nobody is perfect or 'has it all together.' Please do not judge.
- Marijuana for meditation
- Tea
- House music
- Music. It's where I'm lustat.
- The blood of my enemies.
- Water to live
- Mine = coffee, internet, self-harm
- Use? Most have already been shared. I would add food. During childhood it was my source of release.
- Overeating. Oversleeping. Used to drink and smoke (both pot and cigarettes) and do other drugs to "deal" with pain, but quit 7 years ago! Must need to work on healthier ways now.
- Sleeping pills – to deal with stress
- By taking pills you aren't dealing with your stress.
- Yoga
- Overeating was a medicine that gave me control
- Which means you weren't in control...
- Comic dust
- Brave (the Disney pixar movie) It helps me sleep! Heh!
- I used to drink to deal with anxiety, but I quit 73 days ago!
- Alcohol – It makes you look better
- I use coffee with alarming frequency and magnitude. It truly is a crutch for professionals.
- Coffee: I like it and to avoid the headaches.

## **Appendix XIII – Project Presentations**

I presented seven papers and two posters at local, provincial, national, and international conferences over the course of the project.

### **Conference presentations**

McGregor, H. and de Leeuw, S. (November 2012). "Envisioning change: Women's lived experiences of substance use and mental health in northern BC through photography." *Public Health Association of British Columbia, Annual Conference*. Vancouver, BC.

Casey, L. and McGregor, H. (August 2012). "Envisioning change: Women's lived experiences of substance use and mental health across Canada." *International Conference and Exhibition on Addiction Research and Therapy*, Las Vegas, NV.

McGregor, H. (June 2012). "Envisioning change: Women's lived experiences of substance use and mental health in northern BC through photography." *Canadian Collaborative Mental Healthcare Conference*, Vancouver, BC.

McGregor, H. (April 2012). "Envisioning change: Women's lived experiences of substance use and mental health in northern BC through photography" in the session Health in Translation: The art of communicating. *5th Latin-American and 4th Inter-American Health Promotion and Health Education Conference*, Mexico City, Mexico.

McGregor, H. (March 2012). "Envisioning change: Women's lived experiences of substance use and mental health in northern BC through photography." *UNBC 7<sup>th</sup> Annual Graduate Conference*, Prince George, BC.

McGregor, H. (November 2011). "Envisioning change: Women's lived experiences of substance use and mental health in northern BC through photography." *Research Days Conference*, Prince George, BC.

### **Invited presentation**

McGregor, H. (March 2012). "Mental health, creativity, and envisioning change." *CIHR Café Scientifique – HealthArt Panel*, Prince George, BC.

### **Posters**

McGregor, H. (May 2012). "Envisioning change: Women's lived experiences of substance use and mental health in northern BC through photography." *National Collaborating Centres of Public Health Summer Institute*, Kelowna, BC.

McGregor, H. (November 2012). "Envisioning change: Prince George women share their experiences of substance use and mental health through photography." *Public Health Association of British Columbia, Annual Conference*, Vancouver, BC.

Appendix XIV – Ethics Approval Certificate

# UNIVERSITY OF NORTHERN BRITISH COLUMBIA

## RESEARCH ETHICS BOARD

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### MEMORANDUM

**To:** Hilary McGregor  
**From:** Henry Harder, Chair  
Research Ethics Board  
**Date:** June 14, 2010  
**Re:** **E2011.0518.059.00**  
Envisioning Change: Women's Lived Experiences of Addiction and Mental Health Concerns in Northern BC Through Photography

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Thank you for submitting the above-noted proposal and requested amendments to the Research Ethics Board. Your proposal has now been approved.

We are pleased to issue approval for the above named study for a period of 12 months from the date of this letter. Continuation beyond that date will require further review and renewal of REB approval. Any changes or amendments to the protocol or consent form must be approved by the Research Ethics Board.

Good luck with your research.

Sincerely,



Henry Harder

## **Appendix XV - Informed Consent for Use of Photographs**

### **PURPOSE**

This research is a Master's thesis project that is looking at northern women's lived experiences of substance use and mental health in Prince George, BC using participant photography. The purposes of the project are:

1. To generate new knowledge of the multiple factors that impact northern women's experiences of substance use and mental health, including accessing support.
2. To inform northern policy and practice related to these issues with the intention to better meet the needs of women in the north.
3. To increase awareness and dialogue of mental health and substance use issues in order to increase understanding and reduce stigma.
4. To learn about the efficacy of photography as a method for engaging people and sharing results.

### **PROCEDURES**

After participating in the project group sessions and individual interview, participants discussed and agreed to organize a public exhibition of a selection of their photographs at ArtSpace in Prince George in March 2012. The photographs to include were selected by individual participants as was the text to accompany their photographs. The group considered further options to display the exhibition. Further opportunities to exhibit the photographs in Prince George and beyond have and will be sought by Hilary McGregor.

Options include: CMHA fundraising event Women and Wellness March 28, 2012, an International Health Conference in Mexico City in April 2012, collaborative exhibits in other community spaces and organizations including ACE drop-in, etc. A semi-permanent home may be sought for the exhibition so that it will remain in the community and continue to benefit women who experience substance use and mental health issues.

### **RISKS AND BENEFITS**

By participating in this study you will be contributing to a better understanding of the complex factors that impact northern women's substance use and mental health experiences. Potential benefits to you as an individual may include the opportunity to engage in self-reflection, creative photography, and have your work viewed and appreciated by a wide audience.

Public display of your photographs may identify you (if you have chosen to include self-portraits and/or your real name) to people that you had not expected. Public display of your photographs may result in disappointment of expectations regarding response by those who view them. Photographs displayed publicly may be damaged or vandalized. Members of the public and/or media may take photographs of the publicly displayed images and use them in ways that are outside of our control. The use of photographs that are posted online, regardless of security measures taken, cannot be controlled or guaranteed.

## **VOLUNTARY PARTICIPATION**

Your willingness to include your photographs and words in public exhibitions and in an online format is completely voluntary. Below you can decide which formats you would like to have your photographs included. You can withdraw your photographs from either public exhibition or online presentation at any time by notifying Hilary McGregor via email. Please note however, that it may take some time to comply with your request. All of the options below will NOT be for personal profit and WILL be aligned with the purposes of the *Envisioning Change* project (see above).

### **Exhibition Use**

I agree to have the photographs and words I identified for exhibition included in the public exhibition at ArtSpace in March 2012 in Prince George, BC.  Yes  No

I agree to have the photographs and words I identified for exhibition included in **additional** public exhibits in Prince George and elsewhere.  Yes  No

### **Website Use**

I agree to have the photographs and words I identified for public exhibition included on a **website** so long as reasonable efforts are made to secure and protect the images from download by the public.  Yes  No

I agree to the use of **any** of my photographs and text from my interview to be used on a **website** so long as reasonable efforts are made to secure and protect the images from download by the public.  Yes  No

### **General Use**

I agree to the use of **any** of my photographs and text from my interview to be used in **additional formats** including exhibitions, presentations, publications, books, pamphlets, posters, calendars, etc.  Yes  No

## **DISSEMINATION AND ANONYMITY**

If you choose to use a pseudonym in the research, your privacy will be protected. If you choose to use your own name and/or include identifiable images of yourself in the photographs, your privacy and anonymity will not be protected.

## **QUESTIONS OR CONCERNS**

If you have any questions please do not hesitate to contact me. I appreciate your time and thank you in advance for your participation in this project.

Hilary McGregor, Master's candidate  
Community Health Science Program  
Tel: 250-617-9629  
E-mail: [mcgreg4@unbc.ca](mailto:mcgreg4@unbc.ca)

Dr. Sarah de Leeuw, Supervisor  
University of Northern British Columbia  
Tel: 250-960-5993  
E-mail: [deleeuws@unbc.ca](mailto:deleeuws@unbc.ca)

Any concerns about the project or questions about your rights as a research participant in this study should be directed to UNBC's Office of Research, 250-960-6735 or by email: [reb@unbc.ca](mailto:reb@unbc.ca)

**CONDITIONS OF PARTICIPATION**

I have received and read the information above and I agree to the use of my photographs provided for the project in the ways I have identified by checkboxes.

\_\_\_\_\_  
Signature of research participant

Date: \_\_\_\_\_

\_\_\_\_\_  
Printed name of research participant

I believe that the person signing this form understands what is involved with the inclusion of their photographs in the project and voluntarily agrees to participate.

\_\_\_\_\_  
Signature of investigator

Date: \_\_\_\_\_

\_\_\_\_\_  
Printed name of investigator

May I use your name?  Yes  No

If not, please provide below the pseudonym that you would like used when I use quotes from your interview:

\_\_\_\_\_

## Appendix XVI - Acknowledgement and Release for Use of Photographs

### PURPOSE

This is a research project that explores women's experiences of substance use and mental health. I understand that the purpose of this project is for people to photograph their everyday realities, explore strengths and challenges, and the factors that contribute to experiences of substance use and mental health. Participants take photos of their lives, and through interviews with the researcher, share their stories and the reasons for taking their photos. I understand that one of the goals of the research is to inform people working in health policy, promotion, and services in order to better meet the needs of women in Prince George.

I am aware that the person who has taken my photo is a participant of this research project being conducted by Hilary McGregor for the UNBC Community Health Science Master's Program.

I understand that photographs will be accompanied by written narrative from the research participant that will describe their personal reflections, whether they are positive or negative in nature.

This form is to clarify consent for further uses of the photograph of me. All of the options below will NOT be for personal profit and WILL be aligned with the purposes of the *Envisioning Change* project (see above).

### AUTHORIZATION

I understand that I have already provided consent for photographs of me to be included in Hilary McGregor's thesis, the project summary report, in subsequent publications and presentations, and a public exhibition (Artspace, Prince George, March 2012).

#### Exhibition Use

I agree to have the photograph of me included in **additional** public exhibits in Prince George and elsewhere.  Yes  No

#### Website Use

I agree to have the photograph of me included on **websites**, so long as reasonable efforts are made to secure and protect the images from download by the public.  Yes  No

#### General Use

I agree to the photograph of me be used in **additional formats** including (but not limited to) exhibitions, presentations, publications, books, pamphlets, posters, calendars, etc.  Yes  No

I agree to my first name being included in the text accompanying the photograph of me.  Yes  No

I understand that my participation as an individual being photographed for this research project is voluntary and that I may choose to withdraw the photo of myself from the project by contacting Hilary McGregor at [mcgreg4@unbc.ca](mailto:mcgreg4@unbc.ca). I understand, however, that it may take some time to comply with my request.

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I have read and understand all of the above.

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Signature of photo subject

Date

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Printed name of photo subject

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Signature of photographer (research participant)

Date

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Printed name of photographer (research participant)

***As the photograph subject, please keep one signed copy of this form for your records.***

For more information, please contact:

Hilary McGregor, Master's candidate  
Community Health Science Program  
E-mail: [mcgreg4@unbc.ca](mailto:mcgreg4@unbc.ca)

Any concerns about the project should be directed to:  
UNBC's Office of Research  
Tel: 250-960-6735  
E-mail: [reb@unbc.ca](mailto:reb@unbc.ca)