

WHITE TRAUMA:  
TRACING TRAUMA INFORMED RECOVERY AND WHITE SUPREMACY IN SOCIAL  
WORK PRACTICE

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## ABSTRACT

### WHITE TRAUMA: TRACING TRAUMA INFORMED RECOVERY AND WHITE SUPREMACY IN SOCIAL WORK PRACTICE

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This qualitative research study examines how five prominent recovery oriented community based organizations talk out loud about themselves, their service population and recovery. Using a critical discourse analysis, pervasive discursive patterns were revealed through thematic analysis. This study details the way in which trauma-informed care quietly manifests alongside the same guiding principles as the recovery model, creating a compounded site of power whereby one lives both inside and outside the bounds of the other. The purpose of this study is to call attention to the illusive nature of these widely-celebrated models, disrupting the unchecked, institutionalized supremacy of the whiteness that prevails within. Applying the concept of creaming to social service provision in Toronto, this study makes the claim that white trauma is centred within recovery oriented service construction and provision given it causes the least structural disruption. This process ultimately sustains the feel-good culture that envelops recovery based and trauma-informed social work.

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## CHAPTER 1: INTRODUCTION

Trauma lives in the body, mind and heart. It infringes on how we experience ourselves in the world, on how we experience ourselves in relationship to others. It produces dream-like states in our waking life and real life remembering while we sleep. It gets reduced to terms like PTSD, dissociative identity and borderline personality disorder. I invoke the survivor-oriented “we” to situate myself as one who lives with trauma amongst many. As I move into the following chapters, I would like to express to the reader that in my subsequent critique of trauma-informed types of caring, I am not debating the reality of suffering that traumatic exposure breeds. I am also not disaffirming the presence or frequency in which survivor narratives are shared and held in social work practice. What this work has sought to do is to call attention to the relationship between trauma-informed care, the recovery model and the medical model. The infiltrative and unquestioned reliance on these frameworks has meant a continuous failure to acknowledge the way in which they centre white trauma. Important linkages are made within this research that reveal these frameworks as an extension of whiteness and white supremacy, creating racist discrepancies in care.

While obtaining my undergraduate degree, I concurrently held an ongoing contract position in a local recovery program. Using a “trauma-informed” approach was foundational to our work with families in the community and was said to promote and facilitate recovery from early childhood and substance use related traumas. I watched families thrive, returning each week for group programming, parenting groups, counselling, doctor’s appointments and opening their doors to home visiting. We called them *superheroes*. It felt good to surrender myself to such a framework and to watch people advance within it. However, understanding emerges in its own time and as such, questions began to surface. I started to question: *Am I a believer?*

I have sat in quiet critique, “for any critique of recovery is seen as a personal attack” (Poole, 2011, p. 63). Recovery practice is both extremely powerful and surprisingly fragile. It is also stealth; so common and invisible that many of us do not realize we are engaging it and we protect it at all costs when we do. If critique is out of the question, then I’m calling this work an indictment of the recovery model, of all its soldiers (myself included) and of the “trauma-informed” tools by which it is sustained. The current framework of trauma-informed care embedded in mental health recovery is one that neglects the reality that “oppressed people are routinely worn down by the insidious trauma involved in living day after day in a sexist, classist, homophobic and ableist society” (Burstow, 2003, p. 26). Ambiguous and malleable, current recovery practice is far too comfortable a place to sit as a practitioner.

This research holds itself as my first attempt at depicting how an internalized kaleidoscope whitewashes the pathologizing nature of such celebrated frameworks and works to individualize social problems (Gilfus, 1999; Lewis, 1999; Root, 1992 cited by Burstow, 2003). Perceptibly, routine administrative procedures and professional technologies bolster the supremacy of the recovery model by filtering service populations based on their perceived ability to comply with its principles. In sitting with this reality, it became apparent that we are all collectively implicated in either/both the perpetuation and inheriting of trauma. The construction of a “trauma-informed” recovery framework is recognizably used in service provision to differentiate marginalized populations who are forced to live out their traumas in the public arena.

As a white settler from northern Ontario, my privilege has been routinely reinforced and depicted through normalized institutional violence and blatant anti-Indigenous racism operating within the community. Raised by a city fraught with bigotry and unrelenting violence, I grew

acutely aware of the protections that whiteness has offered me. Moreover, that it has dictated my access to personal freedoms that fulfill my basic needs, as well as to the social, ideological and institutional frameworks from which I specifically benefit. Returning to this formative place of learning remains foundational to my ongoing interrogation of what it means to occupy such imbalanced privilege. Through my engagements with this topic, it has become clear to me that the combination of my white privilege as it relates to my own diagnosis, means that I am an ideal candidate for frameworks such as trauma-informed care and recovery frameworks. Moreover, at times during my practice experience, I quietly knew that it was my own set of privileges materializing that created the conditions in which I could distance myself from my diagnosis and be perceived as the “professional”. I often felt in disguise. In my elite seat, I conducted mindfulness exercises, grounding activities and disseminated emotional regulation tactics. I grew accustomed to the expectation that, no matter the toll, I was to fragment myself between mad/“sick” or professional, whereby one presumably can only be performed in total absence of the other.

Recovery-oriented frameworks umbrella all social work practice in some capacity. Our job within neoliberal social work is to move our clients from one destination to the next; to help them recover into another set of problems to be addressed by the next worker. As Klein & Mills (2017) note, “[t]he remedy within neoliberal and psychocentric logic lies in changing individuals and not structures” (p. 1999). Inescapably, service users are inundated with recovery talk, whether it relates directly to recovering from a specific addiction, violence, “mental illness” and trauma or more vaguely, from homelessness and poverty. Perceptibly, the notion of “living well” is shaped by the naturalized domination of the “sane”, well-behaved, middle class, white

standards to juxtapose the mad, the non-Western, and/or the racialized Other (Said, 1978 cited by Pon, 2009).

The deeper I dug into the local recovery landscape, the more pronounced the practice of creaming appeared as a tool by which service provision and access is stipulated. Creaming has yet to be taken up in the context of Canadian mental health services. The literature revealed that creaming has exclusively been explored in relation to “welfare-to-work” employment programs, health care and private education in the United States (Bell & Orr, 2002; Ellis, 1998). Creaming refers to the process by which individuals are selected for service or intervention provision based who is perceived to: “(1) most likely [...] benefit from the program or (2) experience the highest absolute outcomes in the absence of program services” (Bell & Orr, 2002, p. 279). Indisputably, this decision-making process is highly problematic and stipulated by racist, sanist, ableist, gendered and classed assumptions related to assumed capacities that motivate the violence of low expectation. It also signals power hoarding in that systems of authority limit, deny and block the advancement of marginalized people based on these violent assumptions. Moreover, the process of creaming is distinctly concerned with “high performance” individuals who stack the deck in favour of the program rather than addressing the existing gaps which bring people to these programs in the first place. Often, these carefully selected, “high performance” individuals are able to perform in the ways that these programs stipulate given that their needs are typically less dependent on structural change.

Given the pervasiveness of recovery oriented and trauma-informed models embedded within social services, it felt necessary to critically examine how these models are operating locally. Moreover, using a critical discourse analysis emphasized the way in which repeating slogans and prominent discursive patterns in these contexts interlock to reinforce hegemonic

institutional power and authority. In turn, these powerful and interconnected systems influence the way in which psy-affiliated professions, such as social work, conceptualize and purposefully limit understandings of trauma. This process creates the conditions in which service users are unjustly pathologized and responsabilized to recover from manifested top-down violence.

Moreover, this work engaged the way in which clients are understood within these agencies depending on their assumed compatibility with the principles of recovery and trauma-informed care. Finally, attention is called to the shape shifting nature of the recovery model, given this model holds an expressed relationship to trauma-informed care. Both employ seemingly identical theoretical principles that signal an ever-tightening grip of psychiatric authority and dominance.

## CHAPTER 2: LITERATURE REVIEW

### *Overview*

In my review of the literature, a number of discernible themes came to light that call into question the “person-centred” basis on which mental health services are supposedly constructed. Importantly, the literature revealed that the concept of recovery in mainstream mental health is a distinct articulation of the white values and norms of the dominant society. Diverging from the blatant violence exercised by the forensic mental health system, Community Treatment Orders and Assertive Community Treatment (ACT) teams which target non-Western and racialized “mentally ill” persons (Joseph, 2014), this literature review revealed a different kind of insidiousness that is specific to a recovery paradigm. The themes from the literature create a dialogue within this multilayered experience and are as follows: the colonization of healing; recovery as a convoluted trail; risk discourse; trauma-informed recovery care; fear, stigma and privileged narratives.

### *The Colonization of Healing*

The current state of mental health based social work is one that is governed by outcomes, expertise, bureaucracy, “best practices” and neoliberal commodification (Aadam & Petrakis, 2020; Flintoff, Speed & McPherson, 2019). Notably, “mental health programs are typically based on Western knowledge” and therefore the concept of recovery remains “a Western middle class club meant only for those who can afford this particular kind of empowerment” (Cheng et al. 2008 cited by Lavallée & Poole, 2010, p. 272). Given the authority of the mental health system in Canada and its interconnected relationship with all other mass institutions, whiteness maintains its powerful, ideological stronghold over what it means to be and live well.

As a result, diverse cultural understandings of healing have been purposefully delegitimized so that they may be more easily co-opted through white professionalizations of healing and recovery. According to the qualitative research study conducted by Sparkes (2018), there are four interpretive repertoires of recovery: traditional (i.e. clinical); responsabilised-progressive; getting on in the world and connectedness (p. 1740). The findings reported by Sparkes (2018) exclusively discuss “traditional” and responsabilised-progressive repertoires and ignore the latter two. The repeated use of the term “traditional” knowledge is used to communicate that it is “clinical” knowledge, and signals colonial assertions of false superiority that continue to be operationalized through mental health discourses embedded in recovery oriented practice. Although Sparkes (2018) confirmed that recovery is contentious and “polyvalent”, their insistence on merging multiple perspectives of recovery clearly lies within the confines of a white conceptualization and value system in which “mental health recovery” distinctly operates.

Contrary to Sparkes’ (2018) assertions, Hadjipavlou et. al (2018) identified from their qualitative, semi-structured interviews that there are five overarching themes to recovery and healing for First Nations peoples: “experiencing healing after prolonged periods of seeking and desperation; strengthening cultural identity and belonging; developing trust and opening up; coping with losses; and engaging in ceremony and spiritual dimensions of care as a resource for hope”. Importantly, the authors reflect that conducting research in a clinical setting meant that further acknowledgement of the “wider social context” was necessary, and therefore the results were relatively specific to their service population. Furthermore, the merging of Western and Indigenous ways of knowing embodied by this research speaks to the concept of “two-eyed seeing” whereby both knowledge systems are recognized as holding value (Martin, 2012). Using

a two-eyed seeing approach might ultimately foster more inclusive, multifaceted and culturally relevant understandings of recovery, rather than subjecting service users to a competitive knowledge base predicated on notions of superiority.

### *Recovery as a Convoluted Trail*

The concept of recovery has been widely written and re-written about by many mental health recovery “kingpins” (Copeland, 2002; Deegan, 2002; Slade, 2009). Questionable distinctions have been made between the trans-theoretical Personal Recovery Framework and supposedly more prescriptive, practitioner-driven clinical recovery monitoring and interventions such as Illness Management and Recovery (Slade, 2009; Slade et. al, 2014). However, the multiplicity of interpretations, definitions and adaptations of “recovery” amongst mental health practitioners, scholars and advocates, means that recovery has become a site of contentious debate. Within these often contradicting boundaries, one’s recovery is unanimously stated to occur in a non-linear process that will inevitably change over time (Slade et. al, 2014). However, this imprecision means the organizations and individual practitioners who tout “recovery” can shapeshift it’s meaning to suit any given interaction. Although recovery is lauded as a non-linear process, organizational adherence to “relapse” discourse, as well as to the construction of the “treatment resistant” client, is highly indicative of linearity which predominantly produces varying degrees of institutional repercussion for divergent behaviour.

Despite adhering to a larger set of rules or goals such as within Wellness Recovery Action Plan (WRAP) programs or the Connectedness, Hope and optimism, Identity, Meaning in life and Empowerment (CHIME) framework, practitioners may exercise their individual discretion, also known as “clinical judgement”, on a situational basis. Unignorably, such

frameworks place emphasis on the eventual goal of “self-management” (Pratt et. al, 2013) whereby one is arguably taught “self-management” by being “managed” by the mental health practitioner. Furthermore, administrative and prescriptive language is tied to a process that is considered “deeply personal” and “subjective” (Slade et. al, 2014) and signals an underlying set of expectations that influences how we conceive of service users in recovery. These elusive, non-specific expectations steeped in “clinical judgement” make it difficult, if not impossible, for both the service user and the practitioner to know exactly what recovery is and how to do it.

Given the competing and circumstantial interpretations of recovery, contradiction is inevitable. For example, in their qualitative study, Elms et. al (2018) provides us with insight into the specific barriers that block access to such programming for substance involved mothers who have been diagnosed with a “mental illness”. Their study elicited maternal concerns regarding child welfare involvement should they risk disclosing substance use. Furthermore, mothers in this study described the unclear obligations of treatment and recovery (p. 6). Conversely, the semi-structured interviews conducted with mental health professionals by Nolan & Quinn (2012) report that mental health practitioners believe that “taking risks is heralded as a key component of [...] recovery” (p. 176). Notably, this perspective assumes “risk-taking” to be indicative of one’s “commitment” to their recovery and ignores the potential for life altering, damaging effects such as child welfare or criminal justice involvement. Thus, taking risks in this context assumes that the risk-taker is one who is relatively privileged, has less to “lose” so to speak, and can therefore “trust in the process” with credulous faith because the stakes are significantly lower.

*The Business of Risk*

Aadam & Petrakis (2020) argue that the “focus of mental health services remains on the concept of risk” (p. 14). Generic administrative procedures and guiding policies embedded in mental health social work practice emphasize a multiplicity of “risks” associated with doing mental health social work -- “risk assessments”; “high risk clients”; “risk and dangerousness in mental health social work”; “working on the edge of risk”; “risk taking” and “risk responsibility” (Flintoff, Speed & McPherson, 2019; Nolan & Quinn, 2012; Ryan, Healy & Renouf, 2004; Sweeney, Gillard, Wykes & Rose, 2014). This type of rhetoric is common and implies a certain type of heroic saviorism when we cross into “dangerous” terrain to support “high risk” clients. It also makes the sanist assumption that service users are an inevitable risk - to the practitioner, to themselves and to society at large. Operating on an axis of power, the assumption is that social workers are routinely put “at risk” by “high risk” clients, which convolutes how these insidious and profound risk oriented discourses function to further marginalize service users within imposing systems of power.

Risk assessment criteria and other depersonalized, administrative materials can be understood as the tools by which “risk” is both constructed, measured and then managed (Flintoff, Speed & McPherson, 2019; Ryan, Healy & Renouf, 2004). Moreover, these assessment tools ensure worker safety and agency liability within the administrative bodies and other powerful institutions in which these documents circulate. Flintoff, Speed & McPherson (2019) confirm this suspicion, noting the overemphasis on administrative tasks “demonstrates how recording information that could be utilized for decision-making processes” such as adhering to external reporting mandates, are “prioritized over other aspects, such as the client’s perspective or experience” (p. 665). The literature distinctly revealed the way in which risk assessment tools are utilized by service providers in tandem with their clinical “expertise” to

deny, limit or violently enforce mental health interventions onto or away from service users (Ryan, Healy & Renouf, 2004; Sweeney, Gillard, Wykes & Rose, 2014).

### *Trauma-Informed Recovery Care*

The concept of trauma-informed care (TIC) permeated the literature concerning recovery based mental health “interventions” (Elliott et al., 2005; Knight, 2014; Mihelicova, Brown & Shuman, 2018; Watson et. al, 2014). According to Watson et. al (2014), trauma-informed practice in mental health recovery recognizes “the high prevalence of prior trauma for people who experience mental health problems” (p. 535). In essence, the trauma-informed practitioner contextualizes client behaviour within a framework of understanding that recognizes and centres the impact of historical traumatic exposure (Knight, 2014). Knight (2014) states that “the worker acknowledges the trauma directly and responds empathetically, but does so in a way that is consistent with her or his professional role” (Glover et al. 2010; Karatzias et al. 2012 cited by Knight, 2014, p. 27). Failure to adhere to professional boundaries within TIC is said to “lead the worker to extend her or himself in ways that move the relationship away from a professional one into a realm that is more personal in nature” (Knight, 2014, p. 27). Expressly, integrating these practice perspectives are said to facilitate change from coercive mental health approaches which tend to isolate presenting challenges from past experiences (Watson et. al, 2014).

TIC operates within multiple frameworks, all of which prioritize a principled approach to engaging in this type of practice. At its core, TIC promotes the following: “physical and emotional safety; [...] trustworthiness; [...] choice and control; [...] collaboration’ [...] empowerment; [...]” (Fallot and Harris, 2006 cited by Mihelicova, Brown & Shuman, 2018, p. 144). Similarly, Knight (2014) declares that the “four-fold principles of trauma-informed

practice [are]: normalizing and validating clients' feelings and experiences; assisting them in understanding the past and its emotional impact; empowering survivors to better manage their current lives; and helping them understand current challenges in light of the past victimization" (Courtois 2001; Martsof and Draucker 2005; Wright et al. 2003 cited by Knight, 2014, p. 28). This is supposedly done through "cognitive-behavioural strategies" that challenge "[survivors] distortions in thinking" and assist them in recognizing "the connection between present difficulties and the past trauma" (Knight, 2014, p. 29).

Evidently, psy-concepts and discourses are what shape trauma-informed practice/care as a conceptual framework and ultimately reveal its close proximity to psychiatry and the medical model. Unignorably, TI practices attempt to covertly confine trauma within the bounds of the individual and their past experiences and present circumstances, cognitively severing the relationship between trauma and socio-political environments. While fostering and maintaining "safety" was repeatedly expressed as a central tenet of TIC (Knight 2014; Mihelicova, Brown & Shuman 2018; Watson et. al, 2014), the act of depoliticizing manifested trauma or properly rooting it within the systems that facilitate top down violence is indisputably dangerous. Moreover, the foundation of whiteness from which TIC is distinctly operating simply allows for practitioners relying on this framework to pivot away from the realities of structural violence facing service users.

Mihelicove, Brown & Shuman (2018) argue that "trauma may be a consequence of social factors such as poverty and a precipitating factor for mental health and substance use issues, as well as homelessness" leaving people vulnerable to further trauma exposure (p. 141). Seemingly advancing a structural perspective within TIC, these authors go on to attribute "personal characteristics"; "the immediate environment"; and "sociocultural and political factors" as

impacting trauma response (p. 142). Implicating one's "personal characteristics" is not only dangerous and evasive, but also promotes a resilience discourse in which individuals are pitted against themselves depending on how the practitioner perceives how well clients engage with their own trauma. Including this component simply ensures that the individual can be used to offload social, structural and political culpability. Similarly, Knight (2014) states that "survivors' sense of self-efficacy, their ability to cope with challenging events in the future, and their spirituality can be enhanced as a result of exposure to trauma"; this is called "posttraumatic growth" (p. 26). Although taking a seemingly oppositional stance to Mihelicove, Brown & Shuman (2018), this assertion functions on the same intention. Simply, the concept of "posttraumatic growth" operates to reduce, dismiss and deny the survivor experience.

Furthermore, Mihelicove, Brown & Shuman (2018) make the claim that "systemic issues of marginalization, oppression, and stigma *may* intersect with trauma" (p. 142). Citing data collected about "mothers experiencing homelessness and mental illness", Mihelicove, Brown & Shuman (2018) reiterate the study's assertion that one is forced to choose "one form of oppression over the other" such as returning to an abusive relationship in order to secure housing (p. 142). This approach to understanding trauma is ultimately individualistic and additive. The inference that one supposedly exercises personal choice in relation to the extent to which they experience oppression or in what combination they experience it, is profoundly violent. This perspective ignores the way in which institutions and systems work together to modify, limit or prohibit access to basic needs, such as housing, to escape such violence. Moreover, this perspective is responsabilizing. It implies a type of self-motivated management of oppression and denies compounded manifestations of systemic violence, ultimately evading accountability.

Seemingly, TIC has emerged as a new tool used to further compound diagnostic processes within the mental health system given that it blatantly assigns authority to service providers to wield their expertise in the pathologizing of trauma. Apparently, “recovery from trauma” is identified as “a primary goal” of trauma-informed service provision which is said to occur through ensuring that “every interaction is consistent with the recovery process and reduces the possibility of re-traumatization” (Elliott et. al, 2005, p. 462). This blatantly signals the interconnected relationship between the recovery model and TIC, so much so that one becomes invisible within the other.

Interestingly, Elliott et. al (2005) argue that “best practice” requires the service provider to “treat all women as if they might be trauma survivors” (p. 463). In contrast, Knight (2014) asserts that “trauma informed practice doesn’t mean that the practitioner assumes the client is a survivor” (p. 26). Moreover, “the development of the therapeutic alliance... is often a daunting challenge with an interpersonally victimized [client]. The [worker] may be perceived as a stand-in for other untrustworthy and abusive authority figures to be feared, challenged, tested, distanced from, raged against, sexualized, etc.” (Courtois 2001, p. 481 cited by Knight, 2014, p. 26). Furthermore, the literature repeatedly uses survivor-centred language while inherently creating a nuanced depiction of “victimization” whereby a survivor worldview is consistently described as “distorted” (Knight, 2014); their attachment style portrayed as skewed; and their ability to connect past and present experiences as non-existent.

Finally, the literature consistently described “lack of trust” exhibited by trauma survivors as *symptomatic*, and thus pathological, rather than as a deep and knowing attunement to the power and control held by the service provider (Elliott et. al 2005; Knight 2014; Mihelicova, Brown & Shuman 2018; Watson et. al 2014). Evidently, the success of TIC is dependent on the

service user's ability to engage in a larger process of uninhibited trust in the "therapeutic alliance". Elliott et. al (2005) state that "[u]nacknowledged or untreated trauma and related symptoms interfere with seeking help for health, mental health, and substance abuse problems" (p. 463). This type of paternalistic thinking ultimately assigns absolute healing authority to the mental health system and falsely ascribes "untreated trauma and related symptoms" as the sole reason for avoiding such institutions. This assertion ultimately denies the legal, social and interpersonal risks of these types of service engagements. Most importantly, this perspective assumes a position of authority and ignores the multiplicity of interpersonal and community healing rituals that more effectively and intimately foster healing. Finally, "trust" in these contexts can only be understood in relation to the power and privilege maintained by the service user whereby those who are able to trust in these settings are those who are not already and routinely violated by the system.

### *Fear, Stigma and Privileged Narratives*

Sweeney, Gillard, Wykes & Rose (2014) make the assertion that diagnostic mental health labels create a forced confrontation between the recipient and stigmas attached to such labels. The authors add that "whilst stigma is feared, it is not always experienced or negative" (p. 1080). This manipulative assertion ultimately gaslights pathologized persons away from the very real, hyperpresence of psychiatric authority and violence within mental health institutions. Moreover, it simultaneously downloads responsibility onto the stigmatized individual as a way to destabilize the legitimacy of their fear and to divert accountability away from the systems that impose and reinforce such harms. While their study acknowledges the coercive nature of mental health services and related fears embodied by service users, they fail to properly renegotiate the

contours of fear as existing from top down diagnostic power dynamics that contribute to the overall surveillance and stalking of persons interacting with these systems.

Further, Sweeney, Gillard, Wykes & Rose (2014) state that fear is compounded by personal doubt in relation to their ability to “recover” from psychosis. They state “these fears link to power and control: the experiences of psychoses are unknown, their return unpredictable and their impact immense” (p. 1081). Strikingly, the authors centre power and control within the individual; that through accessing mental health support, people are expected to develop a more attuned understanding of their diagnosis and thus learn how to control symptomized expressions of it. This perspective explicitly ignores the immense power and control held by mental health practitioners, specifically as it relates to disseminating a white, psychiatrized perspective of individual experience and behaviours. This process simply naturalizes and therefore makes invisible the violence perpetrated through actions such as diagnostic organizing and resultant, often mandated, interactions between pathologized people and the mental health system.

Although mad scholarship has actively worked to delineate the authority of the biomedical model as it relates to understanding “mental health”, privileged recovery narratives still arise within the scholarly contributions of mad authors. Despite the fact that these contributions have been revolutionary in disrupting monolithic understandings of “mental health/illness”, there is still necessary critique to be had specifically around access and entry. For example, “survivor research” is “the experiential knowledge of service users engaged in sharing their experiences and knowledge” particularly through peer-support and is responsible for challenging positivist paradigmatic authority in research (Faulkner, 2017). However, there

remains an assumed baseline of privilege related to access and entry into the academy and other academic and professional spaces where collaborative research is constructed.

In using mad scholarship to make institutionalized, psychiatric violence visible, the inherent privilege within the ability to do so becomes subverted. Further, creaming is distinctly tied up in the production of scholarly narratives that are considered most palatable, in the behaviours that mimic wellness most convincingly and in the capacities of those who have mastered being mad on a deadline. As Poole (2011) notes, “recovery is only for the moderately mentally ill [...] not for those who are still in hospital, homeless or slipping through the cracks” (p. 60). The more easily the body and behaviour fits into white expectations of the rational and the credible, the less detectable the presence of distress, the more likely we are to be perceived as good, mad scholars with legitimate and valid experience.

### CHAPTER 3: THEORETICAL FRAMEWORK

For the purpose of this research, it was imperative that I employ a blend of critical race feminism, anti-colonial theory and mad studies given that these theoretical frameworks are all founded on critiques of dominant regimes of living and being. These particular theories create an important dialogue with one another that unveils the intrinsic relationship between constructions of madness and of race and is plainly predicated on a longstanding and ongoing legacy of colonialism and white supremacy.

#### *Critical Race Feminism*

Simply put, “critical race feminism seeks to understand how society organizes itself along the intersections of race, gender, class and other forms of social hierarchies” (Verjee, 2012). Born from critical race theory, critical race feminism emerged as a response to “racial and/or ethnic legal women scholars feeling excluded by their male peers and white feminist legal scholars” (Few, 2007, p. 456). Importantly, critical race feminism, in its theoretical orientation, is decidedly non-static, and is an important departure from positivist agendas of “traditional” research inquiry. This theory disrupts white elitism by centring “authentic voices [...] through the process of contextual critical thinking” (Few, 2007, p. 459).

Furthermore, critical race feminism “can be considered a theoretical extension of Black feminism when examining Black experiences” while also “contextualiz[ing] the sociohistorical experiences of any racial and/or ethnic groups” (Few, 2007, p. 457). Centring sociohistorical contexts and location “(i.e., those historical, geographical, cultural, psychic, and imaginative boundaries and axes of self-definition), [...] emphasizes the standpoint of [...] informants without essentializing experience or privileging one voice above others within and outside of the margins” (Sudbury, 1998 cited in Few, 2007, p. 459).

This theory blends aspects of both critical race theory and feminism by exploring the ways in which marginalization is further compounded at the specific intersection of race and gender (Childers-McKee & Hytten, 2015, p. 395). Few (2007) identifies that critical race feminism is “anti-essentialist” in nature, asserting that this theory is not additive and therefore one’s positionality must be taken up relationally, rather than formulaically. Given it’s legal and economic roots, scholars such as Kimberlé Crenshaw, Angela Harris and Adrien K. Wing have been cited as major players in the creation and development of critical race feminism. However, Few (2007) notes that typically those who employ this theory do not necessarily refer to themselves as such. Given that this theory is very much founded on the basis of experience, it is considered a theory that is very much embodied by those who employ it.

Because this major research paper examines race as an entry point into or away from recovery, this work could not function without critical race feminism. Using this particular theory as white, cis woman means that I must handle this theory with consideration, appreciation and in acknowledgement that it’s use by no means makes me privy to the experiences of racialized and impoverished women or persons. It is also necessary to acknowledge that I am directly benefiting in my academic pursuit from the efforts of Black female legal scholars, professionals and advocates.

### *Anti-Colonial Theory*

Anti-colonial theory is defined as the proactive, political struggle of colonized peoples against the ideology and practice of colonialism (Ashcroft, Griffiths, & Tiffin, 2000; Smith, 2012) [...] anti-colonialism can also involve all parties of this colonial relationship. It can thus include the support and actions of people of the colonizer group. Anti-colonial members of both groups challenge the power and operations of colonialism in political, economic, cultural institutions (Ashcroft et al., 2000), and social systems (Hart, 2009). Members of both groups can work together to question institutional power

and privilege and the rationale for dominance by one group of people over another (Hart, Straka & Rowe, 2017)

Anti-colonialism seeks to disrupt the oppression of Indigenous peoples inflicted by a white value system that colonization has violently forced to the centre. Importantly, this theory directly acts as a form of resistance to the historical and present manifestations of colonialism that continue to oppress and rob Indigenous populations of a fulsome relationship with their “belief systems, values, practices, resources, and lands” (Hart, Straka & Rowe, 2017, p. 334). Anti-colonial theory takes into consideration all sides of the “colonial relationship” and requires settlers engaged in this type of theoretical work to be conscious of the “settler move to innocence” (Tuck & Yang, 2012, p. 10 cited by Hart, Straka & Rowe, 2017, p. 334).

Importantly, Hart, Straka & Rowe (2017) teach us that settler “actions must always support Indigenous peoples’ self-determination, and it is always Indigenous people who determine “what is right” as anti-colonial action” (Hart, Straka & Rowe, 2017, p. 334). The use of this theory is action based and is a particular articulation of power renegotiation, as it specifically requires that settlers unsettle their groundless “authority” to foster a more relational collaboration based on the identified and directive needs of Indigenous peoples. Moreover, “without taking Indigenous sovereignty seriously, we remain complicit in a colonial order that continues to target Indigenous people for legal and cultural extinction” (Lawrence & Dua, 2005 cited in Tam, 2013, p. 283). In respect to this request, this work is completed as a responsibility that feels larger than an institutional, academic requirement. Moreover, the use of this theory supports my effort to unsettle and ultimately, put on trial the mental health system for its brutal pathologization and attack on Indigenous peoples. Anti-colonial theory places relationship and responsibility at its heart and my hope is that this work echoes that very sentiment.

It is here that I should note the level of difficulty I experienced in my search for peer-reviewed literature regarding anti-colonial theory. The absence of literature regarding this particular theory has led me toward a pertinent, critical observation. Amidst false assertions that anti-colonial theoretical knowledge is “new” knowledge, “Indigenous researchers have been working to make space in the academy for these ways of knowing that have not been previously recognized by the dominating societies or do not have wide acceptance in the Eurocentric academic context” (Hart, Straka & Rowe, 2017, p. 333).

I suspect that the cream-skimming of anti-colonial theoretical literature is due to the fact that it is an action based theory. Moreover, one of the major tenets of this theory requires the “support and actions of people of the colonizer group” (Hart, Straka & Rowe, 2017 p. 334). This means that settlers, specifically white settlers, must find meaningful ways to both notice and relinquish their own power, and most importantly, they must first be willing to actually do so. Anti-colonial theory perceptibly counters the idyllic and often vague, settler-rhetoric used to smokescreen the development of clearly defined, responsabilized action toward unsettling power, power sharing and decolonization.

### *Mad Studies*

incorporates all that is critical of psychiatry from a radical socially progressive foundation in which the medical model is dispensed with, as biologically reductionist, whilst alternative forms of helping people experiencing mental anguish are based on humanitarian, holistic perspectives where people are not reduced to symptoms but understood within the social and economic context of the society in which they live (Menzies, LaFrancois & Reaume, 2013, p. 2).

Mad studies take issue with the stronghold of the biomedical regime that problematizes individuals or individual behaviour and ignores the social, structural, historical and environmental elements in which people are understood to be unwell. Moreover, “mad studies

originated from consumer/survivor, user, refuser and expatient movements. It rejects a biomedical approach to the domain widely known as ‘mental illness’ or ‘mental health’ and substitutes instead a framework of ‘madness’” (Beresford, 2019, p. 1). Building a mad framework has been paramount to the disruption of top-down psy discourses that have long enforced a binary between the mentally “ill” and the not. It has also tirelessly worked to de-centre the medicalization of mental “illness” and rightfully re-centre it within the systematic, socio-political processes that construct people as ill or cause them to be. Furthermore, mad studies have fostered a collective space of healing and action that is devoid of diagnostic labelling and prescriptive intervention.

Major players in mad studies and mad scholarship include the likes of Peter Beresford, as well as Brenda LeFrançois, Geoffrey Reaume, Robert Menzies among many other influential researchers, activists and scholars. Given that mad studies and the mad movement is a survivor-led initiative, there exists a tension between the field’s adherence to institutionalized, and thereby medicalized, terminology and discourses that show up in mad scholarship (Beresford, 2019). Furthermore, mad studies have faced critique given the overemphasis this field places on prominent white writers who typically hold elite status through academic qualifications. Once more, the theme of palatable madness is evident within the privileged narratives that represent and comprise of mad studies in exclusive spaces which often exclude marginalized groups as a specific expression of Eurocentrism (Beresford, 2019).

Although “users, survivors, mad peoples and their allies attempt to discuss the significance of race, racism, and racialization for mad people’s oppression through using various frameworks for analysis, including analogy, intersectionality, and trauma” (Tam, 2013, p. 281) it is imperative that this theory hold hands with critical race feminism and anti-colonial theory in

order to mitigate any gaps within this research. While mad scholarship and mad studies are crucial components to building the theoretical framework in which I will situate this work, it will not suffice as a stand-alone theory in this context.

A positivist worldview relies on the expectation that humanity be extracted and dislocated from theory; that as researchers we are meant to input our theoretical orientations, and omit how we may have lived them. This disjuncture speaks to the depersonalization and individualism that is intrinsic to what is considered “legitimate”, objective, empirical research and knowledge. Importantly, mad theory and anti-colonial theory came together as grassroots responses to systemic violence, exclusion and oppression, while critical race feminism changed the legal and economic landscape for racialized and impoverished women. These theories are strong examples of the ways in which marginalized groups have mobilized in response to experiences of colonial oppression and speak profoundly to their legitimacy given they were born from experience.

## CHAPTER 4: METHODOLOGY

The central question(s) of this research ask(s): What are the current discourses operating within recovery oriented community based services in Toronto, ON? What purpose do they serve?

Drawing on these questions, the practice of creaming inevitably presented itself as a tool used to limit mental health practitioners' interactions with significantly disenfranchised clients. By viewing service users through a lens of assumed compatibility with the recovery model and readiness for trauma-informed care, individuals who required less agency resources were seemingly constructed as standard and ideal. This process is an intrinsic gesture to the colonial influence of neoliberalism on service provision, creating the conditions in which workers participate in the maintenance and perpetration of systemic violence. While the philosophy of recovery is touted as non-linear and of equal possibility, practitioners are less likely to engage people in service who cannot conform to a linear and rapid trajectory toward static recovery. Local recovery oriented community based services revealed that they remain deeply stipulated by neoliberalism and therefore, whiteness, calling attention to the pacifying effect the recovery model and trauma-informed care has on the activist principles of social work.

### *Methodology*

For the purpose of this research, I conducted a critical discourse analysis (CDA) of website texts, annual reports, and publications at five prominent community based recovery oriented organizations in Toronto, ON. Major players of CDA include Van Dijk, Fairclough, Kress, and Wodak (Wodak, 2009). All documents and data collected were easily accessible online and did not require special permission to access. I felt that conducting a CDA of publicly available documents would be a worthwhile venture into understanding how recovery oriented

programming in Toronto, ON: (1) talks out loud to, and about, its service population; (2) talks out loud about themselves as an organization, their opinion of “best practice” and how they are doing it; (3) talks out loud to similar organizations.

According to Le & Short (2009), CDA examines “social injustice which is manifested in various social practices and [takes] a stance against social abuse, racism, social prejudice and discrimination against dominated or marginalized people” (p. 4). Above all else, CDA attempts to “describe, interpret, and explain the relationship between the form and the function of language” (Rogers, 2004, p. 3 cited by Le & Short, 2009, p. 7). At its core, critical discourse analysis takes stock of prominent, naturalized, repeating discourses in the social realm and draws attention to how they quietly work together to reinforce each other as a function of power. As Poole (2020, Slide 3) notes, “to do a critical discourse analysis is to examine and problematize an aspect of a discourse and to then make change”.

CDA is an “interdisciplinary approach to the description and analysis of text in terms of their wider social and political significance” (Poole, 2010, p. 137). Given this factor, using CDA proved to be successful in revealing the way in which different social and structural systems of power rely on one another to maintain oppressive hierarchies. One powerful system communicates with the other through repeating discourses and language patterns that entrap, surveil and swallow marginalized people deeper into the system. By unsettling such naturalized discourses, CDA brings awareness to “social, cultural and political realities” (Poole, 2010, p. 138) that have been subverted by colonial regimes of power.

### *Methodological Shifts*

In the process of this work, a global pandemic was declared. The escalation of COVID-19, a highly contagious and life threatening illness bloomed in March 2020, enforcing a strict

isolation period for the majority of persons. Accordingly, this impacted the MSW program structuring and otherwise, including the process by which REB approval was obtained. Conducting in-person interviews like I had initially planned, became increasingly more stipulated until we were informed that these interviews could only occur online or via telephone. The MSW cohort was encouraged to find alternative pathways to data collection for our research. In light of this, I chose to abandon my initial pursuit of an institutional ethnography derived from interviews with intake workers in recovery programs. Instead, I shifted my methodology to a critical discourse analysis of information gathered from the websites of local organizations. The ten texts chosen for this research are coded in the following manner:

- Text1
- Text2
- Text3
- Text4
- Text5
- Text6
- Text7
- Text8
- Text9
- Text10

### *Reflecting on Ethics Approval*

In order to engage service providers directly as I had planned, I was required to apply to the Ryerson Research Ethics Board (REB), which I did in January of 2020, for ethics approval. Interestingly, while my application was in orbit of the REB, mandatory revisions were

specifically connected to administrative elements of my major research proposal. Particularly, I was asked to provide clarification regarding how funding/incentives would be paid, to identify the “relevant experience” of my research supervisor, as well as to clarify whether or not I was registered with the Ontario College of Social Workers and Social Service Workers (OCSWSSW).

Although I am aware that it is the job of the REB to ensure the “ethical soundness” of research produced through the school, and that this process is inherently administrative by nature, I could not help but feel alerted to the possibility of creaming. The REB is markedly an access point and dictates which voices and ideas meet the *criteria* to conduct “ethical” research. The administrative tools, criterion and procedures employed by the REB are informed by colonial standards of “ethical” knowledge creation and ultimately cream out proposals that do not or cannot align with these standards. Notably, I was benefitting from this process given that the REB’s proposed amendments provided a clear pathway to approval and was reflective of my own conditioning and white privilege. Based on the nature of my research, the required amendments to my application were not a means to an end, but rather a place of holding until I eventually, and expectantly, would receive approval. Glaringly reminiscent of creaming, these types of expectations are ones that I am able to navigate with relative ease, am privileged within and ultimately set me up to succeed with minimal intrusions.

### *Data Analysis*

Drawing on the data collected from local recovery oriented community services, I relied on the use of a thematic analysis to interpret my findings by exploring the repeating discursive patterns that eventually became the foundation of my research. Importantly, using this qualitative research design helped reveal “the beliefs, values and motives that explain why the behaviours

occur” (Castleberry & Nolan, 2018, p. 808). Thematic analysis asks the researcher to “disassemble” the collected data into meaningful groupings (i.e. themes). It also asks that the researcher consider six important questions in the process of disassembling, which include (Castleberry & Nolen, 2018, p. 809):

- What is happening in the text?
- Who are the actors and what are their roles?
- When is it happening? (preceding event, during event, reaction to event, etc.)
- Where is it happening?
- What are the explicit and implicit reasons why it is happening?
- How is it happening? (process or strategy)

Given that these questions attempt to help the researcher cultivate a space in which reappearing and pervasive discursive patterns reveal themselves and their relationship to others, I felt that thematic analysis most accurately aligned with the scaffolding of a critical discourse analysis.

Following the disassembling of the data into meaningful groupings, thematic analysis asks the researcher to thematically reassemble the data. This stage of analysis typically requires a hierarchical reconfiguration of the data to create “a structure within which to reduce qualitative data as well as communicate relationships among groups, contexts, constructs, and codes” (Castleberry & Nolen, 2018, p. 810). In the spirit of challenging hierarchy, I chose to avoid this structure intentionally. Instead, I analyzed the thematic groupings, paying specific consideration to how they operate in mutual relation to one another. This configuration is called interdiscursivity, also referred to as intertextuality.

*Doing Critical Discourse Analysis*

Although my methodology shifted mid-process, the experience of conducting a CDA revealed itself to be a constructive change. It became a deeply personal exercise in trusting and listening to my own intuition while maintaining the primary goal of uncovering pervasive discursive patterns in local recovery spaces. It also allowed for me to reflect on how I, too, naturalized and engaged specific discursive patterns in my own professional practice. Over the course of several weeks, I scanned, collected, read, re-read, charted, sat with and listened to the information being presented to me through the chosen texts. Although many of the discursive patterns discussed in the subsequent chapters presented themselves almost immediately, I sat stuck with two questions: why? and who benefits? As discursive patterns began to attach themselves to one another, the disjuncture between presentation and practice grew clear. Conducting a CDA directed my attention away from colourful statistical and annual reporting graphics, catchy slogans and client service endorsements, guiding me toward the clues and questions that became the foundation of this work. Engaging the texts with an unwavering critical stance meant that I was more equipped to resist the undertow of rhetoric that is and continues to circulate in local agencies.

Retrospectively, CDA aligns more closely with my own personal strengths and comfort in writing. At the beginning of this endeavor, I was initially intrigued by possibly conducting a CDA but questioned whether I was avoiding the challenges that interviewing inevitably brings. Although I committed myself to conducting interviews, I am certain that the shift toward CDA allowed for me to grow, rather than shrink myself. Furthermore, engaging with the REB process brought on specific fears and anxieties that were later alleviated by shifting to CDA. Given that I am new to research, choosing CDA meant that I could move at my own pace and could process and discuss the intricacies of what the texts were saying to me without breaking confidentiality.

This process deeply influenced and helped refine my analytic voice. It allowed for me to slowly wade into what it felt like to be a critical researcher. Importantly, because this work was conducted and written during the first COVID-19 isolation period, being able to critically and transparently discuss the work that I was living inside served as a point of connection that sustained me during this time.

## CHAPTER 5: FINDINGS/ANALYSIS

### *Recovery: Substance Use, Mental Health, Trauma*

It came as no surprise that recovery discourse turned up as one of the central findings of this work, given the nature and identified focus of my research. However, what slowly emerged during the preliminary assessment phase, whereby I searched for appropriate organizations who fit the criteria for this work, was that “recovery” often goes unnamed despite its discernable grasp on service provision in community based services. While some organizations explicitly identified their adherence to the recovery model or recovery principles (Text1; Text6; Text9), others more or less avoided the word “recovery”. However, these organizations relied, instead, on stealth phrasing to convey that they are in fact recovery oriented in service delivery. For example:

“While helping to bring balance and hope back into the lives of our client” (Text2, Healing from Trauma and Abuse Program)

“Women-centred approach [...] individual needs [...] of our clients” (Text2, Counselling Services)

“With resilience and optimism” (Text2, Impact This Year)

“Healing journeys” (Text3, p. 5)

“Individuals have to accept responsibility for their actions” (Text3, p. 10)

“Our journey both as and with women” (Text4, We Value)

“Our work will honour and value these diverse strengths” (Text4, Mission and Vision)

“We respect and broaden women’s choices to determine their own paths according to their values, hopes and positive self-regard” (Text4, We Value)

The data revealed that “women need support to increase their self-efficacy in order to build new skills to recover and heal from trauma, as well as from the negative impact of mental health problems” (Text1, p. 67). While recovery was once situated within a narrative of moralizing blame and assumed deficit, it has now strategically extended itself to include the responsabilization of survivors to “recover” from violence perpetrated against them. For example, Text3 asserts that their organization “works with clients to help them identify abusive relationships, build strategies to avoid abuse and manage traumatic stress responses” (Text3, p. 5).

According to Text1:

“Safety is the first focus of recovery from trauma [and substance use issues]” (Text1, p. 34)

“Trauma [experiences] and the absence of a safe environment are major obstacles to treatment and recovery” (Text1, p. 56)

“Strong relationships between service providers and women who have experienced trauma are the basis of helping and recovery” (Text1, p. 63)

Similarly, the Healing from Abuse and Trauma program (HFAT) delivered by Text2, claims that this program:

“[...] assists women to establish a sense of physical and psychological safety and wellness while helping to bring balance and hope back into the lives of [our] clients” (Text2, Counselling Services)

Moreover, as recovery oriented service providers, the professed responsibility is to “prepare women for their journey of recovery from traumatic experiences” (Text1, p. 138), inferring that eventual trauma resolution is the anticipated and expected goal of service provision.

According to Text4, experiences of violence are what facilitate the resultant behaviours that are socially constructed and understood as mental illness and addiction, while all three

supposedly require counselling intervention as the primary pathway to recovery. They state on their website that:

[...] women who require mental health and addiction services because they have experienced various forms of violence [...] and/or trauma [...] are twice as likely to not receive needed mental health care as those with no violence history (Lipsky & Caetano, 2007). Often women are denied service, referred elsewhere for services or put on a waiting list.

This was an odd assertion given Text4's website explicitly states, in bold red font,

“ANNOUNCEMENT: Due to the heavy volume of women seeking our assistance, the wait-list for Individual Counselling is currently closed!”.

As I moved through the texts, a significant revelation occurred to me regarding current and local recovery discourses. Repeatedly, employees within recovery spaces are frequently positioned as the builders, providers and cultivators of empowerment, “skills”, resiliencies and hope. This subtle distinction not only speaks to the thriving hierarchy between service user/provider, but also unveils the pervasiveness of feel-good virtue signalling embedded within the historical and modern scaffolding of social work. This was conveyed through statements such as:

“Clients are provided with the skills and resources necessary to develop alternatives to theft, fraud, substance use behaviours and poor decision-making.” (Text2; Reintegration Counselling Services)

“We amplify women's voices and cultivate their skills and resilience.” (Text4, About Us)

“What we offer at [Text5] is our expertise in trauma.” (Text5: 1:27)

“[Text9] provides support and hope to people facing complex mental and physical health challenges, addictions, dementia, homelessness or risk of homelessness.” (Text9, Homepage)

“We serve everyone and judge no one.” (Text9, Our History)

“Since 1953, [Text9] has offered dignity and hope.” (Text9, Who We Are)

## *'Safe/Safety'*

What became increasingly obvious during my discursive scan of the recovery landscape, was that experiences of violence, resultant trauma and 'safety' are new concepts that have been absorbed and naturalized within the current recovery paradigm. Safe/safety as a concept was pervasive and repeatedly revealed itself within many of the materials engaged with during data collection. Often relegated to individual physical, emotional and "cultural" domains, 'safety' routinely appeared as an isolated goal within trauma-informed service interactions. For example:

"In trauma-informed services, the definition of safety expands beyond physical safety to encompass emotional and cultural safety. Women who have experienced trauma often feel unsafe, not only in situations (including the substance use service setting), but also in relationships (including those with service providers). Trauma-informed services strive to incorporate all facets of safety into every aspect of the services they deliver." (Text1, p. 50)

"Safety is created in every interaction and is characterized by physical safety (as perceived by the substance- involved woman) **and** by minimizing or avoiding triggers that could create a trauma response. Safety is also created and demonstrated through cultural sensitivity, including age, race, class, religion, disability status, and sexual orientation." (Text1, p. 50)

Text1 states that in order to facilitate such safeties:

"A trauma-informed service can create and demonstrate the many aspects of safety (including physical, emotional, cultural safety) by engaging in these practice applications: do an environmental scan and develop a checklist; [...] be welcoming, clear and consistent; [...] provide information that can alleviate anxiety or stress; [...] incorporate safety information at every opportunity; [...] take into account all aspects of emotional safety; [...] honour her range of emotions; [...] be open to cultural impacts." (Text1, p. 52-54)

Furthermore, that:

"Fostering choice and control enhances safety and [service] engagement." (Text1, p. 60)

Constant assertions of "safety" throughout Text1 is noticeably undefined, making it unclear whether service users actually experience themselves as safe in environments that adhere to recovery and TIC models. Moreover, the motivating purpose of establishing safety seems to function more broadly as a tactic used to coerce service users into further divulging intimate

details of their trauma history. This ultimately places them at greater risk for harmful social work interventions that pressure service users to feign resolve and recovery from trauma. It also fundamentally contradicts the essence of safety given that safety is consistently treated as a static endpoint rather than nuanced and fluctuating.

Safety in its most simplistic definition is “the condition of being safe from undergoing or causing hurt, injury, or loss” (Merriam-Webster Dictionary, 2020). Applying “safety” within the concept of “whiteness-at-work”, whereby paradoxes exist amongst “beliefs, intentions and actions”, it is clear that these texts imagine safety through a lens of whiteness through which white safety is prioritized (Yoon, 2012, p. 587). Furthermore, the above texts demonstrate the way in which achieving “safety” has become a fundamental expectation within the TI service interaction. Blame becomes rooted within the psychiatric realm of symptomatology given they assert that service users only feel “unsafe” in service interactions as a result of prior interpersonal trauma. Perceptibly sanist, these examples construct safety as dictated by the terms and authority of service environments. Most glaringly, these conceptualizations of safety neglect to acknowledge the immense power imbalance within service dynamics which poses an ongoing threat to safety experienced by the service user. Moreover, the claim that extending “choice and control” enhances safety, an expressed principle of TIC, is particularly volatile given social workers routinely violate the agency of service users through surveillance tactics and mandatory reporting procedures. This frequently incites hurt, injury and loss which both contradicts “safety” and exposes how whiteness-at-work (Yoon, 2012) is carried out through the intentional subversion of this power dynamic.

Moreover, if the goal in this context is to create a safe environment for traumatized people or, a “safe space”, then it is imperative to ask whose safety is being prioritized? The

concept of “safe space” originated in feminist, queer and civil rights movements, with the intention of “keeping marginalized groups free from violence and harassment” (The Roestone Collective, 2014, p. 1346). Overtime, this concept has been rightfully criticized given it has been both co-opted within oppressive environments and because it only ensures the “safety” of those most privileged. Despite contentiousness, multiple organizations insisted that they foster a “safe space/environment” within their organization:

“Relationship building [between the service provider and service user] is a key component in establishing an environment of safety” (Text1, p. 50)

“Environments feel safe to [women] when their experiences are validated and their real needs are addressed” (Text1, p. 35)

“Our free support programs across Ontario offer a safe, inclusive, comfortable place where you can learn more about your condition” (Text6, Just Diagnosed?)

“I do, however, remember feeling a great sense of excitement in that I had found a community that celebrates the stories of artists and gives them a safe space to express themselves not just as people living with mental illness, but as professional creatives.” (Text6)

“Safe: We will strive to provide programs of high quality and standards which are safe for the participants and stakeholders” (Text6, Operating Principles)

“[Text6] provides a safe place for people with mood disorders” (Text6)

“[Text9 Clients] are offered supports but their choices remain their own, and their housing provides safety, security and a sense of belonging” (Text9, Vision, Mission, Values)

“The purpose of the peer support groups is for people with similar experiences to share what they are dealing with in a supportive, non-judgmental, and safe environment [...]” (Text8, p. 11)

What appears to be lacking, is how exactly safety is conceived of and cultivated. Moreover, while the majority of texts leave absent whether clients experience themselves as safe in these environments, Text8 creams in multiple client testimonials to disseminate safe space rhetoric.

Since environmental “safety” is deeply entwined with location, positionality, identity performativity and “how the space is used and controlled” (Valentine 1989, p. 38 cited by The

Roestone Collective, 2014, p. 1349), then safe space rhetoric becomes evidently and solely invested in the protection and preservation of white safety.

“Staff members and volunteers throw their heart and compassion into providing programs and a safe space for people and their families.” (Text8, p. 4, Amy C. - Client Testimonial)

“By the end of the session, he’d offered a few suggestions I could take, but they were offered less as directions and more as things I could try out. All such advice was framed by personal experience, which further increased the trust and safety of the room.” (Text8, p. 10, Mark C. - Client Testimonial)

“The way the program was run coupled with the expertise of the facilitators made me feel so safe and allowed me to be open to sharing my experiences in a highly understanding environment [...] I was with people like me where I felt safe and comfortable.” (Text8, p. 13, LGBTQ Wrap Participant)

“It was great to have a safe space to share and listen.” (Text8, p. 13, LGBTQ LLC Participant)

“The facilitators were empathetic, offering support and creating a very safe environment for sharing.” (Text8, p. 14, From Chaos to Calm: Developing Stronger Boundaries Participant Testimonial)

In reading these client testimonials, I became acutely aware that creaming has been summoned within the process by which individuals were selected to provide statements regarding the organizational environment. These statements are again indicative of whiteness-at-work (Yoon, 2012) as they were evidently selected given the privilege of their “safe” experience. This extends itself to reinforce both safe space rhetoric and to bolster organizational claims that they have cultivated a “safe environment”. These client testimonials explicitly and only fortify white safety and the white experience within these environments.

### *‘Trauma-Informed Care’*

Trauma-Informed Care (TIC) was frequently used throughout multiple organizational websites and texts that I collected data from (Text1; Text2; Text3; Text4; Text5). According to Text1, there is a distinct difference between “trauma-informed practice” and “trauma-specific

services” (Text1, p. 11). Trauma-informed practices “take into account an understanding of the prevalence and impact of trauma and integrate that understanding into all components of an organization”. Correspondingly, trauma-specific services “are designed to focus directly on the impact of trauma and facilitate trauma recovery. Trauma-specific programs and services can include a continuum of specialized interventions from screening, to treatment, to recovery supports; they are delivered by a practitioner trained in the use of these interventions” (Text1, p. 11). I read on:

**Trauma-Informed Practices are:** Recognition of the high prevalence of trauma; [...] Screening processes that allow a woman to identify (if she chooses to do so) that she has had experiences of trauma; Recognition of culture and practices that can be re-traumatizing; Power and control are shared; the client and the service provider work together collaboratively; [...] Objective, neutral language; Transparent systems open to advocacy from and collaboration with relevant and helpful outside parties; Demonstrating respect [...] Private or quiet reminders of schedules, medication time, e.g. asking “can I help?”; Solution-focused responses that involve women and allow for understanding and negotiation; Involving the woman in treatment planning. (Text1, p. 16)

Perceptibly enmeshed with psychocentric practice standards, the *doing* of trauma-informed practice remains vague. Moreover, TIC distinctly contradicts its own idyllic assertions of power/control sharing, choice/choosing to disclose, collaboration, neutrality and transparency by an expressed adherence to assessment, medication, screening, solution-focused interventions.

Moreover, the standards of whiteness by which trauma-informed practices are implemented according is particularly clear. This is evidenced by the disclaimer on page six, which states:

“The vast diversity of experiences and cultures of the women who access our service system has not been fully explored or addressed in these Guidelines [...] Service providers will need to ‘braid’ trauma-informed practices with other culturally-informed practices that they currently use to meet the diverse and varying needs of women” (Text1, p. 6)

This disclaimer embodies cultural competency as new racism (Goldberg, 1993 cited by Pon, 2009) given that “whiteness is the standard by which cultures are differentiated” in this context

(Pon, 2009, p. 60). Furthermore, Text1 includes a chapter on developing “cultural competence” and engaging in anti-oppressive practice called “a multi-dimensional perspective”. Text1 asserts that:

“Cultural competence is critical to trauma-informed practices.” (Text1, p. 38)

“Cultural competence enables all agency staff to work within a woman’s values and reality ... It also acknowledges and incorporates cultural variations in normative acceptable behaviors, beliefs and values ... and incorporates those variables into assessment and treatment.” (Text1, p. 34)

“Every ‘strand’ of a woman’s cultural identity can be a source of both risk and resilience.” (Text1, p. 38)

This section is a particularly precise embodiment of new racism (Goldberg, 1993).

Recognizably, the absence of a thorough and connecting analysis regarding systemic violence and its interpersonal manifestations reveals TIC as a generic framework which centres white trauma.

The *doing* of trauma-informed care requires the practitioner to engage in the following:

Counsellors who provide trauma-specific services should have the following essential skills and knowledge: 1. [...] knowledge of the many types of traumatic events; 2. [...] must have the skills required to assist women to manage a wide range of trauma responses (e.g. grounding strategies); 4. [...] require the ability to conduct assessments in a paced and sensitive way; 6. [...] work within a strengths-based framework; 7. [...] draw upon an array of therapeutic interventions [...] (such as cognitive behavioral strategies) (Text1, p. 128-129)

Interestingly, during data collection, teaching “grounding strategies” and mindfulness practice appeared to be the only explicitly stated and concrete trauma-informed “technique”, specifically in relation to response management (Text1; Text4). For example, as reflected by Text4:

“Survivors might feel frustrated that they can’t effectively ‘reason’ themselves out of their emotions or sensations when triggered, but it’s not due to a lack of strength and willpower [...] fortunately [...] mindfulness can help” (Text4; How Can Mindfulness Help with Trauma?)

Similarly, Text5 states that:

“And that’s part of mindfulness practice is building [...] there’s an opportunity to practice [uh] mindfulness in sort of snip-its, so like in [uh] a way where we start with a breathing exercise of three minutes” (Text5: 1:51)

Although not trauma-specific, Text6 states in their Depression Fact Sheet:

“The most common forms of treatment for depression are antidepressant medication and psychotherapy [...] additional treatments such as massage, mindfulness meditation, shiatsu, therapeutic touch, aromatherapy, tai chi, Pilates and yoga can also help to improve wellness” (Text6; Depression Fact Sheet)

‘Self-care’ also revealed itself as a repeatedly expressed goal of TIC. For example:

“Counsellors can also help to support a woman’s emotional and physical safety by helping her develop a basic skill set for dealing with trauma-based reactions and practicing healthy self-care” (Text1, p. 34)

“Service providers can help women to think about how they can practice healthy self-care” (Text1, p. 77)

“The emphasis will be on self-care, safety planning, information about the link between trauma and substance use, education about the after-effects of trauma, expanding coping strategies, such as grounding techniques to deal with emotions” (Text1, p. 138)

“Basically, we’re looking at trauma but without necessarily advertising that that was happening in the group -- so, a lot of it I understand was around self-care, coping strategies [...]” (Text5: 1:38)

“Through this group you will discover: strategies to take better care of yourself using your creativity” (Text4, Group Counselling; Living Artfully Beyond Trauma)

“The trauma informed service provider understands trauma in its full complexity and knows how to provide the necessary accommodation and space for a trauma survivor to take the initiative in self-care” (Text4, Being ‘Trauma-Informed’; What does it mean to be ‘Trauma Informed’?)

Trauma-informed practices seemingly work to elicit the traumatic narrative while simultaneously seeking to sever the emotional response from the experience(s) (by grounding or practicing mindfulness). These expressions are then measured, assessed and whittled down until the trauma, or the client, is considered treatable and therefore manageable. The function of these non-descript trauma-informed practices are perilous. Reminiscent of creaming, they risk

becoming a motivating force by which individual workers may use their knowledge of a client’s prior trauma to coerce them deeper into the system. Specifically, those who are able to articulate their trauma story in a contained yet compelling manner, embrace mindfulness, grounding and capitalistic expressions of self-care best fit within the landscape of trauma-informed recovery as we know it. The responsabilized assumption that one can and should recover from trauma is inherently toxic because it places individualistic, pressurized and linear expectations on interpersonal manifestations of ongoing systemic violence.

Another major discursive finding of this research was the way in which TIC mimics the recovery model. This was evident when I compared the expressed guiding principles of trauma-informed practice and the recovery model:

Guiding Principles	
Trauma-Informed Practice	Recovery Model
Acknowledgement Safety Trustworthiness Choice and Control Relational and Collaborative Approaches Strengths Based Empowerment Modalities  Text1, p. 13	Responsibility; Hope Trust-Based Relationships Self-Directed (implying <i>choice</i> and control) Control over their own resources Peer and Collaborative Support Strengths-Based Approaches; Empowerment  National Alliance on Mental Illness, 2020; Osborn & Stein, 2017

Importantly, it appears as though the recovery model and TIC function both separately as individual concepts, as well as interchangeably whereby one can stand in for the other. This is a critical finding because it gestures to the widening net of psychiatric authority which cocoons social work practice on the frontline. Specifically, these concepts interlock in order to reinforce

their supremacy while simultaneously extending their reach as separate ideologies that maintain the same limiting intentions.

Furthermore, it is imperative to acknowledge the assertions of Text1, specifically regarding how this document conceptualizes the impacts of trauma and cognitively forces it into relationship with processes of marginalization. Specifically, Text1 constructs trauma as individualistic and isolated, limited to the person or to “families of origin”. Moreover, it places little or vague emphasis on the systems that facilitate violence, poverty and exclusion. Text1 states that trauma can:

“make women more vulnerable to other life stressors, such as poverty and inadequate social support, all of which can increase vulnerability to trauma reactions” (Text1, p. 85)

and that it can:

“affect a woman’s ability to keep her children safe, work effectively with child welfare staff, and engage in her own or her children’s mental health treatment” (Text1, p. 84)

Not only do these assertions drink from the pool of responsabilizing rhetoric, they also imply personal culpability for systemic issues such as poverty or unwanted interactions with oppressive systems such as child welfare.

It appears as though trauma narratives have become a form of emotional currency, whereby service users are expected to trade their story for resources. Despite the assertions of Text1; that the worker/organization must accept “that a woman need not necessarily disclose her experience of trauma” (p. 9), the unstated expectation is that they absolutely must be willing to do so eventually. Simply, service users must “prove” why they require access to services. In the absence of a trauma disclosure, the likelihood of sustaining their relationship to these services reduces significantly and places service users at a higher risk of creaming for “treatment resistant” behaviours. Furthermore, depending on the scope, complexities, or timeline of the

traumatic experience(s), and perhaps most importantly, depending on *who* is doing the disclosing, a trauma disclosure undoubtedly places the service user at an increased risk of surveillance and systemic intervention from other connected bodies (i.e. child welfare, criminal justice system).

Adopting the current iteration of TIC into the dominant clinical model simply allows organizations to use this framework to scapegoat or avoid the realities of systemic violence. Most glaringly, divulging traumatic experiences within these spaces act as a pathway through which social control is enforced. This process is profoundly and exceptionally disempowering. Despite angling organizational speech to reflect “empowerment” as a primary goal, it simply suggests that TI organizations perceive all clients as inherently lacking in power as a starting point. This disguised dynamic unsettles the supposed adherence to “strengths-based” approaches from which TI and recovery models are said to operate. These texts seek to bolster the pervasive discourse of benevolent social worker. Employees in these spaces are the benevolent builders, providers and cultivators of empowerment, despite the fact that clients interacting with these organizations have survived, in many cases, generations of systemic deprivation and degradation; that they cultivated support systems, healing rituals and survival mechanisms that have been condemned by a Christian-colonial worldview in which social work practice is rooted.

### *‘Resilience’*

Resilience discourse appears to be deeply enmeshed with current recovery oriented social work practice and discursive cultures within local organizations, so much so that it has been visibly co-opted into neoliberal social service marketing. For example, when I navigated to Text8, the bold and bright letters forming the word “RESILIENCE” appeared on my screen to

indicate the title of their 2016/17 annual report. Interestingly, *resilience*-talk was relatively absent throughout the remainder of the document, aside from declaring their role as the builders, providers and cultivators of “resilience and wellness” within their service population (Text8, p. 10). This only reinforced the use of this concept as situationally performative, although not devoid of social and political implication.

“Resilience” as a discourse very calculatedly operates as a devaluation of the capacities and lived experience of service users while simultaneously claiming the opposite. The perceptible implication of resilience-talk throughout Text9 was that it distinctly functions as a form of normalizing judgement. This was specifically evident within their description of peer support (i.e. “we emphasize our clients’ strengths and resiliency, and we include them at every service level” [Text9, Building a Brighter Future: Services for Youth]). What is particularly unclear, is how exactly service users are being incorporated at every service level given this organization conveys that they have created a limited space in which designated peer support workers can “share their experiences, wisdom and resources with current clients” (Building a Brighter Future: Services for Youth). Aside from the distinguishable and differentiating “us”/“them” binary, the distinction between peer support worker and “current client” only implies a type of graduating from “unwell, current client” to productive and recovered former client (i.e. peer support worker).

Simply, it implies a hierarchical power dynamic which undermines the intention and origin of peer support as a practice. Moreover, this specific hierarchy is ultimately replicated within the organizational system itself whereby “peer” support is both ideologically and structurally conceptualized as inherently less than “expert” service provider. Seemingly, once an individual is perceived as having “been there” (Text6, Our Motto Is), they are more or less

confined to the limited parameters and low expectations that seek to undermine the value and legitimacy of peer-support. This is very distinctly evidenced by Text7, who states “I was clearly too far gone. Obviously, nothing “soft” like peer support or recovery education would fix me” (Text7, Personal Stories). Although this statement is discernibly facetious, it speaks to the larger cultural, hierarchical positioning of peer support as “soft” and ultimately ineffective compared to the supremacy of psychiatric intervention.

“Resiliency” or “being resilient” has seemingly become a diagnostic element of service provision as evidenced by the texts. This was reflected by both client service endorsements, as well as by the repeated, subtle function of the concept-in-action. Specifically, the client statements (included in multiple documents) covertly imply that in absence of the therapeutic relationship, their personal self-worth would have likely gone unrealized. The way in which resiliency is acknowledged throughout these statements appears to occur as a direct result of service engagement. Seemingly, one is educated on their personal resiliencies by the service provider rather than this occurring by way of community connection and belonging or as an intimate process of self-actualization.

For example, the client statement included in Text10 sketches a triangle of recovery (trauma, psychiatric labelling and substance use) to strategically enforce the cognitive relationship between recovery and resiliency. They state:

“I learned that I am very, very resilient [...] I felt my life had little value’ [...] These moments have now been replaced with moments of resilience” (Text10, p. 5).

A similar sentiment is reinforced by Text7, provided by the holder of a prestigious organizational title and a highly-regarded recovery soldier:

“I am privileged to meet the most courageous, resilient, powerful, fellow travelers on this, our shared journey, to hope, healing, and recovery” (Text7; Personal Stories)

It seems as though a central goal within service provision is that practitioners must always be striving to indoctrinate clients to their personal resiliencies. For example, Text4 states that:

“Trauma survivors are resilient, even if they do not realize it [...] Survivors are resilient, even if they don’t yet see it in themselves” (Text4, Being Trauma Informed)

Similarly, Text1 claims that:

“When the therapeutic relationship recognizes the challenges experienced by each woman and the strengths that enabled her to meet those challenges, the focus can shift to her resilience” (Text1, p. 36)

“Trauma-informed services honour women’s past experiences, focus on the future, and utilize skills building to develop resiliency” (Text1, p. 66)

### *‘Success’*

“Success” was revealed as a prominent operating discourse championed by local recovery oriented community organizations. “Success” is perceptibly wrapped up in neoliberalism, given the way in which it signals a competitive binary. These specific types of infiltrative neoliberal discourses have become naturalized within the landscape of the social work profession and are readily engaged with in both policy and practice (Mearns, 2014). In the context of this work, “success” typically emerged in accompaniment of psy-based interventions, treatments, strategies or skills supposedly meant to facilitate recovery.

For example:

“Researchers suggest that failure to address trauma, both recent and in early childhood, in the context of substance use services may be a factor in difficulty attaining treatment success” (Text1, p. 21)

“Incremental change to reduce harm and build skills may be the most successful approach” (Text1, p. 77)

“Three basic components of staff development must be addressed to successfully implement trauma-informed practices: staff values and attitudes, knowledge and skills” (Text1, p. 103)

“Assessment for Phase Two and Phase Three Services: [...] 7. Ask about her current recovery plans for her substance use and her degree of confidence about the success of these plans” (Text1, p. 139)

“Critical Time Intervention has proven success in transitioning people from precarious and sensitive situations to stability” (Text3, p. 7)

Interestingly, when I navigated to the link provided for more information regarding “Critical Time Intervention”, I learned that this particular intervention is

[...] a time-limited evidence-based practice that mobilizes support for society’s most vulnerable individuals during periods of transition. It facilitates community integration and continuity of care by ensuring that a person has enduring ties to their community and support systems during these critical periods. CTI has been applied with veterans, people with mental illness, people who have been homeless or in prison, and many other groups (Center for the Advancement of Critical Time Intervention, 2020)

Seemingly, this “intervention” is about offloading clients onto alternative community supports and/or “people”, and includes components such as invasive home visiting, “encourag[ing] the client to take more responsibility” (i.e. responsabilization) and reviewing client “progress” presumably as a means of measuring both client and intervention success (Center for the Advancement of Critical Time Intervention, 2020).

“Success” was also repeatedly associated with living a “successful” life. Similarly, this assertion is visibly informed by neoliberal conceptualizations of what it means to be and live well. Importantly, these agencies never explicitly conceptualize or define the standards by which one is understood to be living successfully. As evidence within the texts, those who are considered to be “living successfully” are those who do not depend on the system for support or those who are no longer forced to engage with systems such as child welfare, the mental health

or criminal justice system. This perspective ultimately ignores the reality that prior interactions with these systems places individuals at greater risk for re-interaction and ongoing surveillance.

Text2 identifies that an expressed programming goal is to:

“[...] begin the process of reintegrating back into the community and adopting lifestyle changes that contribute to long-term life success” (Text2, Residential and Housing Services)

Similarly, Text3 asserts:

“[We] work in a framework that aims to successfully reintegrate women into the community and avoid future contact with the criminal justice system” (Text3, p. 3)

and that:

“Together, we can all live successfully in our community” (Text9, Our Vision)

Although Text7 does not use the specific word “success”, the inference of their personal recovery story very clearly operates on the implication of success. Specifically, Text7 repeatedly uses the phrase “I was well [after fifteen years of indescribable emotional, cognitive, and physical pain]” (Text7, Personal Stories). Text7 describes this process as “spontaneous remission” (i.e. a successful recovery) all in thanks to “one dose of a new medication [...] I was well” (Text7, Personal Stories). Not only does this narrative subtly reinforce the hegemony of medically facilitated psychotropic symptom management, it also dangerously constructs a fantastical tale of spontaneity which undermines the very real systemic processes that both construct and cause people to be “unwell”. This specific depiction of recovery is very clearly oriented within a biomedical understanding despite the fact that this organization, of which Text7 is the designated executive director, prides itself on its adherence to a peer-support model.

### *‘Diagnosis’*

“Diagnosis” appeared frequently throughout a number of the chosen texts and often functioned as a naturalized component of recovery oriented and TIC, signalling their affiliation

to the medical model. “Diagnosis” operated in two distinct ways: (1) ‘diagnosing’ trauma (Text1); (2) as a seemingly mandatory or expected stipulation of service provision (Text2; Text6; Text8; Text9). Notably throughout Text1, diagnosis-talk was propped up by the authors; by referencing major texts in trauma-informed care such as *Seeking Safety* by Lisa Najavits; and by the psy-affiliated research materials that informed the document. While Text1 asserts that the focus of service interactions should place emphasis on “behaviours and context” rather than “diagnoses and labels” (Text1, p. 39), the repeated use of the word ‘diagnosis/es’ signals that it underlies service construction, provision and the lens through which service providers view service users in this space. Given that Text1 places repeated importance on treatment, assessment/screening and intervention methods only further emphasized their medical and psychiatric orientation. For example:

“Trauma studies have NOT adequately entered general and professional curricula. Many professional caregivers are not aware of the impact of trauma [on physical and psychological health] nor are they knowledgeable about diagnosis or treatment.” (Text1, p. 5)

“Many women receive multiple diagnoses that do not take into account their traumatic experiences.” (Text1, p. 40)

“For so long I didn’t know what was going on. So many diagnoses. I never felt I fit those categories, but this feels right.” (Text1, p. 131)

The following statements attempt to create a linkage between screening and assessment practices that are not trauma-informed and “misdiagnosis”. This further exemplifies the way in which TIC and the recovery model continue to prioritize diagnostic processes specifically as they relate to “properly” diagnosing trauma.

“Experiences of the Adult: Unseen & Unheard: The woman is not screened or assessed for trauma. Trauma impacts are not identified, are discounted or dismissed. The woman is misdiagnosed. Treatment is misguided, or sometimes harmful.” (Text1, p. 33; Experiences of The Adult [Chart] in Early Experiences of Trauma Can Be Replicated in Service Settings)

“A trauma-informed assessment will help to ensure that the trauma-related responses and adaptations are not misdiagnosed. It will also help to identify other mental health issues that may also be affecting a woman. Mental health issues should be assessed by a qualified clinician who has a good understanding of trauma-informed practices.” (Text1, p. 40)

“Trauma-informed screening is woven into assessment and intake processes in a paced, sensitive, non-intrusive, way and is seen as an invitation to identify issues, rather than being a ‘diagnostic’ process.” (Text1, p. 81)

While the authors suggest that trauma responses are often misunderstood and thus misdiagnosed, the way in which they do this suggests that ‘trauma’ now functions as its own diagnostic label.

Furthermore, the following statements are indicative of the way in which diagnoses are used to undermine trauma experiences:

“Once we have labeled a woman as suffering from a major mental illness, whether that label is an accurate assessment or not, we view her reports of sexual and physical abuse through the coloured lens of her diagnosis ...The stigma of her diagnosis is often sufficient to call her account into question.” (Text1, p. 40)

“Rather than relying on a formal diagnosis of trauma, the assessment process should assume trauma.” (Text1, p. 82)

While attempting to speak to the oppressive stigmatization that occurs through diagnostic activities, these particular statements fail to recognize how “paced, sensitive and non-intrusive” assessments still uphold and participate in the same harmful diagnostic processes. The impact remains equivalent regardless of the pace or situational sensitivity. Moreover, “assuming trauma” within assessment processes is dangerous. This strips service users of their agency and ability to make meaning of their experiences inside and outside of the service dynamic.

“Assuming trauma” also means that practitioners are provided with the baseless authority to prescribe, re-story or alter client narratives so that they may justify psychiatric intervention tactics. Most importantly, “assuming trauma” in this context inherently assumes white trauma,

given that racialized persons are disproportionately diagnosed with more stigmatized mental health labels and subjected to more violent and forced interventions.

Although Text2, Text6, Text8 and Text9 do not speak directly to diagnosing trauma, they do frame “diagnosis” as a naturalized expectation embedded in service provision. For example, Text2 asks:

“To submit a referral on behalf of a client or to self-refer, please complete the form [...] Does your client have a mental health diagnosis? If yes, what is it?” (Text2, Exit Doors Here Program; Referrals).

While the expressed vision of Text6 reads:

“Our Vision: Individuals and families affected by mood disorders recover and heal” (Text6, Our Vision).

This means that individuals seeking service from this organization are expected to have either: a medically diagnosed “mood disorder” or; a self-diagnosed “mood disorder”, which is informed by the same lens of understanding and diagnostic criteria disseminated through the medical model. This is further depicted in Text6’s Toronto Recovery Group: Youth with Mood Disorders section:

“This group may be for you if you are between 18-28, have a diagnosis of depression, bipolar or psychosis, or do not have a diagnosis but struggle with some of the following symptoms:

- Feelings of sadness/hopelessness/low energy
- Mood swings from low to high and feeling elated and really energetic
- Extreme irritability that is affecting relationships and your ability to cope
- Racing thoughts, trouble concentrating, high anxiety, difficulty sleeping” (Text6, Toronto Recovery Group: Youth with Mood Disorders)

The legitimacy that Text6 invests in “diagnosis” is clear given they have allocated a section of their website to specifically address individuals who have recently received a mental health diagnosis:

“If you’ve just been diagnosed with depression, anxiety or bipolar disorder, you are not alone [...] [Text6] is here to support you and your family as you begin your journey to recovery” (Text6, Just Diagnosed?).

Similarly, Text6's Early Intervention Psychosis Program:

"[...] offers confidential support to families and individuals age 15-35 years who have been diagnosed with or are experiencing symptoms of psychosis." (Text8, p. 15)

Moreover, in their 2016/17 annual report (Text8), they fail to properly acknowledge

stigmatization and oppression as the root of "fear and confusion" as it relates to diagnosis:

"We work to dispel the fear and confusion that often comes with a diagnosis of a mental illness." (Text8, p. 2)

A similar sentiment is evident in Text9, by situating "undiagnosed mental illness" as the cause for "fractured" family relationships:

"We listen to many similar stories at [Text9], of people who had fractured relationships with family due to undiagnosed mental health challenges." (Text9, Pauline's Story)

What's more is that despite repeated reference to mental health diagnosis/es, Text6/Text8 assert that peer support groups are:

**"Person-centred, rather than illness-centred:** In Peer Support we focus on the person and their whole life rather than on perceived deficits, symptoms, diagnoses, and illness. We focus on strengths; aiming to find, build, or grow resilience and wellness; and to share our belief that everyone can find their way to live a life that is meaningful and fulfilling." (Text8, p. 10)

This is an important finding because it demonstrates a two-tiered approach to service provision, revealing a contradiction between peer support and non-peer support perspectives operating within this organization. Those with seemingly more organizational authority ascribe to and propagate medical model perspectives of diagnostic "legitimacy", whereas peer support workers perpetuate less authoritative understandings that centre resilience and wellness discourses.

*'Whiteness/Creaming'*

Whiteness as an ideological and structural framework is very clearly implicated in the general maintenance and delivery of all texts engaged with for the purpose of this work. During data collection, dominant psy-discourses permeated, in many cases, the foundation of community based services, creating a disjuncture between how local agencies talk out loud about themselves and how they practice. For example, organizations who provide services to a niche population were perceptibly operating within clinical social work framework (Text1; Text2; Text4). While organizations with more broadly defined eligibility criteria (“people [...] who are living with depression, anxiety or bipolar disorder” [Text6, Home]; or “for people with complex challenges” [Text9, What We Do]) appeared to be engaging in more broad service provision, placing an emphasis on general resource sharing, group programming and case management.

In clinical social work spaces, the presence of creaming was unmistakable, further illuminating a salient relationship between creaming and whiteness. Whiteness is clearly articulated in Text1, who states:

The concept of ‘culture’, as used in this document, is defined broadly in order to maximize inclusiveness and take into account the diversity of women’s lives. Culture can encompass issues associated with gender, age, language, ethno-cultural and racial identification, immigrant/refugee status, sexual orientation, ability challenges, literacy challenges, homelessness or being marginally or under-housed, street involvement, criminal justice involvement, poverty and low-income/unemployment, class and rural, urban or isolated communities (Text1, p. 11)

In the context of this definition, marginalization and culture are inappropriately conflated.

Moreover, this perspective of “culture” is obscured by an inherently negative or conflictual stance (i.e. “culture can encompass issues associated with [...])”. This ultimately problematizes cultural affiliation, and fails to acknowledge marginalization separately, as an intentional result of systemic violence. This particular definition is actively working to create divisive imagery by inherently constructing the service provider as apolitical and *deculturized* in order to enhance the

“deviancy” of the “cultured” Other/service user, thereby justifying assimilatory practice frameworks. Simply, this definition bolsters white supremacy by creating a harmful definition of culture that attaches itself onto marginalized identities and subtly attempts to construct these components of identity as non-normative.

The stealth reliance on creaming as an operative tool in which service provision and agency resources are filtered and managed, thrives equally within the stipulated eligibility criteria of trauma-informed, clinical social work agencies and broader, community based recovery services. In clinical organizations such as Text2, for example, the eligibility criteria for their residential and housing services state that:

“[o]ur intake worker will meet with you to discuss and assess your eligibility for the resident and release plan” (Text2, How to Apply for Residence)

“the target group of women served by the program includes any women who is: on parole, probation or long-term supervision order; [...] motivated to make changes in life” (Text2, Admission Criteria)

Similarly, Text4 states:

“You will be asked a number of questions to assess if we can provide you with the types of services you are looking for [...] the intake counsellor will gather basic information about you and your situation to assess your immediate needs” (Text4, What Happens When You Call?)

Seemingly, the only way in which individuals can access these services is through an exchange-based “assessment” for service compatibility. Being “motivated to make changes in life” (Text2, Admission Criteria) is deeply subjective, intimate and ultimately operates on the foundational expectation that an individual must eventually realize their position within the supreme, hegemonic order. Moreover, because these parameters of eligibility are both narrow and vague, eurocentrism and whiteness at the intersection of trauma, then become the invisible criteria by which access to service is dictated by. This is evident given the landscape of social

work and service provision exists more broadly within a socio-political framework which favours neoliberal and ultimately, colonial constructions of the eligible client.

The construction of eligibility criteria in clinical spaces is a highly-politicized act concerned with individualization and is enmeshed with whiteness given that it is perceptibly organized by psy-discourse within the overarching supremacy of a medical model. This is evidenced in Text1, by consistently locating trauma within the individual person or within the immediate family structure. Although this text states “there is now considerable evidence that the effects of collective trauma are often transmitted across generations, affecting the children and grandchildren of those who were initially traumatized” (Text1, p. 11), this knowledge is relatively neglected throughout the remainder of the document. Moreover, it is specifically ignored within their clinical definition of trauma, which states “in the context of this document, ‘trauma’ refers to psychological and/or emotional trauma, including the psychological and/or emotional impacts of physical trauma” (Text1, p. 3).

Ignoring intergenerational/transgenerational, collective, community and structurally facilitated trauma, which exclusively creates and impacts marginalized populations, simply emphasizes TIC as an institutionally facilitated expression of whiteness. Without thorough recognition and integration into a practical framework that names systemic violence as the catalyst for interpersonal trauma, TIC as we currently understand it ultimately blocks pathways to genuine healing. Moreover, the neutralizing impact of TIC only amplifies its colonial orientation and very clearly prioritizes, or creams in, white trauma because it causes least disruption to systems of power.

In more broad recovery oriented community organizations, creaming was equally apparent as it was in clinical social work spaces. For example, Text6 states that they offer “free

support and recovery programs to people across Ontario, and their families, who are living with depression, anxiety or bipolar disorder” (Text6, Home). Immediately upon reading this, I wondered about the type of messaging this produces within the larger community. I also considered how this distinction impacts recipients of more stigmatized mental health diagnoses, such as schizophrenia or borderline personality disorder, who are explicitly creamed away from services. From my findings, I concluded that relatively “socially acceptable” diagnoses have been institutionally constructed as manageable illnesses that are more commonly applied to white distress. Moreover, diagnoses such as anxiety, depression and bipolar disorder complement the principles of the recovery model, reinforcing its “success” on an organizational, policy and ideological level. This differentiation signals the operation of a sanist hierarchy, whereby individuals who have received profoundly stigmatized diagnostic labels are inherently constructed as unruly and undeserving characters within the social service landscape.

Furthermore, Text7 is inextricably implicated in this particular manifestation of creaming, given that they are the executive director of Text6, a province wide organization. Their enshrined narrative of “spontaneous remission” (Text7, Personal Stories) undeniably holds hands with their thinly veiled pro-medication stance and adherence to a psychotherapeutic intervention model. This inherently contradicts and undermines their declaration to peer-support as a means of “focus[ing] on the person and their whole life rather than on perceived deficits, symptoms, diagnoses and illness” (Text8, p. 10). Chiefly, this contradiction exposes a close relationship between this organization and the medical model, which is a specific and stealth deviation from how they attempt to represent themselves in the community. This is further evidenced by statements such as:

“We are focused on initiatives that encourage routine mental health assessments and early intervention to discover mental health issues as they arise and mitigate their progression and impact” (Text8, p. 2)

“The Streams of Recovery Model developed by [Text6]: helps assess client needs and respond with accessible, timely, and safe programs and supports [...] by answering their questions, helping them learn about their illnesses, and assisting them in finding the resources within their communities” (Text8, p. 6)

### *Summary of Findings*

The data revealed that the recovery model remains a pervasive and naturalized framework within service structuring and organizing. The omnipresence of recovery discourse, its feel-good principles and expected outcome (to recover) means that agencies do not necessarily have to define themselves by it despite obvious entanglements. The myth of recovery that lurks within social work practice simply provides a tasked list of subjective goals or, “guiding principles”, that serve to reduce and control clients through the white, middle-class gaze. This was particularly evident in how these texts attempted to reinforce their necessity by paternalistically denying survivor knowledge and “skills” while repeatedly asserting their own “expertise” in facilitating healing from trauma.

Engaging with the interconnected discourses operating within local recovery services and documents illuminated the way in which these discourses work together to function as a tool used to stipulate service provision. Situated upon a foundation of whiteness, eligibility and service provision are perceptibly constructed for those who are assumed to be most successful in their recovery and most willing to accept their practitioner prescribed resiliencies. Furthermore, recovery discourse continues to grow within the principles and framework of TIC, whereby the pressing outcome of TIC is to assist clients in their “recovery” from trauma. This expectation only compounds harm when people are made to feel that they have failed at their own healing.

The more that trauma awareness enters into social consciousness, the more power TIC and the recovery model gain within the authoritative institutions and organizations that employ them.

Multiple clues were revealed within the data that signal a far-reaching relationship between the recovery model, TIC, the medical model and white supremacy. This relationship furthers my suspicion that these models only benefit white trauma, leaving racialized survivors subject to institutionally sanctioned erasure, rejection and a harmful mishandling of trauma. This relationship was evidenced by a lack of recognition, interrogation and analysis of the impact of systemic violence in many of the chosen texts. It was also apparent in the propping up of interconnected systems such as child welfare and the criminal justice system within TI & recovery programming. Moreover, while some texts acknowledged intergenerational trauma, they neglected to incorporate this knowledge into their organizational conceptualization of trauma and beyond. In addition, these texts limited intergenerational trauma to the family structure and ignored the way in which systems and agents of the state have been the facilitators of violence and resultant trauma. This in turn offloads blame, accountability and action onto traumatized families and communities.

Finally, all of the organizations demonstrated a pro-medication, assessment and psychiatric intervention methods as a cure all for trauma diagnosis and symptom/management. This collective adherence is profoundly dangerous given that racism and anti-Black sanism operates through these very channels (Meerai, Abdillahi & Poole, 2013). Moreover, these practices and interventions have become standardized in mental health work, making the violence of these tactics routine and invisible (Poole, 2013 cited by Meerai, Abdillahi & Poole, 2013). Given that ‘safety’ is prioritized and pervasive within TIC, and therefore within the recovery model, the foundation of whiteness upon which these frameworks are built is once

again revealed. As Poole (2011) notes, racist, psychiatric violence “continue[s] through practices of recovery, evidence-based medicine, and middle-class and decidedly white therapeutic interventions” (cited by Meerai, Abdillahi & Poole, 2013, p. 24). Not only does this reality inform the construction, adherence and dutiful protection of such models but it also incites violence when the traumas experienced by racialized communities are purposefully held in contrast to white frameworks.

## CHAPTER 6: IMPLICATIONS/DISCUSSION

I began this research far from where I have arrived today. Overwhelmed by theories, research terminology and concepts while adjusting to the general shock of beginning a graduate degree program, I questioned my ability to perform in the way that I was being asked to. However, the more I eased into theory and research, moving toward critical race feminist theory, anti-colonial theory and mad studies, the more I realized how closely they aligned with my own perspectives and political orientation. This realization ultimately influenced my research question and process, deeply informing and refining how I engaged with and understood the chosen texts. Building up from this theoretical foundation allowed for me to explicate the ways in which racism and sanism are created and sustained within colonial structures, bolstering white supremacy by growing multiple “therapeutic” branches to disguise and strengthen it. These theories worked together to corroborate my claim that recovery and TIC frameworks prioritize white and well-articulated trauma; that this occurs through the direct process of ignoring, minimizing, denying and inciting systemic and structural violence that targets and traumatizes racialized groups.

Moreover, applying this specific theoretical blend within CDA while using thematic analysis was foundational to the realization and understanding of how recovery and TIC models centre white trauma. The theoretical and methodological blend that I arrived at created a heightened awareness regarding the specific discourses that function in these spaces to signal and reinforce whiteness. In interrogating the utilization of TIC and its deeply enmeshed relationship with notions of “safety” for example, it became clear that these discourses depend on each other to ensure the prioritization of white healing, white safety and white well-being. In reflecting on this research process, I realized that this topic has been developing within me for a very long

time. I feel as though I have finally been able to refine and depict the tension I have held in connection to paradigms of recovery, and to social work more broadly. The heart of this work reflects an intimate process of learning and leaning into the discomfort as it relates to my own previously unacknowledged participation in the maintenance of these pervasive recovery discourses. This work reminds me to move forward with conscious, critical alertness.

*Diagnosis: Liberation/Limitation*

While my research initially sought to add to the pool of critique gathering around the medical model, it is imperative that I express how I once reaped the emotional benefits of having a diagnosis to call my own. Diagnosis is a word formed in place of injury and I began to organize my emotional world around mine as an act of self-liberation. Burstow (2003) notes that through diagnostic practices, “we take away people’s power to name their experiences and subject them to a naming controlled by a powerful international institution at arm’s length” (p. 1300). During my rotation on the other side of the chair, I came to learn that these labels are just as limiting as they are liberating; that in organizing my emotional world around this word, my external world was being organized around it too. The cascading set of privileges afforded to me by way of whiteness allowed my free movement within this system and informed the type of care I received.

I believe that trauma-informed care, and more broadly, recovery as a principled model, is insubstantial because what it ultimately requires is a wholistic framework that includes all implicated parties and structures, past and present, in order to sustain itself. Moreover, tending to trauma inevitably evokes and forces one to confront their living traumas in the process of caring for others. To attribute this type of confronting to (un)professionalism is ultimately reductive and inherently euro/egocentric in its demand for distinct separations that deny our shared humanity.

If ending cycles of violence is the implied goal of trauma-informed care, then we must “shift in focus from the individual to the group [to] allow for proper diagnosis of the source(s) of harm and thus for appropriate solutions” (Oudshoorn & Zehr, 2015, p. 109). Moreover, relying on “a medical PTSD-type model to diagnose trauma” is insufficient and excludes survivors of structurally facilitated collective, shared, intergenerational/transgenerational and community trauma, which affects marginalized communities at a disproportionate rate (Oudshoorn & Zehr, 2015, p. 110). Moreover, PTSD “is a grab bag of contextless symptoms, divorced from the complexities of people’s lives and the social structures that give rise to them (Burstow, 2003, p. 1296). Whiteness exposes its influential role as the main informant to notions of psy-expertise that specifically seek to dominate and oppress. Together they operate, dutifully organizing bodies within the systems that adhere to TIC and variations of the recovery model. This compounded site of power ultimately begs the question: whose trauma matters?

The hyper-reliance on individualizing diagnostic categories, such as PTSD, only preserves trauma and places limitations on healing. It actively minimizes and therefore denies structural culpability, placing instead an isolated emphasis on the symptomatized response rather than the perpetual cause. With close examination, the unstated function of TIC is ultimately concerned with symptom management rather than genuine resolution or healing. Moreover, the application of a diagnostic label to traumatized people “sets the stage for attempting to rid survivors of their knowledge” (Burstow, 2005, p. 435). Unquestionably, explicating the relationship between systemic violence and manifested trauma is fundamental to validating and affirming survivor knowledge. TIC in mainstream mental health is a discernible tactic employed beneath the guise of professionalized “care” and is used to momentarily pacify structural violence on a case-by-case basis. Moreover, to uphold this institutionalized framework with

unconscious praise is quite blatantly an act of structural violence in and of itself.

### *Unsettling “Care”*

As evidenced by the pervasiveness of “trauma-informed care” discourse within this body of work, the term “care” repeatedly appeared as a depersonalized and mechanical function stipulated by neoliberalism which constrains social work as a practice. The incorporation of distinctly medicalized “care”-based frameworks into a neoliberal landscape, which thrives off individualism, ultimately pathologizes trauma and in turn, incites more violence in a competitive manner. This is evidenced by the constructed hierarchies of trauma that manifest in differentiating diagnostic language such as PTSD versus Complex PTSD, for example. “Care” in this context is rooted within a similar hierarchical configuration of professional “care” taker and pathological “care” recipient. I would argue that to “care” is to mutually share in the spectrum of emotion as an equal player. Caring operates on an emotional plane and manifests in feeling, intention and action and is therefore distinctly different from caring in the custody of the medical model.

The author and activist bell hooks (2000) invites a collective love ethic into living and being in the world as a counter approach to the pervasive ethic of domination and violence championed by white supremacy. hooks (2000) states, “[a]wakening to love can happen only as we let go of our obsession with power and domination [...] A love ethic presupposes that everyone has the right to be free, to live fully and well” (2000, p. 87). Moreover, that “cultures of domination rely on the cultivation of fear as a way to ensure obedience [...] when we choose to love we choose to move against fear – against alienation and separation. The choice to love is a choice to connect – to find ourselves in the other” (hooks, 2000, p. 93). Similarly, Goldie (2014)

argues that “love is integral to social justice and it should inform professional practice” (Goldie, 2014 cited by Godden, 2017, p. 405).

A love ethic requires conscious consideration of what collectively unites us and depends on a shared responsibility and personal accountability to one another and to the land. It also holds possibility for a deep and attuned connection within a larger pursuit of universal human rights that addresses the limitations imposed by systems of privilege (Godden, 2017). Simply, a love ethic is profound in its compatibility and commitment to structural level change facilitated through personal connection, shared emotion and collective responsibility. A love ethic blurs the line between the personal and professional self, holding us to a standard of authenticity that neoliberalism has worked diligently to undermine and separate. Thus, incorporating a love ethic requires a paradigm shift away from individualistic and isolated manifestations of medicalized “care” toward a social framework of collectivity and collective care.

As it stands, the reliance on a TI model of caring is obsolete given that we are all implicated in both the perpetuation and inheriting of trauma in some form. This is not to meld and thus devalue the diverse manifestations and structural implications underlying trauma, but rather, to acknowledge traumatic exposure as universal. To assume one lives without trauma is simply naive; creating trauma specific frameworks only perpetuates this assumption. Trauma considerations should therefore be integral to social work practice regardless of the context. Absolon (2019) tells us that through active and conscious efforts made toward decolonizing the mind and spirit, we can collectively form a pathway toward equity and foster “healing of the world” (p. 5). She states, “healing of the land and healing of the people belong together” and moreover that, “all of Creation is sacred, interdependent, and interconnected and is to be regarded as such (Cajete, 1994 cited by Absolon, 2019, pg. 5, 6).

Collective care requires us to wake from our *colonial coma* (Absolon, 2019) in an effort to halt the unconscious upholding of colonization in all that we are and do in the world.

Moreover, Absolon (2019) describes the use of circle work as a counter approach to colonial hierarchies embedded in a colonial worldview, situating this type of work on principles of

“empowerment, equity, inclusivity, and co-creation” (Graveline, 1998; Hart 1997; Nabigon,

2006 cited by Absolon, YEAR, pg. 23). Moreover, Mehreen & Gray-Donald (2018) express that

Collective care refers to seeing ‘members’ well-being – particularly their emotional health – as a shared responsibility of the group rather than the lone task of an individual. It means that a group commits to addressing interlocking oppressions and reasons for deteriorating well-being within the group while also combating oppression in society at large. It places an emphasis on joint accountability, with the aim of collective empowerment. These ideas originate from queer and Black feminist organizing, such as the Combahee River Collective, and disability perspectives. It’s encapsulated in the phrase, “[b]e careful with each other, so we can be dangerous together”

Collective care functions as a direct counter-concept to neoliberal notions of care, particularly in their current, institutionalized and medicalized understandings. Ultimately, collective care requires emotional participation and committed investment in relational systems. Collective care asks us to hold intentional space for the legitimacy of emotional fulfillment, recognition and dialogue as a guiding and unifying foundation. It is intrinsically radical, intuitive and humanistic which runs counter to the supremacy of professionalized forms of caring.

### *Haven or Hospital?*

The data collected from each organization revealed both a thriving dialogue amongst themselves, as well as between themselves and monolithic mental health institutions. Drawing on the historical trajectory of deinstitutionalization of the 1960’s, community based care became a cornerstone to the absolute power of psychiatric dominance (Burrell & Trip, 2011). Seemingly, community-based organizations operate on the shared goal of improving living conditions and

quality of life to mitigate the devastating impact of deinstitutionalization which left a large population of people without access to housing, finances or alternative supports and resources. Simply, these organizations ostensibly exist, and have always existed, as a purported *safe haven* away from the profound violence exercised by the asylum.

The data revealed that all organizations identified in this work maintain some form of programmatic relationship (sometimes referred to as a “collaborative partnership”) with local hospitals or mega mental health institutions. This presented as a powerful observation given the existing tensions between community based care and the overarching authoritative psychiatric dominance of the hospital. These recovery oriented community based services ultimately revealed themselves as a mere extension of the hospital given these “collaborative partnerships” shape the way in which programs and services are ideologically constructed and delivered. This is undoubtedly shaped by funding allocation and paid partnerships which serve to bolster the agency reputation and therefore agency legitimacy within community consciousness. What becomes a point of irony, is the way in which many of these organizations have positioned themselves as praxis-type rabble rousers in their attempt to “get inside” and make change in the institution. More accurately, these relationships are indicative of “settler moves to innocence” (Tuck & Yang, 2012) whereby these organizations employ “strategies to remove involvement in and culpability for systems of domination” by positioning themselves as outsiders inside the institution (Mawhinney, 1998, p. 17 cited by Tuck & Yang, 2012, p. 10).

Profoundly, these partnerships reveal the narrow passageway between haven and hospital. In dressing down community care-as-haven, these partnerships blatantly expose their adherence to the hegemonic order and contradict their expressed identity as the alternative to it. Moreover, these partnerships can and should be understood as a pronouncement of symbolic

violence activated through the “subtle imposition of systems of meaning that legitimize and thus solidify structures of inequality” (Lee, 2013, p. 106). In short, this relationship is demonstrative of the interconnectedness between structures of power and eliminates the possibility for these spaces to operate as “haven”. Moreover, “[m]ental distress is pre-defined in [W]estern culture by the discourses of psychiatry, whose reach has extended beyond the professional clique into the domain of everyday discourse” (Crossley, 2004, p. 162 cited by Lee, 2013, p. 106). Thus, the relationship maintained between seemingly independent community based organizations and mega mental health institutions speaks to the continued adherence to and seeking of psychiatric approval as it relates to professional legitimacy. Ultimately, these supposed “havens” operate on a hair trigger of pathological violence in the same way that mega mental health institutions do; quick to the draw at first sign of disorderly conduct.

### *Mapping Social Work Practice*

What has become obvious throughout this work is the way in which social work has neglected to address how its history permeates modern practice. To examine the roots of recovery is to examine the Christian-colonial roots of social work practice which enlisted white, upper/middle class women to “moralize” and “educate” poor and immigrant communities on how to live (Chapman & Withers, 2019; Blum, 2004). Chapman & Withers (2019) note that social workers in their original iteration as “friendly visitors” were affiliated with the Charity Organizing Society (COS) and that their primary goal was to address and respond to the needs of poor families. Notably, Toronto founded its own COS in 1912, situating the legacy of Canadian social work practice locally at over one hundred years old.

Despite the ubiquitous assertion that conflates social work and benevolence, “friendly visitors” routinely offered “advice” regarding “alcohol consumption or spending, but they

worked toward no changes to the capitalist system that allows a certain percentage of the population to live without enough food, sufficient shelter, and other necessities” (Chapman & Withers, 2019, p. 31). Moreover, while Mary Richmond, one of the founders of social work practice, believed that poverty is shaped by social and political dimensions, she firmly believed that breaking the cycle of poverty was an individual, rather than a collective, responsibility (Chapman & Withers, 2019). This type of bootstrapping rhetoric pervades social work practice today. Moreover, it is specifically rampant in recovery based social work which continues to enact moralizing tactics and routine judgement that manifests in its foundational binary between ab/normal behaviour.

Furthermore, Davidson, Rakfeldt & Strauss (2010) detail the life and work of Jane Addams’ involvement in the settlement house movement, social work development and how her efforts have influenced the recovery movement today. Addams endeavored to address and implicate social and political dimensions within individual experience. Davidson, Rakfeldt & Strauss (2010) echo Addams argument that the promotion of mental “illness” recovery must take a multi-level approach that extends to and includes accountability on a global scale. Despite advancing a progressive perspective for the time, Addams also believed that the best way to approach the helping dynamic in the instance that “a person in need does not know, or will not say, how he or she can best be helped” was to imagine themselves within the same set of circumstances (Davidson, Rakfeldt & Strauss, 2010, p. 97). This assertion embodies the notion of worker expertise, which is routinely used in both modern social work practice and recovery based social work in order to justify prescriptive tactics which strip service users of their agency and subjects them to multi-institutional policing and surveillance.

Even in making progressive and necessary strides toward recognizing how systemic interference impacts upon individual well-being, there remains an obvious undercurrent of whiteness which has carried social work through time. The white, Christian-colonial, middle-class gaze through which social work has always scrutinized service users is built into the fabric of the profession and subsequently influences all social work activities to date. It is a system that is built on and continues to benefit from inequality and social injustice. Moreover, social workers routinely draw on the historically situated discourse of social-worker-as-benevolent, distancing themselves from the harm they inflict under the guise of helping. Finally, while the profession begins to slowly wake to the reality that it functions as a form of moral policing perpetuated through its Christian-colonial roots, this acknowledgement appears to act as a static endpoint which suppresses real action. In acknowledging the power, control and authority that social workers regularly exercise through practice, there is very little evidence to suggest movement made beyond naming it.

## **CHAPTER 7: CONCLUSION**

This research has worked to reveal the current discourses operating within recovery oriented services and texts in Toronto, ON and their role as a functioning pillar within the systematic upkeep of whiteness within social work practice. Furthermore, this research has also made connections between current social work practice and its enmeshment with psychiatry and the medical model. These expressed connections ultimately expose the stealth and growing infiltration of psy-expertise and the biomedical regime which dictates the constructed parameters of both social services and service populations. Moreover, the stealth practice of creaming is forcefully utilized as a tool of oppression within psychiatric and psy-affiliated professions, such as social work, and is wielded through assessments, screenings and exclusion criteria to maintain and reinforce psychiatric domination.

This body of research is not devoid of limitation or personal sensitivities given the duality of my compounded insider (professional/recipient) status as it relates to recovery oriented and trauma-informed mental health care. Johnston (2019) asserts that “[a]n “insider” [...] knows and has personal experience with their targeted group of study, to varying but significant degrees” and thus “there is a responsibility on the insider researcher to critically understand the role of the self in the production of knowledge” (p. 2). This critical energy was applied to and understood within the context of CDA and data interpretation given my motivation was to inform knowledge production regarding recovery services locally and grew from my own multilayered experiences. Moreover, scanning the current landscape of local mental health recovery organizations using a critically reflexive lens was imperative given I will soon be entering into the field once again.

Johnston (2019) contends that co-creating knowledge that consciously situates the self in relation to the subject is an important and intimate process by which recovery and healing can be facilitated. Evidently, recovery does not lay within the isolated bounds of the professional and

their tools, but within reclamation, relationship and co-construction of meaning from the ground up with other survivors. I recognize that the texts that I engaged with for the purpose of the research were filtered through my own identities, knowledge, privileges and worldview and lacked the relational dynamic specific to interviewing. Therefore, using critical discourse analysis meant that service providers within these organizational contexts were unable to respond to or engage with my claims.

My hope is that this work will contribute to subverting the compounded authority of the recovery model and trauma-informed care. More broadly, I hope this work reminds us as critical social workers that no such idyllic frameworks exist within mainstream social work. We must be alert to and suspicious of professionalized models of caring that are enmeshed with psy-disciplines or are psy-adjacent. To quote Mukhopadhyay (2014) “the paradigm of psychiatry atomizes the experience of distress, making it an individual issue for which the collective bears no responsibility” (Mukhopadhyay, 2014 cited by Wilkin & Hillock, 2014, p. 190). Moreover, the current structure of frontline social work is one that continues to “prioritize individual therapy and individualistic solutions to social problems over interventions that link the individual to a broader socio-political context (Specht and Courtney, 1995 cited by Barak, 2016, p. 1777). Advancing a collective care model which centres emotional wellbeing and invests itself in relationship building, mutual responsibility, remembering, accountability and humility is vital in mobilizing toward a structural overhaul.

The purpose of this work is not to deny, reduce or dismiss the very real impacts and diverse manifestations of trauma, nor is it meant to deny the reality or presence of trauma within our frontline engagements with service users. Rather, my hope is that this work inspires a cognitive and paradigmatic shift away from the mishandling of such injuries; to abandon our

professional ego which tells us as social workers that we are the builders, providers and cultivators of any such healing or “recovery”. To assert ourselves as professional authority on trauma and recovery within a broad framework that does not indict the catalyst only diverts our energies and perpetuates harm; it undermines the suffering that lives outside the bounds of diagnostic organizing. We must actively work to explicate and disrupt the covert process by which current models of trauma-informed and recovery type care have come to resemble one another. This compounded site of power alienates its subjects through the pathologizing and diagnostic organizing of manifested structural violence while simultaneously ignoring the foundation of whiteness upon which it is built.

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