

RESILIENCE AS GOVERNMENTALITY: A NARRATIVE STUDY WITHIN MENTAL HEALTH

by

Philip Mach

Honours Bachelor of Science, University of Toronto, 2008

Bachelor of Social Work, Dalhousie University, 2013

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ABSTRACT

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Philip Mach

Program of Social Work,

Ryerson University

The study of resilience in individuals is typically conducted to enumerate the ways in which a person may be resilient to difficult life circumstances. Resilience, in this way, is seen as a means to overcoming adversity in order to succeed in life. In the current study, the concept of resilience is examined in terms of the way it may guide or limit the actions of individuals, as governmentality. Specifically, this study focuses on the lives of survivors of mental illness and ascertains the ways in which resilience affects how they have chosen, or have been taught, to manage their mental illness.

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DEDICATION

To my loving partner, Dr. Miranda Robinson, for believing that an IT guy could become a social worker, for supporting that IT guy as he worked through two university degrees, and for agreeing to spend her life with him.

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Chapter 1: Introduction

When you're going through hell, keep going.

– Winston Churchill

The epigraph to this chapter is a well-known quote by Winston Churchill, the Prime Minister of the United Kingdom who led the country and the allied forces through World War II. It has been chosen because I believe that, at its essence, the quote captures the idea of resilience eloquently despite not using the term. While I believe that the use of the term itself is important, I believe that just as important is the spirit in which the term is often used. In common language, we use “resilience” to identify those who overcome difficult and sometimes impossible odds, to connote a belief that it is possible to endure, and above all, to convey the feeling of hope that there can be a better future. If we examine the epigraph, we may imagine a protagonist who has set out on a journey and has encountered hardship. Perhaps this hardship is of the most tumultuous kind and that chaos and difficulties beset our protagonist from all sides. Despite these conditions, however, a triumphant hero manages to trudge on and surmount the obstacles in their way. Simply stated, while defeat and surrender are attractive when your world is in disarray, to continue on and survive is the core theme of our story.

The familiarity of this story is a central reason for my interest in the concept of resilience. The valiant hero overcoming adversity has been well-documented (e.g., Campbell, 1973) but the status of this story has reached beyond the confines of myth and can be observed in the everyday. Based on my experience as a social work practitioner, I

find that the term resilience has not been used lightly nor has it been used sparingly. From working with those who express suicidal thought to youth involved with the child protection system, I have encountered the term with regularity and typically in situations where those described as resilient faced considerable adversity.

These individuals would sometimes be held up as examples for others, sometimes as inspiration and sometimes as models. I observed, as individuals who felt little hope about their life circumstances were told that they simply needed to be resilient and push on, while others were told that they needed to be stronger so that they could overcome. These practices raised questions as to what the experiences of people were as a result of this idea of needing to be stronger or more resilient. In my own life story, I have encountered professionals who have used the term to describe me and felt the usage to be bittersweet; to be labelled resilient as the result of having survived adversity or trauma is simultaneous an admission of success and an acknowledgement of pain. The question remained, however, how do others experience resilience?

In this project, I explore this question through the help of my participants. This work contains their stories as I have received them. I give them my sincerest thanks as I could not have undertaken this project without them.

Chapter 2: Literature Review

The study of the concept of resilience can be traced back to early work done by Rutter (1985) and Garmezy (1987). These authors approached the topic from largely a psychological perspective as they regarded it as a trait of personality. They believed that such a trait allowed individuals to weather adverse conditions and succeed in life despite of them. While the literature has since explored alternate definitions of the idea of resilience, the notion of succeeding despite adversity is central to all constructions of resilience that I have encountered. The interplay between success and adversity distinguishes different definitions of resilience from one another and the relationship between the two is important to recognizing these differences. Simply stated, the dominant conceptual views concerning the construct of resilience involves viewing resilience as either a protective mechanism or a restorative mechanism (Davydov, Stewart, Ritchie, & Chaudieu, 2010; Rutten et al., 2013; Shaikh & Kauppi, 2010).

Resilience as Protection

The view that resilience is a type of coping or “relatively positive adaptation in the face of heightened risk for maladaptation” (Gardner, Dishion, & Connell, 2008, p. 275) is a prominent view within the literature. This characterization of resilience posits that resilience is a protective mechanism, or comprises of protective mechanisms, which allow individuals facing adversity or stress to succeed despite these factors. As Friedli (2009) argues, there is an inextricable link between mental health and this characterization of resilience. The exact nature of this link and its subtleties, however, remains the subject of

research and discussion (Luthar, Cicchetti, & Becker, 2000). With this said, some preliminary themes can be drawn from within this conceptual position.

Extant literature that approach resilience as protective focus largely on one of two domains: youth development and mental health. This duality is not as defined as one may expect as research concerning resilience of youth often operationalize resilience outcomes as lack of psychopathology (e.g., Werner, 1989). As Davydov et al. (2010) notes, this type of resilience can also be described as resistance to adverse conditions or, to demonstrate the biomedical affiliation of this position, can be thought of as analogous to the body's natural immunity system; namely, that a resilient person is one who has a strong immunity to the social conditions that lend themselves to manifestations of psychopathology or other negative social outcomes. Resilience in this perspective, then, is an individual endeavour concerned with responding to difficult social conditions.

The work of Bonanno (2005) highlights a particular social condition, that of grief and loss, and the manner in which resilience may provide an explanation of observations within this field. The author argues that reactions to loss typically do not result in deviations of normal functioning, but that a resilient reaction – that is, individuals find a means to adapt to the loss and continue functioning at normal levels – is a much more common reaction than is typically thought (Bonanno, 2004; Bonanno et al., 2002). This type of social stress is closely-related to mental health and provides evidence that this framing of resilience has a place within mental health research. Although direct study on the relation between this type of resilience and mental health exists (e.g., Hoge, Austin, & Pollack, 2007), a more common approach to understanding resilience in this manner focuses on the development of youth.

The early work of Garmezy (1987, 1991, 1993) and Rutter (1985) began the study of the protective aspect of resilience through an examination of youth development and this work continues to hold a prominent place in resilience literature. This initial work influenced that of Werner (1989), a seminal piece in the field, who followed a number of youth for over three decades of their lives in an effort to examine those factors which may protect them from negative life outcomes, including psychopathology. Subsequent studies have suggested examining the intersection of resilience and mental health with gender (Brinkman, Brinkman, & Toomey, 2011); race, ethnicity and culture (Johnson & Beamer, 2013; Kulis, Reeves, Dustman, & O'Neill, 2011; Luthar, 1991; Ungar, 2006; Wallace, 2012) as well as general youth adjustment (Gardner et al., 2008; Ungar, 2011; Ungar & Liebenberg, 2009). While important differences exist in the approaches of these authors, these studies have sought to enumerate the factors which may buffer and protect youth from their social conditions but do not look examine the social conditions themselves. In fact, it may be said that in order for such research to take place, negative social conditions are desirable so that resilient individuals can exist.

Resilience as Restorative and Recovery

The second conceptual position, resilience as a restorative mechanism, argues that resilience is a mechanism that allows those individuals who have suffered setbacks to be restored to their previous levels of functioning. The work done within this position provides an important opportunity to connect to another body of research. Research examining the ways in which resilience may be a restorative notion certainly exists and be seen in the work of Fredrickson, Tugade, Waugh, and Larkin (2003). Further work done

(Hobfoll et al., 2009; Marttila, Johansson, Whitehead, & Burström, 2013; Tugade & Fredrickson, 2004) takes on a similar framing of resilience; namely, that resilience in this context is a mechanism that allows individuals to recover, after an initial period of difficulty, and regain pre-trauma or pre-stress levels of functioning. As these authors would argue (e.g., Tugade & Fredrickson, 2004), resilience is a mechanism for bouncing back from, rather than enduring through, adversity. To only consider this area of research, however, misses the opportunity to connect with a largely body of work on recovery (see Anthony, 1993) in the field of mental health. While Bonanno (2004) maintains that the concept of resilience should be considered distinct from the concept of recovery, the similarities between the two constructs is striking.

Recovery, as described by Anthony (1993) and Deegan (1988), is a process of learning to live with mental illness. Davidson and Roe (2007) further develop the concept to distinguish between *recovery from* – the process of regaining previous levels of functioning after an initial period of lesser functioning – and *recovery in* – a process of coping with changes that have lifelong consequences, regardless of level of functioning. If taking the work of these authors together, we find that the *recovery from* position seems to bear more than superficial similarities to the idea of resilience as restorative and that overlap exists between the *recovery in* position and those who succeed despite adversity; specifically, those who can be described by resilience as a protective concept. The discussion here, therefore, agrees with the observations of Howell and Voronka (2012) that the link between resilience and recovery is a rich one.

Tensions within Resilience Research

The apparent agreement in conceptual positions presented here is not meant to overstate the homogeneity of resilience research as there are considerable tensions and disagreements between scholars of the field. The two framings of resilience research presented should be treated as a convenient means of understanding the work of a large group of authors while acknowledging that there is substantial diversity within each group. The field is, by no means, in agreement about the nature of resilience, the process of resilience and how resilience may be understood. Some of these tensions are presented here.

A major area of scholarship within the study of resilience concerns its definition and its scope. The wide range of definitions within resilience research has been noted by a number of authors (e.g., Bonanno, 2004, 2005; Bonanno et al., 2002; Davydov et al., 2010; Edward, Welch, & Chater, 2009; Fleming & Ledogar, 2008; Guest, 2012; Lenette, Brough, & Cox, 2012; Shaikh & Kauppi, 2010; Ungar, 2006; Zautra, Hall, & Reich, 2010) and has resulted in a number of works that have attempted to provide clarity as to what the term *resilience* truly means (see Davydov et al., 2010; Feder, Charney, & Collins, 2011; Luthar & Cicchetti, 2000; Rutten et al., 2013; Shaikh & Kauppi, 2010). Despite these endeavours, defining resilience remains a controversial undertaking and have led authors to argue that to effectively understand resilience, research must move beyond conceptions of the term located within individuals to examining the link between individuals and their social contexts (Ungar, 2011), with others going even further and applying the concept of resilience to entire groups and cultures (Gardner et al., 2008; Johnson & Beamer, 2013; Ungar, 2006; Wexler, 2014). So while it is possible to group the work on resilience into

conceptual categories, the differences in what resilience is and where it is located is a non-trivial matter.

Richardson (2002) and Ungar and Liebenberg (2009) note a shift within resilience research, from the modern to the postmodern, as scholars attempt to account for a wide range of perspectives. The prevalence of this shift, however, should not be overstated as modernist writings on the concept of resilience are still very much present (e.g., Rutten et al., 2013) but should also not detract from the willingness of some scholars to examine conceptions of resilience not based on modernist frameworks. Recent work (e.g., Guest, 2012; Marttila et al., 2013; Theron et al., 2011) has examined experiential framings of the term and have augmented the predominantly quantitative extant literature with a number of qualitative findings. In a willingness to explore a number of perspectives, scholars within this field are now confronted with the possibility of greater complexity as arguments are made about the framing of resilience as a matter of survival (Lenette et al., 2012) or human agency, among others (Shaikh & Kauppi, 2010). The move from modernist conceptualizations of resilience to postmodernist thinking may allow for greater insight in exploring resilience but may further increase tensions as to the true nature of resilience.

Finally, an emerging group of authors have begun to analyze resilience utilizing a critical perspective¹ and have begun to question the nature of resilience whether it may be complicit in reproducing existing inequalities. Guo and Tsui (2010) argue that invocation of the term resilience results in a pathologizing, deficit view of individuals that ignore the structural limitations on their actions. More alarmingly, to focus on this framing of resilience results in a discounting of the important ways that the individual may undermine

¹ See Fook (2002) or Healy (2005), for background on critical perspectives

status quo relationships through micro acts of resistance. Harper and Speed (2012) echo these concerns regarding the individualization of mental illness and the concept of resilience presupposes “strengths” and necessitates “deficits.” They argue that collective action must be taken to produce society-wide recognition of the experience of those who bear a diagnosis. Other authors have made similar arguments (Howell & Voronka, 2012; Morrow, 2013; Morrow & Weisser, 2012), highlighting the connections that such practices have with larger political and knowledge structures, such as neoliberalism². A critique of resilience, then, proceeds from the individualizing nature of the term and recognizes the impact that larger systems have on personal action.

Conclusion

The literature on resilience has become fragmented and is reflective of postmodern and poststructural understandings of the term (Ungar & Liebenberg, 2009). While this fragmentation and differentiation should imply that the literature has become athematic, since the inception of the term there has been little variance in how, mechanistically, resilience is thought to function. The prevailing pattern within the literature is a characterization of resilience as either a protective property or as impetus to recovery. The scope and flavour of these framings have changed as research has progressed to become more nuanced; individual understandings have both been expanded – to include influences of the family, the community and beyond (e.g., Ungar, 2011) – and become more entrenched – through an examination of the biological bases for resilience (e.g., Feder et al., 2011). These changes notwithstanding, my examination of the literature has revealed little variation in recovery as a concept which locates responsibility on mezzo and micro levels

² This connection will be explored in the next section.

with little examination of how dominant discourse and macro systems have resulted in present-day understandings of resilience. It is this examination that has been undertaken in this work.

Theoretical Framework

The current study is Foucauldian in orientation with a focus on the concept of *governmentality* (Foucault, 2000) and its use by scholars within the field of Mad studies and Critical Disability theorists. Specifically, the current work examines the ways in which the concept of resilience may act a technology that may govern and, more generally, affect the lives of “consumers, psychiatric survivors, and ex-patients (c/s/x)” (Adame & Leitner, 2008, p. 146) of the mental health system. The primary point of interest is whether the concept of resilience may be understood through the Foucauldian notion of governmentality and, in particular, whether the experience of resilience reinforces current social inequalities.

Mad scholars and critical disability theorists.

The use of Mad scholarship and critical disability theory in the current work will not be substantial, but provides some insights into the ways in which c/s/x communities experience the concept of resilience. First and foremost, Mad scholarship provides a means to look beyond biomedical understandings of mental health and to examine other possibilities. As Poole et al. (2012) note, the biomedical model of mental health posits that mental health is the result of organic disorder and must be treated through medications. This results in a pathologization of persons through the reduction of individual narratives to a set of symptoms and treatments. The authors further argue that such processes result

in stigma and discrimination and, therefore, provide incentives to look for alternatives to biomedical accounts of mental illness. Furthermore, scholars within this camp (e.g., Harper & Speed, 2012; Hiranandani, 2005; Poole et al., 2012; Poole & Ward, 2013) argue that mental illness should be understood using the social model of disability; namely, that mental illness is a label which results in an experience of disability due to a socially constructed world which favours certain abilities over others.

Governmentality.

Governmentality is first described in Foucault (2000) as a type of social arrangement which grants the greatest convenience to the state. Elaborations on what “convenience” may mean within this context is not done in the work, but has subsequently been taken up by a number of authors. In the work of Tremain (2001), discusses what governmentality may mean for those with disabilities. The author’s central argument is that the labelling of certain bodies as “abnormal” or “disabled” can result in the constitution of a subject with prescribed ways of being; this is referred to as the productive element of power. In reformulating power as a process, Foucault (1980) considers the ways in which power may be conceived as neither repressive nor a commodity, but rather as something which espouses a sensation of freedom while simultaneously directing actions toward increasingly convenient arrangements. More simply, rather than being a force which prevents and inhibits individuals from performing and being, this understanding of power examines the ways in which individuals believe they are acting autonomously but, in actuality, are acting in prescribed ways. Tremain (2001) argues that the discourses and

practices surrounding disability can be described by this type of power and can, therefore, be characterized as a governing of the self.

More generally, Rose and Miller (1992) provide further means to contextualize the current discussion. These authors argue that current governments, in defining the scope of the political and private, aim to exert control over both; however, as neoliberal forces espouse smaller governments, this control must come from a distance and is, thus, indirect in nature. The considerable stake that governments have in the private sphere results as a very natural consequence of the private sphere's role in the creation of citizens and the impact of these citizens on matters that are considered public, such as, the economy of the country. The state, therefore, enacts an indirect control over the private sphere by identifying pertinent problems which become the issues taken up by, what the authors call, the *intellectual machinery of political rationality*. The intellectual machinery can be described as those knowledges which enable the government to perform its functions while political rationality is the larger paradigm which motivates the creation of such knowledge in order to justify its exercise of power.

Social work, then, can be positioned as a cog within the intellectual machinery that allows the state to govern in accordance with neoliberal discourse. Rose and Miller (1992) note the ways in which the state has come to oversee practices within the medical field and simultaneously define proper functioning, arguing that this has resulted in a "responsibilization" of medical conditions. This process occurs through locating responsibility and causality of disease within the individual and absolving the impact of social conditions. Teghtsoonian (2009) examines this concept further in observing the ways it operates within the field of mental health and the subsequent downloading of

responsibility of care to the individual and their families; a trend which fits with the neoliberal decree of shifting costs from public to private domains (George & George, 2013; Joseph, 2013; Teghtsoonian, 2009). In short, a contemporary understanding of governmentality within the field of mental health is one which recognizes the state's desire to constitute individuals who are able to use non-public resources to continue to be productive members of society.

The ultimate end of this governing of mental illness and, more generally, disability is explored in the work of Baker (2002) who argues that eugenic practices documented by historians are not confined to certain time periods, but rather, reflect the ongoing attempts to eliminate disabled bodies. More precisely, Baker (2002) argues that, as violent acts of eugenics became unpalatable after the events of World War II, governing practices that attempt to make disability invisible through treatment and rehabilitation came to the fore. Within the current context, it can be said that the ultimate end to the governmentality of mental illness – and its inextricable link to neoliberal mandates – is to make invisible the disabling effects of certain conditions. Simply stated, the government of mental illness seeks to eliminate those individuals with mental illness through the elimination of their conditions, as the result of individual action. Such an elimination of disability results in the absolution of state responsibility in the welfare of its citizens and the maintenance of status quo relationships of inequality.

Chapter 3: Methodology

For clarity, the question of interest in the current work concerns how the concept of resilience is experienced by members of the c/s/x community. Put another way, this central point of exploration attempts to delineate the effects of resilience on the life experiences of individuals who carry a mental health diagnosis and, more specifically, may affect how they story their experiences with mental illness. The crucial point of inquiry is in the subjective realities of participants and the ways in which these subjective, constructed realities have been affected by understandings of resilience, regardless of the source of these understandings. Therefore, it is the stories of participants that are most relevant.

In fitting with this desire to collect stories, this study has adopted a qualitative, narrative approach to inquiry. Fundamentally, a narrative approach to research is one which focuses on story and storytelling (Riessman, 2002). This approach acknowledges that stories are co-constructed endeavours between researcher and participant and focuses, less on the facts within stories, but rather how stories are told (Creswell, 2013). Above all, however, a narrative approach is concerned with the meanings of experience, as a central premise is that the act of telling stories is what creates our sense of humanity (Squire, 2008). This approach, therefore, allows for a rich examination of the way in which the experience of living with mental illness may be impacted by the concept of resilience.

Although a number of definitions exist for what constitutes a narrative design, the definition taken here is one which is common to the social sciences. A narrative approach, in the current context, is taken to mean an interest in the “interpreted description of the rich and multilayered meanings of historical and personal events” (Josselson & Lieblich, 2003, p. 259). The main features of a narrative approach are provided by Riessman and

Quinney (2005) through five criteria: “reliance on detailed transcripts; focus on language and contexts of production; some attention to the structural features of discourse; acknowledgement of the dialogic nature of narrative; and (where appropriate) a comparative approach” (p. 389). A narrative approach, then, is one which focuses on the richness of constructed and storied realities.

While Josselson and Lieblich (2003) discuss *events*, a more appropriate and fitting evaluation of the content of narrative studies is that of *experiences*. Squire (2008) distinguishes between narrative studies which focus on events and those which focus on experiences and the subsequent differences in analysis. Those studies which focus on events, typically approach analysis through an examination of structure, while those which approach inquiry through an examination of experiences are concerned with meaning. The area of interest of the current study is on the latter, so in accordance with Squire (2008), the current exploration of resilience is conducted on the assumption that (a) narratives are inherently meaningful and that the temporal sequencing of narratives themselves hold meaning, (b) stories are an essential part of humanity and provide the tools to create meaning in life, (c) narratives are a re-presentation of experience that is simultaneously co-constructed by researcher and participant, and (d) narratives are embedded with ideas of change or transformation.

A further point of clarification is around what is meant by the term *narrative*. As Riessman (2002) observes, a number of definitions exist for what constitutes narrative, but the most pertinent to social scientists are those narratives which are either discrete stories or larger accounts; specifically, this means that narratives can refer both to the stories and examples provided by participants during an interview, as well as the interview itself as a

whole. This allows for an analysis of the stories of individuals – that is, the story of an individual, in its entirety – but also individual stories – that is, those stories embedded within the larger narratives provided by an individual.

Data Collection and Sampling

In this study, 1-hour interviews were conducted with 3 individuals who fit the inclusion criteria. To be included in the study individuals must: (a) be between the ages of 18-50, (b) be diagnosed with a mental illness, (c) previously or currently receive services from a mental health professional, (d) previously or currently take medication for a mental health diagnosis, (e) consider themselves to be stable, and (f) not currently be in the care of a health-care facility. The audio from each interview was recorded and then transcribed. Pseudonyms have either been chosen by participants or provided if one was not chosen. The study was approved by the university ethics review board.

The rationale for criterion (a) was to select a sample that would most likely have been diagnosed and first become consumers or users of the mental health system *after* the concept of resilience had become a subject of study within the mental health field. As mentioned, initial research surrounding resilience took place in the 1980s as the result of work by Rutter (1985) and Garmezy (1987). As individuals tend to be diagnosed with mental illnesses in late adolescence (Brown & Scheid, 2010), an individual diagnosed in the 1980s would be approximately 50 years of age at the present moment – the upper limit for inclusion – while the lower limit for inclusion was selected so that only adults were included. The other criteria were selected to ensure that the sample consisted of

participants who were members of the c/s/x community and were in a position to discuss their experiences.

Analysis of Data

As Josselson and Lieblich (2003) note, a narrative approach to inquiry requires the availability of transcripts in order for analyses to be conducted, as transcripts provide some level of constancy compared to analyses based on memory of interviews. In keeping with this, audio recordings were transcribed to provide a stable point for analyses. Briefly, the analysis of transcriptions was done in two ways. Firstly, individual narratives were analyzed in terms of plot, meaning and themes; the relationship between and the function of characters; and the narrator's positioning of themselves in relation to their narrative and other characters. Secondly, an analysis was conducted on the narratives as a group. The complete interviews were analyzed together as a group to identify similarities and differences between individual narratives, while examples and stories of particular events or experiences of importance across interviews were grouped together for analysis as well.

The analysis of narratives, in general, has been a matter of some discussion within the literature (Gubrium & Holstein, 2009), it is therefore the approach of this work to synthesize those techniques of analysis that best fit the current context. To that end, complete interviews were taken as narratives and were the first unit of analysis as has been suggested by a number of authors (e.g., Chase, 2003; Fraser, 2004; Riessman, 2002; Riessman & Quinney, 2005). These narratives were analyzed in terms of plot, with the primary question being, how does the plot develop? (Riessman, 2002) In this analysis, the motivation was to explore why a story has been told the way that it has and why certain

elements were chosen to be included within a narrative while others are left out. Of particular interest was whether the plots of participants' stories mirror the understandings seen within the literature on how resilience functions.

Furthermore, another point of interest is that of meaning and how meaning was constructed through the storying of life experiences. As Riessman (2002) and Squire (2008) note, the sequencing of experience provides insight into the meaning that experience has and, more importantly, provides the basis for humanity. These authors argue that it is through this sequencing and storying that meaning is created and is necessary for human existence. This analysis was undertaken by focusing on the emerging themes within each narrative, the dramatic elements of the story which draw attention and create intrigue, as well as the emotions that were conveyed in the telling and hearing of the narrative.

Another element examined while analyzing individual narratives was that of character. As Gubrium and Holstein (2009) note, a narrative typically contains characters and in deriving meaning from the narrative, it is important to consider the instrumental functions of a character, as well as the semiotic functions of the character. More simply, an analysis of narratives must investigate what a character does and what a character might represent. A complementary concept is the positioning of the narrator in relation to these characters, which requires an examining of the relationships between the narrator and the other characters within the story (Riessman, 2002). A more general analysis of the positioning of the narrator can be done by examining the relation between the narrator and their plot, which bears specific interest to understanding the effect of resilience – as a

narrator's role within their story, as either passive victim or active agent, provides crucial insights to the way in which the concept of resilience has affected their life.

In analyzing groups of narratives, as Riessman and Quinney (2005) note, depending on propriety it was sometimes useful to compare and contrast different narratives. This allowed for similarities across narratives to be discovered but also provided an opportunity to explore the differences in narratives. A more important analysis done with all narratives, both individually and collectively, is described by Tamboukou (2008). In particular, Tamboukou (2008) describes a way in which a Foucauldian approach can be taken to narrative analysis. The author outlines the ways in which this may be done by first discussing the need to examine the context which provides the conditions of possibility for certain narratives to arise. Said another way, the topic of exploration was the manner in which power/knowledge relationships allow for the production of particular stories and narratives; the author acknowledges that this is in recognition of the productive aspect of power. Therefore, a Foucauldian analysis of narrative examines the narratives gathered and how they are products of existing power/knowledge relationships that may involve resilience.

Additionally, Tamboukou (2008) argues that to further acknowledge the productive means of power, the ways in which the subject is constituted through narrative must be examined. While related to an examination of what meaning an individual may derive from a narrative (Squire, 2008), this approach considers meaning situated within the context of power/knowledge. This provides an opportunity to examine how individuals may constitute themselves as a resilient subject. Lastly, Tamboukou (2008) describes the ways in which discourse and narrative must be contextualized to a particular space. The ultimate

end of this reasoning is that not only must the spaces described in narratives be analysed, but the narratives situated within spaces must also be deliberated upon.

Chapter 4: Findings

Three interviews were conducted with individuals who had been diagnosed with a mental illness. The participants were female and high achievers. They had all completed one university degree and were in the process of completing subsequent degrees in postgraduate program or graduate programs while managing their mental health diagnoses. By most metrics (e.g., Andersson & Ledogar, 2008), these individuals would be considered highly functional and resilient. Their narratives tell of the role of outward success in their lives but also the relationship between these successes and their diagnoses.

In keeping with the suggestions of Riessman and Quinney (2005), the exploration that follows of the stories of these three individuals will make every effort to preserve the original meanings but also to provide the meanings which I took away from our conversations. While simultaneously recognizing that meaning in this context is co-constructed between these narrators and myself, I have striven to be as respectful of these stories as possible by inferring meaning from the larger context of a person's story before attempting to infer meaning based on my own thoughts and feelings. It is my hope that while the exploration here will reflect some of myself, it will also reflect the original intent of these storytellers. All names have been changed to maintain confidentiality.

This section proceeds by first presenting the story of each person so that the uniqueness of each story and its contribution to understanding resilience is considered. Each story will be examined using the elements outlined within the previous section, as applicable, since it should be noted that not all elements outlined existed within a particular narrative. The narratives will then be examined together but cautiously. The nature of this work is such that it seeks to understand but not generalize, as that falls

outside a narrative approach to inquiry (Creswell, 2013). Examining the narratives together will provide insight into the different ways these narratives interact and highlight points of interest. In particular, taking the narratives together, it is possible to consider the conditions which may exist that result in the emergence of such narratives.

Within each narrative, I explore several key ideas in an order that, I hope, stays true to the narratives of each story and if the element is pertinent to the particular narrative being discussed. Firstly, I examine each narrator's motivation, as my analysis of these narratives revealed that each narrative had a distinct motivation that provided a mechanism for advancing the plot within their stories. Secondly, I examine each participant's relationship to medication, as medication became an important feature within each account. Thirdly, I examine the diagnoses given to each participant and the semantic functions of these diagnoses within each narrative. Fourthly, I discuss the relationships each narrator has with the medical profession and, more specifically, doctors if relevant. Lastly, I highlight aspects of a narrative that I feel are unique and important to understanding the story.

Katie's Story

In speaking with Katie, she seemed to be an intelligent and thoughtful individual. At the time of meeting, she was a graduate student in her mid-20s and told a story in which major depression played a significant role. The effects of depression had made functioning within an academic environment nearly impossible so she had chosen to take a leave of absence to focus on treating her diagnosis. Having done so, she was about to resume her studies and the timing our conversation left me with a feeling of cautious optimism. Kate

spoke of the difficulties she had faced and while she spoke of her future hopefully, it seemed as though she left space within her conceptions of her upcoming studies for further difficulties. When asked to summarize her story, Katie shared that:

Depression can happen for no reason. Grad school really sucks when you're in depression. It sucks even more when you're on horrible meds. (laughs) Meds are an up and down rollercoaster of trying to adjust to things. And then, once you find the right combination they really help you get to the point where you have enough, you're clear enough and you have enough energy again to start pushing yourself forward because it's not obviously all the meds. They're not magic. You still need to be motivated and get yourself motivated and decide to do things. They help with that. Especially getting on [the right medication] has helped with that, but they give you a steady baseline to start from. You have to be the one who pushes to actually get back to being a functional human being.

Katie's story is one in which the onset of medical condition could not be predicted and the central tension is one of control and treatment of this condition. The place of medications within her narrative is central, but she also hints at the need for elements and developments beyond simply the medication. While Katie emphasized the need to go beyond the medication, the need for medication could not be understated.

The centrality of medication within her story resulted from the way in which Katie understood her diagnosis. She described that, while she had previously experienced depression due to situational factors, her current experience with depression could not be similarly explained and that this led to a belief of her condition being organic. As she explained:

This entire recent bout of depression, there's no cause I can pinpoint, which is why I haven't been doing any actual therapy outside of seeing my psychiatrist, because there's no underlying cause that we can figure out. It's just chemical imbalance.

With the cause of her diagnosis established as organic, medication became a primary plot device within her narrative. The development of the story depended on whether a particular medication was working and whether she was taking them properly. The

counterpoint and counterforce to medication then was, naturally, the diagnosis of major depressive disorder; a seemingly unpredictable and unknowable phenomenon that could only be affected through medication. The symbolic role of medication within her narrative, then, was as a means of removing obstacles and barriers that could be done by no other thing.

A prominent feature of Katie's story was the way in which medication provided a mechanism to control her diagnosis and change which seemed to be her main motivation. As the primary effects of her diagnosis prevented her from functioning as an academic the need to return to that life became a driver for change. She mentioned a number of times the way that her depression prevented her from comprehending articles, thinking critically and her ability to remember; tools that are central to the career of a scholar of any field. Indeed, it was her difficulties functioning within this area of her life that first led her to seek professional help. Katie had just dealt with another medical condition before realizing that something else was happening. She described:

All of sudden I had just entered this like crushing apathy, an inability to want to do anything and an inability to concentrate. My critical thinking skills were so low that I would read a paper five times and not understand what it was about.

These symptoms, then, were the primary indicators of the existence of the diagnosis and were the things that Katie worked to eliminate.

The difficulty of finding a means to effectively treat her diagnosis was highlighted as she described the ultimate goal of this process as being to recover. The effects of her depression caused to feel as though she had lost something of the life she knew and that, perhaps, the life she would lead from that point on would not be the one she wanted. She reflected on the difficulty of this:

There were definitely some points where you just practically lose hope, you think "Ugh, well maybe I'll just be like this forever. Maybe there's nothing that's going to get me back to my old self or my old productivity levels." You know, for most of the past year and a half, I felt like I was like 50 IQ points short. I've always been like top of my class, very bright, sharp-thinker, very good reader, very good at comprehension and critical thinking and all of that disappeared with the depression. And it's finally starting to come back, I feel a lot more like myself these days.

An important feature of her narrative is the rediscovery of herself, her cognitive abilities and, ultimately, the life which she had planned. In "recovering," Katie has described the process of, literally, getting something back.

The apparent decline of her cognitive abilities was a source of distress and was described as one of the reasons for which she sought assistance. For Katie, her cognitive abilities were tied to her livelihood and to her identity, thus, being able to establish that an organic, and possibly treatable, condition was affecting her provided her with a way to understand her experience. Katie characterized the first days of being diagnosed as "relief" as it provided a rationale for her perceived diminishing mental capabilities. She shared that:

I guess it was actually a bit of a relief to know that it wasn't just my brain deteriorating into like early onset Alzheimer's or something, which I was very concerned about being an idiot. (Laughs) I was just like "Huh, what if my brain is broken forever?" And it was nice to find out that all these symptoms of depression I was experiencing – like the inability to concentrate and the memory loss and the inability to focus or perform higher mental tasks – were actually caused by the depression and not just because I was becoming stupider or something. Which (laughs) being an academic I was very concerned about.

Very much central to her fears was the onset of an untreatable ailment that would result in a permanent reduction of cognitive function. The relief indicated here is perhaps indicative of a belief that it is possible to recover from depression and that these symptoms could be reversed, as opposed something with more permanent effects like Alzheimer's.

Katie shared that her symptoms, which consisted of this deterioration of her higher cognitive abilities, had initially been diagnosed as “atypical depression” before it was changed to major depression. This seems to hint at a “typical” way of understanding depression, namely, as a thing which affects mood rather than ability. In addition to this, Katie described having experience a previous bout of depression that fit the archetype of a mood disorder and its dissimilarities to her current condition.

[M]y previous serious bout of depression when I was much younger [...] was situationally-based. And it was all very much emotional, but it didn't impact my school work, it didn't impact my ability to focus or concentrate or enjoy things. It was a very different experience the [first time compared to now] which is why I didn't immediately connect it and why I waited so long [to seek help].

It seems then that Katie's understanding of depression had been based on previous experiences. The development of her story then required outside information that could provide ways of changing her understanding of what types of symptoms could be ascribed to depression. It was important to the story, therefore, for Katie to come across a magazine article that described the ways that depression may affect academics and graduate students different. Perhaps even more important to the story was a self-report questionnaire that allowed readers to assess their own fit for depression. Katie shared her experience of encountering this magazine article.

[T]hat [magazine article] sort of made the light bulb turn on and I thought "Oh! Okay. THAT might be the issue. It might be depression." Because it didn't reflect what I'd previously experience in my life before.

The article then plays a crucial role as without this article, it is unclear whether this narrative would be one of mental health. The nature of her symptoms may have led Katie to consider a number of other avenues related more closely to learning and thinking, such as a

type of learning disability or attention disorder. The essence of this story, as a mental health narrative, is inextricably linked to the discovery of the magazine article.

While much of Katie's story revolved around the struggle of finding the right medications to battle the unwanted symptoms of her depression, much of it also focused on the role her social community played as well. She described being very much involved in a community she cared about and taking on a part-time position as an administrator at one of the centres within her community. The role this job played within her narrative was beyond financial enumeration, but extended into the therapeutic:

It's definitely been helpful for me in terms of measuring my progress and seeing where I'm at. It's a really good litmus test of how well I'm doing in a day. Can I get through all of the day-to-day tasks and move onto something a little more long-term, tasks and things that have to be done over the course of a month or over the course of a year at the [centre], in terms of running it. Like, accounting stuff or things like that. And so, you know, I can tell I'm not doing great if I only just barely get through the emails and stuff. And if I'm doing really well I'll get through all that really quickly and be able to also tackle a bunch of other more long-term tasks that take a bit more planning and just sort of time management. So it's been very helpful I think, plus the fact that it gets me out of the house, (laughs) which when you have depression can be difficult.

She also shared that:

I've actually been doing the vast majority of the day-to-day [centre] running and so that's actually been a really good experience for me because even on bad days, or when I was still adjusting to drugs, I wouldn't mind going in to that kind of work. Because it was answering emails and doing spreadsheets, I can do that in my sleep. (laughs) I'm a grad student! So it was easy and you know all my friends were there so it was a very comfortable environment. So even on days when I was feel like I couldn't do anything, I would just go and even if I had been pretty non-functional the whole day, I would at least get myself up to a point where I could do the basic tasks. So, it was helpful in terms of showing me that I was still was competent and at least basic uh data management and you know, answering question, dealing with people. So it was definitely, it has been very helpful I think. Just having that sort of constant duty in my life as opposed to being totally unemployed and just like sitting at home.

The role of the centre in Katie's narrative then was multifaceted. While acting as a source of financial stability, it provided a proving ground to gauge her treatment progress, it

provided an ongoing source of social contact and provided an opportunity to reassure her that she was still capable of contributing to her community. The sense of routine imposed onto her life, necessarily existing because of the nature of her work, also provided a sense of structure to what she felt would have quickly become unstructured.

Another notable feature of Katie's narrative was that of relationships. The importance of her social relationships were emphasized a number of times, especially regarding the support that her friends and family, her partner and her supervisor provided. While we did not speak about what that support entailed it was clear that, whatever form this support took, it was very much valued. In addition, her relationship with her doctor could be characterised as a partnership. She described her doctors as "more passive" and spent their time listening to the ways that she had been feeling and coping with her diagnosis, and provided recommendations based on her reports. Katie shared an exchange that she had with her doctor that illustrated this. Having just received recommendations by an outside referral on her case, Katie disagreed with the recommendations made and made her concerns with the recommendations clear.

They wanted to do something weird. They wanted to take me off the one drug that was working and put me on Ritalin because they were most concerned about my concentration and focus issues now. And I was like "If I'm going to take Ritalin, I would take a very small dose" like my previous psychiatrist recommended. A very small dose in addition to my medications. I don't want to switch off of the one that has been working that I've been on for a year now, just to try something else. I thought that was a terrible idea. I have no idea why [they] suggested it and luckily my psychiatrist also agreed with that and said, "You know what? Let's just try switching out the [one medication for a different one] and see if that helps." and it has.

So while Katie's doctor could have followed the guidance of his professional colleagues, he chose to work in partnership with Katie instead.

Katie's story, on the whole, hinges on an organic understanding of her condition and the arduous process of finding a combination of medications that effectively nullify the symptoms of this condition. Underlying this process was the drive to recover her previous life and self, to become the academic that she felt that she could be. Her loss of this life and this self were the motivating factors to trudge through the treatment process. In short, she endured because she had to and not because she felt like she had a choice.

[The medications are] not toys. You don't go on these because you got sad one day. You don't go on these because your grandma died and it's a month later and you're still missing her. You know? (laughs) They're really serious drugs and they're not worth the process on and off and side effects and everything else unless you really need them.

Her need to live the life that she wanted was very much linked to her need for the medications. Indeed, the medications provided a tool to mitigate the chemical imbalances in her brain, a thing that was beyond the reach of other tools and could be only be affected through medication. This also meant that her diagnosis brought clarity and relief as it meant that her seemingly deteriorating cognitive abilities could be reversed. In partnership with her doctor, Katie was able to find a combination of drugs that allowed her to regain much of her previous levels of functioning. It should not be overlooked, however, that Katie was still productive during symptomatic periods, as she described her involvement with her community and her work at a centre within her community. Her narrative should be viewed as one in which both the contributions of the medical profession and social networks or communities play a part.

Michelle's Story

In speaking with Michelle, I felt that her demeanour and her story invoked a feeling of tension and ambivalence, as though it would be inappropriate to conclude anything to be wholly positive or negative. Michelle is in her 30s and is a mother of 3 children. She described having felt the effects of mental illness her entire life and that she had always felt that she was not “normal.” This struggle and unease eventually led Michelle to seek help and a diagnosis of borderline personality disorder. Having been asked what she felt was the most important part of her story was, she stated that:

I think it would be a lot easier for people, it would be easier for me, if I felt like I had support of family and friends. (laughs) Maybe people in the healthcare field. If there wasn't such a negative [perception of certain diagnoses], especially this one [borderline personality disorder].

This excerpt highlights some of the ambivalence that Michelle felt in wanting help from others but at the same time, feeling apprehensive in doing so. It also highlights the importance of relationships in her narrative, as well as the various interactions she had with those within the healthcare field.

The plot of Michelle's narrative is one of endurance. She described having lived for most of her life without the involvement of medical professionals despite knowing that she may benefit from such intervention. In fact, Michelle shared several times that she wished that there were medications that she could take that would suppress the symptoms of her diagnosis but was learning to live with the reality that no such treatment existed. She described that:

I had always known that I had suffered depression. I knew that I had serious depression when I was younger. I had an eating disorder when I was very young, like through my 20s type years. And I had a lot of problems back then that I completely buried and tried to avoid. [I] thought I was, I think, above treatment, needing treatment, wasn't going to acknowledge that I needed treatment. At one

point, I had gone to a counsellor at university when I was probably about 20? And that didn't last. And so, I managed, from that age to when I was probably like 36ish, to function without having any sort of help from doctors [or] therapist[s]. I honestly don't know how I got through my younger years without being on any sort of medication or anything.

Michelle seems to have endured a lot through her lifetime and would tell of the other things that she was enduring at the time we spoke. Her approach to toward the mental health system for most of her life was one in which she “avoided the mental health system.” This avoidance likely would have continued had it not been for a series of events.

Michelle described having a “large breakdown” as the result of a relationship ending with her partner and that it was this break up that led to her deciding that she needed outside help.

What triggered me was the break up, when I had gone through the break up with my partner then and I was completely...I've had...which I'm coming to realize (laughs) as I'm older not necessarily typical. But I've had thoughts since I was young about suicide or not wanting to wake up or wanting to be done. They're always there. I've always had those thoughts. The helpless, empty thoughts. I was really, really struggling after that break up. I was really, really struggling like to the point that I couldn't function and I have kids.

It emerged that the main motivator for Michelle was the welfare of her children. Although it was difficult to lose her partner and it was difficult to endure the life that she had up until that point, the impetus for change was to ensure that her children would be okay. In fact, Michelle described her children as her primary survival mechanism. “They really motivate me,” she said. “I'm pretty positive if I didn't have kids, I wouldn't be here on this earth.” Her desire to provide and care for her children provided her with an important reason to seek professional care.

In getting her diagnosis, Michelle's telling of the experience re-invokes the feelings of ambivalence and tension that I felt throughout our conversation. The diagnosis brought

some clarity and organization to her life's experiences but it also became a source of anguish. While helping explain what she has felt throughout her life, Michelle shared that "I'm devastated at the same time. I'm really mixed on [the diagnosis]." In exploring this feeling of devastation Michelle relayed the story of learning about her diagnosis. She described first being considered for the diagnosis by her psychiatrist and stated that she "wasn't very happy with it." What followed after this preliminary appointment with her psychiatrist was a period of research and exploration, during which Michelle learned about borderline personality disorder. Her resourcefulness was omnipresent in this exploration as she contacted friends and acquaintances who had experiences with mental health diagnosis, in general, and borderline personality disorder, more specifically.

In discussing her possible diagnosis with a friend who carried that diagnosis, she began to recognize herself in their stories but, perhaps, the most powerful experience in listening to her story, was in her reading of a recommended book.

[O]ne of the books is called *Sometimes I Act Crazy: Living with Borderline Personality Disorder*. I read it over Christmas. I haven't read a book from start to finish for over a decade because I don't have time. And I read that entire book and I cried through the entire book. And I took that book into the psychiatrist with it all marked up and underlined and he took it and he looked at it and he said, "This is great! You underlined all the right stuff!" And I said, "No, this isn't great! This explains my whole life [and all the ways] that I've tortured myself." And it basically [said] that I'm always going to feel this way, that there is no magic pill and I'm going to feel this way unless I do an awful lot of work.

Her turmoil and distress at the cause of her life difficulties was almost palpable in her telling of this experience. While her diagnosis provided an account of her life story, the explanation brought with it further hardships as it predicted a difficult road ahead for Michelle as she would have to make fundamental changes to her worldview, her personality and, ultimately, to herself. Given the prospect of being required to completely

change everything about herself, the desire for a pill that could drastically alter the landscape of her future was unsurprising.

The diagnosis then became a way of understanding herself but also became a kind of judgment and possible condemnation of the self. Michelle desired to be “normal” but, having been given the diagnosis, knew that that was no longer a possibility without substantial changes to her thought patterns. Michelle describes that one of the features of her diagnosis is the ability to affect how others feel. Specifically, Michelle described a common occurrence in her relationships, both past and present, in which she made it difficult for her partner to spend time away from her. She shares that:

[I]f he wants to go out for the night and I don't want him to go out for the night, I can really kind of make him feel bad about his choice to go out for the night and that, he's leaving me or leaving me with the kids or make him feel guilty.

It would seem that for Michelle there were a number of occasions when she was reluctant to have her partner leave her. There was a need that she felt was being met by her partner's continued presence. It may have been the case that her need to be with her partner was underpinned by the perpetual “emptiness” Michelle described as being an enduring element of her experience of borderline personality disorder. As Michelle shared:

I realized that I try to get all my fulfilment kind of out of the relationship. And when I'm not getting it, when he's kind of pulling back or when he's doing something – which is completely understandable for him to go out and take a few hours off especially when he would offer to stay home and watch the kids so I could go do something – I'll kind of use that to my advantage.

Michelle attributed her awareness of this behaviour and her labelling of this behaviour as undesirable was the result of the explanatory ability of the diagnosis. Having gained this awareness, Michelle found alternate ways to address behaviours that she feels are “self-destructive or that is destructive to the relationship.” She shares that:

I'll stop myself and I'll call myself out on it and I'll actually even point it out to him. And the last time I called myself out on it because he was starting to feel bad. I said, "No, this is what I do. There's nothing wrong with what you're doing."

So while there was a time that such disagreements resulted in blame being placed on others, as a result of her therapy, Michelle illustrated how she has begun to recognize her own role in these situations. This should not to imply that the diagnosis is an overly positive object in Michelle's narrative, but that there are some constructive outcomes as the result of it. An interpretation that fits with the theme of ambivalence that is prevalent throughout this story is that while the diagnosis provides some possibilities for change, it also forces a reinterpretation of Michelle's life story up until when the story was told.

It's really hard to accept the fact that a lot of the crap and basically stuff that you've done to yourself, or that you've done, that the torture you've endured is because of your personality and because of yourself. That you can't blame that all on an outside source.

The feeling of ambivalence and tension is rooted in a conflict between Michelle and herself. It is one in which the difficulties she has face are the result of her personality and while this firmly positions her in the role of an active agent within her life narrative, it also forces the responsibility for the pain and suffering she has endured onto her own shoulders. In short, the feeling of ambivalence emerges as Michelle attempts to do battle with herself.

Michelle indicated near the beginning of our conversation that the interpersonal relationships are a difficult matter for those diagnosed with borderline personality disorder and this quickly became a chief concern in her story. Her relationship with her partner played a pivotal part in her decision to seek professional help but further to this, her relationship with her children was crucial to her narrative as well. Michelle spoke about her children motivating her to find ways to survive as she was pre-eminently concerned with their wellbeing. It was then a source of apprehension for Michelle to

elucidate the ways in which one of her daughters had begun to exhibit the same behaviours that Michelle had come to believe were problematic. As Michelle describes:

[W]e've known that there was something different with her since she was in kindergarten actually and had problems with her (laughs) interpersonal relationships. She's fine with adults but she's always had problems with peers and I've kind of worked with her over the years and she's gotten some maturity and she's gotten better but she's also approaching her teenage years...She has a lot of days when she shuts down and she knows that she's different and she doesn't understand why her brain kind of works the way it does. I think, we've had enough dialogue and she knows that we think very similarly, so she trusts me to come talk to me and we do practice quite a few of the - I have another workbook [based on the therapy that I'm using] (laughs) - we'll fit [it] in and work through things in the workbook for how to calm ourselves down when we're in the moment.

The unsettling nature of the diagnosis for Michelle's story extends beyond her own life narrative, it seems, and has become part of the narrative of her daughter's as well. The responsibility to find a different way of existing has pushed Michelle not only to employ therapeutic techniques on herself but on her daughter as well.

Related to this discussion on interpersonal relationships, Michelle also spoke of the negative connotations ascribed to the diagnosis of borderline personality disorder, which she spoke of as stigma. Michelle described an employment interview:

[I]n the interview they're giving different scenarios of different clients, client scenarios and things they would come up with. [...] In the interview, there's the main woman and another social worker, [they talked] about how they also have people with mental health diagnoses who are there [...] who they're working with. And she's talking about people who have borderline personality disorder and who are very difficult and I'm sitting there trying to keep a straight a face as I can. And she was giving me a negative. [...] And she's saying about them being difficult to work with, so I'm kind of embarrassed and struggling more with it. But then, when I'm reasonable and I step back and look at it, I understand what she's talking about. I understand the whole interpersonal. The what's at play if it's not me and how someone can be difficult. But it's definitely not something I want my employer to know.

So in addition to the generally stigma against mental health diagnoses, Michelle's story highlights stigma even within the mental health system. Specifically, we see an example here of the negative judgments attributed to a particular diagnosis and the ways in which it may affect the delivery of services and the barrier that it presents to certain individuals in looking for employment.

In sum, Michelle's story is one that centres on a non-organic understanding of mental health. The diagnosis of borderline personality disorder resulted in a desire for the existence of medications that could alter the effects of the diagnosis but the repercussion of the learned nature of this diagnosis left Michelle with only the option to examine herself. The diagnosis itself, subsequently, became a source of tension: it provided clarity and explanation of Michelle's life experiences but also cast Michelle into the role of saboteur within her own life. The uncomfortable nature of the diagnosis extended to the various relationships in the story and, most poignantly, into the life narrative of Michelle's daughter. Having identified a number of her actions to be tied to her diagnosis, she noticed that her daughter had learned them as well and resulted in a further layer of anguish in this story. Lastly, Michelle spoke of the negative ways in which this diagnosis is framed.

Lucy's Story

Lucy's story is one that invoked a feeling of tenacity and an unwillingness to be overcome. At the time of telling, she was in her 30s, married and had 3 children. She talked much about her difficulties with medications and, more generally, the medical system and her choice to stop taking medication for anxiety and obsessive compulsive disorders. Her

complete and total reliance on herself was a dominant feature of her story. When asked about how she would summarize her overall story, she stated that:

Well, you've kind of made me see, that the mental health system kind of screwed me. Because I think the easy fix was the pills, put me on pills. Nobody really wanted to hear my story. And then [...it took] a huge life change that made me have to deal with these people [in the medical system] head-on that kind of changed my life. And made me in control. I was able to kind of deal with things without having to pop these pills but deal with them in a different way even though I have the same issues. Because those issues have never really gone away. I just deal with them in a different way. I guess there are alternatives. The answer isn't just about popping the pills. I do think it's possible for people to rewire their brain.

The life change that Lucy speaks about here is the birth of her second daughter, who has complex medical needs that require Lucy to interact with medical staff often. The excerpt, in its entirety, speaks to the feelings of sheer perseverance and determination that I felt in listening to her story. These feelings, I believe were the result of Lucy's complete unwillingness to allow anything, including these diagnoses, to prevent her from reaching her goals.

Lucy's motivations are numerous and complex, reflecting the changes that she had undergone throughout her life story and her role within her life story. For much of her story, Lucy acted in the best interests of others and often seemed bound to the decisions made by others. In this sense, it may be said that there were periods within her story, where the story happened to her and she was a passive character within the story. This is reflected from the moment that Lucy and I began our conversation:

It's kind of a long story. It started...I was living with somebody. I was ready to go to university and I waited a year so they were ready to go. And we'd been living together for over a year and when we both went to university a week after we got there, he dumped me. He finishes me. And it was in a big city. I was a country girl. I wasn't used to being on my own and kind of into this loopy, paranoia state and it kind of change my life basically. That was the trigger. That was a trigger. And I was supposed to move into [a residence] and I didn't. I moved into a house so I could be

near him even though he was in a [residence]. I wasted everything. I kind of put everything on hold for this guy, which was ridiculous. But yeah, I don't know what happened to me but that's when the triggers and everything started. The anxiety um, it started to go downhill from that moment, from then.

While it might be said that Lucy makes choices to accommodate her partner at this point, I believe that it would be equally reasonable to say that Lucy takes on the role of a character within the life of another. In this sense, the story is someone else's and Lucy is simply a part of it.

As a result, the breakup of the relationship left Lucy without a life story and within that context, the ending of the relationship is understandably distressing. Lucy described the period after the break up:

I became obsessive. So I would be calling all the time, calling him all the time. If I wasn't speaking to him, I'd be in my bed. I couldn't leave. I was like frozen. I used to have to hide underneath, in my bed. I used to have to go on the train. I would think I was going to jump in front of the train. I was hearing voices telling me to jump. [...] It sounds really bizarre now, thinking about it, but at the time it just took over me, took over my world. It was [a] really strange, strange experience. I started making like obsessive compulsive. It was how I was. I don't know. And that's how I am now and that was my trigger. And it's funny that how something so ridiculous just triggers in me that has now lasted me, almost twenty years?

The loss of the relationship spurred Lucy to attempt to regain it and sparked what would be a battle that she would wage with herself over the course of twenty years. Lucy described a number of changes after this breakup but the constant factor across these stories was the feeling of the story happening to her and that she played a supporting role within the lives of others while ignoring her own needs. Lucy stated this succinctly and compellingly:

I just feel like I have given up everything for everyone else. I feel like in my house, nothing would run without me. I don't care what [my partner] says (laughs), I know that he wouldn't be able to deal with that. If there's always been an emergency, anything, I'm the one that deals with it. Every single time. He freezes. I'm being forced into the situation and I just deal with it. [...] Like how many times I've had to

call 911. It's always me that does it. I'm the one that has always had to deal with it. Every time. I've had to put my life on hold for the last, I don't know, 14 years? 15 years? And now, when I say it's my time, I've found something that I really want to do [...] Like I've always wanted to do what I do now, like years ago. But I never had the guts to do it and now I'm doing it. And I feel like nobody's going to take it away from me. Nobody. So it is my time. And that's how I think that the feeling of pleasing myself. I'm just determined.

It can be said that at some point within her narrative, Lucy became an active agent, creating and directing a narrative that suited her needs.

In asking Lucy at what point this change occurred or whether this change may have occurred over a period, she suggested that this may have happened when her second daughter was born. Because her daughter has complex medical needs, Lucy became an advocate for her and much of the time, she was advocating in opposition to the recommendations of medical staff. In speaking to that change, she says:

I think it was when [my daughter] was born and she was in the hospital. And I felt like when she was in the hospital, we thought she was going to die. You know the doctors were saying one thing to us and telling us to let her go and I was like, "No." I became this person that was just fighting for her. And I was think it was then. Really. I just got this strength, I guess. I had to learn to advocate for her and I'd never ever done that before, for anyone. So I wanted her to live so much that I think that's when I became this person.

The motivation then for Lucy to change her approach to life was initially the wellbeing of her daughter. In leading a life in which she perceived her role to be the support of others, it seems that this was repeated in her advocacy of her daughter. It might be said that a side effect of this advocacy was that she became a person who was able to assert her point of view in opposition to others. In her learning to advocate for her daughter, she learned to advocate for herself.

The differences in opinion between Lucy and medical professionals did not begin with the birth of her daughter, making the change in Lucy's communication with medical

professionals noteworthy. In reflecting on her experiences with mental health professionals, in general, Lucy shared that she felt that nobody had taken time to listen to her and her story. Rather, the prescription of medication to treat her diagnoses, left her feeling dismissed.

I ended up going to my GP and they just prescribed me pills and that was their answer to everything. Just pills. So that has basically been my mental health system every time I have seen a health care professional. I've been given tablets. Not really anything probably different to anyone else, but that was their fix, their quick fix.

She described that as being the end of her relationship with this doctor as there were no follow-ups sessions. She was expected to take the medications and very little attention was paid to whether the use of medications addressed her experiences. The feelings this inattentiveness invoked were clear. In describing her interactions with the GP, Lucy stated:

I didn't really feel like they were hearing me. They would just try to medicate me without even really prodding. I was never really given a diagnosis until [later]. But, you know, it really was being medicated and that was it. That even balled my life because I had side effects from the medication that they had given me.

The side effects might have been justified, in this narrative, had the medications been effective, but in Lucy's case the medications were largely ineffectual. The apparent dismissiveness of the GP combined with ineffectual medications, with their host of side effects, left Lucy feeling markedly worse.

It was after a miscarriage that Lucy decided to cease taking medications completely. She had received a publication from a hospital indicating that the medication she was taking had the side effect of increasing the risk of miscarriage. This knowledge, coupled with the other side effects and ineffectual nature of the medication, meant that the medications were doing more harm than good. At the time of our conversation, Lucy had

discovered ways to cope with her diagnoses that did not involve medication. A main strategy was to keep herself busy.

I have to keep busy. If I keep busy, I don't think about things. If I am lying in bed, it gives me more time to think about things. And obsess and process and that's not a good time for me. I stay awake a lot. Something bugs me in the middle of the night I have to deal with it first thing in the morning. [...] I have to keep busy and that's why I take on so much. That's my coping strategy. I don't have down time at all. Right now, I work for hospital. I deal with people who are dying and people that are in bereavement. I don't have any downtime, so the moment I leave work till I come home, I've got the kids to deal with. That's my day, every single day.

In this way, Lucy has managed to care for her children while completing a university degree and attained acceptance into a graduate program. She has been able to accomplish a substantial amount and the strength of her spirit suggests that she will continue to accomplish and achieve.

To summarize, Lucy's story is one that invokes a feeling of tenacity. Her discovery of an inner strength and her creativity in finding ways to cope with the effects of her diagnoses provide a glimpse at possible ways to deal with mental illness without using medications. Her motivations are complex, beginning with the wellbeing of her daughter and then becoming more self-focused. Through advocating for her daughter she found ways to voice her distrust of the medical profession and found ways to further advocate and stand up for herself.

The Narratives and Conditions for Existence

In examining the narratives altogether, I found that across the four common features discussed – namely, the motivation of the narrator, the participant's relationship to medication, the diagnoses carried by a participant and its semantic functions, and the narrator's relationship to the medical professional – there were a number of striking

differences and similarities. The most striking was the relationship between medication and each narrator, as the relationship could be described as *need*, *want* and *reject*, respectively. In Katie's story, there was an unwavering *need* for medication – rooted largely in an organic understanding of mental illness – while in Michelle's story there was a desire to, or at the very least the option to, take medication to affect her diagnosis. This was further contrasted in examining Lucy's story in which a total rejection of medication took place. These three very different relationships to medication highlighted the uniqueness of each of their stories, their personalities, and their diagnoses. It also indicated a different kind of relationship between narrators and doctors. While Katie and Michelle had good working partnerships with their physicians, this was not Lucy's experience and, as a result, was left to fend on her own. It would seem that the relationship between medication and a person may be a complex one and hinges on a number of factors.

The existence of medication as a tool to change the behaviour of a person, at the volition of a person, would seem to indicate a certain set of conditions. It seems to presume that control of the self is desirable and, as the theme of needing to function was common, it may be the case that the control of the self is desirable for the very purpose of being able to function and survive within society more effectively. In each of the narratives, the "trigger" that moved each narrator to seek medical intervention involved an inability to function. For Katie, it was an inability to function as a graduate student; for Michelle, it was the inability to function as a parent; and for Lucy, it was the inability to function independently. The disruption of performance seemed to underlie each of the reasons for seeking treatment.

To continue this line of reasoning, the desire to care for the self and loved ones insinuates that if that duty was not carried out by these narrators, that they would go

undone. It seems to imply that the care of the self and of others in their lives is an endeavour that resides at the level of the individual. The urgency created through loss of functioning was so great that it seemed as though the very existence of these narrators and their families depended on the restoration of this functionality. It might be said that the feeling and spirit of their narratives intimated that to be productive is the only manner in which to exist.

Chapter 5: Analysis

The narratives presented by the participants in this study have provided an intriguing glimpse into the possibility of understanding resilience through a Foucauldian perspective. The exploration of these narratives has highlighted the uniqueness of each story but has also suggested a number of similarities. Firstly, the plots of the stories seem to mirror the way in which resilience is conceptualized within the literature; namely, as either a protective or restorative mechanism. Secondly, understandings of governmentality have an apparent focus in neoliberalistic discourses of productive and individuality that also emerged within my interpretation of the life stories shared during this work. Lastly, a closely related point is the use of medications and other treatments to control the self in order to exist within a neoliberalist society. These three ideas speak loudest in considering the narratives within this work alongside the work of other scholars.

Resilience as Restoration and Protection

The plots of the stories provided by participants bear a striking similarity to dominant ways in which resilience is presented within the research literature. In particular, an examination of Katie's story – which can be characterized as one where the protagonist is high-achieving, encounters adversity and then recovers through the aid of medical support – mirrors the way a number of authors (e.g., Hobfoll et al., 2009; Marttila et al., 2013; Tugade & Fredrickson, 2004) understand the concept of resilience. This conceptualization of resilience also corresponds with the work of Davidson and Roe (2007); specifically, that *recovery in* best captures the experience of coping with mental illness as it describes a process of learning to live with the effects of illness. It is noteworthy

that an organic understanding of mental health diagnoses underpins the writings of many of the cited authors, as well as the narrative of Katie. This understand perhaps reflects the historical relation between this conceptualization of resilience and its origins in the field of biology (Davydov et al., 2010).

The plots of the stories of the other two participants seemed to be best explained through understanding resilience as a protective phenomenon. Both Michelle and Lucy were able to function at high-levels with little medical intervention, suggesting that they were buffered from the assumed negative effects of their diagnoses. Both were able to raise families, complete university and find employment while experiencing the symptoms of their diagnoses. In this way, their experiences would seem to reflect the work of authors who believe that resilience protects individuals from adverse conditions (e.g., Brinkman et al., 2011; Gardner et al., 2008; Johnson & Beamer, 2013; Kulis et al., 2011; Luthar, 1991; Ungar, 2006, 2011; Ungar & Liebenberg, 2009; Wallace, 2012). The subtleties within these stories, however, should not be ignored as it was evident that the supposed protective effect of resilience was far from complete. Each narrator poignantly conveyed the difficulties they faced within their lives and should not be trivialized by reducing their story to one of empathetic achievement.

Resilience as Governmentality

A recurring notion within the narratives explored were the related ideas of production and function. More specifically, the context in which production and function emerged was within that of desire, as participants noted that they desired to be productive individuals who were capable of functioning within society. This is perhaps suggestive of

the discourses of neoliberalism successfully pervading society to the degree that responsabilization (Rose & Miller, 1992) has extended beyond systems and structures, and has become an object of desire. The need to perform and function was a key motivator within each narrative and suggests that not only has the responsibility for maintaining health and wellbeing been downloaded to individuals (George & George, 2013; Teghtsoonian, 2009), but that individuals themselves have constructed their identities to include responsibility as a core trait. Each participant emphasized the role of individual action in their stories while the obligations of institutions were scarcely mentioned. The desire of participants to act in their own best interests is congruent with the neoliberal desire for smaller governments (Rose & Miller, 1992). For participants to require greater former support, this necessarily requires further administration and would eventually result in larger governments and greater government spending (Joseph, 2013). This desire for independence then may be a recasting of neoliberalism as self-governance.

The eventual end-goal of this self-governance, as noted by Baker (2002), is to render invisible disabilities of all sorts. The stories presented here suggest that this result may have been accomplished with some success. The reluctance in which participants discussed their diagnoses, the ways in which participants sought to control their diagnoses, and, above all, the ways in which participants sought to fit in and behave like others, suggest that governmentality as new eugenics (Baker, 2002) may be a notion relevant to understanding mental illness. While social models of disability argue that impairment is not a necessary result of disability (Hiranandani, 2005), it is unclear what might result if disability is destroyed through self-government.

Treatment as a Technology of the Self

In reading resilience as a type of governmentality, treatment modalities must then be read as ways of enacting that control of the self, a type of technology. Katie's story provides likely the clearest account of such a situation. Her use of medications allowed her to affect the unaffected and control something that would be typically be beyond her control. Together, her story and Lucy's reflects treatment based on a biomedical understanding of mental illness (Poole et al., 2012). While Michelle's narrative is absent of medications, her use of therapeutic techniques to control her thoughts is somewhat analogous to the use of medications. In both cases, the treatment undergone takes on the function of a controller of symptoms within the life of the narrator.

Michelle's case, however, deserves further analysis as the use of a therapy to control actions has other implications. In this situation, the use of techniques to affect thought, mood and actions require a level of active agency that it somewhat different from the use of medications. The requisite agency to control through technique suggests a different flavour to this possible example of governmentality. In all the stories examined, a diagnosis necessitated a constituting of the self as "abnormal" or "disordered" which led to the undergoing of treatment as the obligatory next step but in Michelle's story, the diagnosis of a personality disorder required a labeling and continued labeling of thoughts, mood and actions as "disordered" that was on a different scale than others. For Michelle, the constituting of the self was perhaps an event that may have occurred a number of times each day. The use of the treatment as prescribed course of action after constituting the self as "disordered" seems to keep with Tremain's (2001) description of the productive aspect of power.

Chapter 6: Conclusion

The exploration undertaken here is one of the first empirical studies done in an attempt to examine the idea resilience through the lens of governmentality. The findings and analysis suggest that reading resilience as governmentality may have some empirical bases, but further research is required to more thoroughly investigate the ways in which the concept of resilience may govern the self within the context of mental health. In undertaking such an investigation, it may become possible to shift the discussion on mental health from a place of governance to a place of emancipation. While it is beyond the current work to answer the question of whether this reading of resilience will generate dialogue around the ways that the concept of resilience may be used to transform and to challenge status quo relationships of inequality, it is my hope that even if this conversation does not occur, that it becomes an option in the future.

The topic of resisting the status quo through resilience concepts must be situated within the findings of this work and, specifically, within the tension between the individual and the system. This work has proceeded on the basis that the current system is unjust and has suggested that the conditions that allow for the existence of the concept of resilience is an artefact of that injustice. The facile conclusion may be that the system must adapt itself to better accommodate diversity, as some notable authors have argued (e.g., Poole et al., 2012). In the current work, however, I feel that such a conclusion goes against the tone and spirit of the stories I have had the privilege to be part of, as a desire for “normality” and to function in ways similar to others have been dominant within each narrative. I suggest that this tension between the individual and the system, when situated within the narratives given, may require us to look beyond a dichotomous relationship.

The move from a dichotomous, mutually exclusive, binary of individual and system may be appropriate in considering the needs of the individual. The desire to function and be like others, while can be considered a symptom of the productive means of power, is an outcome desired by some within the c/s/x community. If this is the case and the wishes of c/s/x community members are to honoured, as is suggested by the professional values of social work (Harms & Pierce, 2011), this creates a further complication that may not be easily resolved. Plainly, if resilience is a self-governance concept which reproduces inequality, then the abolishment of resilience and inequality may have to be undertaken together. But if resilience is also a desirable trait, according to the people served by social work, the path forward is less clear. What is the proper treatment of a concept that may be both oppressive and empowering?

This discussion extends far beyond the current work, in its examination of the nature of the relationship between individuals and their discursive environments (e.g., Butler, 2001), the possibilities of micro resistance (e.g., Hardt & Negri, 2009) or the creation of knowledge with an awareness of its political ramifications (e.g., Potts & Brown, 2005). It is my suggestion, however, that the current work may add a modest amount to these conversations and that, perhaps, the move toward social transformation may require conversations regarding the transformation of the self. It would seem that the desire to compete in a neoliberal environment, may be an act of erasure but could also be situated within the discussions concerning the use of the *master's tools* (e.g., Strega, 2005). It is difficult to envisage conditions in which becoming “normal” does not translate to seeking membership within dominant groups.

A possible way through these difficulties may be to engage in complementary explorations concerning resilience and social transformation. The participants within this study seemed to have suggested that the need for resilience is rooted in pragmatic concerns, as less resilient individuals trend toward physical extinction. The difficulty in proceeding in this line of reasoning without consideration toward social conditions lies within the trend toward the possible extinction of dialogue regarding social inequality and inclusion. Perhaps it may be relevant to examine the ways theories and actions aimed toward social transformation may complement the very real need for resilience to survive in harsh and difficult conditions. How that dialogue might unfold and how the challenges within that dialogue may be navigated, I believe is an avenue for further research.

In closing, the current work has attempted to investigate whether reading resilience as a type of governmentality might be reflected within the narratives of those who have used the mental health system. In analyzing the stories provided by the participants of this study, it was found that a Foucauldian reading of resilience was indeed possible, but the extent to which this might be done is something that I believe may be a topic for future research. A somewhat unexpected finding was the desire of participants to take on the self-governing elements of resilience and this desire to self-govern resulted in the need to consider the apparent tension between a social justice position, which might consider self-government of all forms to be closely linked to oppression, while simultaneously espousing a need to honour the perspectives of service users. While I do not know if this tension can be resolved, I believe that this work aids in furthering an understanding of this tension.

Appendices

Appendix A – Consent Form

CONSENT FORM



CONSENT TO PARTICIPATE IN RESEARCH

Narratives on the Experience of Resilience in Mental Health Settings

You are being invited to participate in a research study. Please read this Consent Form so that you understand what your participation will involve. Before you consent to participate, please ask any questions necessary to be sure you understand what your participation will involve.

INVESTIGATORS

This research study is being conducted by Philip Mach, a graduate student from the School of Social Work at Ryerson University in partial fulfillment of a Masters of Social work under the supervision of Dr. Henry Parada. The results of this study will be used to complete a major research project and for possible publication.

If you have any questions or concerns about the research, please feel free to contact Henry Parada, Faculty Supervisor, at hparada@ryerson.ca, phone: 416-979-5000 ext. 6223 or the Principal Investigator, Philip Mach, at pmach@ryerson.ca.

PURPOSE OF THE STUDY

The purpose of this study is to gather stories on what it is like to live with mental illness. The focus of the study is to learn more about the ways those with mental illness manage their day-to-day lives.

3-5 people are being asked to participate in this study. Only people who have said that they live with mental illness have been asked to participate.

DESCRIPTION OF THE STUDY AND YOUR PARTICIPATION

If you volunteer to participate in this study, you will be asked to do the following things:

A researcher will interview you about living with mental illness. During this interview, the researcher will ask you some questions about your experiences.

The interview will take about an hour and a half and will take place in quiet location near Ryerson University. During the interview you might be asked about the kinds of things you do to manage your mental illness. Some example questions or things you may be asked to talk about are:

What kinds of things do you do that you think are important for managing your mental

illness?

Describe a time when you feel like you were doing well.

For this study information on your age, gender, name and mental health diagnosis will be collected. The interview will be audio recorded and transcribed. If you are uncomfortable with being audio recorded, the interview can be done without being recorded.

After the interview, you will be contacted about a follow-up session. You will be given the chance to check the transcript of the interview. If you find anything on the transcript that you would like removed, tell the researcher at that time and it will be removed and not used in the study.

A copy of the research findings is available to participants. A copy can be sent to you by mail or email if you provide the researcher with your contact information.

POTENTIAL RISKS AND DISCOMFORTS

The risks in this research are low.

Some of the questions may be personal and may bring up difficult memories. This may make you feel uncomfortable or distressed. If that happens, you may choose to take a break or not answer the question. If you feel like you would like to stop the interview at any time, it is your right to do so.

In sharing your stories with the researcher, others may be able to identify who you are. You will be given the chance to review your interview transcript with the researcher to remove things that you do not want to be included in it. The researcher will also remove information that might suggest you are when reporting on your interview.

The researcher has provided you with a list of referrals that you may contact for more support.

POTENTIAL BENEFITS TO PARTICIPANTS AND/OR TO SOCIETY

This study will help researchers get a better understanding of what it is like to live with mental illness and the types of things people living with mental illness think are important.

You may find that talking about your life experiences may help you feel heard and supported.

I cannot guarantee, however, that you will receive any benefits from participating in this study.

PAYMENT FOR PARTICIPATION

You will not be paid to participate in this study.

CONFIDENTIALITY

The researcher will be audio-recording and taking notes during the interview. The audio-recording will then be transcribed. You will be given you a participant number or you may choose an alias that will be used to identify which audio-recording and transcript is yours. A list will indicate your participant number or alias and will be kept in a locked filing cabinet.

The raw audio-recordings and transcripts will be kept on a password-protected computer that only the researcher will be able to access. The transcripts will be edited to remove any identifying information. The transcripts will be used to complete a research project and others may be involved in analyzing your transcript. The transcripts may also be used for article publication.

Confidentiality will be maintained to the extent allowed by law.

You can review or edit your transcript. The researcher will contact you when the your transcript is available for review or edit and you will have 2 weeks to do so from that point.

The audio-recordings and transcripts will be destroyed within two years.

VOLUNTARY PARTICIPATION AND WITHDRAWAL

Participation in this study is voluntary. You can choose whether to be in this study or not. If you volunteer to be in this study, you may withdraw at any time without consequences of any kind. If you choose to withdraw from this study you may also choose to withdraw your data from the study. You may also choose not to answer any question(s) and still remain in the study. You may request that the interview be done without audio recording. Your choice of whether or not to participate will not influence your future relations with Ryerson.

QUESTIONS ABOUT THE STUDY

If you have any questions about the research now, please ask. If you have questions later about the research, you may contact:

Philip Mach
pmach@ryerson.ca

This study has been reviewed by the Ryerson University Research Ethics Board. If you have questions regarding your rights as a research participant in this study, please contact:

**Toni Fletcher, Research Ethics Coordinator
Research Ethics Board
Office of the Vice President, Research and Innovation
Ryerson University
350 Victoria Street
Toronto, Ontario M5B 2K3
416-979-5042 or toni.fletcher@ryerson.ca**

SIGNATURE OF RESEARCH PARTICIPANT/LEGAL REPRESENTATIVE

Your signature below indicates that you have read the information in this agreement and have had a chance to ask any questions you have about the study “Narratives on the Experiences of Resilience” as described herein. Your questions have been answered to your satisfaction, and you agree to participate in this study. You have been given a copy of this form.

Name of Participant (please print)

Signature of Participant

Date

Your signature below indicates that you are providing consent to be audio-recorded for the study “Narratives on the Experiences of Resilience” as described herein.

Name of Participant (please print)

Signature of Participant

Date

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