In this article, the use of the term “I” relates to the first author’s experience and has been maintained throughout the text. The second author contributed to reflectively framing this experience within the theoretical and empirical literature.

Two weeks into my mental health fieldwork placement as a student occupational therapist in a transitional day program, I met a client with a complex personal history whose mannerisms, words and tone conveyed to me a sense of deep sorrow and isolation. Her apparent struggles reminded me of my own darkest episodes, when striving to express myself in a rational way took unbelievable effort, making me feel worthless, alone and misunderstood. Had I been in the client’s place then, I would have wanted to know that I was not alone, and that there was hope for things to change. I believed that if she knew she was talking to someone who could comprehend the enormity of the demons she faces, she might feel less alone.

I decided to relay a small nugget of my personal experience, explaining that change is a slow process but it does happen, and that I know this because it happened for me. Upon hearing this, the client appeared relieved, her face relaxed and she smiled a little. A key element of recovery is connectedness (Leamy, Bird, Le Boutillier, Williams, & Slade, 2011), including connection with health-care professionals. Mental health care is not a one-way street where only the client feels understood; rather, it is a mutual regard (Fraser, 2000) wherein both provider and client are in a professional and genuine therapeutic relationship. I felt we developed an understanding that both she and I were in this together.

My fieldwork supervisor commented on how I was able to use my personal experiences in an appropriate and effective manner. In the weeks that followed, the client disclosed that she felt increasingly safe to talk with me, and shared that our discussions had motivated her to take steps toward making changes in her life. Although I have no way of knowing whether my support had any lasting impact for her, I do know that my choice to briefly open up helped her feel connected to another person, and that it fostered a shift in her vision of possibility for her future.

The team with whom I worked comprised experienced and caring professionals, yet I noticed that these qualities alone did not necessarily translate to the development of relational partnerships (Jacobson & Greeley, 2001), an essential element of recovery-oriented care. I observed that judicious disclosure of relevant information embodying the notion of a shared journey of growth and discovery (Slade, 2009) was not the norm within a model of biomedical expertise. Further, I observed that stories about past service users were told on occasion with a judgmental or flippant tone, including comments such as, “With so much money and social support, what is she depressed about?” The attitudes underlying these kinds of conversations struck me as stigmatizing, and I wondered about their impact on caring practices in this setting.

In general, I believe that in an environment where the tenets of recovery-oriented care are applied, stigma can be challenged and explored respectfully (Pickles, 2014; Pietrus, 2013) through dialogue. As occupational therapists, we have an important role as change agents who educate and advocate (Canadian Association of Occupational Therapists, 2012). Demonstrating self-acceptance to colleagues can be beneficial in questioning stigmatizing assumptions, and I am learning that the words and actions we use around self-disclosure may also colour their impact. For example, if I say I am “sharing” parts of my story as a means to foster hope, I may be taking on a role akin to that of peer support worker, which includes a type of reciprocity characteristic of mentors or friends (O’Hagan, Cyr, McKee, & Priest, 2010). If I use the term “judicious self-disclosure,” it may indicate a deliberate choice to use personal experiences toward a therapeutic purpose, which may be more in keeping with an expert role or may be associated with the medical model.

Advocacy can take many forms, and I believe that sharing selective personal realities can have a powerful impact on normalizing mental health issues and promoting compassionate, respectful and accepting attitudes toward persons with such challenges. When asked directly about my medication and treatment, I chose not to answer, as I believe this disclosure would not have helped the client make informed decisions about her own care. In all situations and practice settings, I must consider whether personal disclosure is the most effective strategy for a given issue. Timing, cultural and therapeutic safety, mutual trust and respect, and my professional reputation are all important considerations. To this end, the authors propose a series of reflexive questions that...
It is not uncommon to question whether disclosing one’s history with fluctuating mental health poses a risk to professional credibility (Carter & Motta, 1988). However, if normalizing mental health challenges is part of our role, then how can health-care professionals expect clients to believe there is no shame in living with mental illness when those of us with comparable life experiences keep them entirely separate from our professional lives? How can we advocate for dispelling stigma through authenticity, applying this standard to others but not to ourselves? By communicating aspects of my experiences of anxiety and despair, alongside positivity and hope, I have been able to connect with clients and professionals in a unique and powerful way. Many of the clients in the program thanked me for my contribution to their recovery process. As some of them told me on my final day of the fieldwork placement, my willingness to share relatable portions of my lived experience made them feel understood, valued and supported.

When practiced with discernment and critical reflection (McCorquodale & Kinsella, 2015), sharing one’s personal truths can foster meaningful connections and empowerment in others. In sharing my student perspective on being “seen” as a strategy for connection and advocacy, and as a part of recovery-oriented practice, my hope is that others will begin to question their assumptions and perceptions regarding boundaries between the personal, the professional and the political, and evaluate the significant benefits to making some room for vulnerability in their practice.

References

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Photo by Hina Mahmood
Hina says: “This image represents the value of mindfulness meditation and how it can contribute to recovery and quality of life. Occupational therapists can incorporate this practice into client-centred care, providing a means of empowerment and personal control over healthy lifestyle management.”