

Co-Developing a Radical Mental Health Doula Model of Support: Reflections on Doing Feminist Participatory Action Research

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This paper reflects on the application of Feminist Participatory Action Research (FPAR) as a methodology during the development of a Radical Mental Health Doula (RMHD) framework and the accompanying training curriculum. Women and their experiences with mental health systems and services are at the centre of this project. Experts through their own experience, women co-researchers (WCRs) were instrumental in identifying problems and determining how to address gaps in what they recognized as an often cruel, fragmented and dehumanizing model of mental health care. The FPAR approach allowed us to question the roles of expert, researcher and subject. This enabled an exploration of how women's voices and experience, which are traditionally silenced, can challenge hierarchical and patriarchal practices in mental health systems and research. Reflecting on the use of FPAR, through an analysis of data from consultation meetings with WCRs, we identified three key practices that led to the successful application of this methodology in the RMHD project. This paper highlights the voices of women co-researchers to examine 1. Relationship building, 2. Inquiry with women co-researchers and respect for lived experience, and 3. Holding space to share vulnerability and emotion in the FPAR process.

Canadian women consistently report having poorer mental health than men and have higher reported rates of stress, anxiety, and suicidal ideation (Government of Canada, 2006). Gender-based inequalities in mental health have been further exacerbated since the start of the COVID-19 pandemic (Government of Canada, 2022). In part, this is because women's mental health was disproportionately and negatively impacted by the inequitable "gender division of unpaid family work" during times of quarantine (Moyser, 2020, p.7). Mood disorders such as depression and bipolar disorder are the most common forms of chronic mental illness in Canada, and are consistently, persistently, and more severely diagnosed among women (Health Canada, 2002).

Understandings of mental health and illness and subsequent treatments and diagnoses have been dominated by "male normativity" and related concepts of "sanity" (LeFrançois, Menzies & Reaume, 2013). While Canadian women are more likely to seek out mental health support than men, they consistently report worse mental health outcomes and a failure of the current mental health care system to address their needs (Moyser, 2020). In the wake of a looming global mental health crisis (Kelland, 2020), it is imperative that we – as critical

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feminists – challenge the oppressive dominance of psychiatric systems designed to meet the needs of men (David & Smith, 1975) and heed the call for more gender-informed mental health policies, services, and therapeutic options (Abel & Newbigging, 2018).

Barnes et al. (2009) outline a number of characteristics that can make mental health services more gender-sensitive and inclusive towards women. This includes: understanding mental distress in the context of women's lives; co-designing services with women with lived experience; being sensitive to the diversity of women's needs, experiences and backgrounds including race, sexuality and disability; providing women-only spaces; enabling women to make choices about their care and treatment; addressing sexual abuse, domestic violence, and body image concerns as structural barriers to health and wellbeing; empowering women to develop skills for addressing their difficulties; and promoting advocacy for women who need support to voice their views.

Our study offers a women-focused interpretation of the Canadian mental health system through the eyes of those who have encountered it. Specifically, we look to the often-silenced voices of women who use mental health services to challenge and inform the hierarchical and patriarchal practices in mental health systems and research. As part of a larger research project which explores new approaches to mental health service delivery that upholds individuals' rights and dignities, we worked alongside women with lived experiences of mental health distress and system navigation to develop a new type of mental health support - the Radical Mental Health Doula (RMHD) - that centers on women's lived expertise and addresses their specific needs.

This paper examines the process of using a Feminist Participatory Action Research (FPAR) methodology in this project. We examine how FPAR provided the opportunity to challenge institutional hierarchies that exist within research processes to co-develop a RMHD framework and training curriculum informed by women's experiences in the mental health systems. This paper provides a reflection on the key practices that we identified as central to the successful application of this methodology in community-based, women-centred research. These practices are: 1. Relationship building, 2. Inquiry with women co-researchers and respect for lived experience, and 3. Holding space to share vulnerability and emotion.

Background

Participatory Action Research and Feminist Participatory Action Research

Participatory Action Research (PAR) is a qualitative research process that acknowledges the varying skills and insights participants bring to a study and involves working together to pursue creative, genuine and useful solutions (McIntyre, 2008). PAR focuses on embracing the different skills and insights of participants, increasing collaboration, and challenging hierarchical research processes, to strengthen and transform research (Yoshihama & Carr, 2002; Johnson & Flynn, 2021). Designed by people within a community, for the people of a community, the PAR framework uses study design techniques to enact positive social change (Singh, Richmond & Burns, 2013). Members (or co-researchers) are part of the planning, implementation, and dissemination of the research, throughout which they support the goal of producing and sharing socially transformative knowledge (Schneider, 2012; McIntyre, 2008). This allows community members to be active change agents rather than simply the recipients of change (Johnson & Flynn, 2021).

Expanding on the key principles of PAR by drawing on feminist research and theory, FPAR acknowledges the tangible impacts that gender and other intersecting identities have on women's everyday lived experiences (Singh et al., 2013; Gillberg & Reid, 2014). As McGibbon (2021)

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highlights, critical perspectives are necessary to disrupt and resist institutional practices that promote injustice and structural violence, which if left unchecked, lead to “the erosion of human dignity and of all associated dimensions, including confidence, overall well-being and security” (United Nation Children’s Fund, 2018, p.2).

Intentionally centralizing the perspectives and experiences of women, FPAR reverses traditional power hierarchies typical in community/academic collaborations, where despite being called “partners in research”, the latter often retain power over the former when it comes to what is presented, and whose interests are favoured (Langan & Morton, 2009). This methodology recognizes that power dynamics exist between researchers and the researched, but rather than attempting to erase these dynamics, the focus is on facilitating knowledge-building between academic and community researchers in the interest of affecting positive change in women’s lives individually and collectively (Gatenby & Humphries, 2000; Podems & Negroustoueva, 2021; Reid et al., 2006).

Using this approach enables researchers to consider how intersecting systems of oppression constrain and shape women’s lives. For one, research is often centralized in socially valued institutions, and expertise is drawn from professionals (i.e., academics, service providers, physicians). A hierarchy of expertise is sustained while the voices of people with lived experience are diminished. In mental health, service users are especially vulnerable to having their insights, opinions and preferences disregarded (LeFrancois et al., 2013). The voices of women with histories of mental health struggles are often silenced in both contexts (Barnes, Davis & Rogers, 2009). At a time when community engaged scholarship is gaining momentum, we see the opportunity to reimagine expertise in more equitable ways, challenging the traditional researcher/subject relationships and gender-based stratifiers. FPAR researchers engage with community members to enact solutions to problems faced by the community with the ultimate goal of improving the everyday lives of girls and women (Gervais et al., 2018).

We used this methodological approach to co-create a RMHD model of care that is rooted in the values of support, comfort, education, and advocacy. Traditionally, the role of a doula is focused on supporting women during childbirth. Today, based upon evidence that continuous support from a known and trusted person greatly increases maternal satisfaction and results in better health outcomes, the doula role has expanded and professionalized (DONA, 2020). The successes of childbirth doulas have led to the creation of other types of doulas, including but not limited to, postpartum, bereavement, and death doulas. Radical doulas, like traditional doulas, retain emphasis on continuity of care while expanding doula practices by attending to diversity and intersectionality (Basile, 2019; Carathers, 2019). Radical doulas focus on the recognition that freedom of choice and agency around birth does not apply to all people especially with regard to race, class, sexuality, and social location. Radical doulas prioritize underserved communities and emphasize the need for doulas and their clients to represent multiplicity and diverse identities (Perez, 2007). The radical doula movement is rooted in social activism, and is inherently feminist, antiracist, anticlassist, and connects activists, professionals and allies within a social justice framework (Basile, 2019).

Methods

Twenty-two people with lived experiences of mental health struggles were recruited through snowball sampling and through referrals by the core research team’s (CRT) community partners and professional networks in *City, Province* to act as co-researchers in part or all of the

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development of a RMHD framework and training curriculum. For the purposes of this paper, we will focus on the sixteen women co-researchers (WCRs) who either identified as women or used she/her pronouns, and who are current or past mental health services users and/or caregivers of service users.

The CRT consisted of two faculty, a postdoctoral researcher, and five undergraduate students. All CRT members identify as women. Faculty researchers work in Disability Studies and the team brings various levels of individual and professional experience with feminist research and methodologies, mental health and illness, and addictions. Student members of the CRT worked on the project as part of their practicum experiences, through paid research internships and salaried summer studentships. Three of the five students worked through multiple phases of the project.

Spanning 2022, WCRs were invited to three rounds of preliminary consultations, followed by three additional rounds of curriculum development sessions. This consultative process gave the opportunity for WCRs to share their individual experiences with mental health systems. In total five preliminary consultation sessions and six curriculum development sessions were held both online and in person. Multiple time slots were offered for each of the sessions including days, evenings, and weekends to accommodate WCRs availability and to encourage participation. Informed consent and voluntary participation were discussed prior to each session to ensure WCRs continued to want to engage in the consultative process and were aware that they were not required to do so.

The preliminary consultation meetings were meant to gather broad insights into women's experiences of mental health struggles and of accessing, or failing to access, needed mental health supports and services. This knowledge was used to identify existing gaps in services and to understand how a RMHD could support women in these underserved areas as an alternative, community based, peer-led, gender-informed resource. Curriculum development sessions, in turn, were designed to gather WCRs insights on the skills, knowledge and resources required to support people in the RMHD role.

Facilitation questions and workbooks were provided at each semi-structured session. WCRs were also asked to complete a one-hour take home reflection following the one or two-hour consultation. The content of subsequent sessions was shaped by the discussion of the previous session and guided questions developed by the CRT. The WCRs were compensated with gift cards or honoraria of \$25 per hour of consultation and reflection. All consultations were audio recorded and transcribed. Handwritten workbooks and reflections were digitized by the CRT. Notes taken by the CRT were also included in the data set. Data was coded by the CRT including faculty and student co-researchers. The WCRs were not a part of this process. Faculty/Post Doc co-researchers coded alone, and student co-researchers worked in pairs. The CRT then came back together as a larger group to discuss and debate codes and develop subsequent themes. A librarian assisted in the set up of Nvivo software so that codes could be developed, and themes were identified both by hand and using Nvivo.

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In this section we identify key themes that emerged using FPAR in this project. As both a research-based and community-driven project seeking to enact solutions, the FPAR process revealed, through the centring of these women's voices, three key practices which exemplify

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how FPAR research can empower women and enable social action. This includes: 1) relationship building, 2) inquiry with WCRs and respect for lived experience and 3) holding space to share vulnerability and emotion.

Relationship Building

Guided by the values of a FPAR approach, we made relationship-building a priority from the beginning of the project. These relationships formed the basis of the work. The findings presented below highlight how collaborative partnerships informed the research project, the importance of a sense of belonging and the actions that supported team building.

The RMHD project started with the development of a network of community partners. This mainly consisted of organizations that engage in areas such as mental health service provision, addictions, domestic violence, municipal government, and support for people who are unhoused. The team of WCRs volunteered to participate through these partnerships and network connections. One WCR (09), the parent of a child who experiences mental health struggles, for example, heard about the project through her work at one of the partner agencies. Through this existing relationship, she was able to provide expertise on her perspective of the mental health system as a parent. Another WCR (07), a self-described “long time mental health service user” who sought to offer her perspective, became connected to the project through a mutual acquaintance at the university. A third WCR (10), a volunteer at a community partner agency, brought their experience in mental health crises and domestic violence after hearing of the project through this agency. The community partnerships developed early in the project helped to lay the foundation for relationship building and trust, which in turn contributed to a sense of pride and deep commitment to the work. Reflecting this, a large proportion of the WCRs took part in multiple consultation sessions over several months, engaging in more than one phase of the project (i.e. consultation and curriculum development). Some of the WCRs participated in alternate formats if they were not available for the scheduled sessions (i.e., for work, vacation). Despite potential barriers, such as traveling long distances, or balancing work and caregiving responsibilities, participation levels were high overall.

While some trepidation was discussed prior to starting the consultations, the WCRs generally described feeling welcomed and encouraged in the space. WCR 07 noted

I woke up this morning, and I was like so stressed about this. I was nervous. I knew it was going to be a smaller group, and I'm like, "I don't think I'll be able to talk." When there's more people, so I don't have to talk as much, which sounds surprising. But thank you so much. All of you have been so wonderful, and I feel super encouraged, and I was so scared to come, and I was working through that anxiety. So I'm really grateful for all of you for being so kind and smiley and validating and encouraging. So, thank you.

Other women described being excited about the project and posted publicly on social media about their involvement. As noted above, many of the women expressed gratitude for the opportunity to share their lived experiences and to have found a community doing so.

While the WCRs described previous experiences of seclusion both within and as a result of the mental health system, it is worthwhile to note the sense of belonging and its identified importance that was cultivated in the WCR/CRT team over time. As WCR 12 stated, “I find that a sense of belonging in community is key. Isolation is a killer. Isolation is a killer, killer, killer.”

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The meaningful social participation in a research-context that is encouraged by PAR was tangibly felt among our group. In testament to the value of these relationships, one WCR shared that her reason to get involved in the project was that “I wanted to make connections with you ladies” (WCR 07).

The importance of team building was also a top priority when choosing the physical space for the meetings. For budget reasons, all consultation sessions were held on the university campus where costs for meeting rooms and parking were covered. While ideal for budget reasons, there were concerns given that the teaching hospital is attached to this part of the university campus. We were aware that some of the WCRs likely would have had unpleasant or traumatic experiences in this hospital setting and this could negatively impact relationship building and developing trust. Noting this, particular attention was paid to creating a space that was welcoming and safe. Coffee and snacks were provided, and comfortable meeting rooms were chosen. Donuts, as an example, became a popular topic of small talk and a way to break the ice (e.g., discussions about favourite flavours, shops around town, and who got to take home the leftovers). Name cards, ice breaker activities and team building exercises were also used to make the WCRs feel more comfortable and to introduce new co-researchers to those who had participated previously. Small group activities and break-out rooms (for online consultations) provided opportunities for the WCRs to get to know one another and develop relationships. As CRT 5 noted, “Our discussions were not strictly limited to the scope of the project. We heard all sorts of aspects about their lives and concerns, including their interests, hobbies, pets and anything else they wanted to share”. The consultation process was flexible, and often diverged from the consultation guide so the co-researchers could speak freely and would not feel rushed or pressured.

Regular one-on-one communications between the WCRs and members of the CRT also took place outside of the formal consultation process contributing to a level of trust that allowed the WCRs to feel comfortable in sharing their stories and experiences. Outside of consultations, often during the breaks or after the recorders had been turned off, the CRT members would learn of many significant events that were taking place in the women’s private lives (losing a job, initiating a divorce, navigating troubled relationships with kids). By building these relationships the whole research team was able to have meaningful consultations that allowed the project to move forward and to develop a RMHD framework that reflected the wants and needs of the women in the room.

Inquiry with Women Co-Researchers and Respect for Lived Experience

Care was taken during the consultations to limit hierarchical research team structures and power imbalances that traditionally exist between “those conducting the research” and “those being researched”. This was especially important considering the affiliation of the project with an academic institution, where legitimacy of knowledge is typically judged and validated by one’s educational background, institutional affiliation, and publication record. During consultations everyone was addressed by their preferred name, pronouns, and the use of titles such as “Dr.” or “professor” were avoided. Conversations were deliberately held using an informal tone, and jargon and specialized terminology (i.e. social justice, feminist theory, intersectionality) was explained. The WCRs brought their own knowledge and language to the consultations. Meeting rooms were set up to allow everyone in the room to have a clear view of one another, and with the CRT sitting amongst the WCRs. We ensured that the number of CRT

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members in the space never outnumbered the WCRs. Smaller group discussions were also regularly used to ensure all voices were heard.

The co-researchers were provided detailed information about the scope and purpose of the project ahead of time. As CRT 04 noted, “Many phone calls, emails and in person conversations were had...to explain the full scope of the project and to ensure each co-researcher understood their value.” It was reiterated throughout the sessions that as co-researchers, the women were the experts and that as partners in the research process, they had different, but equal influence on the outcome of the RMHD framework and curriculum. “There’s no hierarchy in the sense of anyone says something that’s more valuable or more right or whatever. We’re here together” (CRT 03). Despite these efforts, some of the WCRs grappled with their role as experts in the project and entrenched ideas about professionalism, institutional structures and hierarchies of knowledge persisted.

The WCRs questioned the distinctions between their own roles, and the roles of the CRT. Some expressed that they sometimes felt uncertain about sharing their ideas or suggestions, linking this to past experiences of feeling unheard by healthcare professionals. The shame and devaluation that the women described experiencing in the past within mental health care settings made some of the women feel as though they had “nothing to contribute” (WCR 15). Although attempts were made to diverge from traditional research approaches WCR 04 demonstrated remaining discomfort and the embedded hierarchies that they expected in research projects by referring to the group of WCRs, for example, as a team of “guinea pigs”. It took time for the WCRs to begin identifying with the role of expert on the project and to feel more comfortable acknowledging the importance of their contributions. Through prolonged engagement on the project, however, a noticeable shift did take place. In later consultations, the WCRs began to see themselves as central to the development of the RMHD role that they helped to conceptualize and create. WCR 4 exemplified this saying.

The term wounded healer I think is really important. So, if you are in the middle of a difficult moment, that doesn't mean you have nothing to give. It doesn't mean you must sit there and receive until you are healthy. And I think sometimes in the system, that's what's expected.

The WCRs described a shared sense of hope and excitement for the future and felt that they were part of something bigger than themselves. Co-developing the RMHD framework was seen as “a mental health revolution” (WCR 07), “a higher calling” (WCR 08), and the recognition that they have “the ability to make an impactful difference” (WCR 06).

Throughout the consultations, the WCRs worked side by side with the CRT. While the CRT brought expertise in data collection and analysis, for example, the WCRs brought expertise through their lived experiences. The WCRs provided first-hand knowledge of a mental health system that has ignored the diversity of their needs, their experiences and backgrounds as women of different races, ages, cultures, religions, family makeup, parental status, sexuality, disability and occupations. In the consultations, the WCRs emphasized the importance of considering intersecting identities and the need for individualized women-centered support. Speaking from their different social locations and diverse backgrounds, the WCRs provided a breadth of information in areas such as access to public and private health care, experiences of taking prescribed medications, in-patient and out-patient care, and involvement with the justice system.

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The WCRs also brought knowledge in areas such as coaching, somatic and holistic healing, and family support. The broad level of expertise was widely recognized and appreciated. As WCR 12 remarked, “I am just so excited by the knowledge in this room.”

When it comes to how women experience mental health support, WCR 05 noted “...it's not only the services that are being accessed, but the role that we each play, that different people play and how that then impacts their experience. It's just, it's hugely vast.” The WCRs also recognized the significance of experiential knowledge to the RMHD role.

I feel like there is a piece of our lived experience that's crucial or really important.

There's something about actually living in that that really changes your understanding of it. (...) I think having a doula [who] had their own personal experience that they have overcome...will make them that much more compassionate, empathetic, understanding, a better listener, a better friend (WCR 04).

The ability for a RMHD to act as a peer and share emotional bonds with the people they support was identified as a way to potentially ameliorate the power imbalances the WCRs described experiencing in encounters with medical professionals such as doctors and psychologists.

In the provision of mental health support, empathy and shared lived experience was identified by the WCRs to be equally as important, as subject-matter expertise in the development of the RMHD role. WCR 18 described a commonly felt frustration when “experts” tell patients that they know what they are going through.

And it's like, no, you don't. You just have a degree on paper that says you do, but you actually don't. And no disrespect to that at all. But it's just personally I'm a recovering alcoholic and addict and having a treatment center of all the counselors and psychologists who are all in the 12-step program, they're all grateful, recovering addicts like 12 plus 25 years. I couldn't believe how approachable they were and kind, and loving, and understanding, and didn't make me feel like I was a piece of shit.

Holding Space to Share Vulnerability and Emotion

Creating a space where the WCRs could share vulnerable and emotional experiences was crucial in the FPAR process and the development of the RMHD framework and curriculum. Through the consultations the CRT purposefully built-in time and space for the WCRs to discuss their experiences, frustrations and difficulties. It became evident that the discussions around individuals' experiences were highly emotional but that the sharing of these experiences was central to the development of the RMHD framework and curriculum. It was important to not only hold this space for the WCRs to share during the consultations, but to also create a safe space after the consultations by ensuring members of the CRT were available if the WCRs wanted to talk further or debrief. The CRT also made it a policy to check in with any of the WCRs who seemed upset during the consultations.

In the space created for sharing the WCRs discussed at-length the negative treatment and harm that they experienced in the mental health system. Events with physicians, nursing staff, security, family members and police were some of the areas mentioned as “traumatic” and as forms of “torture”. In sharing her story, WCR 01, an immigrant to Canada, described the fear and confusion she faced when she went to the hospital to seek assistance.

It was so a miserable experience for me because I have to stay by myself, and they put me in isolated room, and they don't talk to me. I never expect that in Canada they treat

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patient like this in mental health units. So I just wanted to share my experience. And I know it wasn't right. Because when you are anxious, you need someone to talk to, you need your friend, you need your family, you need a huge support from people [...] I was screaming, and they locked me in a room... I've done nothing. I keep shouting [but] they never opened that door.

Negative and harmful experiences were further shared in WCR 19's description of her therapist. I have had therapists who... would like gaslight me all the time about things that she had said and that was very, very triggering... that actually caused me more trauma... Not only did you not help me to heal, but like you made me sicker.

The mothers of children with mental health struggles also described how they felt judged and were treated negatively by hospital staff when seeking medical care for their children. Feelings of sadness, anger, and resentment were described by the WCRs when discussing the often-cruel nature of practices such as competency hearings and community treatment orders. Speaking of the lack of humanity provided to her son in hospital, WCR 15 recounted some of the ways that his personhood had not been acknowledged. She said "my son is an artist you know? But they [staff and inpatient care facility] never ask about his art. All they care about is whether or not he has taken his meds... it was hurtful." Experiences of dehumanization, a lack of choice and bodily autonomy, as well as little to no support upon being released from hospitals all came up as significant gaps in current service provision. WCR 12 said "they [people seeking help for mental health] are just thrown out there into the wilderness with absolutely no map. I think that, for me, a map is critical because it releases so much of the, "what if" and the shame, and then everything".

Not all experiences were negative, and the WCRs shared aspects of positive professional encounters that RMHDs could learn from, including the importance of genuineness and continuity of care. WCR 12 recounted her experiences of being admitted to ER after an episode of self-harm:

the most memorable one [moment] is a police officer coming back into the emergency room when he was done with me, and he didn't have to come back. But he came back and said, "We're here for you. Call us if you need us." And that was more memorable than anything my family has ever said in support. To have that police officer take that time to give me encouragement.

The importance of having positive relationships and interactions with service providers and medical staff was further clarified by WCR 07 who described the fear of losing a positive therapeutic relationship:

I get so attached to my... team of professionals. One of them is preparing me one day for when he retires, my psychiatrist and that's really scary for me... because they've been with you in this journey for so long, and they've helped you and they've made you feel safe and they've worked through so much stuff, and then one day they're going to be gone.

Holding this space for emotional discussions not only allowed the WCRs to share their experiences openly but also to navigate conflicting opinions in a safe space. Disagreements arose among the WCRs on the use of the DSM (American Psychiatric Association's Diagnostic and

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Statistical Manual of Mental Disorders), the role that social and biological factors play in trauma, and the importance of bodily autonomy. A particularly heated discussion took place around whether it was an essential right for patients to request a psychiatrist of a specific gender in a constrained ER context. One WCR argued that patient choices must be considered within the capacity of the system to meet that choice, while another regarded a patient's capacity for choice to be a fundamental right, whether that choice was based on desire (want) or necessity (need).

Recognizing that disagreement in opinions is reflective of the wide spectrum of human experience, the CRT consciously maintained a neutral stance during consultations. In our facilitation, we intentionally stayed away from agreeing or disagreeing with personal opinions or labeling any experiences and reflections as "good" or "bad". When the above-mentioned discussion began to escalate, however, the facilitators felt it was necessary to validate both women's opinions about the topic, reflecting the doula value of not making judgements, and to then bring them back to common ground. Following this reset, other WCRs shared their observations about the courage that it takes to confront one's personal biases, and the growth that can come from such confrontations.

I hope it's okay to say thank you both for putting your humanity on the table. The discussion, I think this is where the learning comes in ... I think the conversation you're willing to engage in...from the different perspectives... maybe this would help doulas learn. How do they learn about their own biases until they come up in front of them?
(WCR 10)

While some of the WCRs and CRT members felt positive about how this disagreement was resolved, some of the research team members described feeling "triggered" and "upset" by the discussion. Reflecting on this event, WCR 04 noted that "hurting people hurt others," and that sometimes "forgiveness" is required. Following the consultation, a private email was sent to each of the WCRs with an invitation for debriefing about what happened. No follow-up conversations were scheduled. All the WCRs returned for future consultation sessions and continued their involvement on the project.

Discussion

The strengths of FPAR lie in the blurring of lines and the challenging of expertise and structures. Working in a traditional academic research environment it can be difficult to identify and trouble these lines while upholding a research program or agenda. According to White and Pike (2013), how mental health and illness is made sense of is closely related to "who is entitled to participate in the production of mental health knowledge, who has the ability, or inability, to control what becomes 'common' knowledge, and moreover, who is permitted, or not, to be seen and heard in the making of MHL (mental health literacy)" (p. 239). Through our research we purposefully challenged the traditional understanding of "expertise", as being produced, and validated by those within academic and medical institutions, and instead centralized the knowledge and voices of women with mental health challenges. "Experts by experience" (Beresford, 2013) the women in this research were considered expert co-researchers whose lived experiences formed the basis for the development of a new women's mental health support. In this paper, and throughout the RMHD project, we referred to the women taking part in the research process not as "subjects" or "participants", but as our "co-researchers". The relationship that was built as a result of this partnership, along with the sense of community and belonging that ensued, allowed for spaces to be opened up for honest and vulnerable discussions.

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Working side-by-side with the WCRs brought forth powerful voices of experience and the opportunity to pursue genuine and useful social change in support of women's mental health. By embracing the skills and abilities of all members of the research team we were able to widen our collective knowledge, to gain deeper understandings of gaps in women's mental health and determine ways that we might transform some of these supports. Despite the challenges of using FPAR, which included prolonged efforts to transcend traditional hierarchical research structures and relationships, experiencing the heaviness of sharing deeply personal experiences and the discomforts that come with holding divergent viewpoints, adopting a FPAR approach in the RMHD project was instrumental in the development of a tangible framework and training curriculum for the first cohort of RMHDs.

Conclusion

This paper demonstrates the benefits of FPAR as a progressive methodological framework to undertake community-based and women-centred research. Through the research process, the WCRs reclaimed ownership of their stories and lived experiences of mental health challenges and felt empowered by their engagement in the creation of a new type of doula and woman-centered mental health support. The restructuring of traditional research hierarchies centered on women's lived experience, highlighted the importance of these voices.

In tandem with these "experts by experience," we have found points of convergence with traditional doulas, radical doulas, and critical feminist disability theorists. With the team of WCRs we have developed a RMHD framework that applies traditional doula principles to the broader context of mental health. RMHDs will provide comfort, care and support in ways that are individualized, client driven and continuous. At the same time, they draw from radical doula principles by recognizing and prioritizing the diversity and unique facets of women's mental health experiences while challenging barriers to choice and agency. The WCRs have contested hegemonic forces of medicalization and psychiatrization, in areas such as diagnoses, community treatment orders or competency hearings reflecting the work of critical feminist disability/mad theorists. They have insisted that RMHDs uphold the rights and dignities of all those who come within their care.

The use of FPAR as a methodological approach in this project has offered us the opportunity to critically unpack the deeply rooted oppression that lies at the intersection of gender, mental health and mental health research. This work challenges perceptions and treatment in women's mental health support and radically brings the voices of women impacted by mental illness, so often silenced or dismissed, to the forefront. Using FPAR practices through relationship building, inquiry with women co-researchers, respect for lived experience, and holding space to share vulnerability and emotion we have co-developed a novel, women-centred mental health support.

While there are many benefits to this approach, we must also be aware of the challenges, including the difficulties of eradicating power imbalances within the research team, and the blurred boundaries and distinctions of the roles and responsibilities of WCRs and CRT members. As female critical disability scholars who are housed within a male-dominated health sciences department in the faculty of medicine, making ourselves heard and recognized can often feel like an uphill battle. Leveraging the potential of collective action through FPAR, we must recognize our own privilege and the benefits we gain from working with less privileged and sometimes powerless co-researchers who uphold our goals and allow us to challenge the institutions that we

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are a part of yet fight against. As we move forward with the RMHD project and the continued implementation of FPAR research we need to continually reflect on how to create more equitable and genuinely collaborative and reciprocal relationships as we conduct further research and share knowledge.

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