Experiences of Canadian Distance Education Social Work Students with Mental Health (dis)Abilities

by

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Abstract

Distance education gives a diverse group of social work students access to post-secondary education. Research addressing the overall experiences of Canadian distance education social work students is limited. No known studies to date have focused specifically on the experiences of distance education social work students with mental health (dis)Abilities in Canada.

For this thesis research, narrative methods, interviewing and analysis were used to gain insights on the experiences of distance education social work students with mental health (dis)Abilities and, further, how online programs could better support these students throughout their studies. Using narrative autoethnography, I included my own insights as a student living with mental health (dis)Abilities completing online social work studies. Six study participants from two Canadian universities shared multifaceted experiences of adapting, coping, and navigating through their online courses and programs. Participants also shared suggestions on how their institutions could be more supportive.
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
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<tbody>
<tr>
<td>BSW</td>
<td>Bachelor of Social Work</td>
</tr>
<tr>
<td>CASW</td>
<td>Canadian Association of Social Workers</td>
</tr>
<tr>
<td>CASWE</td>
<td>Canadian Association for Social Work Education</td>
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<tr>
<td>DSM</td>
<td>Diagnostic and Statistical Manual of Mental Disorders</td>
</tr>
<tr>
<td>EAP</td>
<td>Employee Assistance Program</td>
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<tr>
<td>MSW</td>
<td>Master of Social Work</td>
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<td>UDL</td>
<td>Universal Design for Learning</td>
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</table>
Thank you to the participants who offered their time, their insights, and their ideas. I hope this research raises and honours your voices. Also, thank you to the two participating Schools of Social Work for their support and involvement in the study.

Thank you to my thesis supervisor, Dr. Judy E. MacDonald. Through your examples, your teachings, and your wisdom, you taught me how to embrace my own identity and to tell my own story. I am forever grateful for your mentorship and your endless support throughout this learning journey.

Thank you to my committee members, Dr. Cassandra Hanrahan and Dr. Carolyn Campbell, and external reviewer, Dr. Susan Hardie. I truly appreciate the time, the guidance, and the feedback you provided.

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Chapter One - Introduction

For a diverse array of social work students, access to post-secondary training has dramatically expanded with distance education programs (Collins, 2008; Kliempeter, 2005; Kurzman, 2013; Oliaro & Trotter, 2010; Phelan, 2015; Tandy & Meacham, 2009; Vernon, Vakalahi, Pierce, Pittman-Munke, & Adkins, 2009). By continuing their education online, mature learners, working professionals, parents, those facing financial difficulties, and/or persons from marginalized groups, have access to furthering their credentials (Collins, 2008; Blackmon, 2013; Brown et al., 2012; Inoue, 2007; Müller, 2008; Reamer, 2013; Vernon et al., 2009). Access and opportunity to obtain further education is a cornerstone of distance education social work; aligning with the values and principles of the social work profession (Blackmon, 2013; Pardasani, Goldkind, Heyman, & Cross-Denny, 2012; Kurzman, 2013; Phelan, 2015; Reamer, 2013; Tandy & Meacham, 2009). Both the Canadian Association of Social Workers (2005) and Canadian Association of Social Work Education (2015) promote social justice and encourage equitable participation of diverse populations across society. For learners who may not have access or the opportunity to attend post-secondary programs on-campus, distance education offers an alternative (Collins, 2008; Blackmon, 2013; Pardasani et al., 2012; Phelan, 2015; Reamer, 2013; Tandy & Meacham, 2009). These learners also bring much diversity in terms of their identities, locations, and lived experiences, enriching their social work programs and schools. Social work students with mental health (dis)Abilities are one of these diverse groups of learners gaining increased access and opportunity to
further their social work credentials through distance education. I am one of these learners.

1.1 Researcher’s Voice

Distance education allowed me to further my social work credentials. Many times arose where it seemed my life circumstances and lived experiences would prevent me from achieving my educational and career goals. I am a mature learner, a working professional, and a parent. Because of the high costs of post-secondary education, balancing multiple roles and responsibilities as well as online studies was the only option I had to further my social work credentials. In the midst of my career and my continuing studies, I also held the seemingly polarizing positions of service provider and service user. I had gathered the strength and courage to seek support for the extreme distress and trauma I was experiencing as a result of being a survivor of abuse. Consequently, I was labelled and psychiatrized by the very professionals helping me. I was devastated and degraded. The process of being assessed and receiving diagnoses individualized the larger social issue of abuse and pathologized my reactions to it (Burstow, 2003, 2015; Davis, 2014). Despite being impacted by the effects of the abuse for years, I went from not having to having mental disorders in a matter of hours. Opportunities to make meaning of my experiences were diminished through medical professionals reducing my responses to the abuse into categorized symptoms for which medications could be used to suppress how the abuse affected me (Burstow, 2003, 2015). I refused to medicate my distress and I was left considering what affordable alternatives were available to help me heal. At the same time, I had to navigate a profession, which was often not welcoming of
colleagues with stigmatized identities and othered those with mental health (dis)Abilities (Beresford & Boxall, 2012; Poole et al., 2012; Reid & Poole, 2013; Stromwell, 2002).

I developed an interest in the topic of distance education from the onset of my online social work studies. This interest formed not only because of my own experiences as a distance education social work student, but also through further exploration of the topic in assignments and through my involvement as a student representative and a student delegate. In these student roles, I connected with my online classmates. I realized I shared similar struggles around isolation and limited institutional support available at a distance. I also discovered I was not alone in my challenges with juggling my studies, career, and other roles and responsibilities.

As I continued with my online social work studies, the idea of pursuing a thesis on distance education social work became a not-so-distant dream. My earlier involvement as a student delegate led to my continuing student involvement and membership with the national social work education association and attendance at subsequent conferences. I attended presentations on distance education social work. I also completed various assignments on distance education related topics during my online social work studies. I learned that online social work courses and programs had increased across Canada, but the corresponding research and literature had not kept up with the expansion of distance education in social work. Even less was known about distance education social work students and their experiences from their own perspectives.

At a time where I was seeking support for the distress I was experiencing, I attended a social work education conference. Students with mental health (dis)Abilities were mentioned in some presentations; however, they were portrayed as problematic and
time-consuming. Social work educators and staff, perhaps unknowingly, presented a negative perspective of working with students with mental health (dis)Abilities. While my own lived experiences clearly influenced my reaction, I was left feeling uncomfortable. I wondered about the missing perspectives and experiences of fellow distance education social work students with mental health (dis)Abilities. I debriefed with some trusted fellow social workers about the conference and my ideas. I found no literature or research focusing specifically on Canadian distance education social work students with mental health (dis)Abilities. That discomfort motivated me to do something.

After completing the necessary graduate program requirements, I gave the thesis option more thought. I was very fortunate to find a thesis supervisor with a wide range of expertise, who agreed to join me on this journey. My thesis supervisor provided encouragement and guidance on researching from an anti-oppressive framework and from a first voice perspective. Approaching the research respectfully and reflexively was crucial. Traditional, positivist research, as Brown and Strega (2005) state, “has silenced and distorted the experiences of those on the margins, taking a deficit-informed approach to explaining their lives and experiences” (p. 11). Stigma, the negative stereotypes, and sanism, the discrimination and oppression, are already realities for those living with mental health (dis)Abilities (CMHA Ontario, 2015; Large & Ryan, 2012; Poole et al., 2012). Social work students with mental health (dis)Abilities are no exception (Poole et al., 2012; Reid & Poole, 2013). By reinforcing psychiatrized perspectives and excluding the voices of those with mental health (dis)Abilities, mainstream research often further oppresses (Beresford, 2013; Hardwick & Worsley, 2011; Morrow, Boaz, Brearly, &
Ross, 2012). Anti-oppressive and social justice oriented research strives for the opposite, by challenging oppression, promoting knowledge creation by marginalized persons, and centring on social change (Brown & Strega, 2005; Danso, 2015; Levoie, MacDonald, & Whitmore, 2010; Potts & Brown, 2005; Strier, 2007; van de Sande & Schwartz, 2011).

Dedicated to doing research differently, I included approaches that aligned with anti-oppressive and social justice oriented research. The intent of my study was to give voice to fellow distance education social work students with mental health (dis)Abilities; providing an opportunity for their insights and suggestions to be heard. Using narrative inquiry in this study allowed for elevating the voices of participants’, while highlighting their experiences and expertise (Hardwick & Worsley, 2011; Padgett, 2012; Riessman, 2013). Narratives and stories shared by the participants offered previously unheard perspectives on this topic, as covered in later chapters (Moosa-Mitha, 2005; Riessman, 2013).

Reflexivity was central in understanding what I was bringing to the research and how the research was impacting me. I located myself - my lens, my subjectivity, my identities, my positionality - within this research (Berger, 2015; Creswell, 2013; D’Cruz & Jones, 2009; Gibson, 2012; Hardwick & Worsley, 2011; Nash, 2011). As already shared in this introduction, my own interests and experiences were intertwined with this study. I was “personally invested” in this research (Lillrank, 2012, p. 282). Support from my thesis supervisor and continuing reflexivity was crucial to examining this interconnectedness throughout the research process (Berger, 2015; herising, 2005; van de Sande & Schwartz, 2011). As the researcher, I did not exclude myself from study. I took the risk to also share my own narratives, not leaving this vulnerability solely to the
participants (MacDonald, 2004, 2008; Potts & Brown, 2005). Narrative autoethnographic contributions in the form of text boxes, titled “Researcher’s Voice”, were used throughout the rest of the writing of this thesis to link and to differentiate my own experiences and insights from those of the participants.

1.2 Research Questions

With no known studies to date on the experiences of Canadian distance education social work students with mental health (dis)Abilities, an exploratory, qualitative approach seemed a suitable starting point for this study. Inspired by interests, experiences, conversations, and literature, I asked the following research questions:

- What are the experiences of distance education social work students with mental health (dis)Abilities at two Canadian universities?
- What struggles or limitations do distance education social work students with mental health (dis)Abilities face during their studies? What are the benefits or positive aspects of distance education social work studies for these students?
- How could Canadian distance education social work programs improve for online social work students with mental health (dis)Abilities?

By exploring these research questions, initial understandings around the experiences of Canadian distance education social work students with mental health (dis)Abilities at two universities could be identified. Distance education social work students, with or without mental health (dis)Abilities, often have multiple roles and responsibilities, structuring their studies around their lives. Some of these students have struggles inside and outside of their programs; ones that are neither being addressed nor supported. Without a unified place to share their concerns, these students’ experiences become concealed and leave them feeling isolated (Collins, 2008). As social work students with mental health
(dis)Abilities may already be “negatively labelled”, sharing their experiences, insights, and voicing their concerns individually might feel unsafe (Collins, 2006, p. 455). Through this research, the six study participants and myself have come together as a collective voice. We have shared our experiences, insights, and ideas, with the intent to initiate discussions and promote changes within and across Schools of Social Work, on how to better include and support distance education social work students with mental health (dis)Abilities.

1.3 Research Concepts

Concepts are abstract ideas requiring further explanation, for how they are described and defined in the research (Grinnell & Unrau, 2011; van de Sande & Schwartz, 2011). Clarifying these concepts allows readers to gain understandings of the meanings the researcher intended (van de Sande & Schwartz, 2011). For this purpose, included are conceptualizations of distance education, (dis)Ability, and mental health (dis)Ability as they pertain to this study.

1.3.1 Distance Education This research focused on the experiences of students with mental health (dis)Abilities in distance education social work programs delivered online (and not face-to-face). Conceptualizing distance education is challenging, as it is an evolving term with no agreed upon definitions (Cummings, Foels, & Chaffin, 2013; Moore, Dickson-Deane, & Galyen, 2011). Distance education, distance learning, online learning, and e-Learning are often used interchangeably, with distance education being the broadest and most widely used term (Moore et al., 2011). Common to all the terms is the instruction by the educator and/or learning by the student occurs separated by time and/or space (Cummings et al., 2013; Moore et al., 2011). Within educational institutions,
many departments and social work programs use the term distance education, but have moved to delivering courses and programs online (Coe Regan & Youn, 2008; Raymond, 2005). As such, I opted to use these terms interchangeably in the research.

1.3.2 (dis)Ability Conceptualizing and defining (dis)Ability is difficult. There is not one accepted and agreed upon view of (dis)Ability (Kudlick, 2009). Understandings of (dis)Abilities are informed by the historical and current societal contexts as well as contemporary theories and models, as described in the theoretical framework chapter.

The World Health Organization (2015) defines (dis)Ability as an “umbrella term, covering impairments, activity limitations, and participation restrictions” (para. 1). It is further described as a “complex phenomenon” between the person and the society they live in, requiring “interventions to remove environmental and social barriers” (WHO, 2015, para. 2). The United Nations (2006) Convention on the Rights of Persons with Disabilities describes persons with (dis)Abilities as “those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others” (art. 1, para. 2).

Within the Canadian context, the Canadian Human Rights Act (1985), in section 25, defines (dis)Ability as “any previous or existing mental or physical disability and includes disfigurement and previous or existing dependence on alcohol or a drug”. The Employment Equity Act (1995) in section 3, for example, defines people with (dis)Abilities in terms of limitations, stating these are “persons who have a long-term or recurring physical, mental, sensory, psychiatric or learning impairment”. Rothman (2003) describes (dis)Ability in terms of the person first; essentially, as people trying to live life
in meaningful ways. MacDonald and Friars (2009) explain (dis)Ability more fully and with a critical lens, with “(dis)” to respect the person’s social and physical connection with disability, and “Ability” to highlight the creative and innovative ways of dealing with societal barriers” (p. 140). Capitalizing “Ability” emphasizes peoples’ capabilities, rather than the traditional deficit view, while acknowledging the oppressive societal contexts persons navigate. It is this conceptualization of (dis)Ability by MacDonald and Friars (2009), which informed the use and writing of (dis)Ability throughout this research.

1.3.3 Mental Health (dis)Ability

Conceptualizing and defining mental health (dis)Ability is also complicated. Similar to (dis)Ability, there are no universal understandings and terms related to mental health. Past and present contexts have brought forth a range of concepts used to describe and define mental health (dis)Abilities. In conceptualizing mental health (dis)Ability, both dominant and progressive sources were utilized to reflect the current context for this complex concept.

Mental health is the normative state, from which mental disorders or illnesses are assessed, categorized, and compared (Price, 2013). For instance, the World Health Organization (2014) defines mental health as a “state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community” (para. 1). In contrast, what the World Health Organization (2014) terms “mental disorders” is explained as a “broad range of problems, with different symptoms…characterized by some combination of abnormal thoughts, emotions, behaviour and relationships with others” (para. 1). Similarly, the Public Health Agency of
Canada (2013) views “mental illnesses” as “alterations in thinking, mood or behaviour associated with significant distress and impaired functioning” (para. 1). Mental health (dis)Abilities may also be characterized by overwhelming feelings, fears, or obsessions, mood changes, and/or disturbances in thoughts and perceptions, which impact functioning over a period of time (CAMIMH, 2012; MacKean, 2011; MDSC, 2011; WNUSP, 2008). Based on medicalized classifications from the *Diagnostic and Statistical Manual of Mental Disorders* (or *DSM*), some names and examples of mental health (dis)Abilities are: anxiety and mood disorders, schizophrenia and psychotic disorders, personality disorders, eating disorders, neurodevelopmental disorders, concurrent disorders, and dual diagnosis (American Psychiatric Association, 2013; CAMIMH, 2012; CMHA Ontario, 2015; MDSC, 2011; Regehr & Glancy, 2010, 2014).

People with mental health (dis)Abilities use a range of terms to describe what they are living with. Some use mainstream medicalized labels, while others prefer reclaimed terms – or both. Psychiatric survivor, ex-patient, service user, consumer, crazy, lunatic, neuroatypical, neurodivergent, or mad are some examples of the commonly used and reclaimed terms (Beresford, 2012, 2015; Boxall & Beresford, 2013; Graby, 2015; Liegghio, 2013; OHRC, 2012; Poole & Ward, 2013; Price, 2013).

With all this variation in how to name and describe mental health, (dis)Ability, and mental health (dis)Abilities, I chose a definition, which reflected the current complexities and context (Price, 2011; Price, 2013). Naming and defining mental health (dis)Ability to reflect my theoretical orientation and research approaches was a crucial consideration for me. I also wanted to identify mental health (dis)Ability in a way that would be recognized in research locations and settings; for instance, in educational
institutions often influenced by dominant discourses (Brabazon, 2015; Hibbs & Pothier, 2006). Thus, in my thesis research, mental health (dis)Ability is used as an all-encompassing term referring to the self-identification of experiencing and/or living with mental health concerns, mental health issues, psychiatric (dis)Abilities, psychosocial (dis)Abilities, and/or as being psychiatric survivors, ex-patients, mental health service users, consumers, or as being mad (Boxall & Beresford, 2013; CACUSS, 2013; MacKean, 2011; Madaus, 2011; OHRC, 2012; Price, 2013; Reid & Poole, 2013; WNUSP, 2008). Instead of relying on professional, pathologized understandings and medicalized diagnoses, self-definition honours peoples’ lived experiences and their own diverse perspectives of mental health (dis)Abilities (Boxall & Beresford, 2013; Price, 2013).

1.4 Thesis Overview

Following this introductory chapter, the thesis is comprised of six further chapters, plus references and appendices.

Chapter Two, on theoretical framework, outlines the foundational theories and models informing the research. Anti-oppressive theory and practice, (dis)Ability theory and models of (dis)Ability and mental health (dis)Abilities, ableism, sanism, as well as the role of social work within the areas of (dis)Ability and mental health are discussed.

Chapter Three, the literature review, covers predominant topics and themes in the literature related to distance education, mental health (dis)Abilities, post-secondary students and social work students with mental health (dis)Abilities.

Chapter Four, on methodology, outlines the research approaches and methods in this study. Narrative inquiry and autoethnography, reflexivity, and the linkages of these
methodologies to social work are described. Sampling, recruitment, and data collection methods used are discussed, followed by the transcription and transcript verification processes, narrative data analysis strategies, and lastly, the limitations to this research.

Chapter Five, the discussion, shares the findings and a subsequent discussion linked to the literature, on the participants’ experiences of being distance education social work students with mental health (dis)Abilities. Five key categories capturing the experiences of the six participants are explored in the chapter.

Chapter Six, on recommendations, highlights and summarizes the suggestions brought forth by the participants on how distance education social work programs could be more supportive. Six main categories of recommendations are covered within this chapter.

Chapter Seven, the conclusion, reviews the significance and implications of the study. Next steps for dissemination of this thesis research are included. Future areas of research relating to the topic of distance education social work students with mental health (dis)Abilities are explored. Final thoughts about the research are also included.

Elevating the voices of distance education social work students with mental health (dis)Abilities must not stop here. Promoting and implementing changes around inclusive online practices and programs creates the conditions and the environment for social work students with mental health (dis)Abilities to be welcomed, heard, and supported throughout their studies. Through this thesis research, the participants and myself offered some of the ways this can start to happen.
Chapter Two - Theoretical Framework

2.1 Introduction

Theory “is an organized statement of ideas about the world” (Payne, 2005, p. 5). Social work theories are comprised of models, perspectives, and explanatory theories, which guide practice situations or research, describe values or worldviews, or explain cause and effect in certain circumstances (Lundy, 2011; Payne, 2005). Social work theory, practice, and research are interconnected; one is informed by the other (D’Cruz & Jones, 2009). Theoretical frameworks outline the theories, perspectives, and models, which inform social work research (van de Sande & Schwartz, 2011). Reflexive researchers are transparent about their theoretical frameworks, by acknowledging and describing their positioning (D’Cruz & Jones, 2009; van de Sande & Schwartz, 2011). As a reflexive researcher, in the following chapter, I outline the theoretical framework, which influenced this study. Specifically, I describe anti-oppressive theory and practice, (dis)Ability theory and models of (dis)Ability and mental health (dis)Abilities, and the role of social work within the areas of (dis)Ability and mental health.

2.2 Anti-Oppressive Theory & Practice

Anti-oppressive theory is centered on equality, inclusion, and social justice for marginalized, excluded, and oppressed persons, groups, and communities (Baines, 2007, 2011; Payne, 2005; Rogers, 2012). Anti-oppressive practice is a “social justice-oriented practice model” (Baines, 2011, p. 26), which identifies and challenges the unequal power and lack of privilege experienced among those who are segregated from the mainstream (Dominelli, 2012; MacDonald, 2008; McLaughlin, 2007; Rogers, 2012). Anti-oppressive
theory and practice focuses on social change, positive social relationships, and celebrating differences (Baines, 2007; Dominelli, 2003; McLaughlin, 2007) through the “compassionate embrace of humanity in all its diversity and adversity “(Baines, 2011, p. 26).

Mainstream social work throughout history (and even today) centred on helping the “sick” or “needy”, with a focus on “care and control” (Dominelli, 2012, p. 329). Oppressive practices have long been associated with social work (Strier, 2007; Wilson & Beresford, 2000), largely due to normative assumptions, power imbalances, and pressures from outside forces and institutions (Moosa-Mitha, 2005; Strier, 2007). People, groups, and communities have been disadvantaged because of their difference from the mainstream “norms” (Moosa-Mitha, 2005, p. 63). As Dominelli (2012) explains, “binary classifications of superior and inferior” or “us” versus “them” are imposed on these persons and groups (p. 331). Much of this categorization or “othering” is based on identity, such as ability, gender, race, class, age, and sexual orientation (Dominelli, 2012, pp. 332-333). Anti-oppressive theory and practice arose out of grassroots movements and radical social work to address these divisions and, today, still attempts to promote social change, transformation, and social justice through both individual and collective action (Baines, 2007, 2011; Dominelli, 2012).

For persons with mental health (dis)Abilities, anti-oppressive approaches focus on empowering the person and changing society (Larson 2008; Wehbi, 2011). People with mental health (dis)Abilities are not seen as “passive victims”, but as strong and resistant to oppression (Wehbi, 2011, p. 137). Anti-oppressive practice and research elevates the first voice perspectives of persons with mental health (dis)Abilities. Lived experience
brings forth understandings and knowledge, which confronts mainstream assumptions, expertise, and evidence, with the goal of creating social change and promoting social justice (Campbell, 2003; Dominelli, 2012; MacDonald, 2008; Moosa-Mitha, 2005; Potts & Brown, 2005).

**Researcher’s Voice**

Anti-oppressive theory and practice has been central to my social work journey over the past six years. It has been a part of almost every course I have taken in my social work studies. Throughout my social work education, I have been encouraged and challenged to apply anti-oppressive approaches to my social work practice. While this study is not a typical anti-oppressive research project, in that it does not utilize participatory action research or community-based research methods (Potts & Brown, 2005, Reid & Poole, 2013), it is true to anti-oppressive approaches by using narrative methodologies to centre on first voice experiences (Campbell, 2003; MacDonald, 2008; Moosa-Mitha, 2005; Strier, 2007). I could not remove or separate the influence anti-oppressive theory and practice has had on my approach to this research.

2.3 (dis)Ability

Throughout history, persons with (dis)Abilities have been marginalized, excluded, and oppressed (MacDonald, 2005; MacDonald & Friars, 2009). Persons with (dis)Abilities were institutionalized, segregated, sterilized, euthanized, and executed (Barnes, 2012; MacDonald, 2005; MacDonald & Friars, 2009; Rothman, 2010). This unjust treatment provides the context of how persons with (dis)Abilities have been defined by and situated within society (MacDonald, 2008; Rothman, 2010).

2.4 (dis)Ability Theory & Models

Theory and models of (dis)Ability provide contemporary explanations for what it means to live with a (dis)Ability, ranging from individual experiences to disabling
societal contexts (Rioux & Valentine, 2006). Dominant discourses around (dis)Ability locate it as an unfortunate, abnormal, medical problem; whereas, progressive views of (dis)Ability challenge these mainstream assumptions as well as the politics and power that uphold them (Devlin & Pothier, 2006; Hiranandani, 2005; Pease, 2010).

2.4.1 Medical Model Through the medical model, (dis)Ability is viewed as an individual impairment, limitation, and deficit due to abnormal abilities and functioning (Barnes, 2012; Hiranandani, 2005; Oliver, 2009; Rioux & Valentine, 2006; Rothman, 2010; Shakespeare, 2013; Stienstra, 2012). Medical experts diagnose, treat, and attempt to fix individuals with (dis)Abilities, with the goal of curing their abnormalities (MacDonald & Friars, 2009; Mackelprang, 2012; Oliver, 2009; Stienstra, 2012; Wehbi, 2011). Using this expertise, medical professionals also dictate what interventions, services, and programs persons with (dis)Abilities are eligible for; holding tremendous power over the life circumstances of people with (dis)Abilities (Devlin & Pothier, 2006; Rothman, 2010). In the medical model, all persons are expected to operate with fully functioning bodies and minds; if not, they are viewed as needing medicalized interventions and rehabilitation to attain or to return to normalcy (Davis, 2013; Devlin & Pothier, 2006).

2.4.2 Social Model The social model of (dis)Ability, as named and developed by (dis)Ability activist and academic Michael Oliver in 1983, was a response and rejection to the individualization and medicalization of (dis)Ability (Barnes, 2012; Lundy, 2011; Oliver, 2009; Shakespeare, 2013; Stienstra, 2012). In contrast to the medical model, the social model of (dis)Ability outlines that society needs to be fixed and changed, rather than the person (Rioux & Valentine, 2006; Siebers, 2008). Within the social model,
impairment is an “attribute” or “condition”, whereas (dis)Ability is “how society responded to, or failed to respond to, the needs of people with impairments” (Cameron, 2014, p. 137). Society creates inequalities and excludes people through: individual stereotypes and prejudices; normative assumptions, practices, and policies; inaccessible environments; institutional barriers; and systemic discrimination (Barnes, 2012; Oliver, 2009; Rothman, 2010; Wehbi, 2011). In applying the social model, “the real priority is to accept impairment and to remove disability” (Shakespeare, 2013, p. 216). As Stubblefield (2009) accurately explains, it is the society in which a person lives that truly disables them; not their physical, biological, or mental attributes. Within the social model of (dis)Ability, as MacDonald and Friars (2009) illustrate with this example, “the stairs-only entry to the bank is viewed as a community-access problem, not the personal problem of the wheelchair user” (p. 141). Society continually fails to fully include persons with (dis)Abilities, resulting in disabling contexts, which further disadvantage, exclude, and oppress (Barnes, 2012; MacDonald & Friars, 2009; Oliver, 2009; Shakespeare, 2013; Stienstra, 2012).

2.5 Ableism

A consequence of our disabling society is ableism. This term describes the oppression experienced, lived, and internalized by persons with (dis)Abilities (Loja et al., 2013; Pease, 2010, Reeve, 2014). Ableism equates with prejudice and discrimination, because of the socially constructed and societal preference for “normative abilities”; framing persons with (dis)Abilities as “less able” (Wolbring, 2008, p. 253). Social constructions of (dis)Ability and normalcy results in categorization, exclusion, and marginalization based on perceptions about difference (Davis, 2013; Johner, 2013;
Persons with (dis)Abilities continue to be viewed as different, as the “other”, in comparison to people who allegedly fit with the norm (Wendell, 1996, p. 61).

2.6 Social Work & (dis)Ability

Social workers often work with people with (dis)Abilities. Their role, however, is not always viewed as supportive or person-centred (MacDonald & Friars, 2009; Reeve, 2012; Rothman, 2010). Social workers themselves may have ableist views. They might work within agencies and administer services, which adhere to the medical model (Boxall & Beresford, 2013; Hiranandani, 2005; Rothman, 2010). Whether intentionally or unintentionally, many social workers contribute to the oppression experienced by persons with (dis)Abilities. Yet, as Hiranandani (2005) states, social workers can “re-think” and “re-vision” (dis)Ability (para. 44) through progressive understandings and actions.

2.7 Mental Health (dis)Ability

Persons with mental health (dis)Abilities have similar, yet different historic contexts, compared to persons with other forms of (dis)Abilities. Madness, in the middle ages to 16th century, was associated with religion, ranging from divine insights to being possessed by evil spirits (Burstow, 2015; Cohen, 2008; Fawcett, 2012; Mackelprang, 2012). Persons with mental health (dis)Abilities were part of the community, often living with family members (Burstow, 2015; Cohen, 2008). In the 18th century and onwards, the Enlightenment brought forth “privileged rational scientific thought and positivist objective thinking over religion” (Fawcett, 2012, p. 516). Madness became individualized, medicalized, and removed from religion (Burstow, 2015; Cohen, 2008). Through this medicalization, madness was interpreted as disease, resulting from a
“disordered brain” and faulty genetics (Fawcett, 2012, p. 516). Asylums and institutions were used to confine and imprison persons with mental health (dis)Abilities who were forced to receive inhumane and invasive medical treatments (Burstow, 2015; Cohen, 2008; Joseph, 2013; Reaume, 2009). In the mid-20th century, after World War II, deinstitutionalization, in conjunction with increased pharmacological-based interventions, dominated (Menzies et al., 2013). Pharmaceuticals provided cost-effective ways to treat persons with mental health (dis)Abilities in the community, but did not eliminate the hospitalization and forced interventions upon those deemed unfit and unwell (Burstow, 2015; Cohen, 2008). Anti-psychiatry, psychiatric survivor, and mad pride movements arose in the later-20th century, critiquing the categorization, psychiatrization, and involuntary institutionalization of persons with mental health (dis)Abilities (Lewis, 2013; Menzies et al., 2013). These movements continue and gain momentum as persons with mental health (dis)Abilities remain marginalized and excluded (Lewis, 2013).

2.8 Mental Health (dis)Ability Models

2.8.1 Medical Model Similar to (dis)Ability, models pertaining to mental health (dis)Abilities have focused on medical and social perspectives. The medical model positions mental health (dis)Abilities as individualized illnesses, diseases, or disorders of the brain (Beresford, 2012; Burstow, 2015; Cohen, 2008; Joseph, 2013). Medical experts diagnose these mental illnesses or disorders based on observed and reported symptoms, which are then classified and diagnosed according to the *Diagnostic and Statistical Manual of Mental Disorders* (or *DSM*) (Doherty, 2005; Fawcett, 2012). The *DSM* has undergone several revisions, with it now being in its fifth edition (Stein, 2013). Much debate and critique surrounds the changing classifications and criteria of the *DSM*
For instance, a number of ‘new’ issues have now been medicalized due to the release of the DSM-5 (Lacasse, 2014). Psychiatry has moved towards “pathologizing and “treating” everyday life” (Burstow & LeFrançois, 2014, p. 4). As Stein (2013) explains, the actual “boundaries between normality and pathology can be fuzzy” (p. 661). However, the medicalization of mental health and the influence of psychiatry (Beresford, 2012; Price, 2011; Szasz, 2012) have created binary distinctions between “normal versus pathological” (Lewis, 2013, p. 116). With the focus on medicalizing and pathologizing, the medical model emphasizes individual deficits, illness, disease, and disorders (Beresford, 2015; Boxall & Beresford, 2013).

Within the medical model, persons with mental health (dis)Abilities are viewed as submissive recipients of diagnoses and prescribed treatments, having little to no input in their care (Stromwall, 2002; Larson, 2008). Diagnoses remain central in the eligibility and planning of treatments (Davis, 2014). Mental health treatment and maintenance is biologically oriented, with an emphasis on medications (Goldner, Jenkins, Prairie, & Bilsker, 2011; Regehr & Glancy, 2010, 2014). Pharmaceutical-based interventions are used to “stabilize the chemical imbalances in the brain” (Cohen, 2008, p. 21), while psychotherapy provides emotional support and cognitive-behavioural restructuring (Fawcett, 2012). The medical model perpetuates the idea that people with mental health (dis)Abilities must be assessed, managed, and controlled, as they are a risk to themselves and/or others (Fawcett, 2012). In every aspect, whether through practice, programs, services, policy, or law, the medical model extends its influence on the lives of persons with mental health (dis)Abilities (Beresford, 2002, 2012).
**2.8.2 Recovery Model** Next to the medical model, the recovery model has become influential across the mental health field. As a response to the medical model, original notions of the recovery model included hope, empowerment, choice, respect, positive relationships, peer-support, self-determination, and meaningful life opportunities (Davis, 2014; Deegan, 1996; Regehr & Glancy, 2014). The recovery model, according to Regehr and Glancy (2014), encompasses the “inherent belief that individuals can and do recover from severe mental illnesses” (p. 8). In this model, persons with mental health (dis)Abilities “accept and overcome” their individualized illnesses and labels, by becoming productive members of society (Poole et al., 2012, p. 25). Services, programs, and policies incorporating the recovery model are viewed as progressive, providing hopeful and holistic alternatives to medicalized perspectives (Regehr & Glancy, 2014). However, with its increasing influence and mainstreaming, the recovery model has lost much of its promising vision (Cohen & Tseris, 2014; Mental Health Recovery Study Working Group, 2009; Morrow & Weisser, 2012). In many ways, the recovery model has become a “re-packaged” and “re-labelled” medical model (Poole, 2011, p. 68). Influenced by psychiatry and the neoliberal context, as Morrow (2013) explains, recovery has become a personal quest “requiring the “manpower” of the individual to create a healing environment, and his or her family and social support network to provide the engine of hope” (p. 329). Lacking in the recovery model is acknowledgment of the “social and structural inequities” impacting mental health and well-being (Weisser, Morrow, & Jamer, 2011, p. 10).

**2.8.3 Social Model** The social model of mental health (dis)Abilities, commonly referred to as the social model of madness and distress, offers another perspective on the

Uptake of this social model into the psychiatric survivor or mad community has been mixed due its association with impairment and (dis)Ability, which some resist or reject as part of their identity (Beresford, Nettle, & Perring, 2010; Beresford, 2012, 2015; Graby, 2015; McWade, Milton, & Beresford, 2015; Spandler & Anderson, 2015; Withers, 2014). There is no agreement on the concepts of impairment and (dis)Ability within the mental health community (Sapey, Spandler, & Anderson, 2015). Some persons acknowledge living with an impairment and/or a (dis)Ability. Some may also deny it, but are perceived by others to have an impairment and/or a (dis)Ability. Acceptance of impairment and/or (dis)Ability may also be necessary to access certain social services and health care programs, and/or be protected under human rights codes and laws (Spandler & Anderson, 2015). Others refuse notions of impairment and/or (dis)Ability altogether; positively viewing their lived experiences as a reflection of diversity (Beresford, 2015; Graby, 2015). While there is on-going debate around the notions of impairment and (dis)Ability, this social model of madness and distress is deemed as a way to align with various (dis)Ability communities to resist and change dominant discourses through activism and solidarity (Beresford et al., 2010; Beresford, 2015; Graby, 2015; McKeown & Spandler, 2015; McWade et al., 2015).

Central to this social model of madness and distress is it does “not defer to professional definitions” and is “not bounded or controlled by professional expertise”
(Boxall & Beresford, 2013, p. 592) to make meaning of mental health (dis)Ability.

Distress and madness is a consequence of facing and living through difficult circumstances and events, whether it is poverty, abuse, violence, loss, war, or other life traumas (Burstow, 2003; Fawcett, 2012; Tew, 2015; Ussher, 2011). While psychiatric interventions can offer immediate results, these medicalized approaches do not address the many underlying issues contributing to mental health (dis)Abilities (Bracken & Thomas, 2001; Bracken et al., 2012). Endless obstacles and barriers are a reality of everyday life for persons with mental health (dis)Abilities (Beresford, et al., 2010). Unlike the medical or recovery models, the social model of madness and distress views exclusion and marginalization as a cause of mental health (dis)Ability (Graby, 2015; McWade et al., 2015). Distress and madness also arise from internalized oppression (McWade et al., 2015; Reeve, 2012), resulting from the sanism experienced all too often by people with mental health (dis)Abilities.

2.9 Sanism

Prejudice and discrimination against persons with mental health (dis)Abilities is referred to as sanism (Large & Ryan, 2012; Poole at al., 2012; Poole & Ward, 2013). Sanism reveals itself on micro- and macro-levels, whether through individual interactions and attitudes to laws and policies (Large & Ryan, 2012). Through the sanist lens, persons with mental health (dis)Abilities are viewed as incompetent, unpredictable, and dangerous (Charles & Bentley, 2014; Liegghio, 2013). Sanism is oppressive, keeping people with mental health (dis)Abilities “silenced and dehumanized” (Liegghio, 2013, p. 124). Sanism keeps people with mental health (dis)Abilities in a vicious cycle of oppression.
Researcher’s Voice

For years, unknowingly and unconsciously, medical and recovery models have influenced me. I was devastated by the labels placed on me; even with external forces – lived experiences of abuse and trauma - being the basis of my mental health (dis)Abilities. Despite being equipped with progressive social work theories, models, and ideals, allowing me to re-examine the root causes of my own mental health (dis)Abilities, it is not enough to reverse the daily effects of sanism. Every day I am reminded about the negativity and disadvantage, which come with the labels.

2.10 Social Work & Mental Health (dis)Ability

The social work profession has both challenged and contributed to sanism, whether through individual ideas, agency practices, or educational courses and programs (Poole et al., 2012). In the area of mental health, according to Cohen and Tseris (2014), social work holds a “contradictory position” of being “simultaneously engaged in both a critique of and a participation in psychiatric hegemony” (p. 689).

Social work brings understandings of the broader societal constructs, contexts and structures impacting mental health (Beresford, 2012; Larson, 2008; Lundy, 2011; Schwartz & O’Brien, 2009). Progressive social work challenges the “medicalization of relatively normal feelings and responses to extreme adversity and life stressors” (Lundy, 2011, p. 205) and critiques the power and influence of psychiatry and other institutions, which perpetuate mainstream models of mental health (Burstow & LeFrançois, 2014; Dreikosen, 2009; Menzies et al., 2013). Social work academics promoting alternative social work theories, perspectives, and approaches unsettling mainstream models and practices in mental health include (but are not limited to): anti-oppressive practice (Larson, 2008); anti-sanism (Poole et al., 2012); critical mental health (Joseph, 2013;
Morley, 2003; Morley & Macfarlane, 2010); service-user led (Beresford, 2012; Beresford & Boxall, 2012; Boxall & Beresford, 2013; Wilson & Beresford, 2000; Beresford, 2013); structural (Lundy, 2011; Schwartz & O’Brien, 2009); mad studies and critical disability studies (Chapman, 2014; LeFrançois et al., 2013).

Despite these alternatives, much of the social work profession remains complacent in enforcing and reinforcing the medical and recovery models (Beresford, 2012; Charles & Bentley, 2014; Poole, 2011; Wilson & Beresford, 2000). Mental health social workers often work in interdisciplinary teams in health-related settings (Larson, 2008), partnering with medical professionals to provide support and treatments for persons with mental health (dis)Abilities (Lundy, 2011; O’Brien & Calderwood, 2010). Through assessment, interventions, and case management, social workers are instrumental in monitoring and controlling persons labelled and psychiatristized (Beresford, 2012; Burstow, 2015; Cohen & Tseris, 2014; Wilson & Beresford, 2000). Social work remains influenced by destructive, dominant discourses and mainstream models of mental health (dis)Abilities and, thus, perpetuates sanism in many aspects of the profession (Poole et al., 2012).

2.11 Summary

This chapter outlined the theoretical framework informing the research. Anti-oppressive theory and practice, (dis)Ability theory and models of (dis)Ability and mental health (dis)Abilities, ableism, sanism, as well as the role of social work within the areas of (dis)Ability and mental health were described. These theories, models, and information provide a foundation of understanding mental health (dis)Ability, on which the following chapters build upon. The next chapter comprises of a literature review, providing an
overview of what is known and unknown in the published literature relating to distance education social work students with mental health (dis)Abilities in Canada.
Chapter Three - Literature Review

3.1 Introduction

Research addressing the overall experiences of online social work students is limited (Oliaro & Trotter, 2010; Pardasani et al., 2012; Thyer, Artelt, Markward, & Dozier, 1998), particularly for distance education social work students with mental health (dis)Abilities in Canadian contexts. While research exists pertaining to Canadian social work students with (dis)Abilities (Carter, Hanes, & MacDonald, 2012; Dunn, Hanes, Hardie, Leslie, & MacDonald, 2008; Myers, MacDonald, Jacquard, & Macneil, 2014) and Canadian social work students with mental health (dis)Abilities on-campus (Reid & Poole, 2013), no known studies to date have focused specifically on the experiences of distance education social work students with mental health (dis)Abilities in Canada.

3.2 Distance Education

Distance education separates students and instructors through time and/or place, with the intent to create more accessible and flexible learning opportunities (Ayaia, 2009; Inoue, 2007; Morrison & Anglin, 2012; Spector, 2012; Stoessel, Ihme, Barbarino, Fisseler, & Stürmer, 2015). According to the National Center for Education Statistics 2015-2016 Integrated Postsecondary Education Data System, distance education is defined as “Education that uses one or more technologies to deliver instruction to students who are separated from the instructor and to support regular and substantive interaction between the students and the instructor synchronously or asynchronously” (para. 1). The National Center for Education Statistics 2015-2016 Integrated Postsecondary Education Data System further defines a distance education course as one
“in which the instructional content is delivered exclusively via distance education” (para. 3), whereas a distance education program is “a program for which all the required coursework for program completion is able to be completed via distance education courses” (para. 4).

The delivery of distance education has occurred through mail, print, texts, radio, television, compact discs, and, most recently, Internet. With the evolution of technology, hardware, such as desktop computers, laptops, and mobile devices, and software, such as learning management systems, deliver education online (Jones & Meyer, 2012; Larreamendy-Joerns & Leinhardt, 2006; Picciano, 2015). Asynchronous learning online, through learning management systems using lecture recordings, text-based course materials and assignments, email, and discussion forums, is currently the most common approach to distance education (Oztok, Zingaro, Brett, & Hewitt, 2013; Yamagata-Lynch, 2014). Synchronous learning opportunities may also be incorporated; for instance, real-time classes delivered by audio- or video-conferencing or live chats using instant messaging (Jones & Meyer, 2012; Oztok et al., 2013; Yamagata-Lynch, 2014). As technology evolves, new and innovate ways to deliver education and learn online continue to emerge (Kauffman, 2015; Meyer, 2011).

### 3.3 Distance Education Students

Distance education is viewed as an accessible and flexible way for a diverse group of students to purse and to continue post-secondary education (Inoue, 2007; Simpson, 2012; Stoessel et al., 2015). Availability, convenience, and compatibility with life’s demands attract students to distance education, with many online learners fitting the profile of non-traditional students (Britto & Rush, 2013; Meyer, 2011; Stoessel et al.,
Definitions of non-traditional students vary; however, the characteristics of non-traditional students may include: delayed enrolment to post-secondary education; part-time or less than full-time course loads; part-time or full-time employment outside of their studies; mature or older students (i.e., 21 years of age or older); have dependents; are caregivers; identifying with underrepresented group(s) (i.e., with a (dis)Ability, as LGBTTQQIAP, and/or with racially visible groups); disadvantaged or low socioeconomic status; and/or are the first generation in their family to attend post-secondary education (Guglielmetti & Gilardi, 2011; Panacci, 2015; van Rhijn et al., 2015). In comparison, traditional students are: young learners recently graduated from high school; who attend post-secondary education shortly thereafter; attend classes on a full-time basis; reside on or near their educational institutions; come from families of medium to high socioeconomic statuses; and, who often identify with the dominant groups (Cordie, Witte, & Witte, 2016; Guglielmetti & Gilardi, 2011; Panacci, 2015). Similar to non-traditional students, online learners are often older or mature students, representative of marginalized and disadvantaged groups, as well as balancing employment, family, caregiving, and studying (Inoue, 2007; Kahu, Stephens, Leach, & Zepke, 2013; Meyer, 2011; Milman, Posey, Pintz, Wright, & Zhou, 2015; Sweitzer, 2005; Simpson, 2012; Stoessel et al., 2015; Tait, 2014).

3.4 Distance Education Challenges

Distance education has tried to deliver the promise of learning “anytime” and “anywhere” (Tandy & Meacham, 2009, p. 315). Yet, online students face multiple challenges (Stoessel et al., 2015; Tait, 2014; Zirkle, 2001). Individual student and institutional factors contribute to the higher attrition rates of online students, compared to
their on-campus counterparts (Brown et al., 2013; Kurzman, 2013; Rust, Brinthaupt, & Robbins, 2015). Student factors impacting online learner attrition include: educational background, experiences, expectations, and workload; learning characteristics; barriers in accessing and using various technologies; financial pressures; and conflicting demands between employment, family, and school (Britto & Rush, 2013; Kauffman, 2015; Kahu, Stephens, Zepke, & Leach, 2014; Lee & Choi, 2010; Milman et al., 2015; Nichols, 2010; Rust et al., 2015; Simpson, 2013). Certain socio-demographic factors may also add to online student drop-out (Stoessel et al., 2015). Additional stress and pressures arising from gendered roles and responsibilities, for instance, put women at higher risk of leaving their online studies (Arric, Young, Harris, & Farrow, 2011; Kazmer & Haythornthwaite, 2001; Müller, 2008; Selwyn, 2011; Stoessel et al., 2015). Distance education often becomes an add-on to already demanding lives for women, who may not have the support or option to share some of their existing roles and responsibilities (Arric et al., 2011; Home, 1997). Following two shifts of paid and unpaid work inside and outside the home, online learning often becomes a third shift for female distance education students (Inoue, 2007; Willems, 2011). Online learners face and overcome many obstacles in order to persist and complete their programs.

Inadequate interactions and supports are institutional factors related to the higher attrition rates of online students (Lee & Choi, 2010; Rust et al., 2015). Because students in distance education programs have very little (and sometimes no face-to-face) contact with faculty or staff, these barriers can potentially discourage them from completing program requirements (Angelaki & Mavroidis, 2013; Nichols, 2010; Simpson, 2012; Simpson, 2013). University services widely available to on-campus students, such as
counselling and (dis)Ability support, are not easily accessible to them (Barr, 2014; Zirkle, 2001). If they are struggling with course content, technology issues, or personal matters, they are not always able to find institutional support. Despite increasing online student enrolments and program expansions, online student support services have not kept up with the continuing growth of distance education (Crawley & Fetzner, 2013; Jones & Meyer, 2012; Nolan, 2013). Services and supports available online are imperative to student success in distance education (Milman et al., 2015; Nichols, 2010).

3.5 Distance Education Social Work in Canada

Over the past few decades, increasing numbers of social work courses and programs have been offered through distance education (Acker, 2005). The 1970s and 1980s brought forth the development of distance education social work in Canada (Callahan & Wharf, 1989; Dempster, 2005; Seagar, 2005). At the time, on-campus studies were considered superior. Distance education was a newly emerging way to study, but also uncommon and unrecognized (Callahan & Wharf, 1989). Several Schools of Social Work acknowledged the importance of reaching students unable to attend courses and programs on-campus (Callahan & Wharf, 1989; Dempster, 2005). Distance education allowed for greater access and inclusion of students living and practicing in rural and remote areas as well as those who could not relocate due to personal or professional commitments (Dempster, 2005; Fuchs, 2005; Gilroy, 2005). Over time, more Schools of Social Work added distance education courses and programs, especially with the development of the Internet and other new technologies (Ayaia, 2009; Roberts, 2005). In the last decade, there has been a rapid expansion of social work studies available online (Ayaia, 2009; Pelech et al., 2013). In Canada, there are now
approximately ten Schools of Social Work offering distance education. These offerings range from individual courses, hybrid programs, to fully online programs with a variety of foci and specializations (CASWE, 2015). Currently, five of these Schools of Social Work have programs primarily online (and not in hybrid formats) at the Bachelor of Social Work or Master of Social Work level (CASWE, 2015). While there is resistance to this expansion of online social work studies, citing it as an unsuitable modality to teach helping professions, the reality is distance education in social work shows no signs of declining in scope or popularity (Pelech et al., 2013). Through this expansion, distance education continues to give a diverse group of social work students access to further post-secondary education.

3.6 Mental health (dis)Abilities in Canada

Mental health concerns are a leading cause of (dis)Ability, both in Canada and globally (CAMH, 2012; Kohn, 2014). Approximately one in three or 9.1 million Canadians in 2012 identified living with a mood disorder, anxiety disorder, or substance use issue during their lifetime (Pearson, Janz, & Ali, 2013). When all mental health (dis)Abilities are considered, one in five Canadians experience a mental health (dis)Ability at some point in their lives (CAMH, 2012). Globally, lifetime prevalence estimates indicate one in four people will live with a mental health (dis)Ability (Kohn, 2014; Lundy, 2011).

All Canadians are impacted by mental health (dis)Abilities in some way (MHCC, 2009). The Mental Health Commission of Canada, through mental health promotion and research has helped raise public awareness around mental health and stigma (MHCC, 2016). Drawing on the voices of various stakeholders, the development of the first
Canadian mental health strategy, *Changing Directions, Changing Lives* by the Mental Health Commission of Canada (2012) brought forth national attention to the need for systematic change as well as subsequent recommendations and strategic directions. Despite increasing public awareness around mental health as well as anti-stigma initiatives and campaigns, people living with mental health (dis)Abilities continue to experience reduced health, social, and economic outcomes (OHRC, 2012).

Mental health (dis)Abilities have wide ranging impacts, individually and across society. Reduced educational, employment, and career opportunities, strained relationships, housing challenges, diminished health and quality of life, and higher mortality rates are just some of the impacts individuals with mental health (dis)Abilities face (Davis, 2014; Goldner, Jenkins, Prairie, & Bilsker, 2011; Pearson et al., 2013). Economically, the costs of mental health (dis)Abilities to society are extensive. Smetanin, Briante, Stiff, Ahmad, and Khan (2011), in their study on behalf of the Mental Health Commission of Canada, “conservatively estimated that the cost of mental illness was $42.3 billion in direct costs and $6.3 billion in indirect costs” in 2011 alone (p. 6). Direct costs of mental health (dis)Abilities include the burden on the health care system, whereas indirect costs encompass labour force productivity impacts (Smetanin et al., 2011).

Barriers to employment are a major concern. Attaining and retaining work remains a challenge for persons with mental health (dis)Abilities (Dewa & McDaid, 2011). Unemployment rates range from 70 to 90 percent for persons living with severe and persistent mental health (dis)Abilities (CAMH, 2012; CMHA, 2015; MHCC, 2012). Human rights laws forbid discrimination; yet, employers remain unwilling to hire and

3.7 Post-Secondary Students & Mental health (dis)Abilities

Persons with mental health (dis)Abilities have been and continue to be disadvantaged in post-secondary programs and underrepresented in the professional jobs these programs often lead to (Chambers et al., 2011; CMHA Ontario, 2015; MHCC, 2009, 2012; Stienstra, 2012). Obtaining post-secondary education does not eliminate the occupational barriers faced by persons with mental health (dis)Abilities; however, it can improve the chances of finding employment and earning a steady income after graduation (Brabazon, 2015; Gruttadaro & Crudo, 2012; Stienstra, 2012). Post-secondary education is one approach to promote inclusion of persons with mental health (dis)Abilities (Brabazon, 2015; Stienstra, 2012).

In recent years, increasing awareness and attention has been given to post-secondary students and their mental health, due to the high prevalence of mental health concerns among this group (American College Health Association, 2013; Heck et al., 2014; MacKean, 2011). Post-secondary students are the highest-risk age group for the onset of mental health issues, in combination with the life and social stressors that come with furthering their education (Hanlon, 2012; MacKean, 2011; OCHA, 2009; Statistics Canada, 2003). Greater numbers of students with mental health (dis)Abilities are also attending college and university, plus more post-secondary students are actively seeking support from their institutions (CACUSS, 2013; Condra et al., 2015; MacKean, 2011).
However, the majority of post-secondary students with mental health (dis)Abilities do not complete their studies (Belch, 2011; Collins & Mowbray, 2005; Hartley, 2010; Kupferman & Schultz, 2015), with up to 86 percent of these students withdrawing before degree completion (Kessler, Foster, Saunders, & Stang, 1995). By 2020, mental health (dis)Abilities are anticipated to be the most prevalent group of (dis)Abilities represented at Canadian universities (Hanlon, 2012), adding urgency to understanding and addressing the needs of post-secondary students with mental health (dis)Abilities (Condra et al., 2015).

3.8 Social Work Students & Mental Health (dis)Abilities

The prevalence of mental health (dis)Abilities among Canadian social work students, let alone distance education social work students, is unknown. Post-secondary students are not required by Canadian equity and anti-discrimination laws to disclose their (dis)Ability at the time of application or during their studies (Carter et al., 2012; Reid & Poole, 2013). Institutions are expected to accommodate students with mental health (dis)Abilities; however, not all students connect with (dis)Ability services for such support (Carter et al., 2012; Condra et al., 2015; Dunn et al., 2008; Jacklin, 2011). Faculty and staff in social work distance education programs anticipate and are often aware some students may be living with mental health (dis)Abilities; however, students might not self-identify or openly share this information. While human rights laws are intended to protect against discrimination, stigmatization and other potential repercussions often prevent social work students with mental health (dis)Abilities from disclosing (Collins, 2006; Covarrubias & Han, 2011; Jacklin, 2011; OHRC, 2003; Reid & Poole, 2013; Thompson-Ebanks, 2014). Social work students’ academic and field
placement success may be impacted by their mental health (dis)Abilities, especially when left unaddressed or without appropriate supports in place (Gillis & Lewis; 2004; Horton, Diaz, & Green, 2009). Retention and graduation rates of social work students with mental health (dis)Abilities are also of concern for these same reasons (Collins, 2006). Full inclusion and support of social work students with mental health (dis)Abilities in Canada has yet to come to fruition.

3.9 Social Work Education & Social Work Students with Mental Health (dis)Abilities

The Canadian Association of Social Work Education (CASWE) Standards of Accreditation (2014) “encourage and support diversity and social justice in all aspects/domains of social work programs” (p. 3), while outlining that social work departments “ensure students, faculty, staff and field instructors are informed about existing university policies and procedures regarding harassment, appeals, discrimination, disability accommodation and codes of conduct” (p. 6). Mental health (dis)Abilities are not explicitly mentioned in the CASWE Standards of Accreditation (2014), but presumed to be more broadly included under “diversity” and “disability” (p. 3).

Social work, as a profession, recognizes and values “individual and professional diversity” (CASW, 2005, p. 2). Yet, social work students with mental health (dis)Abilities are often problematized in social work education literature and research. Perspectives of educators prevail, with few providing space for students’ insights on the issues presented. Social work students with mental health (dis)Abilities are positioned as complex, challenging, time-consuming, vulnerable, stigmatized, impaired, and potentially unsuitable and unfit to practice in the profession (Collins, 2006; Gillis & Lewis, 2004;
GlenMaye & Bolin, 2007; Goldberg, Hadas-Lidor, & Karnieli-Miller, 2014; Horton et al., 2009; Mazza, 2015; Poole et al., 2012; Reid & Poole, 2013; Stromwall, 2002; Zellmann, Madden, & Aguiniga, 2014). Extensive attention has been given to social work students with mental health (dis)Abilities in the areas of gatekeeping, professional suitability, and protecting the public (Currer, 2009; Gillis & Lewis, 2004; Lafrance & Gray, 2004; Mazza, 2015; Regehr, Stalker, Jacobs, & Pelech, 2001; Sowbel, 2012; Urwin, Van Soest, & Kretzschmar, 2006; Watkinson & Chalmers, 2008), with little emphasis on how social work students with mental health (dis)Abilities contribute to the profession (Collins, 2006; Stromwall, 2002; Poole et al., 2012; Reid & Poole, 2013). Social work strives for “humanitarian and egalitarian ideals” (CASW, 2015, para. 15); yet, the profession remains influenced by dominant discourses of mental health (Beresford, 2012; Burstow, 2015; Poole et al., 2012; Poole & Ward, 2013; Reid & Poole, 2013). Often unaddressed is how many social work students and social workers are likely impacted, given the prevalence of mental health (dis)Abilities. Social work students and practitioners with mental health (dis)Abilities are “already effective service providers and valued professional colleagues” (GlenMaye & Bolin, 2007, p. 121). Human rights and legal issues aside, social work students with mental health (dis)Abilities are currently in social work programs, graduating, or working in the social work field, whether the profession is willing to accept it or not (Poole et al., 2012; Reid & Poole, 2013; Stromwall, 2002). Social work students with mental health (dis)Abilities are an asset to the profession (Goldberg et al., 2014; Poole et al., 2012; Reid & Poole, 2013; Stromwall, 2002), not a liability as they are often made out to be (Watkinson & Chalmers, 2008).
3.10 Summary

Distance education social work students with mental health (dis)Abilities in Canadian contexts have not been represented in social work research and literature. Much of the existing research and literature pertaining to social work students with mental health (dis)Abilities has been written from the perspectives of educators and staff (Collins, 2006; Gillis & Lewis, 2004; GlenMaye & Bolin, 2007; Lafrance & Gray, 2004; Mazza, 2015; Regehr et al., 2001; Sowbel, 2012; Watkinson & Chalmers, 2008), with few studies emphasizing the voices of students (Goldberg et al., 2014; Reid & Poole, 2013; Thompson-Ebanks, 2014). The next chapter, on methodology, outlines the research processes of connecting with the six participants who shared their experiences and their ideas for better supporting distance education social work students with mental health (dis)Abilities.
Chapter Four - Methodology

4.1 Introduction

To begin to understand the experiences of Canadian distance education social work students with mental health (dis)Abilities, an exploratory, qualitative study design was employed. Grinnell and Unrau (2011) explain that exploratory, qualitative studies are suited for investigating new or emerging research areas. This approach seemed an appropriate starting point for this inquiry, as there are no known studies to date specific to Canadian students with mental health (dis)Abilities in the context of online social work education.

4.2 Research Questions

Developing the research questions was an iterative process, informed by the literature, conversations, and lived experiences. I arrived at the following research questions:

- What are the experiences of distance education social work students with mental health (dis)Abilities at two Canadian universities?
- What struggles or limitations do distance education social work students with mental health (dis)Abilities face during their studies? What are the benefits or positive aspects of distance education social work studies for these students?
- How could Canadian distance education social work programs improve for online social work students with mental health (dis)Abilities?

To explore these research questions, I selected a qualitative research methodology, which would honour the experiences and stories of fellow distance education social work
students with mental health (dis)Abilities, while allowing for my reflections and insights on my own related experiences.

4.3 Methodology

4.3.1 Narrative Inquiry Narrative inquiry is a range of approaches, which vary in definition and across disciplines (Chase, 2005; Clandinin, Pushor, & Murray Orr, 2007; Lichtman, 2013; Riessman, 2008; Wells, 2011). Connelly and Clandinin (2006) view narrative inquiry as “the study of experience as story” (p. 477). Narrative inquiry, according to Kim (2015), is a “storytelling methodology that inquires into narratives and stories of people’s life experiences” (p. 304). As Riessman (2008) explains, narrative inquiry encourages participants to give voice to their experiences through storytelling. Narrative research, as Polkinghorne (2007) summarizes, “is the study of stories” (p. 471).

4.3.2 Narratives & Stories Similar to narrative inquiry, the definitions and use of the terms narrative and story vary. In some cases, narrative and story are used interchangeably (Riessman & Quinney, 2005). Chase (2005) explains that “a narrative” may range from a short story about an interaction, event or experience, an extended story about a major life event, to a life story or life history (p. 652). Kim (2015) differentiates “narrative” from “story” in that narrative refers to “partial description of lived experience” and story to “a full description of lived experience” (p. 9). Thus, a story can be understood as a series of “narrative events” (Kim, 2015, p. 8) and these “narrative events” as “personal accounts told to others as stories” (Lorem, 2008, p. 62).

Narratives and stories are central to our understandings of our experiences, our identities, and how we see others and the world around us (Creswell, 2013; Lewis, 2011; Lorem, 2008; Wells, 2011). We use narratives and stories to make sense of and make
meaning in our lives (Lewis, 2011; Wells, 2011). The process of sharing our narratives and stories allows us to “organize our experiences into meaningful episodes” (Fraser, 2004, p. 180). As Atkinson (2012) states, “We think in story form, speak in story form, and bring meaning to our lives through story” (p. 115).

4.3.3 Narrative & Social Work Narratives and stories are intertwined with social work. Hearing others’ narratives and stories is a core component of many social work roles (Riessman & Quinney, 2005; Wells, 2011). Narrative research highlights how knowledge and multiple perspectives can be constructed and produced through the interactions and communications typical of social work contexts (Fraser, 2004; Riessman & Quinney, 2005; Wells, 2011). Awareness and understandings arise from the narratives and stories of those commonly excluded or silenced. Giving voice to oppressed persons, groups, and communities is fundamental to both narrative and social work research (Larsson & Sjöblom, 2010; Moosa-Mitha, 2005).

The voices of persons living with mental health (dis)Abilities are often still silenced. Research true to progressive theories, models, and perspectives position persons identifying with mental health (dis)Abilities as “active participants and experts on their own state of being” (Cohen, 2008, p. xi). Anti-oppressive and social justice oriented social work research raises voices and empowers, whereas traditional research often further silences and oppresses (Brown & Strega, 2005; Danso, 2015; Levoie et al., 2010; Potts & Brown, 2005; Strier, 2007; van de Sande & Schwartz, 2011). The narratives and stories shared by persons living with mental health (dis)Abilities give voice to personal experience and insights (Lorem, 2008; Patterson, 2008), which carry the potential for social change and transformation (Fraser, 2004). The narrative and social work research
methodologies used in this study allowed for the voices of the participants - fellow distance education social work students with mental health (dis)Abilities - to be heard.

4.3.4 Narrative Autoethnography To incorporate my own voice and experiences into the research, I turned to narrative autoethnography. This type of narrative research, according to Kim (2015), focuses on the “critical self-study or an analysis of the experience of the self” (p. 123). With narrative autoethnography, researchers “turn the lens on themselves” (Chase, 2005, p. 660) and connect their own personal experiences to their study (Crawley, 2012; Creswell, 2013; Fook, 2014). As Crawley (2012) explains, this approach “works to breach the positivist edict of objective distance from the data” (p. 146). By using narrative autoethnography, as Chase (2005) describes, “traditional research approaches, representations, and observations are disrupted” (p. 660). Through narrative autoethnography, researchers analyze how their personal experiences are linked to “larger social, cultural, and political contexts” (Kim, 2015, p. 123) and “dominant and alternative belief systems and practices” (Witkin, 2014, pp. 3-4). Blurring the “traditional distinctions” between the researcher and participants (Borer & Fontana, 2012, p. 55) allows for the connections between their narratives and stories, which can promote further understandings on topics previously not explored (Borer & Fontana, 2012; Ellis & Berger, 2002). Together, these narratives and stories give voice and bring attention to issues faced by those of us excluded or on the margins (Borer & Fontana, 2012; Kimpson, 2005) with the potential to produce and construct new knowledge to inform social change and transformation (Ellis, Adams, & Bochner, 2011; Kimpson, 2005).

Including my own autoethnographical narratives in separate text boxes, titled “Researcher’s Voice”, allowed me to link and differentiate my personal perspectives and
experiences to those of the participants, while connecting my own narratives to the contexts around me. These narrative autoethnographical contributions were not used as part of the data analysis. Visually, these text boxes show my own autoethnographical narratives within the writing of this thesis (Finlay, 2012; Kim, 2015).

Taking a traditional, positivist approach to this research seemed unreasonable and unethical as I cannot claim “objective distance from the data” or research (Crawley, 2012, p. 146), given my personal interests in this study and my shared identity as a distance education social work student with a mental health (dis)Ability. Another layer to my autoethnographical narratives and the entire research process was reflexivity, which I discuss next.

4.3.5 Reflexivity Reflexivity is the on-going, critical self-reflection and self-awareness that the researcher undertakes throughout the research process (Finlay, 2012; Lichtman, 2013; Kim, 2015; Morrow, Boaz, Brearly, & Ross, 2012). Reflexivity in narrative and social work research encourages researcher introspection, subjectivity, honesty, and transparency at all stages of the study (Strega, 2005; Wells, 2011). Through reflexivity, the researcher examines their roles, biases, values, perspectives, locations, and experiences (Creswell, 2013; King & Horrocks, 2010; Riley & Hawe, 2005). Reflexive researchers share and openly discuss how their experiences shape the planning, representations, interpretations, analysis, findings, and writing of the research and, further, how this impacts the participants and readers of their study (Creswell, 2013; Kim, 2015; Lichtman, 2013; Riley & Hawe, 2005; Wells, 2011). The personal nature and personal importance of this research lends itself to reflexivity. Throughout this study, I
was attentive to how I was affecting and intertwined with the research process and, in turn, how the research process was impacting me.

4.4 Sampling & Recruitment

4.4.1 Study Population & Criteria The study population was current and recently graduated distance education social work students who self-identify with mental health (dis)Abilities at two Canadian universities.

Criteria for participating in the study was as follows:

- Bachelor of Social Work or Master of Social Work distance education students who self-identified with a mental health (dis)Ability and who were currently enrolled or a graduate of these programs within the last two years (from 2012-2014) from one of the two selected Canadian universities.

Criteria for the institutions included was having both Bachelor of Social Work and Master of Social Work distance education programs, which were offered primarily online (and not in hybrid formats or face-to-face). The Schools of Social Work also had similar theoretical approaches to social work education and student representation from coast-to-coast. For purposes of maintaining anonymity, further details on the criteria for selecting the two Schools of Social Work were not included. Throughout this thesis report, if needing to differentiate between the two, I refer to the institutions as “School of Social Work 1” and “School of Social Work 2”.

I included both Bachelor and Masters level of studies, as distance education students in these programs likely had similar institutional supports and programs they could access. The time-limit for recent graduates was two years, as distance education social work programs update and change over time. Social work distance education
students’ experiences several years ago would not be a true reflection or comparison to those now.

I asked participants to self-identify whether they lived with a mental health (dis)Ability. I did not include exclusion criteria pertaining to whether participants had a formal mental health diagnosis or not. Honouring the participants’ own identification and definitions of mental health (dis)Ability aligns with the anti-oppressive, social justice and social model informed approaches to this thesis research. Self-identification respects the participants’ perceptions, understandings, and lived experiences of mental health (dis)Ability, instead of focusing on medical ‘expert’ categorizations and diagnoses (Boxall & Beresford, 2013; Price, 2013). Further, accessing and obtaining a formal mental health diagnosis can be a lengthy and costly process, dependent on personal and community resources. Moreover, a formal mental health diagnosis does not give a clear picture of students’ strengths or limitations. Two students with the same diagnosis may have entirely different experiences and supports (Collins, 2006).

4.4.2 Sampling A non-random or non-probability sampling approach was utilized (Bryman et al., 2009; Rubin & Babbie, 2011). I followed the convenience sampling strategy, as described by Robinson (2014): “select those who meet the required criteria and who respond on a first-come-first-served basis until the sample size quotient is full” (p. 32). The targeted sample size was four to eight interviewees. Given the in-depth narratives and stories typically shared by participants when using narrative interviewing, I sought out to conduct approximately four to eight interviews (Riessman, 2008; Squire, 2008). This range was selected to allow for sufficient narrative data analysis, while respecting the time limitations of a Master’s thesis. After receiving ethics approval from
the Dalhousie University Health Sciences Research Ethics Board (REB #: 2014-3327), I moved forward to recruitment phase of the study.

4.4.3 Recruitment Instrument The recruitment instrument I used was an electronic invitation outlining the basic parameters of my thesis research (Appendix A – Interview Invitation). In this electronic invitation, to ensure transparency, I self-identified as a graduate student living with mental health (dis)Abilities completing distance education social work studies at the Master of Social Work level. Jowett, Peel, and Shaw (2011) recommend being open about the research and researcher at the recruitment stage to build connections with potential participants online. Being aware and transparent about my own identity was an essential component of my reflexivity and ethical considerations. To some, my own experiences as a student living with mental health (dis)Abilities completing distance education social work studies could be viewed as a conflict of interest, whereas to others it could be viewed as an asset. I wanted any potential participants to be aware of my identity as a distance education social work student with mental health (dis)Abilities.

4.4.4 Recruitment Process Recruiting participants through their institutional affiliations can present both opportunities and challenges (Robinson, 2014). Prior to recruiting participants through institutional communication channels, such as group email, researchers must obtain the correct permissions (Robinson, 2014). As part of my ethics application, I approached the Director and Associate Director of the Schools of Social Work from the two selected universities, requesting their support and commitment to my thesis research. Once I received ethics approval, I contacted these Schools of Social Work for their assistance in recruiting current and recently graduated (from 2012-
distance education social work students living with mental health (dis)Abilities. My interview invitation (Appendix A – Interview Invitation) was sent via email and email attachment through the various Listservs for Bachelor of Social Work and Master of Social Work distance students as well as for alumni of these programs. I also shared the interview invitation with the distance education student representative group from the School of Social Work 2. The student representative group from the School of Social Work 1 was comprised of primarily on-campus students. As such, I did not forward them the interview invitation. The recruitment phase of the study took place in the fall term of 2014.

Given the challenges around recruiting participants, especially those with stigmatized identities (Matthews & Cramer, 2008), I was apprehensive about the response rate. I received immediate interest and responses from potential participants. Following the approach as described previously, I selected those “who met the required criteria and who responded on a first-come-first-served basis” (Robinson, 2014, p. 32). Some potential participants did not meet the criteria, mostly due to them having completed a hybrid version of their distance education social work program. Other potential participants who showed initial interest did not reply to email responses or chose not to continue with the study. As James and Busher (2012) explain, “asynchronous email communication is susceptible to participants dropping out after several email exchanges…It is not always clear, why some disappeared” (p. 184). I speculate these potential participants either did not feel ready to partake in the study at the time and/or they were juggling multiple roles and responsibilities along with their studies and not in a position to take on the time commitments associated with the
research. In total, six participants from the two Schools of Social Work volunteered to move onto the next stages of the study.

**4.4.5 Informed Consent Process** I distributed via email attachment a detailed informed consent form (Appendix B - Informed Consent Form) to interested participants, outlining (but not limited to): what the thesis research was about, their voluntary participation in the study and that they could decline in answering any questions and were free to withdraw from the research before data analysis was complete, the nature and length of their involvement, potential benefits, risks, or discomfort arising from participating, how information would be used and stored, and their confidentiality and anonymity. No compensation was provided to participants for their involvement in the study. I encouraged participants to ask any questions about the informed consent form via email, phone, or in the pre-interview meeting. Participants either emailed the signed, scanned informed consent form to my university email address or mailed their signed informed consent form to my home address if they did not have access to a scanner. Due to my own geographic distance from my university, I could not collect any participant mail on-campus.

**5.4.6 Research Location** The research location for the pre-interview meetings and interviews was the Internet. Conducting qualitative research online or using the Internet is becoming more common and more feasible (Jowett et al., 2011). According to James and Busher (2012), traditional qualitative research designs and methods may be used and modified for online environments. Progressive software and technologies have also created “new ways and altered contexts where research can take place” (James & Busher, 2012, p. 177). However, James and Busher (2012) caution that using the Internet
for online interviews should not been viewed as an “easy option” and, instead, be considered in light of the qualitative research design and methods (p. 188). King and Horrocks (2010) speak to this, in terms of holding qualitative interviews online when it aligns with the research topic and research question. In order to connect with fellow distance education social work students with mental health (dis)Abilities about their experiences, using the Internet and online interviewing made sense from a research question, design, and logistical perspective. By using the Internet and online interviewing, I could sample, recruit, and collect data over a large geographical area (Matthews, & Cramer, 2008; Robinson, 2014) – from distance education social work students living across the Canada. I could also reach participants without having to spend the time or money to travel to meet them in-person (Flick, 2014; 2015; Matthews, & Cramer, 2008; Robinson, 2014; Jowett et al., 2011). As the participants were located in different geographic areas from me, all the pre-interview meetings and interviews were conducted online. All the pre-interview meetings and interviews took place in the fall term of 2014.

Cost-free videoconferencing technologies - Skype and FaceTime - available to participants were used for meeting and interviewing (Bryman et al., 2009; Dodd & Epstein, 2012). Skype and FaceTime allow for online synchronous, real-time interactions, meaning both the researcher and participant could engage in dialogue as they would in a traditional face-to-face interview (Flick, 2015; James & Busher, 2009; 2012; Jowett et al., 2011). Skype and FaceTime were also selected to provide a visual context for the interview, to facilitate non-verbal communications between the researcher and participant despite the geographic distance.
Another consideration with interviewing participants online, across Canada, was the time zone differences (James & Busher, 2012; Jowett et al., 2011). Scheduling and meeting online for the pre-interview meeting and interview at mutually agreed upon times went more smoothly than originally anticipated, due the flexibility and commitment of the participants to the study. Some meetings and interviews took place in the daytime, while others in the evenings or on weekends. The timing reflected both the time zone differences and the schedules of distance education social work students.

Online interviews also allow for flexibility in terms of the physical space the researcher and participants choose to meet in (James & Busher, 2009). Interview locations, according to Herzog (2012), should be, for the participant, somewhere convenient, comfortable and private. Herzog (2012) explains that interviews about personal, private, and sensitive matters are often best located at home. All participants were in their homes for the pre-interview meeting and interview. I also elected to interview from the privacy of my home. Through the Internet, we could share each other’s contexts and environments (Herzog, 2012).

Interviewing online has unique ethical considerations. James and Busher (2009) explain that research conducted using the Internet may present certain risks around participant confidentiality and privacy. Participants were made aware on the informed consent form (Appendix B - Informed Consent Form) that using Skype and FaceTime could not guarantee the confidentiality, privacy, and security of the information they provided during their online meeting and interview.

With online interviewing, both the researcher and participants need fast Internet connections, be comfortable with technology, and have access to certain software (James
Participants were familiar with Skype and/or FaceTime likely due to distance education social work programs requiring students to be comfortable utilizing a variety of Internet technologies for their studies. All participants already had a Skype or FaceTime account, either on their home computers or mobile phones. One participant created a Skype account as we had connectivity issues when using FaceTime. Because of the knowledge and comfort level participants had with Internet technologies, this aspect of online interviewing did not present as a limitation as it could in some studies (Jowett et al., 2011; Matthews & Cramer, 2008).

4.4.7 Pre-Interviews Before the interview, a brief meeting online via Skype or FaceTime with individual participants was arranged to introduce myself, to review the informed consent form, and to ask any questions or address any concerns they had about the research, and to schedule an interview if they wished to continue with the study. The pre-interview meetings also proved helpful in testing Skype or FaceTime and Internet connectivity.

During the pre-interview meeting, participants were asked how they wished to be identified in the research. Participants had the option to use their own first name or give another name, such as a pseudonym. I also provided the example of using Participant 1 or Participant 2, which some chose. This choice was important. Participants may feel using their own first name gives voice to their narratives or stories and strengthens their mental health (dis)Ability identity, while others may not comfortable sharing this information (Donohue-Smith, 2011; Kaiser, 2012; Sawyer, 2011).
During the pre-interviews, interviews, and debriefing, with the use of self-disclosure, I followed social work practice principles. Self-disclosure may help “build trust and authenticity”, but could also deflect attention away from the participant and their story if used inappropriately or extensively (Harms & Pierce, 2011, p. 127). If participants asked or if I felt it was relevant in terms of timing or context, I disclosed aspects of my own experiences to connect with participants in a way that did not focus on my fulfilling my own needs or was burdening them with my struggles (Harms & Pierce, 2011; Hepworth, Rooney, Dewberry Rooney, & Strom-Gottfried, 2012). Overall, our shared identities seemed to build trust, rapport, and positively influence our comfort levels during our pre-interview meetings and interview (Jowett et al., 2011).

4.5 Data Collection

4.5.1 Interviews Narrative interviews seek to “generate detailed accounts rather than brief answers or general statements” (Riessman, 2008, p. 23). Focusing on narratives and stories in interviewing is a more flexible and “more natural form of communication” (Grbich, 2013, p. 216). Through narrative interviewing, participants are encouraged to “communicate their personal experiences” (Flick, 2014, p. 264). Narrative interviews focusing on experiences are often semi-structured (Squire, 2008). Narrative semi-structured interviews focus on narratives and stories “relevant for the subject under study”, instead of the participants’ entire life story or life history (Flick, 2014, p. 279). Such interviews are also appropriate for exploratory studies, as they allow for beginning investigations of the topic area (Alvesson, 2011). Narrative semi-structured interviews, according to Morse (2012), commonly have “six to ten prepared questions to guide the interview or conversation” (p. 194). In this study, I conducted semi-structured narrative
interviews utilizing an interview guide (Appendix C - Interview Guide) with seven main questions to address specific areas of my research questions, while allowing for the exploration of topics brought up by the participants (Bryman et al., 2009; D’Cruz & Jones, 2004; Dodd & Epstein, 2012; Morse, 2012; Squire, 2008; Rubin & Babbie, 2011). Each participant was asked to partake in one interview, with the intent to obtain sufficient narratives and stories about their experiences from their interview (Flick, 2014).

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<td>Prior to the interviews with participants, I met with my thesis supervisor via Skype. We spoke about narrative interviewing and its impacts on both the interviewer and interviewees. This conversation helped me be more emotionally and mentally prepared for hearing the narratives and stories of fellow distance social work students with mental health (dis)Abilities and, at the same time, reflect more on my own experiences.</td>
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At the start of the individual interviews, I asked participants if they had any questions, explained the debriefing protocol (Appendix D – Debriefing Protocol), and, asked if I could start recording when they were ready to begin with the interview. All interviews, with permission of the participants, were audio-recorded using QuickTime Player to help facilitate the narrative data collection and later transcription and analysis (Bryman et al., 2009; Dodd & Epstein, 2012; Rubin & Babbie, 2011). During the interview, participants were asked questions from the interview guide (Appendix C - Interview Guide) about their experiences as a distance social work student with mental health (dis)Ability and, also, given the time and space to explore other areas relevant to them. Interview durations ranged from 31:23 minutes to 1:05:54 minutes, with a median of 46:11 minutes and mean of 53:29 minutes. This did not include the times before or
after the recording, which we used to address any questions or concerns, debrief, and discuss next steps.

Seidman (2013) explains how the researcher must “transfer their voice and image on the screen” in a way that “honours the process of interviewing” (p. 114). Online interviews differ from traditional, face-to-face interviews in several ways. The focus on rapport and active listening still applies, but may be communicated more easily through verbal prompts (i.e., mhmm) than body language due to the limited visual provided through videoconferencing technologies, such as Skype or FaceTime (Jowett et al., 2011). I utilized verbal prompts frequently throughout the interviews, as it was difficult to show open and welcoming body language on a small screen. I conveyed active listening through reflecting on and paraphrasing participants’ responses, being attentive to details, attempting to understand the participants’ perspectives, and by connecting their narratives to their overall story (Lillrank, 2012).

Technical troubles, such as audio feedback, reduced audio and visual quality, and Internet connectivity issues, interrupted some of the interviews. When this occurred, it was a disruption to the flow of the conversation and interview (Jowett et al., 2011). Fortunately, participants were forgiving of such unforeseen issues and either continued or re-started where they had left off.

Narrative interviewing requires researcher sensitivity, particularly due to the private, personal, and emotional narratives and stories that may be shared by participants (Hydén, 2008; Larsson & Sjöblom, 2010). Given how difficult it can be to speak about personal experiences of living with a mental health (dis)Ability, I was sensitive to how this could negatively and/ or positively impact participants. For instance, I remained in
tune with their emotions during the interview, checked-in with participants, and offered debriefing resources after our interviews. Even though social work pedagogy and practice encourages critical reflection, analysis, and evaluation skills (MacDonald et al., 2003), I was also aware that participants could be uncomfortable commenting on their programs. While participants openly shared their experiences and suggestions (as described in the discussion chapter), I was vigilant about protecting their identity through the research process, as I did not want them to encounter any potential repercussions from their openness and honesty. For this reason, I did not include a section or chapter in this thesis re-storying the participants’ lives, which is not uncommon in narrative research. Instead, I included a more general profile of all the participants. Some participants shared that they saw this research as a medium to anonymously speak to the issues they had been experiencing as a distance education social work student with a mental health (dis)Ability and were thankful for the opportunity to do so.

4.5.2 Debriefing Once the interview was completed and recording stopped, we debriefed about the interview. We spoke about next steps, including the transcript verification process. I also emailed and reminded participants about the debriefing protocol (Appendix D - Debriefing Protocol), which had information on resources and referrals for support and counselling as needed.

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<td>Immediately after ending the Skype or FaceTime conversation with each participant, I also took time to debrief on my own, as part of my own reflexivity. I journaled about the interviewing experience, reflecting on my initial reactions, emotions, and thoughts brought up through the interview process. I was moved by the narratives and stories shared by the participants and impressed by their recommendations to improve distance</td>
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education social work programs for fellow students with mental health (dis)Abilities. My
thesis supervisor was also available on short notice for my own debriefing as needed.

4.5.3 Transcription & Transcript Verification Before transcribing the interview
audio-recordings, I developed a transcription protocol and notation system, as adapted
from Poland (2002), University of Washington (2007), and Wells (2011). Transcription
considerations included formatting, voice, nonverbal, background, and expressive
sounds, paraphrasing, identifying information, questionable text, inaudible audio or
information, and so forth (Appendix E – Transcription Protocol). Interview audio-
recordings were transcribed verbatim following the transcription protocol and notation
system. Approximately seventy-seven pages of single-spaced text were transcribed from
the six interviews. Each transcript was then checked and reviewed against the audio-
recording three times before sending it to the participant for transcript verification. By
personally transcribing and reviewing the interview transcripts, I became familiar and
close to the narrative data on an auditory and textual level through these processes (Flick,

Each participant was contacted via email with the request to review, verify, and
edit their interview transcript of any information they did not want shared. I also included
the transcription protocol, so participants could decipher the notation system. Having
participants review, verify, and edit their transcripts ensured a level of accuracy and level
of comfort with the narratives and stories they were willing to share with others through
this research (Poland, 2002; Polkinghorne, 2007; Richards, 2005; Ross & Green, 2011).
Most participants elected not to make any changes to their transcripts. One participant
edited a detail pertaining to identifying information. Where technical issues had impacted
the audio quality during the interview, one participant made edits around certain words, which improved the accuracy of the final transcript.

4.6 Narrative Data Analysis

Narrative analysis, as Riessman (2008) explains, “refers to a family of methods for interpreting texts that have in common a storied form” (p. 11). According to Wells (2011), narrative analysis “takes stories as its primary source of data and examines the content…or context” (p. 7). In this study, the narratives and stories shared by participants in the interviews was the data to be interpreted and analyzed for its content and context (Chase, 2005; Flick, 2014; Wells, 2011).

Unlike in other qualitative approaches, narrative analysis seldom includes concrete descriptions or steps of how to interpret and analyze the narrative data (Esin, Fathi, & Squire, 2014; Squire, Andrews, & Tamboukou, 2013). With narrative analysis, “a researcher may decide to use or adapt one or more existing analysis systems” (Smith, 2000, p. 331). Before deciding on a specific narrative analysis approach, I reviewed texts and literature on narrative analysis, both with and without a social work research focus (see Beal, 2013; Braun & Clarke, 2006; Creswell, 2013; Flick, 2014; Fraser, 2004; Kim, 2015; Larsson & Sjöblom, 2010; Patterson, 2008; Riessman, 2008, 2013; Saldaña, 2009; Smith, 2000; Wells, 2011). This review brought me to the narrative analysis approaches developed by Lieblich, Tuval-Mashiach, and Zilber (1998).

Lieblich et al. (1998) developed a model “for reading, interpreting, and analyzing” narratives and stories, which focuses on “two main independent dimensions” (p. 12). These are: 1) holistic versus the categorical approaches; and 2) content versus form (Lieblich et al., 1998, p. 12). With the first dimension, the emphasis is on the “unit
of the analysis”, which may vary in definition from “an utterance”, a narrative, to a life story (Lieblich et al., 1998, p. 12). With the second dimension, the focus is either on content or the actual literary form of the narratives and story (Lieblich et al., 1998). These two main dimensions then intersect to produce four ways to read, interpret, and analyze narratives and stories:

<table>
<thead>
<tr>
<th>Holistic-Content</th>
<th>Holistic-Form</th>
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</thead>
<tbody>
<tr>
<td>Categorical-Content</td>
<td>Categorical-Form</td>
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(Adapted from Lieblich et al., 1998, p. 13).

The holistic-content approach views the narratives and story of the participant as a whole, whereas the categorical-content perspective compares and contrasts the content of the narratives and stories across all participants (Beal, 2013; Larsson & Sjöblom, 2010; Lieblich et al., 1998). Examining the holistic- and categorical-content of the participants’ narratives and stories, compared to interpreting them from a form or literary orientation, made more sense in understanding the experiences of distance education social work students with mental health (dis)Abilities. Holistic-form analysis focuses on “plots or structure” of stories, whereas the categorical-form approach centres on the “stylistic or linguistic characteristics” of narratives (Lieblich et al., 1998, p. 13). Analysis focusing on content, rather than form, could potentially produce narrative data more relevant to the research questions around the participants’ experiences, insights, and recommendations. By combining the holistic-content and categorical-content perspectives, I read, interpreted, and analyzed the participants’ narratives and stories with these two lenses (Beal, 2013; Larsson & Sjöblom, 2010; Lieblich et al., 1998). First, I began by reading,
interpreting, and analyzing each participant’s interview transcript, following the steps as adapted from Lieblich et al. (1998) for the holistic-content perspective:

1. Read the material several times until a pattern emerges, usually in the form of foci of the entire story.
2. Put initial and global impressions into writing.
3. Decide on special foci of content or themes to follow in the story as it evolves from beginning to end.
4. Using coloured markers, mark the various themes in the story, reading separately and repeatedly for each one.
5. Keep track of the results in several ways: Follow each theme throughout the story and note conclusions and be aware of each theme’s start, end, transitions, context, etc., and of any contradictory episodes (pp. 62-63).

Second, I read, interpreted, and analyzed participants’ interview transcripts, following the steps as adapted from by Lieblich et al. (1998) for the categorical-content perspective:

1. Select the subtext;
2. Define the content categories;
3. Sort the material into the categories; and
4. Draw conclusions from results (pp. 112-114).

While this model provides concrete steps for narrative analysis, applying these “requires complex decisions on the part of the researcher” (Lieblich et al., 1998, p. 114). Attentiveness to the research purpose, questions, and my own reflexivity guided my choices around how to define, interpret, and analyze the narratives and stories, as well as how to create and condense categories and themes (Alvesson, 2011; Creswell, 2013; Lieblich et al., 1998; Saldaña, 2009).

4.6.1 Narrative Analysis Verification My thesis supervisor contributed to the “coder reliability” or “consistency checking” (Richards, 2005, pp. 141-142) of the
interview transcripts and narrative analysis. A series of email communications and Skype meetings allowed for discussions between my thesis supervisor and myself around my narrative data and analysis choices and interpretations. For instance, my thesis supervisor analyzed two interview transcripts, from which we compared and discussed our resulting categories and themes. Further discussion with my thesis supervisor around the final categories and themes allowed for consultation, critique, and reflection around what narrative data was being included or excluded. As Squire, Andrews, and Tamboukou (2013) explain, “narrative data can easily seem overwhelming: susceptible to endless interpretation, by turns inconsequential and deeply meaningful” (p. 1). Taking these extra steps, with my thesis supervisor, permitted a level of confirmability and verification of the narrative analysis (Jensen, 2008), while allowing for further engagement and reflexivity with the narratives and stories of the participants.

4.7 Limitations

Narrative methodology is not exempt of criticisms and limitations. As previously discussed, narrative inquiry and analysis vary greatly in definition and application (Chase, 2005; Clandinin et al., 2007; Lichtman, 2013; Riessman, 2008; Wells, 2011). Narrative approaches may be viewed as lacking rigor, due to disagreements about validity and limitations in reliability and generalizability, compared to other research methodologies (Crawley, 2012; Creswell, 2013; Kim, 2015; Miller, 2008; Polkinghorne, 2007; Riessman, 2008; Saumure & Given, 2008; Wells, 2011). Narrative researchers have countered these critiques, often by claiming narrative methodologies fall outside the traditional, positivist research realms (Chase, 2005; Crawley, 2012; Kim, 2015; Polkinghorne, 2007; Riessman, 2008). As Riessman (2013) explains, “the (narrative)
approach does not assume objectivity; rather, it privileges positionality and subjectivity” (p. 169). Narrative researchers have offered alternatives to address rigor in narrative studies. Assessing validity, for instance, varies from evaluating the narrative study against a set of criteria or questions (Fraser, 2004; Wells, 2011), letting the in-depth descriptions of the narratives and stories speak for themselves (Polkinghorne, 2007), to the practical applications of the narrative research to social change and transformation (Miller, 2008; Riessman, 2008). Others attend to trustworthiness through processes included in this study, such as reflexivity, member checks, consistency checks or verification, and debriefing (Jensen, 2008; Miller, 2008; Richards, 2005; Wells, 2011).

Narrative studies do not claim reliability and generalizability, due to the small sample sizes and difficulty in replicating and applying the findings in other contexts (Donmoyer, 2008; Grinnell & Unrau, 2011; Maxwell & Chimel, 2014). Instead, the goal of such inquires is to “describe, understand, and interpret” (Lichtman, 2013, p. 139). While these arguments around rigor have relevance, the true “validation and judgment” of the research comes from the participants (Riessman, 2008, p. 199).

Limitations to sampling and interviewing in this study are also a consideration. For instance, the sampling criteria pertaining to the institutions involved could be a limitation. Two Canadian universities were part of the study; however, including other Schools of Social Work with fully online programs might have yielded different results. The two Schools of Social Work involved had similar theoretical approaches to social work education. Distance education social work students at other institutions may have had different experiences, for example, if their Schools of Social Work solely adhered to dominant discourses of mental health (dis)Abilities in their courses and programs.
Another aspect was self-selection bias, meaning: “individuals who consent to be involved in interviews may be different to those who do not, in ways that are not related to sampling criteria” (Robinson, 2014, p. 36). The narratives and stories of the participants who volunteered to be part of the study could be dissimilar from those who chose not to. Thus, if another group of participants had volunteered, the findings and discussions might differ. Further, the narratives and stories provided by the participants who were part of the study would have been influenced by the questions asked or not asked; thereby recognizing the co-creation of meaning and knowledge through the interviewing process (Lillrank, 2012; Polkinghorne, 2007; Rapley, 2012).

While the Schools of Social Work included had student representation coast-to-coast, the sample by chance included participants from a geographically dispersed area. This study did not intentionally address issues of demographics or diversity within the selection criteria and sample itself. As noted, the intent of this exploratory research was initial understandings around the experiences of distance education social work students with mental health (dis)Abilities at two Canadian universities. In the interview questions, I also did not attend to issues of diversity and intersectionality, for instance, the combined identities of participants with mental health (dis)Abilities and gender, sexual orientation, race, and/or age (MacDonald, 2016). Rather, this research is a starting point for future studies, including understanding the experiences of distance education social work students with marginalized intersecting identities.

4.8 Summary

This chapter outlined the research approaches, questions, methods, and limitations of the study. Narrative methodologies were described, in addition to their link to social
work research. Sections pertaining to sampling, recruitment, data collection, transcription, data analysis and verification were also included. The next chapter moves into the findings and discussion of the narratives and stories shared by the participants about their experiences as distance education social work students with mental health (dis)Abilities.
Chapter Five – Discussion

5.1 Introduction

The experiences of Canadian distance education social work students with mental health (dis)Abilities have been unknown to date. Through this study, six participants shared insights on their experiences as well as their suggestions for program improvements. From the narrative interviews, initial understandings were developed around what distance education social work students with mental health (dis)Abilities face during their studies. Alongside these findings are narrative autoethnographic contributions, titled “Researcher’s Voice”, in which I share my reflections and experiences as a distance education social work student with a mental health (dis)Ability. While my experiences provide “insider knowledge” (Finlay, 2012, p. 321), I differentiate these through the text boxes as I cannot represent or speak directly to the experiences of other distance education social work students with mental health (dis)Abilities (Crawley, 2012; Finlay, 2012).

As described in the methodology chapter, using the narrative analysis model developed by Lieblich, Tuval-Mashiach, and Zilber (1998) allowed “for reading, interpreting, and analyzing” (p. 12) the participant narratives and stories from two perspectives. Through the holistic-content perspective, participant narratives and stories were viewed as a whole. With the categorical-content perspective, content was extracted, compared, and contrasted across all the participants’ narratives and stories (Beal, 2013; Larsson & Sjöblom, 2010; Lieblich et al., 1998). Resulting from the narrative data analysis were five key categories capturing the experiences of the six participants:
Great responsibility and care comes on the part of the researcher to ensure the participants’ perspectives are represented in the best possible way (Alvesson, 2011; Riley & Hawe, 2005). Envisioned through these next chapters is the opportunity to honour the insights and recommendations shared by fellow distance education social work students with mental health (dis)Abilities. In this chapter, following the participant profile is a discussion of these findings. Recommendations on program improvements for distance education social work students with mental health (dis)Abilities as suggested by the participants are outlined in the next chapter.

5.2 Participant Profile

The six participants informed this research not only through their personal experience narratives, but also through their identities and locations. Included is a general profile of the participants, to allow readers to appreciate the participants’ personal contexts and the impacts on this research.

All participants were mature students with partners and all the participants were women. Five participants had children, while all had family-related responsibilities. All participants were helping professionals with experience in the human services field. As it is a requirement of social work programs, all participants had completed previous post-secondary education. At the time of the interviews, one participant was studying full
time, while the rest were working as social workers and/ or in the social services field as they progressed through their distance education social work studies. Three participants were current Master of Social Work students, one was a Master of Social Work recent graduate, and two were current Bachelor of Social Work students.

Every participant self-identified with a mental health (dis)Ability. Four participants shared they had mental health (dis)Abilities their entire life or as long as they could remember, although they may not have recognized it at the time. Two participants shared mental health (dis)Abilities had been a part of their life since their teenage years. Although it was not part of the selection criteria for the study, all participants had a formal mental health diagnosis. Some participants had received a diagnosis before entering the social work field. Others received a diagnosis in recent years, after already having worked as a social worker. Every participant generously gave their time and contributed their unique insights and helpful recommendations to this study.

5.3 The Experiences

Within the next sections, findings from the narratives and stories shared by the participants about their experiences as distance education social work students with mental health (dis)Abilities are identified. Also included is a discussion with connections to the literature.

5.4 Flexibility & the (im)Balancing Act

“...A distance ed program made all the difference, um, because it meant that I could work at my own pace, at home, that I didn’t have to be juggling family and work and driving a commute, or, you know, showing up for classes at a particular schedule, that
kind of thing. Um, so it really took an enormous amount of pressure off, ah, in terms of the stress of, of going back to school.” – Michelle

The distance education social work students with mental health (dis)Abilities in this research juggled their studies alongside the existing multiple roles and responsibilities in their lives. Participants cited flexibility as the most beneficial or positive aspect of distance education, whereas a common challenge with their studies was the current commitments already in their lives - all while managing their mental health.

5.4.1 Flexibility

“Just the sheer flexibility of being able to, um, you know, not go to class, not do a posting if I don't want to, or…if I’m not up for it that night, um, and instead do it the next night or do it three hours later. Um, that has made much more, MUCH more easy for me to balance life. Right? That has made it a, um, great deal easier for me to manage my mental health.” – Michelle

Distance education social work programs provide opportunities for study for those who may not have the chance to otherwise. By continuing their education online, a diverse group of social work students, whether they are working professionals, parents, mature learners, facing financial difficulties, and/ or persons with mental health (dis)Abilities, have access to furthering their credentials (Collins, 2008; Blackmon, 2013; Brown et al., 2012; Inoue, 2007; Müller, 2008; Reamer, 2013; Vernon et al., 2009).

Participants in this research were mature students with other commitments in their lives, in addition to their online social work studies. While participants had completed previous studies on-campus, their current circumstances required the flexibility of distance education. Completing Bachelor of Social Work or Master of Social Work programs on-
campus was not an option for most, given their situations. Other commitments (i.e., family, caregiving, employment, medical appointments, etc.) in the participants’ lives required them to consider flexible educational opportunities.

Flexibility with distance education lies in the choices students have around when and where they study. They are not required to attend certain classes, on-campus, at a particular time (Kahu et al., 2014). Distance education social work programs follow semesters set out by the universities. Within the term, distance education students are required to complete coursework and assignments by certain due dates - similar to on-campus courses. However, distance education students select when they listen to lectures, read course materials, contribute to discussions, and complete assignments within these predetermined time frames (Kent, 2015; Thomas, 2012). Distance education students also choose where they study, whether at home or elsewhere (Thomas, 2012; Willems, 2005).

The flexibility of distance education also made it possible for participants to maintain and manage their mental health. As stated in the narrative above, the flexibility of distance education allowed one participant to create balance in her life, which made it easier for her to maintain her mental health, despite the very full life she was leading. Attending mental health related appointments, while successfully completing her online studies, was possible for another participant. Adjusting their course loads, for instance, by taking one course at a time, was another element of flexibility mentioned by some participants. The flexibility of distance education, for several participants, helped create balance and opportunities for better mental health.

For students with mental health (dis)Abilities, the flexibility of distance education accommodates diverse ways of learning (Kent, 2015; Lindera et al., 2015; Reamer, 2013;
Terras, Leggio, & Phillips, 2015). Participants described how they would adjust their coursework according to how they were feeling. When they were feeling at their best, they made progress and, at times, would work ahead if the course materials were available to do so. On the other hand, if they were not feeling well, their productivity was impacted. The flexibility of distance education around time and space worked for almost all participants. One participant for whom on-campus studies would have been challenging due to her work situation and the agoraphobia she was dealing with, the online format allowed her to go back to school and further her social work education. Another participant appreciated the flexibility of distance education, but found the structure and scheduling of on-campus, in-class studies helped keep her motivated and on-track. She explained how her mental health (dis)Ability often presented as a barrier to her online studies; an area explored in another section of this discussion. Common to all participants was the connection between their mental health (dis)Ability and the flexibility of distance education.

Researcher’s Voice

The flexibility of distance education was positive for me. Having choice in where and when to study was beneficial, providing an unplanned accommodation for my mental health (dis)Ability. Whenever possible, I could work with my mental health (dis)Ability, rather than against it. Certain times of the day and particular locations were more conducive to learning; a realization I made after already being enrolled in a distance education social work program. At times, I would be more focused and energized in the morning; at other times, in the late evening. Some of my study spaces were preferable for reading, whereas others were better for writing. While I could not always take advantage of these more productive times and locations due other commitments, the occasions where I could were beneficial to my overall online learning experiences.
5.4.2 Multiple Roles & Responsibilities

“…The difficult aspect of it is trying to balance it out …In the beginning of the program, that is when I was struggling the most, when I got depressed. Basically, I was doing too much…it’s all this caregiving mixed up with work and school.” – Mary

Participants in this study had multiple roles and responsibilities in their lives, in addition to living with a mental health (dis)Ability. Online social work studies were often an added area of responsibility to their lives, without removing any of their existing ones (Kazmer & Haythornthwaite, 2001). While the flexibility of distance education “theoretically makes it easier to fit study into their lives” (Kahu et al., 2014, p. 525), distance students are still faced with the challenge of “finding appropriate temporal and physical contexts in which to learn” (Selwyn, 2011, p. 378). Despite the flexibility of online studies, students are confronted with new challenges as they continue their education. Distance education students, when compared to on-campus students, tend to have more hours dedicated per week to employment as well as family and caregiving commitments (Brown et al., 2013). Gendered roles and responsibilities are additional pressures for women who further their education online (Arric et al., 2011; Kazmer & Haythornthwaite, 2001; Müller, 2008; Selwyn, 2011). Several participants spoke to the challenges of managing their mental health, employment, family, and caregiving responsibilities, while meeting the demands of their program. For a few participants, this was most apparent when they started their online social work studies. As multiple roles and responsibilities clashed with the school workload, some participants faced increased stress and negative impacts on their mental health. Moreover, the emotional engagement with the course content was also challenging for some participants, who were already
stretched beyond their limits. Social work education can be an uncomfortable learning and unlearning process for social work students; often unsettling their previously held assumptions, while transforming their perspectives and worldviews (Campbell, 2003; Campbell & Baikie, 2012; Hughes, 2011). Online social work students may deal with this intellectual and emotional learning in isolation, while still attending to the other responsibilities in their lives. Overall, the participants adapted to these various stressors as they adjusted to their social work programs and the conflicting demands in their lives.

Researcher’s Voice

Combining online social work studies with other commitments was challenging. No matter what I did to alter my schedule or reduce my responsibilities where possible, it never seemed that I could get it just right. Financial pressures required I work throughout my online studies. Often I would get up very early or stay up very late to complete coursework and assignments around my shift work schedule. Unexpected events also arose - illnesses, loss of a loved one, and other crises – that I was not prepared for. My distance education social work journey, like those of many other online students, was a delicate (im)balancing act.

5.5 Inaccessible Accessibility Services

“I registered with accessibility services and, I found that when I called, um, while there’s sort of...sort of a general philosophy about accessibility, but when I’d called I’d get redirected to the website…to get my information, but it was the actual website I was having difficulties with in accessing…” – Participant 1

Participants in this research were asked whether they had accessed support through their schools. Surprisingly, participants accessed little to no supports through their institutions and received few, if any, accommodations. Only one participant had registered with accessibility services, even though all participants had a formal diagnosis
and technically would have been eligible for their services. This participant who had registered with accessibility services, generally found their support to be limited and unhelpful for a distance student. Reaching the accessibility services office by phone was difficult. The accessibility services office was only open during business hours, but located in another time zone. She worked full-time hours; the hours she was available to phone did not align with the hours the accessibility services office was open. As demonstrated in the narrative above by this participant, the support received often was not effective. Generally, she found connecting directly with faculty more beneficial; more or less notifying them of her (dis)Ability early in the term in the event she needed accommodations. She stated she registered with accessibility services in case she needed it. For the rest of the participants, who did not register with accessibility services, a number of reasons were cited as to why this was the case. Several participants spoke to the lack of promotion and awareness around accessibility services directed towards distance education students. It was also unclear what services and supports they could offer distance education students. A number of participants did not think to register with accessibility services as it did not apply to them as distance education students with mental health (dis)Abilities. Some felt that the accessibility services office was directed towards students with other forms of (dis)Abilities. As one participant explained, “Because, let’s face it, when I grew up a (dis)Ability was something physical. Or…like someone with Down’s Syndrome. Mental illness was something on its own separate spectrum or whatever”. How mental health (dis)Ability is defined and self-identified is complex, as discussed in previous chapters. In the context of accessibility services, as Megivern (2002) explains, “students are either uncertain about their own disability status
or they are not aware that psychiatric illness may be recognized as a disability” (p. 27). With both distance education and on-campus studies, it is common that students with mental health (dis)Abilities do not formally disclose their (dis)Ability or seek accommodations through their institutions (Collins & Mowbray, 2005; Gruttadaro & Crudo, 2012; Getzel & Thoma, 2008; Hutcheon & Wolbring, 2012; Kent, 2015; Roberts, Crittenden, & Crittenden, 2011; Terras et al., 2015; Thompson-Ebanks, 2014). Overall, for the participants in this study, the accessibility services offices were, in many ways, inaccessible for distance students.

Findings from this research also contradict the literature problematizing social work students with mental health (dis)Abilities. Distance education social work students with mental health (dis)Abilities in this study were not even recognized or categorized by their schools as receiving (dis)Ability services or mental health related supports, with the exception of one participant registered with the accessibility services office. While a few participants asked for extended deadlines on assignments, other non-labelled students in their programs would also have requested and received such informal accommodations (McKenzie, 2015). Participants progressed through their online programs, without being the complex, time-consuming, and challenging students with mental health (dis)Abilities they are often made out to be by the social work literature (Collins, 2006; Gillis & Lewis, 2004; GlenMaye & Bolin, 2007; Horton et al., 2009; Mazza, 2015; Reid & Poole, 2013).

Participants welcomed and suggested having more services and supports available to distance education students, as outlined in the recommendations chapter. One participant spoke of feeling disconnected from the university’s services, as they were tailored to on-campus students. Another participant described how she likely would have
accepted supports and services through her school, if someone had connected with her. She explained how her mental health (dis)Ability often prevented her from reaching out for support. Students with mental health (dis)Abilities might not actively seek out accessibility services and other supports (Hutcheon & Wolbring, 2012; McKenzie, 2015; Olney & Brockelman, 2003), highlighting the importance of institutions proactively communicating what is available and reaching out to distance education students (Barr, 2014; Roberts et al., 2011; Terras et al., 2015).

5.5.1 Own Supports

“You have to build up your own supports, where you are, like at home… as you go along in the program.” – Mary

Participants in this study did not obtain mental health services and supports through their schools. Consistent with the literature related to institutional supports (Barr, 2014), participants reported that they did not obtain mental health services and supports through their schools, as such supports were not available to them as distance education students. Instead, participants connected with formal and informal supports in their local communities. They saw their family doctors, connected with therapists, and utilized the hospital in times of crisis. Participants who were employed accessed counsellors through their employee assistance programs (EAP). Formal services and supports were connected with as needed, demonstrating the participants’ motivation for attending to their mental health needs (Horton et al., 2009; Zellmann et al., 2014). Informal networks, such as family and friends, were a significant source of support for participants. This mirrored the findings by Reid and Poole (2013) in their research with on-campus social work students. Informal supports have fewer barriers to access, often being equally or more effective.
than formal services within the mental health system. During times where their mental health was stable, some participants shared that their informal networks provided them with sufficient support. In addition to their own formal and informal supports, participants promoted access to online mental health services and supports through their institutions, as highlighted in the recommendations chapter.

**Researcher’s Voice**

I recall reviewing the accessibility services webpage, looking into how it might be helpful to me as distance education student with a mental health (dis)Ability. There was lengthy paper work, which needed to be filled out by a medical professional. Between the barriers of getting the paper work completed and the irrelevant services available for distance education students (i.e., note taking, writing exams in other locations), I did not pursue it any further. Similar to the participants, I connected with formal and informal supports in my own community as needed.

5.6 Misunderstanding Mental Health (dis)Abilities

“…. I don’t think anybody, um, and I’m sure this is the case for a lot of things, but I don’t think anybody who’s never been through a mental health problem, of any type, can really understand.” – Mel

Navigating through life with a mental health (dis)Ability is not easy. Students with mental health (dis)Abilities frequently experience stigma and sanism (Condra et al., 2015; GlenMaye & Bolin, 2007; Hartley, 2010; Link & Phelan, 2001; Olney & Brockelman, 2003; Phelan & Basow, 2007; Poole et al., 2012; Quinn, Wilson, MacIntyre, & Tinklin, 2009; Reid & Poole, 2013; Thompson-Ebanks, 2014). Negative experiences become familiar and impact many aspects of their lives. Participants in this study shared their experiences around misunderstandings of mental health (dis)Abilities, how they
responded to this, and how it impacted their decisions around disclosures, as described below.

5.6.1 Lack of Understanding & Knowledge around Mental Health (dis)Abilities

“…I guess I was just a little surprised by it, and I think it was lack of information about that diagnosis. But within a social work setting, to have something, sort of, so closed off, um, to kind of label everyone with one disorder, to kind of write them off as not being able to perform at a certain level.” – Participant 1

Misinformation and misunderstandings of mental health (dis)Abilities were encountered by most participants. Two participants described the lack of understanding and knowledge around various mental health issues and diagnoses amongst their classmates, which arose during assignments. Surprising to both participants was how misinformed their social work classmates were about mental health (dis)Abilities. Part of one participant’s narrative is shared above, in which she describes this experience. It seemed that the participants’ social work classmates were influenced by dominant discourses on mental health (dis)Abilities. One participant spoke of how her situation was misunderstood by classmates. She was on medical, stress-related leave from work. However, some classmates viewed her situation as having it easy or they would compare their own circumstances and problems, such as having to work full-time and complete their studies. In these instances, the participants’ classmates were unaware of the realities of those living with mental health (dis)Abilities.

5.6.2 Reluctant Disclosures

“…I didn’t feel as though there was enough safety within the online community with the students to discuss, um…discuss our own sort of issues around mental health, our own
Distance education social work courses have assignments, group projects, discussion boards or other interactive features for students to integrate course content with their practice and personal insights. At times, online students may disclose their lived experiences with their classmates and instructors, resulting in opportunities to share and learn from another (Reamer, 2013). However, for the participants in this study, disclosures were a cautious endeavour. As one participant described in her narrative, her experience was the online community in her courses and program did not have enough safety to disclose such personal information. She spoke of how it seemed inappropriate and not the place to share with classmates in the online space. As Olney and Brockelman (2003) state, students with mental health (dis)Abilities “employ a range of strategies to manage information about themselves”, including sharing if it is safe to do so or disclosing on a “need to know basis” (p. 36). Other participants described how the disconnected nature of distance education did not lend itself to disclosing about their mental health (dis)Abilities, compared to a face-to-face setting. In the online context, some participants spoke of how sharing through text-based discussion boards could be misread or misinterpreted. On occasions where participants did disclose on discussion boards or postings, some experienced supportive replies, while others received limited to no responses from classmates or their instructors. In-person or in the classroom, participants explained they could get a better sense of someone’s response to their disclosure and provide further explanation or clarification as needed. With distance education, according to Berger, Stein, and Mullin (2009), there is more risk of
“stereotyping and misunderstandings because of loss of capturing of nuances in non-verbal communication” (p. 477). The online environment made disclosing about mental health (dis)Abilities much more difficult.

Group work in online courses brought forth unique situations where participants were faced with choosing whether to disclose their mental health (dis)Ability. Group assignment expectations and deadlines created circumstances where one participant felt forced into disclosing, if she could not work at the same pace of other group members. Some participants found group projects more stressful than completing assignments individually due to the uneven distribution of the group work. However, these participants did not necessarily share with group members about their mental health (dis)Ability. One participant viewed group work as an opportunity to connect with classmates. However, she found that fellow distance students were focused on getting schoolwork done and not talking about personal matters. Another participant also found this to be the case in her courses. Kahu et al. (2013) explain that mature, distance students “tend to have more complex, full lives which leave little time, or potentially desire, to work with other students” (p. 800). Opportunities to grow connections with classmates, beyond the tasks at hand, were inhibited by the busy lives of distance education social work students.

While participants were hesitant to share with online classmates, they were often also reluctant to disclose to distance education instructors. One participant spoke of the mental and emotion energy required with disclosing a mental health (dis)Ability, along with the uncertainty of whether the professor would be supportive and understanding. Another participant included aspects of her mental health (dis)Ability in assignments, but
she did not receive any acknowledgments or comments about this from the faculty grading these papers. For another participant, writing about her lived experiences around mental health was positive for her, as was receiving supportive assignment feedback from the professor. Common to all participants was the “intricate decision-making process” and risks involved in disclosing (or not disclosing) about their mental health (dis)Ability (Olney & Brockelman, 2003, p. 49).

5.6.3 Professional Identity

“So it’s kinda become part of my professional identity to talk a little bit about it but not to get too graphic because I’m, I’m worried about judgment from my superiors, right? So that, that’s become a kinda careful habit, a careful professional negotiation, and it’s something I don’t let go of very easily even going into a school setting with people that are a country away.” – Michelle

Social work students with mental health (dis)Abilities, who are also employed as social workers or helping professionals in the field, face added dilemmas around disclosures. Classmates and instructors could potentially be their work colleagues or supervisors. Workplaces are not exempt from stigma and sanism. Fellow social workers may view their colleagues identifying with mental health (dis)Abilities as incompetent or impaired (Charles & Bentley, 2014; Liegghio, 2013; Poole at al., 2012; Reid & Poole, 2013; Stromwall, 2002; Thompson-Ebanks, 2014). As shared in her narrative, one participant carefully considered her professional identity when interacting with classmates and instructors in the online course context. She explained how sharing too much could be viewed as unprofessional or inappropriate. Two other participants were concerned about the consequences that sharing online could have in their professional
lives. As Olney and Brockelman (2003) explain, “Coming out of the disability closet is a personal decision that has serious repercussions for the individual in terms of relationships and opportunities” (p. 49). Social work students and social work practitioners with mental health (dis)Abilities are not viewed as equals within the profession (Leslie et al., 2003; Stromwall, 2002). Negative experiences from sharing their mental health (dis)Ability in the workplace also prevented two participants from being more open in online courses. Judgement from others was the main concern for the three participants who discussed this. Social work students with mental health (dis)Abilities feel discouraged from disclosing, as their lived experiences are not always openly welcomed or valued (Goldberg et al., 2014; Poole et al., 2012; Reid & Poole, 2013; Stromwall, 2002). Protecting their professional identity as a social worker becomes paramount, as revealing their stigmatized identity leaves them vulnerable to the sanism that comes from others’ misunderstandings of mental health (dis)Abilities (Moll, Eakin, Franche, & Strike, 2013; Quinn & Earnshaw, 2013; Poole et al., 2012; Reid & Poole, 2013; Richards, Holttum, & Springham, 2016; Stromwall, 2002; Thompson-Ebanks, 2014).

5.7 Mental Health (dis)Abilities Intersecting with Distance Education Social Work Studies

“…so, the experience that I had with just starting out in distance ed then, being on medical leave, was, um, I was suffering from a lot of anxiety. And, I mean, just enormous fear, and agoraphobia, I didn’t want to leave the house, um. And so, it was great to be in front of the computer.” – Anne
Experiences of being in a distance education social work program and living with a mental health (dis)Ability were intertwined for the participants. As described in the narrative above, one participant found the distance education format worked well during a time where it was difficult to leave the house due to her mental health (dis)Ability. Studying by distance education allowed her to further her social work education, while maintaining social connections online (Kent, 2015). Certain stages of the programs had more of an impact on participants’ mental health; particularly, starting their studies and doing their field placements. Participants’ mental health was also affected by their overall school workloads. Distance education social work studies also had a role in recovery, by providing a healthy distraction and increasing one participant’s self-worth and self-esteem.

5.7.1 Starting the Program

“...when I started the program in September, I was very unwell. It was quite the battle to manage mental illness, family responsibilities and then on top of that, um, not only the workload of a Masters program, but also the content of what I was going to be, um, learning in the Masters program.” – Participant 2

Beginning a distance education social work program created challenges for some participants. With multiple roles and responsibilities already taking their time and energy, participants creatively incorporated online studies into their lives, as echoed in literature addressing distance education (Angelaki & Mavroidis, 2013; Kahu et al., 2014; Willems, 2005). At the start of the program, as reinforced by the literature, there was an adjustment period for several participants until they found ways to complete online studies around other commitments (Brown et al., 2012; Getzel & Thoma, 2008; Kazmer &
Haythornthwaite, 2001), but with the added challenge of maintaining their mental health. As shared in the narrative above, when starting the distance education program, it was difficult for one participant to manage her mental health, family and employment responsibilities, and online graduate-level studies. Trying new treatments, medications, and their side effects impacted her focus, concentration, and energy levels, all while adjusting to online studies and attending to her other roles and responsibilities. For another participant, the first term was the most demanding and detrimental to her mental health, until she adapted to the online program, in addition to her employment, family, caregiving commitments, and put her own supports in place.

Triggering course content and comments from classmates also impacted some participants’ mental health. At the start of her program, one participant shared that she was unwell, making her more vulnerable to being triggered by course content and discussions. She described how distance education made social work students more susceptible to being triggered when studying late at night and not having support available to process it, as would be the case in-class. Social work education encourages critical self-reflection and analysis; however, challenging course content can also contribute to personal crises for students during their educational journey (Campbell, 2003; Hughes, 2011; Sellers & Hunter, 2005; Zosky, 2013). During the mandatory on-campus portion of the program, one participant provided an example of a classmate talking about something, which was very triggering for her. She did not feel there was anyone she could talk to afterwards about the experience. Both participants emphasized the importance of having support from their schools and instructors, as they faced
triggering and challenging course content and discussions (Campbell, 2003; Hughes, 2011; Sellers & Hunter, 2005; Zosky, 2013).

5.7.2 Mental Health & School Workload

“I'm spending all my time struggling to get out of bed, let alone do research and write fifteen, twenty pages.” – Mel

Social work education, taken in any modality, can be stressful for students (Collins, 2006; Mazza, 2015; Ying, 2009). For distance education social work students with mental health (dis)Abilities, the impact of this stress may be even greater. Some participants in this study shared how a decline in their mental health was often related to their school workloads. One participant talked about making changes in her life around her responsibilities, school workload, and getting counselling for her mental health, rather than taking medication and not addressing the stressful circumstances in her life. Another participant spoke about coursework and deadlines piling up, especially when she was feeling unwell. As shared in the narrative above, there were times where she really struggling with her mental health; preventing her from making progress or completing major assignments and research papers. Both participants did not openly share with distance education course instructors when they were struggling with their mental health, while trying to complete assignments or papers. One participant explained how the lack of drive or lack of motivation of distance education students participating in discussions or in completing coursework may be perceived by online course instructors as disinterest or laziness. However, these instructors may not be aware of the mental health (dis)Abilities some distance education social work students are living with. Another participant described the process of opening up to a professor and providing proof (i.e., a
doctor’s note) of her struggles was more stressful than just finishing the assignment or paper. Obtaining medical proof of a (dis)Ability entails associated costs of the assessment, documentation, and of the time taken off work for medical appointments, whereas disclosing a mental health (dis)Ability involves risk of judgment and discrimination (Brabazon, 2015; Condra et al., 2015; Mullins & Preyde, 2013). In comparison, students requesting religious accommodations are not required to provide documentation concerning their faith. By requiring medical professionals to prove the reality of their (dis)Ability and their needs, the rights of students with (dis)Abilities are diminished within post-secondary settings, compared to other groups under human rights codes (Brabazon, 2015; Mullins & Preyde, 2013). Because of such barriers, participants in this study worked on and completed assignments when they were unwell. They also did not reach out or receive support from their schools for their mental health (dis)Ability. This raises concerns about unidentified distance education social work students with mental health (dis)Abilities who are submitting assignments, which do not fully reflect their capabilities.

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<td>Countless times, I wrote and completed tests, assignments, or papers when unwell. Similar to other’s experience, the stress of sharing my struggles and obtaining proof often prevented me from connecting with online course instructors or professors. Instead, I would write, complete the assignment or paper, hope what I submitted made sense, and move onto the next challenge.</td>
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5.7.3 Placement Challenges

“But when it comes to the placement I asked like what are the accommodations that somebody is allowed to do for a placement, right?...And, for me to be able to work full-time and go to school part-time is difficult enough as it is sometimes…” – Participant 1
Field education presented challenges for some of the distance education social work students with mental (dis)Abilities in this study. As shared in her narrative above, one participant was concerned about completing her practicum, coursework, while also living with a mental health (dis)Ability, working full-time, and raising her child. The limited flexibility around when the field placement and online practicum course could be completed was a major barrier. She was concerned about finishing her program, if she could not find a way to complete her field placement in a way that would fit with her existing responsibilities, while not negatively impacting her mental health. For another participant, finding a placement and completing the required hours was especially difficult when feeling unwell. Both participants identified stresses associated with field placements and its impact on their mental health (Horton et al., 2009).

Triggers arising from difficult situations in practicum was another area of concern for the distance education social work students with mental health (dis)Abilities in this study. For one participant, who was very aware of the triggers she experienced (Sussman et al., 2014), these triggers still contributed to an increase of mental health symptoms at times during her practicum. Gillis and Lewis (2004) explain, “It is not uncommon for social work interns to experience psychiatric problems during an internship” (p. 401). Compared to coursework, field education is recognized as being more difficult since social work students integrate theory into practice, support persons facing complex challenges, and relate their lived experiences to their practicum work (Gursansky & Le Sueur, 2012; Mazza, 2015; Pooler et al., 2010). Lack of support from the field education team and field education liaison or advisor during her distance education placement was concerning for one participant. While she felt supported by her field education (or
agency) instructor, she noted minimal support from her school during her placement. Given the challenges of field education and its potential impact on social work student mental health and well-being (Gursansky & Le Sueur, 2012; Pooler et al., 2010), more interaction and support from field education teams is crucial for distance education social work students.

5.7.4 Course Work as Part of Recovery

“It was a healthy coping mechanism. And more so than anything to be honest, um, it allowed me to feel valued in my life again…. And it kind of just brought me out of a situation where I was just feeling so, um, just lacking any sort of self-worth or self-esteem.” – Participant 2

Distance education social work studies, for some participants, became a part of their recovery. Course work and assignments, for instance, provided opportunities for exploring, researching, and reflecting upon topics related to participants’ lived experiences. For example, one participant wrote about mental health recovery and what could be helpful for students recovering from mental health (dis)Abilities. Another participant explained how a particular assignment in one of her courses required writing about her lived experiences, in which she took a risk and focused on her mental health journey. She described this assignment and writing process as very difficult, but also as one of the most beneficial experiences of her program. As Wiles (2011) explains, “Difficult life experiences do not necessarily produce successful students, but the insightful resolution of such issues is often considered to be a positive attribute for would-be social workers” (p. 41). Some participants utilized coursework and assignments
for further learning, gaining insights, and reflecting upon their lived experiences of mental health (dis)Abilities.

Post-secondary education relates to recovery as it provides meaningful opportunities for personal growth, development, achievement, and transformation (Davidson et al., 2005; Deegan, 1988, 1996; Mulvale & Bartram, 2009). One participant described, as shared in her narrative above, how success in her distance education social work courses and program increased her self-worth and self-esteem at a time where she felt guilt about being unwell. Online social work studies were a positive distraction and healthy outlet for her, but also contributed to her recovery. She spoke about achieving excellence in her studies, during a time in her life where that seemed unlikely. Success in post-secondary education contributes to recovery through creating a positive identity outside of the labels or mental health (dis)Ability (Deegan, 1988; Mulvale & Bartram, 2009; Schiff, 2000), while also building a sense of empowerment, hope, and well-being (Mead & Copeland, 2000; Mulvale & Bartram, 2009).

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<td>Social work education, distance or on-campus, can be such a valuable undertaking. Opportunities for learning, un-learning, exploring, researching, and reflecting on lived experiences through coursework and assignments were central to my personal growth, development, and transformation. Having faced and overcome countless obstacles throughout my life, many times I doubted I would ever get this far in my social work education journey. Successes in my online social work courses and programs were major personal accomplishments; proving it was possible to battle and overcome many barriers.</td>
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5.8 Building Connections & Building Community

“It doesn’t have to be about somebody having a mental health issue or a (dis)Ability. But more about building connections and building a community. Because as it is, I don’t
Building connections and building community are central to the distance education experience. In the participant’s narrative shared above, she highlights how this is critical for all distance educations students; not only those with mental health (dis)Abilities. In the online learning context, Conrad (2005) defines “community as a general sense of connection, belonging, and comfort that develops over time among members of a group who share purpose or commitment to a common goal” (p. 2). If social work distance education students feel welcomed and comfortable in their courses and programs, they will be more likely to connect with one another. Meaningful and trusting relationships help create a sense of safety and belonging for all online (Baxter, 2012; Exter et al., 2009; Kahu et al., 2013). Online connections and communities create positive conditions for learning, development and collaboration, while possibly preventing distance education social work students from struggling with and in isolation (Angelaki & Mavroidis, 2013; Baxter, 2012; Brown et al., 2013; Conrad, 2005; Kahu et al., 2015; Pardasani et al., 2012; Shackelford & Maxwell, 2012; Thomas, 2012). While all participants addressed the disconnection and isolation they experienced during their studies, they also shared positive instances of connecting with others.

5.8.1 Disconnection & Isolation

“So, it makes it seem very impersonal, which, for me at least, tends to exacerbate problems. Because I don’t feel like I can...I don’t feel like I can explain things to anybody” - Mel
Distance education is recognized as often being impersonal and isolating (Appana, 2008; Baxter, 2012; Brown et al., 2013). Disconnection and isolation was the most negative aspect of the participants’ distance education experiences. Some participants felt segregated from their schools in terms of services or supports, while others felt disconnected in terms of relationships with classmates, professors, and staff. Half of the participants shared feeling disconnected from their programs entirely - from classmates, professors, staff, services, and supports. As Angelak and Mavroidis (2013) explain, “students of distance courses often experience the emotion of loneliness and isolation due to geographical distance, lack of personal contact and due to the fact that they should meet the requirements of the course mainly on their own” (p. 88). While many distance education students feel isolated, what differed for the participants in this study is how that isolation also impacted their mental health. As described in her narrative above, the impersonal nature of distance education made it harder for one participant to explain her circumstances to others; therefore, compounding her struggles. Another participant shared how she did not feel any true connection to classmates or instructors, which contributed to the isolation she already felt and added to the agoraphobia she was living with. According to Baxter (2012), inadequate “online friendships” and “feelings of exclusion” contribute to distance education student failure and drop out (p. 122). Countering isolation with meaningful online connections with classmates, professors, and staff as well as key services and supports is vital to distance education student success and well-being, whether these students identify with a mental health (dis)Ability or not.
Distance education is a lonely endeavour. Countering this isolation was crucial for me. I sought out ways to connect to others from my program beyond traditional coursework and assignments. Volunteering as a distance education student representative as well as attending events and conferences helped offset feelings of disconnection. However, as social work students and practitioners, we train and yearn to build connections and community in ‘real-life’. Why should the online social work environment be different? The need for true online connections and online communities exists in our distance education social work programs.

5.8.2 Connections with Others

“I certainly developed some connections through the program, which have been really positive. Um, there have been several people, just in our area, that we have connected…. Um, but developing some of those relationships was really fantastic. And those have been maintained throughout my MSW. Some of people I met in my first course are very close to me at this point.” – Participant 2

Connections with others were crucial to the participants in this study. For distance education social work students, as Pardasani et al. (2012) explain, “emotional connectedness was a critical factor in the students’ evaluation of their experiences” (p. 416). When participants formed connections with fellow classmates in their programs, often times these became lasting friendships. As shared in her narrative above, one participant developed meaningful relationships with classmates who lived in the same geographic area as her. She explained they would meet in person, study together, and act as a support for one another. Another participant spoke about a friendship with a classmate she developed through her program. They met in-person when she happened to be visiting the city her classmate lived in. This participant described how had it not been
for their connection through their online studies, they would never have met. Another participant made connections with fellow online social work students and alumni outside of her courses, for instance, meeting through work and discovering the commonality that they happened to be in the same program. Connections with online classmates, according to Angelaki and Mavroidis (2013), alleviate feelings of isolation and promote student well-being. With their online classmates, students communicate their shared experiences around successes and challenges in their distance education journeys (Angelaki & Mavroidis, 2013; Kahu et al., 2015). With the importance of connections to distance education social work students, “greater opportunities to meet and form collaborative relationships with similar peers” (Kahu et al., 2013, p. 802) must be included in throughout their programs.

Positive professor interactions and connections were also important for the participants. Generally, participants had limited contact with faculty in the online format. Some participants shared experiences of positive professor interactions. When disclosing her mental health (dis)Ability at the start of a course, one participant found the professors to be more supportive compared to the accessibility services office. Another participant spoke to the positive experience she had with the professor when she wrote about her mental health journey in her assignment. One participant talked about the connection she made with an instructor during the on-campus requirement of one of her online courses. Professors who build connections and community in online courses, according to Conrad (2005), are “present, prompt, energetic, responsive, and knowledgeable” and show “a level of passion for their teaching and their subject” (p. 12). Participants valued such positive professor interactions and connections.
For the participants in the study, connections with classmates, faculty, and staff as well as services and supports were crucial to offset some of the disconnection and isolation they experienced. Although some participants spoke of positive individual interactions and connections, they did not experience a true sense of online community in their courses and programs. Feeling welcomed, accepted, having meaningful interactions, and positive learning experiences within a supportive online environment creates a sense of community for distance education students (Dixon, 2015; Milman et al., 2015; Moore & Shelton, 2013). Online student learning, motivation, satisfaction, and retention are positively impacted when distance education students experience a strong sense of community online (Brown, 2001; Milman et al., 2015; Moore & Shelton, 2013). Participants in this study highlighted how important online connections and communities are to distance education students.

5.9 Summary

Findings from the participants’ narrative interviews and a discussion linked to the literature were presented in this chapter. The six participants shared multifaceted experiences of adapting, coping, and navigating through their courses and programs. These six women with mental health (dis)Abilities furthered their social work education online, all while juggling gendered roles and responsibilities as well as financial and employment pressures. When (im)balancing social work studies, mental health (dis)Abilities, and life, the flexibility of distance education provided participants relief and an informal accommodation. Social work students with mental health (dis)Abilities can create their own schedules around their online studies to address their mental health needs, while still attending to other responsibilities in their lives.
The inaccessibility of accessibility services and mental health supports online reveals the possibility that many distance education social work students with mental health (dis)Abilities may not be registering for or getting assistance from their institutions. Stigma and sanism - inside and outside of their social work programs - contribute to this issue, as distance education social work students with mental health (dis)Abilities might not want to take the risk to disclose. Instead, these distance education students might be dealing with issues in isolation or in their home communities. At the same time, without their disclosures, universities do not have accurate data on how many distance education students actually identify with a mental health (dis)Ability.

Participants shared how stronger connections and communities online within their courses, programs, and schools could help counter the isolation they feel, not only as distance education students, but also as students with stigmatized identities. Recommendations from the six participants on how their institutions could be more inclusive and supportive of distance education social work students with mental health (dis)Abilities are summarized in the next chapter.
Chapter Six - Recommendations

6.1 Introduction

Through this research, six participants from two Canadian Schools of Social Work shared their experiences as well as their ideas for program improvements for online social work students with mental health (dis)Abilities. Participants shared their suggestions through their narratives, but were also specifically asked the following question in the final stages of the interview:

How could Canadian distance education social work programs improve for online social work students with mental health (dis)Abilities?

From the narrative data analysis, six key categories emerged from the suggestions of the participants:

- Education & Professional Development
- Financial Assistance
- Technology
- Accessibility
- Accommodations
- Additional Supports

Under these six key categories are recommendations from the perspectives of the participants. Some categories resulted from recommendations from one participant, whereas multiple participants’ suggestions supported other categories. Purposefully, I have not included literature to validate or confirm the participants’ recommendations. I am honouring the voices of the participants by allowing their suggestions to stand-alone. Instead, I have opted to use the “Researcher’s Voice” text boxes, to include my own
ideas, suggestions, and any supporting literature. Together, these recommendations are summarized in the sections below.

6.2 Recommendations

6.3 Education & Professional Development

6.3.1 Mental Health Education & Professional Development Four participants highlighted the need for education and professional development pertaining to mental health (dis)Abilities. Some participants felt the focus of such initiatives should be directed towards faculty, while others emphasized further education for staff and/or students. Combating the misunderstandings around mental health (dis)Abilities, for instance, could be aided through education offered to faculty, staff, and students. Professional development targeted towards professors around mental health as well as how to respond to and support students with mental health (dis)Abilities was recommended by some participants. Initiatives encouraging instructor mental health education, awareness, and well-being was also suggested by one participant.

6.3.2 Social Work Courses Two participants recommended more course content and actual courses relating to mental health, trauma, and self-care for social workers. Both participants emphasized the link between mental health, trauma, and self-care in personal and professional domains. One participant described the importance of preparing future social work practitioners and clinicians not only with knowledge of mental health (dis)Abilities, but also for the trauma many social workers experience as part of their employment - the difficult situations social workers face daily. This participant also addressed how classmates disclosed their mental health concerns, yet there was no course or course content pertaining to how to live, cope, and practice as a
social worker with a mental health (dis)Ability and/or as a social worker affected by trauma. Two participants proposed including courses or course components of self-care for social workers to prepare for and prevent the negative impacts of trauma, whether related to social work practicums, professional practice, and/or personal experiences.

**Researcher’s Voice**

Social work students, such as myself, often come to the profession with a range of lived experiences. Personal histories of social work students may include individual or family difficulties relating to relationships, abuse, violence, trauma, mental health, substance use, and/or poverty (Collins et al., 2010; Wiles, 2011; Smullens, 2015; Zosky, 2013). For students already practicing in social work related professions, stressful work conditions may be contributing to experiences of distress, burnout, and trauma (Kim, Ji, & Kao, 2011; McFadden, Campbell, & Taylor, 2015). Mental health and well-being may not yet be a priority for these social work students, their institutions, for social work practitioners, or for the organizations they work for (Crisp & Beddoe, 2013). Welcoming social work students, practitioners, and educators alike to speak openly about their mental health and well-being is crucial. Moving away from individualized, stigmatized, and medicalized views of mental health is a much needed change across the social work profession. Such problematic perspectives are a significant barrier, preventing many of us from sharing, learning, and reflecting with one another, because of the likelihood of stigma and sanism. Truly embracing critical, anti-oppressive, social justice, mad, and other progressive approaches to mental health and well-being across the social work profession is a starting point for this change to occur. Social work courses and programs can be that safe space for students to reflect on their personal histories and professional experiences, while learning and sharing ways to increase coping, resiliency, and well-being during their training and within careers (Collins et al., 2010; Crisp & Beddoe, 2013; Fouché & Martindale, 2011; Zosky, 2013). An opportunity exists within social work education to stop stigma and sanism, while promoting mental health and well-being across our profession.
6.4 Financial Assistance

Limited scholarships and bursaries exist for part-time, distance education students, as well as for students with mental health (dis)Abilities. One participant spoke to the overall lack of financial assistance available to distance education social work students with mental health (dis)Abilities, suggesting more scholarships and bursaries be offered to online students who fit this criterion.

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<td>Many funding opportunities are unavailable to part-time and distance education students, due to strict eligibility criteria. If the distance education student is working, they are likely not eligible for government student loans. Few bursaries and scholarships exist specifically for students with mental health (dis)Abilities. Throughout my online social work studies, I tried to find financial assistance, but often without much success. I faced the predicament of taking on more paid work, which reduced the time and energy I had for my online studies, as well as my other roles and responsibilities. Consequently, I was very stressed. This resulted in a viscous cycle of getting physically ill and mentally unwell, but never having the time to fully recover. Every day was demanding and an (im)balancing act. I have wondered what it would be like to study without these added barriers. How would my health have improved? What if I had more time for my family? Would I have enjoyed my studies more? How much learning did I miss out on? How would my grade point average have differed or improved? Would I have gotten more involved in volunteer opportunities related to our profession? Enough barriers exist for students with mental health (dis)Abilities; alleviating financial barriers is just one less obstacle for us to face. Increasing financial assistance for online students with mental health (dis)Abilities would reduce the financial pressures that may lead to overwhelming stress, reduced mental health, having to take on additional paid work, unsatisfactory academic achievement, and possible attrition (Chambers et al., 2011; Collins et al., 2010; Thompson-Ebanks, 2014).</td>
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6.5 Technology

Distance education requires online students possess a level of comfort and competence with technology. Learning all the technological aspects of distance education may be challenging for some students (with or without mental health (dis)Abilities). One participant suggested having extra technical support available, especially after-hours when most students are online and attempting to complete their course work or assignments.

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<td>Many distance education social work students are employed during regular business hours, leaving them evenings and weekends for their studies. Others may live in time zones completely different from their institutions. Social work students new to distance education may not be fully aware of the technical requirements and skills needed to succeed in their online programs. When online students encounter technical challenges, it is often at times not convenient to accessing technical support. While online students do attempt to help one another, sometimes the technical issues are system related and beyond the scope of fellow students. For us online students who are pulled in many directions because of our multiple roles and responsibilities, such technological problems create an added stress and obstacle. Technology challenges divert time and energy, which could be spent studying or on assignments. Technical support via phone, email, chat, or video-conferencing available to online students encountering issues after-hours is central in successfully accessing and completing their courses and programs (Britto &amp; Rush, 2013; Crawley &amp; Fetzner, 2013; Jones &amp; Meyer, 2012; Milman et al., 2015).</td>
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6.6 Accessibility

6.6.1 Accessibility Services Increased awareness and promotion around accessibility services for distance education students with mental health (dis)Abilities was suggested by most participants. Several participants recommended relevant and available accessibility services for distance education students, instead of accessibility
services tailored only for on-campus students. An example provided was extended and after-hours support for distance education students, who often work full-time during traditional office hours and/or live in other time zones. Offering accessibility services support through the application process was suggested by one participant, who spoke of the barriers she experienced when completing all the required application paperwork and forms to apply to the program. Without adequate support throughout the application process, some potential social work students may be deterred altogether from applying. This contradicts the vision and mission statements of many Schools of Social Work, which encourage and value diversity and inclusivity - not only in the student body and institution, but also across society.

6.6.2 Course Design & Course Content One participant provided several recommendations relating to course design and course content. For instance, she suggested that keeping course layout and design consistent makes it easier for online students to navigate between their courses within the learning management system. She added that concise course materials were more conducive to learning and knowledge retention. This participant also explained how course materials presented and tested in various ways worked better for diverse learning styles; common to students with different types of (dis)Abilities. Having course outlines available in advance was another suggestion, so distance education students could better prepare for the term and workload ahead. Wherever possible, this participant also recommended all course modules be visible and available at the beginning of the term, allowing distance education students (with or without mental health (dis)Abilities) to work ahead, for instance, when they are feeling better and/or when their schedules permit it.
Accessibility is incorporated into every aspect of an online course and program when using Universal Design for Learning (UDL), from the design to the learning experience (Brabazon, 2015; Kent, 2015; Kirkpatrick, 2015; Roberts et al., 2011; Terras et al., 2015). Less time and resources are needed for accommodations, as accessibility for all is the goal from the start (Bastedo, Sugar, Swenson, & Vargas, 2013; Brabazon, 2015; Lightfoot & Gibson, 2005). For instance, course outlines and materials available ahead of time allow online students, like myself, to better plan our studies around our multiple roles and responsibilities, in conjunction with managing our mental health and well-being. Course content presented through video also including description, captioning, transcript, and available for review multiple times, benefits a range of students’ diverse learning styles (Bastedo et al., 2013; Brabazon, 2015; Dunn et al., 2008). Varying formats of course content and materials are beneficial for all. I have a preference for visual learning, compared to auditory learning; whereas some of my fellow classmates likely have opposite learning styles. As UDL promotes inclusion and accessibility for all, irrespective of (dis)Ability status, it also gives online students more choices around their (dis)Ability disclosures as fewer modifications and accommodations need to be made (Bastedo et al., 2013; Brabazon, 2015; Kent, 2015; Roberts et al., 2011; Thompson-Ebanks, 2014).

6.7 Accommodations

6.7.1 Accommodation Process Several participants recommended both relevant and practical accommodation strategies for distance education students with mental health (dis)Abilities. One participant emphasized eliminating the stigma and shame around reaching out to instructors and professors, through further education or professional development around supporting students with mental health (dis)Abilities as previously mentioned. Two participants recommended improving the overall process around obtaining accommodations. Required documentation, such as doctor’s notes, may be difficult to obtain, depending on the availability of the physician, office hours,
location, and the distance education student’s schedule. Variability among professors in requiring such documentation also deterred one participant from seeking accommodations when needed.

Welcoming, open communication, and flexibility from professors was viewed by participants as central to the accommodations process. During a mental health crisis, a student might not be in a place to discuss assignment or other coursework completion and possible accommodations. Rather, as one participant recommended, the professor and student in crisis could connect briefly so the professor is informed of the situation; with the understanding they will re-connect in twenty-four or forty-eight hours or so to make a plan. Discussing assignment or coursework completion when the student is in crisis may only add to the crisis, instead of waiting until it has passed and the student is ready for this conversation.

Researcher’s Voice

Obtaining medical proof and documentation of a mental health (dis)Ability involves time and costs, and is an added barrier for students seeking support and accommodations (Condra et al., 2015; Brabazon, 2015; Mullins & Preyde, 2013). In contrast, documentation verifying faith is not required for students requesting religious accommodations. Accommodations commonly requested by students with mental health (dis)Abilities include medical or treatment related absences, deadline extensions, and test time adjustments (Brockelman, 2011; Gruttadaro & Crudo, 2012; Kupferman & Schultz, 2015; Terras et al., 2015). Participants and myself requested deadline extensions at times during our programs. In the few instances when I requested this accommodation, I did so only when there was a family emergency (i.e., loss of a loved one) or I was very unwell. Because I was not registered with the (dis)Ability services office and my mental health (dis)Ability was not disclosed, I was concerned if I would receive the extension at the times I was physically and mentally unwell (the death of my family member was not disputable). The faceless nature of communications between students and professors in
distance education may contribute to this. Requesting an extension by email is more impersonal, potentially leading to more questions or misunderstandings on the part of the professor. Without face-to-face contact, as is possible in classroom settings, it is difficult to determine if disclosing such personal information, such a mental health (dis)Ability, would be well received and understood. In the few instances I made a request, I kept the details minimal (i.e., I was ill). Otherwise, it was not worth the added stress to an already overwhelming situation to request an accommodation in such an impersonal way. Such accommodations require understanding, trust, and flexibility from professors and students, with minimal costs to the institution, and could be provided for students with mental health (dis)Abilities, with or without medical certification (Collins & Mowbray, 2005; Condra et al., 2015).

6.7.2 Field Placement Accommodations One participant recommended accommodations around field placements. She proposed more flexibility with the time frames the practicum hours and online course could be completed in. Increased flexibility with field placements could reduce the added stress distance education social work students (with or without mental health (dis)Abilities) experience when they have to complete practicum, coursework, and still attend to the other roles and responsibilities in their lives.

6.8 Additional Supports

6.8.1 Mental Health Promotion All participants recommended increased support for distance education students with mental health (dis)Abilities. One participant emphasized the importance of universities initiating and welcoming conversations around mental health and wellness. Participants suggested online communities, resources, and information on mental health and wellness, as created and promoted by universities, as an avenue to reach students online. Province-wide initiatives and communities of practice,
such as Healthy Minds, Healthy Campuses (2015), was brought up by one participant as a web-based example that promotes campus mental health awareness and well-being for all.

6.8.2 Orientation Some online social work programs include a brief residency or on-campus week. When distance education social work students are on-campus, one participant suggested having students be introduced to and meet all support staff. This way, distance education social work students have the opportunity to meet with support staff when on-campus and/or feel more comfortable reaching out to these staff later when they are back in their home communities.

6.8.3 Outreach Two participants recommended checking in with distance education social work students throughout their programs. Reaching out to distance education social work students at different stages, outside of coursework related instructions or questions, was suggested as a way to see how students are coping, how they are integrating critical and anti-oppressive social work theories into their practice, into their lives, and, at the end of their programs, how they are progressing into the next stages of their careers. In general, as one participant explained, distance education social work students would feel more connected with this approach and, also, have opportunities to ask questions and discuss aspects of the social work profession outside of the coursework. By Schools of Social Work initiating this contact, as another participant described, distance education social work students with mental health (dis)Abilities who experience barriers when trying to reach out and connect with faculty or staff would not be missed and feel less isolated.
6.8.4 Online Groups Another area of suggestions from participants was offering a range of online supports for distance education social work students with mental health (dis)Abilities. Online groups or forums for distance education students with mental health (dis)Abilities to connect with one another was recommended by some participants. These online groups or forums could provide distance education social work students with mental health (dis)Abilities a common place to talk about their struggles and successes, as well as suggest further supports or services.

6.8.5 Self-care Resources for self-care, such as tool kits, workbooks, and other interactive activities, available online was also recommended. One participant provided the example of the University of Buffalo School of Social Work’s Self Care Starter Kit (2015) website, which includes a series of self-care resources available online for social work students and/or practitioners.

6.8.6 Online Counselling Having counselling available to distance education social work students was also recommended. On-campus students have access to counselling services, while no such equivalent exists for distance education students. One participant suggested offering counselling online or by phone. Another idea from this participant was for universities to collaborate and to create a network of counselling services, allowing distance education students to access counselling at local campuses of other institutions in their home communities. Student benefits plans, including counselling similar to EAPs, being available to distance education students for an affordable fee, regardless of whether they are registered part-time or full-time, was another suggestion. Distance education social work students (with or without mental health (dis)Abilities) experiencing difficult life events or demanding personal
circumstances might benefit from counselling being available, especially if they do not have access to counselling otherwise. Two participants stressed supporting distance education social work students experiencing trauma or triggers during their studies. Both participants explained no such support existed in their programs. Online social work students experiencing trauma or triggers from coursework, at field placements, or at other points during the program might utilize counselling as a form of support.

**Researcher’s Voice**

Distance education social work students may need services and supports at times during their studies. Stresses related to school, placements, or career, or unexpected personal crises, such as illnesses, losses, family or relationship issues, may arise during their studies. Access to counselling as a distance education student would have been beneficial, not only for support during the social work program, but also for those of us who do not have counselling available through work or other avenues. Had this service been available, I would have utilized it. Having an accessible and confidential support affiliated with the university, to process emotions and triggers related to course content or material, as well as my own learnings and reflections, would have had a positive impact on my own mental health and well-being during my social work studies; instead of dealing with this alone.

Online counselling is an accessible and flexible modality of therapeutic support. Using audio- and video-conferencing technologies allows distance education students to obtain counselling by removing barriers of time and place, while reducing the stigma that may be experienced when seeking support in-person or on-campus (Mishna, Bogo, & Sawyer, 2015; Thomas, Lee, & Ess, 2015). Further, counsellors affiliated with the institution may have better understandings of the issues faced by online students, compared to clinicians through an EAP or community agency. Utilizing online counsellors through the university also encourages collaboration between the students’ institutional services and supports, particularly in preventing or managing difficult times or crises.
6.8.7 Field Placement Support During field placements, one participant highlighted the need for increased connections between the school, student, and agency or field instructor. More awareness about social work student mental well-being and additional communications, such as check-ins, were recommended, ensuring distance education social work students are coping and feeling supported by the school during their practicums.

6.8.8 Advocates For distance education students with mental health (dis)Abilities, two participants recommended having an advocate assigned to them throughout their program. This advocate would be one consistent person who assists and supports these students for the duration of their studies. One participant explained how the current process is fragmented for distance education students. They deal with many different people and go through various departments. Distance education students with mental health (dis)Abilities are put in a position to have to tell their story over and over again. Instead, an advocate could get to know these distance education students with mental health (dis)Abilities and the issues they are facing. Another participant described how an advocate could facilitate communications with professors around accommodations when the distance education student was struggling to do so themselves. With an advocate, distance education students with mental health (dis)Abilities would have an ally and consistent support person, instead of having to address issues in isolation.

Researcher’s Voice

Connecting with an advocate before commencing an online social work program would help distance education students, like myself, understand their (dis)Ability rights as well as locate, access, and navigate various academic, administrative, and student support services (Britto & Rush, 2013; Crawley & Fetzner, 2013; Gruttadaro & Crudo, 2012; Milman et al., 2015; Nichols, 2010). Allowing distance education students to self-identify
with a mental health (dis)Ability as eligibility to connect with an advocate would also eliminate the access barriers resulting from medical assessments and documentation typically required for such services. Making advocates available in this way would encourage more distance education students, like me, to actually disclose our mental health (dis)Abilities to our schools and connect with potential services and supports as needed.

An advocate could remain as the key university contact for the distance education student throughout the social work program, checking in via email or phone and/ or meeting with the online student via video-conferencing technology; offering linkages to supports and services, and facilitating communication between the student and faculty or staff as needed (Barr, 2014; Britto & Rush, 2013; Nolan, 2013). Working with an advocate would promote distance education social work students with mental health (dis)Abilities to proactively access and utilize institutional services and support, minimizing a reactive approach to any issues they encounter (Gillis & Lewis, 2004; GlenMaye & Bolin, 2007), while, at the same time, encouraging successes and retention in their programs.

6.9 Summary

Recommendations on distance education program improvements for social work students with mental health (dis)Abilities were outlined in this chapter. Suggestions covered six key categories, including: education and professional development, financial assistance, technology, accessibility, accommodations, and additional supports.

Making mental health a priority within social work education - for students, staff, and faculty - increases awareness, inclusion, and encourages well-being across our profession. Replacing dominant discourses on mental illnesses and disorders with progressive perspectives on mental health and well-being within our own Schools of Social Work is an act of social justice and social change. Not only would this challenge stigma and sanism, it could be an example to other university departments and to the larger post-secondary community.
Approaching distance education social work programs with the principles of universal design for learning (UDL) promotes inclusion and accessibility for all (Dunn et al., 2008). Both distance education and UDL encourage equitable participation of diverse groups, which is also central to the values and principles of the social work profession (CASW, 2005; CASWE, 2014). Further, UDL upholds the social model of (dis)Ability, by reducing the disabling aspects of post-secondary education (Brabazon, 2015).

Improving online services and supports benefits distance education students with mental health (dis)Abilities, but also other students. Removing the barriers of time and place could improve accessing institutional services and support, regardless of (dis)Ability status or studying at a distance (Barr, 2014; Crawley & Fetzner, 2013; Jones & Meyer, 2012). When distance education courses and programs are created and continually improved using universal design for learning (UDL) principles, fewer modifications and accommodations are needed in the first place (Bastedo et al., 2013; Brabazon, 2015; Kent, 2015; Roberts et al., 2011; Thompson-Ebanks, 2014). If distance education students with mental health (dis)Abilities do request accommodations, these accommodations need to be approached from a place of understanding and trust. As suggested by participants, creativity and flexibility on the part of the professors and institutions is required, so students with mental health (dis)Abilities are not discouraged from accessing or disqualified from receiving accommodations. Social work students, with and without mental health (dis)Abilities, should be feel welcomed, supported, and encouraged to succeed in their distance education programs.

Focusing on the voices of the students with mental health (dis)Abilities, these recommendations bring forth insights and experiential knowledge, which will hopefully
influence and shape future distance education social work program initiatives and improvements. Overall, as the participants shared, building awareness around mental health, as well as improving inclusion, accessibility, communications, connections, and community online benefits and supports all distance education social work students, not just those with mental health (dis)Abilities.
7.1 Collective Voice

Giving voice to fellow distance education social work students with mental health (dis)Abilities has been the most meaningful outcome of this research. My discomfort with the lack of voice given to social work students with mental health (dis)Abilities is what brought me to this research in the first place. Prior to this study, our voices were silent. The isolating aspects of being distance education social work students, disempowered by our stigmatized identities, created conditions that make it harder for us to be heard. Coming together as a collective voice, the six study participants and myself told our stories. We spoke of our experiences of being a distance education social work students with mental health (dis)Abilities. We shared our strengths and our struggles as online learners living with mental health (dis)Abilities. We offered suggestions on how to better include and support distance education students - with and without mental health (dis)Abilities - throughout their social work programs. I hope our voices will be valued and heard.

7.2 Learnings from the Research

Through this study, we have learned much from the experiences, insights, and suggestions of the participants. Distance education allows many social work students to continue their studies. While all these social work students potentially benefit from the format and flexibility of distance education, these benefits are intensified for social work students with mental health (dis)Abilities who synchronize their Abilities and their lives with their studies. Summarized in Table 1 is what the participants have told us about their unique experiences as distance education social work students with mental health
(dis)Abilities, together with recommendations for improvements reflecting anti-oppressive, social justice, and social model approaches to social work distance education.

Table 1 – What the participants have told us

<table>
<thead>
<tr>
<th>Experiences</th>
<th>Recommendations</th>
</tr>
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<tbody>
<tr>
<td>Flexibility of distance education &amp; the (im)Balancing act</td>
<td>-Creative, flexible accommodations processes, not requiring medical certifications / paperwork</td>
</tr>
<tr>
<td>-Multiple roles &amp; responsibilities (i.e., work, family) plus online studies</td>
<td>-Improve financial assistance for distance education social work students with mental health (dis)Abilities</td>
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<tr>
<td>-Complete course work when feeling well</td>
<td>-Make online course content / modules available ahead of time, so students may work ahead</td>
</tr>
<tr>
<td>-Attend mental health related appointments or services around online studies</td>
<td>-Online self-care courses / resources</td>
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<td>-Create balance &amp; opportunities for better mental health</td>
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</tr>
<tr>
<td>Misunderstanding Mental Health (dis)Abilities</td>
<td>-Mental health promotion, education &amp; professional development for all</td>
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<tr>
<td>-Lack of understanding &amp; knowledge around mental health (dis)Abilities</td>
<td>-Progressive mental health courses / content deconstructing dominant discourses</td>
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<tr>
<td>from classmates, staff, &amp; faculty</td>
<td>-Challenge stigma &amp; sanism within social work education &amp; profession</td>
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<tr>
<td>-Reluctant disclosures</td>
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<td>-Professional identity</td>
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<tr>
<td>Mental health (dis)Abilities intersecting with distance education social</td>
<td>-Orientations introducing supports &amp; services available</td>
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<tr>
<td>work studies</td>
<td>-After-hours supports &amp; services</td>
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<td>-Initial challenges when starting the program</td>
<td>-Universal design for learning, in courses &amp; programs</td>
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<tr>
<td>-Mental health impacted by school workloads &amp; triggers from course content</td>
<td>-Field placement accommodations &amp; on-going support</td>
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<tr>
<td>-Field placement challenges (i.e., lack of support from school, experiencing</td>
<td>-Social work courses, content, &amp; assignments promoting first voice perspectives &amp; valuing lived experiences</td>
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<tr>
<td>triggers)</td>
<td></td>
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<tr>
<td>-Course work as part of recovery, using assignments to explore mental health</td>
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<tr>
<td>topics &amp; own journey</td>
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<tr>
<td></td>
<td>-Increased awareness &amp; promotion around accessibility &amp; mental health services / supports for distance education students with mental health (dis)Abilities</td>
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<tr>
<td>Inaccessible accessibility services &amp; lack of mental health services or</td>
<td>-Application process support</td>
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<tr>
<td>supports online, resulting in utilizing own supports</td>
<td>-Improved hours of operation, across times zones</td>
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<tr>
<td></td>
<td>-Online counselling</td>
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<tr>
<td>Disconnection &amp; isolation, combined with mental health (dis)Ability</td>
<td>-Advocates</td>
</tr>
<tr>
<td></td>
<td>-Create connections &amp; community online, with welcoming, open conversations about mental health &amp; wellness as well as through outreach &amp; online groups</td>
</tr>
</tbody>
</table>

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7.3 Future Directions for Social Work

We must continue raising our voices. Each stage of this thesis allowed for further explorations and reflections on how mental health (dis)Abilities are conceptualized within social work education and practice. I continue to be alarmed by the destructive and divisive dominant discourses of mental health (dis)Abilities within our supposedly social justice oriented profession (Beresford, 2012; Burstow, 2015; Poole et al., 2012; Poole & Ward, 2013; Reid & Poole, 2013). I reiterate and build on the “call to action” set forth by Poole et al. (2012) “with respect to how social workers theorize, research, and respond to madness now” (p. 22). We all must speak up to change the status quo. Social work students and social workers with mental health (dis)Abilities must not stay silent. Our stigmatized identities become embraced and replaced with strength as we connect with others on similar journeys. Individually, we are marginalized. Together, we can start to rise above the exclusion. By sharing our stories, our experiences and expertise become known. Our perspectives are valuable and must be heard. Our colleagues must welcome us and join us as allies. Our actions can be exemplars of social justice and social change. Together, we can disrupt dominant discourses. We can replace mainstream models of mental illnesses or disorders in social work (Beresford, 2012; Menzies et al., 2013; Morrow & Weisser, 2012; Poole et al., 2012; Poole & Ward, 2013; Reid & Poole, 2013). We can welcome and learn about progressive perspectives on mental health and well-being. We can create new understandings, knowledge, and education about mental health (dis)Abilities from first voice perspectives (Church, 2013; Menzies et al., 2013). We can challenge and end the stigma and sanism, which prevails in our own profession (Poole et
al., 2012; Poole & Ward, 2013; Reid & Poole, 2013). We can create a renewed, improved, inclusive social work profession.

### 7.4 Research Dissemination

Next steps for dissemination of this thesis research include an executive summary, which will summarize aspects of the study and the recommendations proposed. The executive summary will be first sent to the participants and the two Schools of Social Work involved in the study. These two universities may wish to use the recommendations to initiate and implement changes within their own programs. After the participants and two universities involved in the study have received the report, Canadian Schools of Social Work offering distance education will also be sent the executive summary. Nationally, these Schools of Social Work may consider the suggestions of the participants to find ways to improve their distance education programs for current and future social work students.

Additionally, the executive summary will be shared with the Canadian Association for Social Work Education (CASWE) (dis)Ability caucus. Sharing the executive summary with the (dis)Ability caucus could raise further awareness about improving the inclusion and support of distance education social work students with mental health (dis)Abilities, while also further disseminating this research within the national social work education organization involved with accrediting Canadian social work programs (Carter et al., 2012; CASWE, 2014).

Opportunities to share findings from this research at conferences have also been pursued. Preliminary aspects were presented at the Canadian Association for Social Work Education 2015 conference (Singh, 2015). An abstract has been accepted to present this
research at the Joint World Conference on Social Work, Education, and Social Development in the summer of 2016. Attendees at these conferences include social work faculty, staff, students, and practitioners; allowing this research to be shared with interested parties across the profession.

Submitting a manuscript for publication in a relevant social work or post-secondary education journal is also planned. Publishing this research could contribute to the limited body of literature on the experiences of distance education social work students with mental health (dis)Abilities, while also disseminating this research to a broader audience.

7.5 Future Research

This exploratory, qualitative study was a starting point for future research, pertaining to distance education social work students with mental health (dis)Abilities. Future research opportunities could draw on the experiences of distance education social work students at additional universities, nationally and/or globally. Comparisons between the experiences of distance education social work students with mental health (dis)Abilities in fully online programs versus hybrid or blended programs could offer insights into how the different delivery formats influence students’ experiences and outcomes. Supporting online social work students with and without mental health and/or other forms of (dis)Abilities is another area of future inquiry. Limited research exists pertaining to online student services and supports specific to mental health (dis)Abilities (Barr, 2014). Developing and implementing the online student services and supports, as recommended by the participants, could result in opportunities to evaluate their impact from the perspectives of the social work students, faculty, and staff.
Another area of inquiry is how the development and implementation of online student services and supports benefits not only distance education social work students, but also those who attend on-campus. As on-campus students use technology in their studies and lives every day, having online student services and supports could be advantageous for on-campus students who may face barriers to accessing services at their schools. Removing the time and space obstacles for all students may help them access any needed institutional supports and services (Jones & Meyer, 2012).

Future studies focusing on the experiences of distance education social work students with other marginalized and intersecting identities is another potential area of research. For instance, how might the experiences of online social work students be similar or different when demographics are also included within the selection criteria and sample? How does gender, sexual orientation, race, age, and/or (dis)Ability impact the experiences of distance education social work students? What are the experiences of online social work students with other types of (dis)Abilities? This research raises questions about how social work students with marginalized intersecting identities may be experiencing in their online studies as well as opportunities to investigate what recommendations these students suggest for making their programs more supportive. As distance education in social work continues to expand, both nationally and globally, the need for research in these many areas persist.

7.6 Final Thoughts

Distance education social work students with mental health (dis)Abilities deserve and have a right to accessible and inclusive programs. Online student services and support, available regardless of time or place, offer distance education students with
mental health (dis)Abilities help where and when they need it (Barr, 2014; Crawley & Fetzner, 2013). Supporting social work students with mental health (dis)Abilities throughout their online education ensures future practitioners who diminish the divisions between service providers and service users, challenge stigma and sanism, bring insights and expertise from their lived experiences to improve services and programs, and integrate diverse perspectives into our profession (Beresford, 2012; CASW, 2015; Collins, 2006; Crawshaw, 2002; Gilbert & Stickley, 2012; Goldberg et al., 2014; Poole et al., 2012; Zellmann et al., 2014). Distance education social work students with mental health (dis)Abilities must be welcomed and celebrated as valued contributors and members of the social work profession (Mackelprang, 2012; Poole et al., 2012; Reid & Poole, 2013).
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Appendix A – Interview Invitation

Experiences of Canadian Distance Education Social Work Students
with Mental Health (dis)Abilities

RESEARCHER
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Phone: 1-xxx-xxx-xxxx

SUPERVISOR
Dr. Judy MacDonald
Dalhousie University
School of Social Work
Email: Judy.MacDonald@Dal.ca
Phone: 1-902-494-1347

Are you a School of Social Work 1 Bachelor of Social Work or Master of Social Work
distance education student who self-identifies with a mental health (dis)Ability and who is
currently enrolled or a graduate of these programs within the last two years (2012-
2014)?

If you answered yes to the above, you are eligible to participate in my thesis
research focusing on the experiences of distance education social work students with
mental health (dis)Abilities.

My own experiences as a student living with mental health (dis)Abilities
completing distance education social work studies at both the Bachelor of Social Work
and Master of Social Work level instilled a deep interest in exploring this topic. My hope
is this research will bring forth feedback and recommendations to be shared with distance
education social work programs across Canada to improve these programs for current and
future students with mental health (dis)Abilities.

If you volunteer to participate in this research, I will ask you to do the following things:
• Meet briefly online for approximately ten to twenty minutes via Skype or FaceTime
before the interview so we may introduce ourselves, review the informed consent
form, and address any questions or concerns you may have about the research, and
schedule an interview if you are interested in participating in the study.
• Email or mail the signed, informed consent form to me.

1 Personal phone number removed for privacy
• Create a Skype or FaceTime account if you do not have one already.

• Participate in one interview, approximately forty-five minutes to one hour and thirty minutes in length, at a mutually agreed upon time. The location of the interview will be online through videoconferencing technologies - Skype or FaceTime - as we (the researcher and participant) will likely be separated geographically from one another.

• I will ask for your permission to record the interview using QuickTime Player and to share the content of the interview, including any direct quotations. I will also ask what name you would like to use.

• During the interview, I will ask you to share your experiences about being a distance education social work student living with mental health (dis)Abilities.

• After the interview, I will transcribe the interview content. I will contact you and request you review, verify, and edit your interview transcript of any information you do not want shared. This transcript verification process may take you about sixty minutes to ninety minutes. You will be asked to return the verified transcript to me via email within two weeks.

• Interview transcripts will be analyzed by me and verified by my thesis supervisor.

• Findings from the research will be presented in my thesis. I will email a summary and recommendations document to you at the end of the study.

This research has been reviewed and approved by the Dalhousie University’s Research Ethics Board to conform to the standards of the Canadian Tri-Council Policy Statement on Research Ethics. If you have questions or concerns about this research, you may contact Catherine Connors, the Director of Research Ethics at 1-902-494-1462 or ethics@dal.ca. Participants who live at a distance from Halifax, Nova Scotia may call collect.

If you wish to participate in this research, please contact me at:

Rose Singh
Dalhousie University
School of Social Work
Email: Rose.Singh@Dal.ca
Phone: 1-xxx-xxx-xxxx
Appendix B – Informed Consent Form

STUDY NAME

Experiences of Canadian Distance Education Social Work Students with Mental Health (dis)Abilities

RESEARCHER

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SUPERVISOR

Dr. Judy MacDonald
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Phone: 1-902-494-1347

INTRODUCTION

You are invited to participate in a research project conducted by graduate student Rose Singh, from the School of Social Work at Dalhousie University. This research is part of the thesis requirement in the Master of Social Work program through the School of Social Work at Dalhousie University.

Your participation in this study is voluntary and you may withdraw from the study at anytime before the data analysis is complete. The study is described below. This description tells you about the potential risks, inconveniences, or discomforts, which you might experience. Participating in this research might not benefit you, but we might learn things that could benefit others. Please discuss any questions or concerns you have about this study with me, the researcher, Rose Singh, my thesis supervisor, Dr. Judy MacDonald, or with the Dalhousie University contacts, provided below in this form.

PURPOSE OF THE RESEARCH

This thesis research focuses on the experiences of distance education social work students with mental health (dis)Abilities at two Canadian universities. I will also investigate whether these programs meet the support needs of Canadian distance social work students who self-identify with mental health (dis)Abilities.

WHO CAN PARTICIPATE

You may participate in this study if you a:

- School of Social Work 1 Bachelor of Social Work or Master of Social Work distance education student who self-identifies with a mental health (dis)Ability and who is currently enrolled or is a graduate of these programs within the last two years (2012-2014).
WHO WILL BE CONDUCTING THE RESEARCH

Graduate student Rose Singh, from the School of Social Work at Dalhousie University, will be conducting the research.

WHAT YOU WILL BE ASKED TO DO

If you volunteer to participate in this research, I will ask you to do the following things:

• Meet briefly online for approximately ten to twenty minutes via Skype or FaceTime before the interview stage so we may introduce ourselves, review the informed consent form, and address any questions or concerns you may have about the research, and schedule an interview if you are interested in participating in the study.
• Email or mail the signed, informed consent form to me.
• Create a Skype or FaceTime account if you do not have one already.
• Participate in one interview, approximately forty-five minutes to one hour and thirty minutes in length, at a mutually agreed upon time. The location of the interview will be online through videoconferencing technologies - Skype or FaceTime - as we (the researcher and participant) will likely be separated geographically from one another.
• I will ask for your permission to record the interview using QuickTime Player and to share the content of the interview, including any direct quotations. I will also ask what name you would like to use.
• During the interview, I will ask you to share your experiences about being a distance education social work student living with mental health (dis)Abilities.
• After the interview, I will transcribe the interview content. I will contact you and request you review, verify, and edit your interview transcript of any information you do not want shared. This transcript verification process may take you about sixty minutes to ninety minutes. You will be asked to return the verified transcript to me via email within two weeks.
• Interview transcripts will be analyzed by me and verified by my thesis supervisor.
• Findings from the research will be presented in my thesis. I will email a summary and recommendations document to you at the end of the study.

POTENTIAL RISKS AND DISCOMFORTS

Potential risks or discomfort to you as a participant in this research is it might be difficult speaking about your experiences living with a mental health (dis)Ability.

Social work students are often encouraged to critically reflect and evaluate during their studies; however, you may be uncomfortable doing this about the program and school you are enrolled in.

You do not have to answer any questions you are not comfortable with. I will also provide you with information on resources and referrals for support and counseling should you wish to access these.
POTENTIAL BENEFITS TO YOU AND POTENTIAL BENEFITS OF THE RESEARCH

Some participants may find sharing their experiences helpful or rewarding.

This research could potentially contribute to the limited body of literature on the experiences of distance education social work students with mental health (dis)Abilities.

At the end of the study, I will email a summary and recommendations document to the participants and the Schools of Social Work involved in the study as well as the Canadian Schools of Social Work offering distance education. These Schools of Social Work may consider the feedback and suggestions of the participants to improve their distance education programs for current and future students. There may also be future opportunities to share findings from this research at conferences or in publications.

COMPENSATION / REIMBURSEMENT

You will not receive payment or remuneration for participating in this research.

VOLUNTARY PARTICIPATION AND WITHDRAWAL

Your participation in the study is completely voluntary. Your decision not to volunteer will not influence the research project or the relationship you may have with the researcher or your relationship with Dalhousie University, either now or in the future.

If you volunteer to be in this research project, you may refuse to answer any questions you do not want to answer and still remain in the study. You may also exercise the option of removing your data from the thesis research before data analysis is complete. Your decision to refuse to answer particular questions or to stop participating will not affect your relationship with the researcher, Dalhousie University, or any other persons associated with this research.

Should you decide to withdraw from this thesis research, before the data analysis is complete, all associated data collected will be destroyed.

CONFIDENTIALITY AND ANONYMITY

Information collected during this thesis research will be stored on the researcher’s password protected personal computer. Your signed, informed consent form, interview recording, and interview transcript will also be stored in encrypted files on the researcher’s personal computer.

Your identity and participation in this study will be known to the researcher, but kept confidential in any interview recordings, transcripts, the final thesis report, the summary report, and any future opportunities where the research findings may be shared. You have the option to use your own first name, if you prefer, or to give another name.
The online meeting and interview will be conducted online using Skype and FaceTime. These videoconferencing technologies are not secure and, therefore, the researcher cannot guarantee the confidentiality, privacy, and security of the information you provide during our online meetings.

With your permission, your interview will be audio-recorded using QuickTime to facilitate the collection of information. The researcher will contact you about verifying your interview transcript. As a participant, you have the right to review, verify, and edit your interview transcripts before data analysis is complete. The interview recordings and transcripts will be erased five years after completion of the thesis. The interview content will be analyzed by the researcher, verified by the thesis supervisor, and presented in the researcher’s thesis. With your permission, direct quotations will be included. Identifying information and data obtained from the interview recordings and transcripts will not be accessible to any other persons or groups beyond the researcher and thesis supervisor, unless you give permission to include this information. You may request to review the final thesis by contacting the researcher.

There are ethical or legal limits to confidentiality, for example, should the researcher obtain information subject to mandatory reporting and disclosure to authorities, such as suspected child abuse or neglect, the abuse or neglect of an adult in need of protection, and/or person(s) at imminent risk to themselves or others.

**QUESTIONS OR CONCERNS ABOUT THE RESEARCH**

If you have questions about the research in general or about your role in this research, please contact me at Rose Singh via email at Rose.Singh@dal.ca or via phone at 1-xxx-xxx-xxxx or my Thesis Supervisor, Dr. Judy MacDonald via email at Judy.MacDonald@dal.ca or via telephone at 1-902-494-1347. You may also contact my Graduate Program – School of Social Work, Dalhousie University - at 1-902-494-3760 or social.work@dal.ca

This research has been reviewed and approved by the Dalhousie University’s Research Ethics Board to conform to the standards of the Canadian Tri-Council Policy Statement on Research Ethics. If you have any difficulties with, or wish to voice concern about, any aspect of your participation in this research, you may contact Catherine Connors, the Director of Research Ethics. Participants who live at a distance from Halifax, Nova Scotia may call collect.

Catherine Connors, Director, Research Ethics
Research Ethics, Dalhousie Research Services
Henry Hicks Building, Room 231
Dalhousie University
P.O. Box 15000
Halifax, Nova Scotia, B3H 4R2 Canada
Telephone: 1-902-494-1462
Email: ethics@dal.ca
Experiences of Canadian Distance Education Social Work Students
with Mental Health (dis)Abilities

SIGNATURE OF RESEARCH PARTICIPANT
I have read and I understand the explanation about this research project. I have been
given the opportunity to discuss it and my questions have been answered to my
satisfaction. I am not waiving any of my legal rights by signing this form. I hereby
consent to take part in this research study; however, I realize my participation is
voluntary and I am free to withdraw at anytime before the data analysis is complete. I
have been given a copy of this form. My signature below indicates my consent.

____________________________________
Name of Participant (please print)

____________________________________
Signature of Participant

____________________________________
Date

Please also indicate your specific consent for the following, by checking the boxes and
signing below:

[ ] Audio-recording  [ ] Use of direct quotations
[ ] Re-contacting for future phases of research or other studies

____________________________________
Name of Participant (please print)

____________________________________
Signature of Participant

____________________________________
Date

SIGNATURE OF RESEARCHER

____________________________________
Name of Researcher (please print)

____________________________________
Signature of Researcher

____________________________________
Date
Appendix C – Interview Guide

Experiences of Canadian Distance Education Social Work Students with Mental Health (dis)Abilities

RESEARCHER
Rose Singh, MSW Graduate Student
Dalhousie University
School of Social Work
Email: Rose.Singh@Dal.ca
Phone: 1-xxx-xxx-xxxx

SUPERVISOR
Dr. Judy MacDonald
Dalhousie University
School of Social Work
Email: Judy.MacDonald@Dal.ca
Phone: 1-902-494-1347

Interview Questions

• Could you please describe your experiences as a distance education social work student identifying with a mental health (dis)Ability?

• What struggles or limitations have you faced as a distance education social work student with a mental health (dis)Ability? What have been the benefits or positive aspects of distance education social work studies?

• How long have you been living with a mental health (dis)Ability?

• Have you shared with others at school that you self-identify with a mental health (dis)Ability? If so, what was your experience like? What were the responses of others? If not, what prevented you from doing so?

• Have you accessed support through your school? If so, what was your experience like? If not, what stopped you from doing so?

• How could Canadian distance education social work programs improve for online social work students with mental health (dis)Abilities?

• Is there anything else you would like to add or that I missed?
Appendix D - Debriefing Protocol

Experiences of Canadian Distance Education Social Work Students with Mental Health (dis)Abilities

RESEARCHER
Rose Singh, MSW Graduate Student
Dalhousie University
School of Social Work
Email: Rose.Singh@Dal.ca
Phone: 1-xxx-xxx-xxxx

SUPERVISOR
Dr. Judy MacDonald
Dalhousie University
School of Social Work
Email: Judy.MacDonald@Dal.ca
Phone: 1-902-494-1347

Debriefing: Sharing experiences may be difficult and trigger certain emotions. Should you wish to speak to someone after the interview, the following resources have been provided to assist you with locating such support.

Counselling Services

School of Social Work 1
Counselling Services
Address
Phone number

Mental Health

eMentalHealth.ca provides information on mental health services, help, and support in communities across Canada. The database is available at: http://www.ementalhealth.ca/

Crisis Lines Across Canada

The Canadian Association for Suicide Prevention website provides a listing of crisis centres across Canada: http://www.suicideprevention.ca/in-crisis-now/find-a-crisis-centre-now/

If you are in distress or crisis, please call the crisis line number listed below in your area or dial the local emergency telephone number (often 911). Crisis centres can also assist you in finding support in your area.
Crisis Centres Serving British Columbia

BC Interior Crisis Line Network – Crisis Line 1-888-353-CARE (2273)
The following five crisis lines form the Interior Crisis Line Network. Serve area is the Interior Health Authority area.

East Kootenay Crisis Line (CMHA Kootenays)
Serving east Kootenay region from Golden to the Alberta and USA borders
Crisis 24 hour: 1-888-353-2273
39-13th Avenue South, Cranbrook, BC, V1V 2V4

People in Need Crisis Line (CMHA Vernon)
Serving North Okanagan, Vernon, Revelstoke and surrounding area
Crisis 24 hour: 1-888-353-2273
#3100 – 28th Avenue, Vernon, BC, V1T 1W3

Kelowna Crisis Line
Serving Kelowna, Westbank, Windfield, Lakecounty
Crisis 24 hour: 1-888-353-2273
Kelowna Community Resources, #120 – 1735 Dolphin Ave, BC, V1Y 8A6
Website: www.kcr.ca

West Kootenay Boundary Regional Crisis Line
Serving Trail & Rossland, the West Kootenay and Boundary regions, including Nelson, Grand Forks, Castlegar, Christina Lake, New Denver, Nakusp and Salmo
Crisis 24 hour: 1-888-353-2273
c/o Trail Family and Individual Resource Center Society, 2079 Columbia Ave, Trail, BC, V1R 1K7
Website: www.trailfair.ca

Crisis & Counselling Program (Williams Lake)
Serving 100 Mile House to Bella Cola and all areas in between
Crisis 24 hour: 1-888-353-2273
c/o CMHA – Cariboo Chilcotin Branch, 51 – 4th avenue, Williams Lake, BC, V2G 1J6
Website: www.cariboo.cmha.bc.ca

Crisis Centre for Northern BC
(Prevention, Intervention and Information)
Serving all of Northern BC from the Alberta border to Haida Gwaii in addition from Quesnel north to the Yukon border inclusive.
Crisis 24 hour: 250-563-1214
Crisis toll free: 1-888-562-1214
Youth line: 4-11pm 250-564-8336
Youth on line chat: www.northernyouthonline.ca
5th Floor, 1600-3rd Ave., Prince George, BC, V2L 3G6
Website: www.northernbccrisissuicide.ca
Vancouver Island Crisis Society
Serving all of Vancouver Island
Crisis 24 hour: 1-888-494-3888
Crisis Chat: 6-10pm via website www.vicrisis.ca
P.O. Box 1118, Nanaimo, BC, V9R 6E7
Website: www.vicrisis.ca

North Island Crisis & Counselling Centre Society
Serving Mt Waddington area
Crisis 24 hour: 250-949-6033
P.O. Box 2446, Port Hardy, BC, V0N 2P0
Website: www.nicccs.org

KUU-US Crisis Line Society
Serving Port Alberni and area
Crisis 24 hour: 250-723-4050
Teen Line: 250-723-2040
Aboriginal line: 1-800-588-8717 (serving all of BC)
P.O. Box 294, Port Alberni, BC, V9Y 7Y7
Website: www.kuu-uscrisisline.ca

CTC Telecare Crisis & Caring Line
Serving all of BC
Crisis 24 hour: 604-852-9099
Toll free: 1-888-852-9099
P.O. Box 8000-451, Abbotsford, BC, V2S 6H1
Website: www.telecarebc.com

Fraser Health Crisis Line
Serving Fraser Health region – Burnaby to Boston Bar
Crisis 24 hour: 1-877-820-7444
c/o Options Community Services, 9815-140th Street, Surrey, BC, V3T 4M4
Website: www.options.bc.ca

S.U.C.C.E.S.S. Chinese Help Lines
Cantonese Help Line: 10 am – 10 pm 604-270-8233
Mandarin Help Line: 10 am – 10 pm 604-270-8222
28 West Pender St, Vancouver, BC, V6B 1R6

Chimo Community Services Crisis Lines
Serving Richmond, South Delta, Ladner & Tsawwassen
Crisis 16 hrs (8am – midnight) 604-279-7070
#120-7000 Minoru Blvd, Richmond, BC, V6Y 3Z5
Crisis Intervention & Suicide Prevention Centre of BC
Serves Vancouver, North Vancouver city & district, Bowen Island and West Vancouver
Crisis 24 hour: 604-872-3311
Crisis 24 hour TTY: 604-872-0113
Online chat for youth: www.youthinbc.com 12:00 noon to 1:00 am daily
Online chat for adults over 25 years: www.crisiscentrechat.ca 12:00 noon to 1:00 am daily
763 East Broadway, Vancouver, BC V5T 1X8

Crisis Intervention & Suicide Prevention Centre of BC
Serving Powell River & area, Sunshine Coast, Squamish, Whistler, Pemberton and Howe Sound-the Sea to Sky corridor
Crisis 24 hour: 1-866-661-3311
Website: www.crisiscentre.bc.ca

VictimLINK (Information Services Vancouver)
Serving the province of BC
Crisis 24 hour: 1-800-563-0808
202-3102 Main Street, Vancouver, BC V5T 3G7
Website: www.victimlinkbc.ca

S.A.F.E.R. (Suicide Attempt Follow-up, Education, & Research)
Intake Worker, 8:30 am to 4:30 pm, Monday to Friday 604-675-3985
#301-1669 East Broadway, Vancouver, BC, V5N 1V9

Crisis Centres Serving Alberta

Doctor Margaret Savage Crisis Centre
Cold Lake, AB T9M 1P1
Crisis 24 hours: 1-866-594-0533
Website: www.violetnet.org

St. Paul & District Crisis Centre
Serving all Alberta and Northeastern Saskatchewan
Box 1237, St. Paul, AB T0A 3A0
Crisis 24 hours: 1-800-263-3045

Salvation Army Community & Family Centres
9620-101 A. Avenue, Edmonton, AB T5H 0C7
Hope Line – Mon – Friday, 9:00 am – 11:30 pm: (780) 424-9223 Greater Edmonton Area
Website: http://www.salvationarmy.ca/alberta/

Distress Line of Southwestern Alberta (Canadian Mental Health Association)
Serving Chinook Health Region and south part of Calgary
426-6 Street South, Lethbridge, AB T1J 2C9
Crisis 24 hours: 1-888-787-2880
Website: http://www.lethbridge.cmha.ab.ca
Distress Centre Calgary
Serving Calgary and surrounding areas
Suite 300, 1010-8 Avenue SW, Calgary, AB T2P 1J2
Crisis 24 hours
Main Crisis Line: (403) 266-4357
ConnecTeen: (403) 264-TEEN
online chat support: www.calgaryconnecteen.com
Website: http://www.distresscentre.com

Wheatland Shelter Crisis Line (Community Crisis Society, Wheatland Shelter)
Box 2162, Strathmore, AB T1P 1K2
Crisis 24 hours: 1-877-934-6634

Wood’s Homes
805, 37 Street NW, Calgary, AB T2N 4N8
Crisis 24 hours: 1-800-563-6106
Website: http://www.woodshomes.com

Crisis Support Centre, a program of The Support Network
Serving Edmonton and Northern Alberta
400 – 10025 106 Street, Edmonton, AB T5J 1G4
Crisis 24 hours: 1-800-232-7288 (Toll free service available to Northern Alberta)
Crisis 24 hours: (780) 482-HELP (4357)
Website: http://www.crisissupportcentre.com

Crisis Centres Serving Saskatchewan

Mobile Crisis Service (Saskatoon)
(Saskatoon Crisis Intervention Service Inc.)
Crisis 24 hours: (306) 933-6200
103, 506-25 Street East, Saskatoon, SK S7K 3J7

Southwest Crisis Services
Box 1102, Swift Current, SK
Website: www.swiftcurrent.ca
Website: www.shelternet.ca

FHHR Mental Health & Addiction Intake Worker
(Five Hills Mental Health & Addiction Services Centre)
Crisis 8am-5pm, Mon-Fri: 1-877-564-0543
455 Fairford Street East, Moose Jaw, SK S6H 1H3

West Central Crisis & Family Support Centre
Crisis Mon-Fri, 9am-5pm: (306) 463-6655
Box 2235, 116-1 Avenue West, Kindersley, SK S0L 1S0
website: www.westcentralcrisis.ca
North East Crisis Intervention Centre
Crisis 24 hours: 1-800-611-6349
103 McKendry Avenue East, Melfort, SK S0E 1A0

Hudson Bay & District Crisis Centre
Crisis 24 hours: 1-866-865-7274
Box 403, 203 Patricia Street, Hudson Bay, SK S0E 0Y0

Prince Albert Mobile Crisis Unit
Crisis 24 hours: (306) 764-1011
196 B, 9 Street East, Prince Albert, SK S6V 0X5

Regina Mobile Crisis Services
Crisis 24 hours: (306) 525-5333
Crisis after hours: (306) 569-2724
1646-11 Avenue, Regina, SK S4P 0H4
Website: http://www.mobilecrisis.ca

Crisis Centres Serving Manitoba

Klinic Community Health Centre
Serving Winnipeg
870 Portage Avenue, Winnipeg, MB R3G 0P1
Crisis 24 hours: 1-888-322-3019
Manitoba Suicide Line: 1-877-435-7170
Website: http://www.reasontolive.ca
Website: http://www.klinic.mb.ca

Crisis Stabilization Unit
Serving Winnipeg Health Region
(WHRA Mental Health Crisis Response)
2 floor, 180 Henry Avenue, Winnipeg, MB R3B 0J8
Crisis 24 hours: (204) 940-3633
Website: http://www.wrha.mb.ca

Mobile Crisis Unit (MCU) & Crisis Stabilization Unit
(Prairie Mountain Health Crisis Services)
Serving Prairie Mountain
404, 13 Street, Brandon, MB R7A 4R1
Crisis 24 hours: 1-888-379-7699

Mental Health Crisis Service
(Karen Devine Safe House)
Serving Central Regional Health Authority
159, 5 Street SE, Portage la Prairie, MB R1N 1H4
Crisis 24 hours: 1-888-310-4593
Crisis 7 days/week 4:30pm-8:30am
North Central: (204) 857-6369
South Central: (204) 325-9700
Website: http://www.rha-central.mb.ca

Crisis Centres Serving Ontario

Ontario Association of Distress Centres (www.dcontario.org)
Website has lists of Ontario distress centres
Website: http://www.dcontario.org/centres.html

Ontario Suicide Prevention Network (www.ontariosuicidepreventionnetwork.ca)
Website has lists of Ontario crisis centres.
Business: 416-670-4689
Website: http://www.ontariosuicidepreventionnetwork.ca

Crisis Centres serving Quebec

Centre de prévention du suicide de Québec
(1-866-APPELLE) 1-866-277-3553
Services d’intervention 24 heures/24, 7 jours/7: 418-683-4588
Website: http://www.cpsquebec.ca

Crisis Centres serving New Brunswick

Chimo Helpline
Serving New Brunswick bilingually 24/7
P.O. Box 1033, Fredericton, NB E3B 5C2
Provincial toll-free Crisis line: 1-800-667-5005
Fredericton area: 450-HELP (4357)
Website: http://www.chimohelpline.ca

Crisis Centres serving Nova Scotia

Mental Health Mobile Crisis Team (MHMCT)
Telephone intervention throughout Capital District, mobile response for Halifax, Dartmouth, Bedford
Crisis intervention & short term crisis management: 902-429-8167
Toll free number: 1-888-429-8167
Available 24/7

Pictou County Help Line
Serving Nova Scotia
75 Lavinia Street, Suite 119, New Glasgow, NS B2H 1N5
Crisis 12 noon-12 midnights, 7 days/week: (902) 752-5952
FEED NOVA SCOTIA Helpline
Toll Free 1-877-521-1188
Available 24/7

Eastern Regional Help Line
Serving eastern region of Nova Scotia
1482 George Street, Sydney, NS B1P 1P3
Crisis 6pm-midnight, 7 days/week: 1-800-957-9995

Crisis Centres serving PEI

Island Helpline
24 hour province wide Serving Prince Edward Island
24 hour province wide bilingual service: 1-800-218-2885
P.O. Box 1033 Fredericton, PE E3B 5C2

Crisis Centres serving Newfoundland and Labrador

Mental Health Crisis Centre (Newfoundland and Labrador)
Serving Newfoundland and Labrador
47 St Clare Avenue, St. John’s, NF A1C 2J9
Crisis 24 hours: 1-888-737-4668

Crisis Centres serving Northwest Territories and Nunuvut

NWT Help Line
Serving Northwest Territories
Crisis 7pm-11pm (Mountain Standard Time) 7days/week: 1-800-661-0844
Yellowknife, NT X1A 2PG
Website: www.nwthelpline.ca

Nunuvut
Awareness Centre
This is a temporary RCMP crisis line
Crisis 24 hours: (867) 982-0123
P.O. Box 271, Kukluktuk, NU X0B 0E0

Nunavut Kamatsiaqtut Help Line
Serving Nunavut and Nunavik (Arctic Quebec)
Crisis 7pm-11pm (Eastern Standard Time) 7days/week: 1-800-265-3333
P.O. Box 419, Iqaluit, NU X0A 0H0
Website: www.kamatsiaqtut.com
Appendix E - Transcription Protocol

Experiences of Canadian Distance Education Social Work Students with Mental Health (dis)Abilities

Formatting

The researcher (Rose Singh) will transcribe all individual interviews and use the following formatting:
1. Word document file, saved as a .doc file in an encrypted folder on the researcher’s password-protected computer, labeled as interview transcript, plus the first name chosen by the participant for the study
2. Arial 12-point font
3. 2.54 cm margins
4. Text will be aligned with the left margin with no indents, left justified and single-spaced
5. Page numbers will be included

Individual interview transcripts will include the following information at the top of the document:

Study title:
Date of Interview:
Name of Researcher / Interviewer:
Name of Research Participant / Interviewee: *

* First name the Research Participant chose to be used for the study *

Recording

The researcher / transcriber will indicate the start and end of the interview, in upper case letters.

Example
START OF INTERVIEW
END OF INTERVIEW

Voice

Questions or comments from the Researcher / Interviewer will be indicated with an R: at the left margin.

Responses, questions, or comments from the Research Participant / Interviewee will be indicated, also at the left margin, with the first letter of the first name they have chosen to be used for the study (i.e., Jane = J:, Participant 3= P3:, etc.).
R: Could you please tell me about your experiences as a distance education social work student?
J: Okay. I think, overall, it has been a positive experience, but with some challenges.

Content

Audio-recordings will be transcribed verbatim using words and symbols as described below.

Nonverbal, Background, & Expressive Sounds

These noises and sounds will be indicated in parentheses.

Example
J: I couldn’t believe it (laugh).
R: Excuse me (cough).
J: I barely remember it (pen clicking).

Filler Words

Filler words will be transcribed.

Example
Um, ah, yeah, uh hmm, mhmm, etc.

Emphasis

Capital letters / caps will be used to convey emphasis in volume and/ pitch.

Example
J: They said, “WHAT are you doing?!”.

Held Sounds

Held, repeated sounds will be shown through separations and hyphens.

Example
J: There was no-o-o-o-o way I could give up my job to go back to school.

Paraphrasing

Quotation marks will be used to express inner voice or parodying others.

Example
J: Well, I thought it was a good idea until they said, “You’re never going to finish that degree and work at the same time”.

**Identifying Information**

Any names used during the interview will be replaced with the first name selected by the participant / interviewee to be used in the study.

Example

P3: And they said, “Hey, Participant 3, are you sure about that?”

Any potentially identifying information will be indicated with equal signs before and after.

Example

J: I completed my undergraduate degree at the =University of Waterloo=. Then, I completed my BSW at =Laurentian University=. My best friend, =Lucy Smith= and I were roommates at the time.

**Overlapping Speech**

Should the interviewer and interviewee talk at the same time and it is difficult to determine what was said, overlapping speech will be noted in parentheses where this occurred.

Example

R: What were you all balancing? (overlapping speech).
J: Work, school, family…life.

**Interruptions**

If an interruption occurs, a hyphen will be used to mark where speech was broken off.

Example

R: What is the pos-

**Pauses**

Short pauses, a two to four second break in speech, will be indicated with three dots.

Example

J: Um…I think that was the case.

Long pauses, a break in speech of five seconds or more, will be noted with long pause in parentheses.

Example
J: Hmm, let me think about that (long pause).

**Questionable Text**

Words, phrases, or sentences that the transcriber / researcher is unsure of, in terms of accuracy, will be noted by questionable text in parentheses, surrounded by question marks.

Example
J: I grew up in ?(Oromocto)?, before we moved to Iqaluit.

**Inaudible Audio or Information**

Any segments of the audio-recording that are inaudible, have dead air, and/ or the transcriber cannot determine the possible content or information (i.e., words, phrase, sentence), will be labeled as inaudible in parentheses.

Example
J: My mental health and wellness is key to my (inaudible).
R: Sorry, could you please repeat that?

Should there be a longer inaudible part of the interview, the approximate time of this will also be included.

Example
R: I think we lost our connection. Can you still hear me? (inaudible: one minute of interview missing).

**Reviewing for Accuracy**

The researcher / transcriber will check and review the transcription against the audio-recording three times before sending it to the participant for transcript verification.

**Transcriber**

After END OF INTERVIEW is noted, each transcript will state who transcribed the interview. The researcher (Rose Singh) will transcribe all interviews.

Example
Interview transcribed by: Rose Singh (Researcher / Interviewer)

**Transcript Verification**

At the end of the transcript document, the researcher (Rose Singh) will also note the date the verified transcript was received from the research participant.
Transcription protocol adapted from:

