

# **INDO-CARIBBEAN CANADIAN MENTAL HEALTH SERVICE RECIPIENTS**

**By**

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**INDO-CARIBBEAN CANADIAN MENTAL HEALTH SERVICE RECIPIENTS:  
PROCESSES OF POWER AND CONSTRUCTIONS OF IDENTITY**

**By**

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## ABSTRACT

The purpose of this study was to create a space to explore and center marginalized knowledge, and voices of Indo-Caribbean Canadian mental health service recipients. I did this by interviewing five participants, with the aim of examining processes of identity construction of racialized people involved in formal mental health systems, and the forces that shape this construction. Areas of inquiry included definitions of mental health and illness and their treatment; processes of identity construction around race, ethnicity, and mental health identity within this system; the power structures that shape these constructions, and the notion of cultural relevance. In a parallel process of exploration, as a means of addressing power through transparency, I also examined my identity and positioning as a researcher.

At the outset of this study I anticipated tensions and discrepancies between participants' constructions of identity and mental health, and the dominant discourses and constructions in the mental health system. Results indicated a general endorsement of mental health system involvement, but differences in constructions of mental health and illness between culture of origin and Canadian culture. Tensions were evident in terms of racialized identity, in the context of acculturation and racism. My analysis of the results, surfaced the importance of the contextualization of experience, a reframing of ethno-racial and cultural service provision toward cultural relevance, and the process of social construction.

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“Act normal. That’s crazy enough.” - Anonymous

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## **I. Introduction and Theoretical Frameworks**

### **Introduction**

*“I was not speaking of a marginality one wishes to lose – to give up or surrender as part of moving into the center – but rather of a site one stays in, clings to even, because it nourishes one’s capacity to resist”*  
(bell hooks, 1990, as cited in Sin & Yan, 2003, p.36).

bell hooks describes the choice of residing in margins as a space of resistance. It is in the margins that this research is situated, and from which we travel to the center. To do this, it is necessary to engage with the notions of marginality, dominance, and the processes of construction that support both. Research is commonly presented as an objective process in which a neutral researcher determines objective truths. Like many critical qualitative scholars however, I believe instead that “the researcher becomes a learner and must view research as a process of self-discovery and self-examination” (Dei, 2005, p. 6). It is only by examining both the research, and its process for the researcher, can we accumulate thick accounts of that which we study. It is in this manner also, that we can actualize the full potential of data that is contextualized and positioned. This research study, examining the world of ethno-racial mental health, has been motivated by the culmination of a series of my life experiences.

I identify as an Indo-Caribbean Canadian woman who experiences skin privilege, is a formally educated social worker, and is able-bodied and heterosexual. What does this mean to me and to others? What do they see? How am I engaged with systems of dominance and in individual interactions as a result of this self-identification within predetermined categories of identity? Why am I as the researcher so present in this paper as to be the focus of the introduction, and why am I uncomfortable with taking this space? The purpose of beginning with a



focus on me as the researcher is to first expose what has driven this research. As data that was meant to privilege participant voices was being collected and analyzed, a reciprocal process of discovery and transformation was in progress. It involved me and the research acting on each other, facilitating my growth as a researcher and individual. I could stand outside of myself and observe my role in this process, how it affected me, my participants, and the research process. I believe this critical self-reflection can be as relevant and valuable for research as are the results of this study. Also necessary, as will be discussed more in depth throughout the paper, is the positioning and transparency of researcher intents and ideology, which can more fully contextualize the interpretation and dissemination of results. This is crucial in terms of challenging power imbalances in the research process.

My first experiences with issues of equity came as a result of growing up as a woman of colour born to immigrant parents, and dealing with racism. Individual acts of discrimination that I faced, the act of my parents instilling in me a sense of identity, and their attempt to try to prepare me for what I would have to face in life as a person of colour, grounded my awareness of myself as “other”. These influences also allowed me to recognize the disparity between my knowledge of myself and how I was constructed. I became acutely aware of being positioned in in-between spaces - between these constructed identity categories - first through the influence of my parents living in mentally transnational spaces, as Canadian immigrants from a country that is a former British colony. Guyana shares a cultural base with the West Indian islands but is located off the cluster of islands known as such, on the mainland of South America. The history of their country of origin, and the political and cultural ramifications of colonialism, were my earliest experience with the influences of these forces on identity. And like many, much later I also found myself in the in-between space of a person who has experienced mental unwellness, not involved in formal mental health systems, thereby not reaping the rewards or consequences of

inclusion in that identity. Early in life I recognized how one can become lost when being awkwardly placed into finite categories of identity, constructed and imposed upon me, with the expectation that it is my responsibility to cram myself into these categories despite injury or the discomfort of a poor fit.

With this initial awareness I unintentionally moved in the direction of social work. I began volunteering at crisis lines, then moved into the violence against women (VAW) sector, and later, into community mental health. During my time at a few agencies that were grounded in a feminist integrated, anti-oppressive framework, and one additionally operating from an antipsychiatry perspective, I began to develop a critical consciousness. My initial leanings in the direction of social justice took shape and blossomed, becoming pivotal for my personal and professional transformation. These agencies worked in a manner that connected constructed identities of women and psychiatrized people, to oppression. This was further developed through my education in social work. I was seduced by the language of anti-oppression that actually gave voice to issues that I had struggled with, and gave me a forum to talk about them. I was given a sense of community with like-minded individuals who were just as passionate. I found a sense of belonging in those spaces of marginality, and became more involved in social action movements. The cumulative total of these growth experiences gave me an awareness of my social location and positioning in relation to others. It also gave me an awareness of the larger political, historical, and social forces that influenced my construction in various spaces by those with whom I interacted; and later on, my privilege and how I was complicit in these arbitrary constructions. After a number of years working through the volatile, yet rewarding field of VAW, I moved back toward my other passion – mental health. In the mainstream mental health sector, I once again found myself struggling to place myself and my voice, as well as those of ‘my clients’ of colour. During this time I also saw trends in social work in terms of a push toward credentialization and the effects of the neo-liberal agenda on social work. I was involved in policy

and procedure committees and began to see how managerialist ideals undermined the same grassroots feminist-based agencies that had contributed so profoundly to my personal and professional identity. Although I had always wanted to do my Masters, it became quite apparent this credentialization would be required to move forward and do the kind of work that I wanted to do.

It is my passion for issues of equity in mainstream mental health systems and for people of colour that prompted this research. It is the excluded voices that fall in these in-between spaces that I endeavour to help create a space for. I chose, as would be a natural step in my evolution, to first attempt to surface the voices that I believed sounded like mine, as thus far they have been almost completely underrepresented. There is little to no demographic information on the Indo-Caribbean population in the greater Toronto area, the problem being that, as Razack (2003) notes, Caribbean cultures have been subsumed under 'recognizable' categories in that Black Caribbean falls under Black Canadians and Indo-Caribbean under South Asian. These categorizations not only fail to accurately describe our cultural and ethnic identity, but also reflect a complete misrepresentation of colonial history in Canadian education and media. I therefore chose to invest in my own community with this research.

In this study, I interviewed five Indo-Caribbean Canadian people who had accessed mental health services in the greater Toronto area. I explored definitions of mental health and illness and their treatment; processes of identity construction around race, ethnicity, and mental health identity within this system; the power structures that shape these constructions; and the notion of cultural relevance. The aim of my study was to consider the relationship between participants' constructions of mental health, and dominant discourses in the mental health system. I suspected that there would be a significant discrepancy, and contemplated the tensions this might create for service recipients. I also aimed to surface some of the forces shaping and impacting participants' constructions and

experiences of themselves as racialized subjects in the mental health service system.

More broadly, I intend with this research to explore “alternate” marginal space, and center the content of those spaces through a process of social construction that includes me as a researcher. My hope is to position marginalized realities in relation to prevalent systems of mental health service, and to add to the present canon of information on specific ethno-racial constructions of mental well-being and illness. I will attempt to do this by describing my research and the parallel process of construction that engaged every aspect of it.

The remainder of this chapter will describe the theoretical frameworks that have guided the research process and its analysis. Chapter two will begin with a historical contextualization of the ethnic classification of “Indo-Caribbean”. This will be followed by a summary of related and relevant literature regarding mental health with differently categorized racialized people, as there is no body of work that discusses Indo-Caribbean mental health exclusively, and lastly issues of power involving racialized mental health service recipients. Chapter three describes the methodology and its rationale. Chapter four offers results of the study through highlighting the voices of the participants, followed by discussion of these results and implications for further research and service delivery in chapter five.

### **Theoretical Frameworks**

#### ***Anti-Oppressive Practice***

Anti-oppressive practice is a practice theory (Healy, 2005) that not only guides an approach to research and the acquisition of knowledge, but is meant to guide interventions in service provision. This theoretical framework is useful for this study for its recognition of the following principles: that social difference exists along lines of race, gender, class, sexual preference, disability, age, and others, due to power imbalances among social groups; and individual

circumstances must be placed within the context of social and political systems, as well as historical and geographical context (Burke & Harrison, 2002). It involves surfacing power dynamics and minimizing power imbalances, challenging oppressive social structures, power sharing, understanding how social location affects relationships; and it calls for the constant vigilance of critical consciousness (Larson, 2008; Sakamoto & Pitner, 2005). Also inherent in this theory is the recognition of multiple forms of oppression and the effect of their intersectionality (Healy, 2005). A most comprehensive definition of anti-oppressive practice has been offered by Dominelli (1994) who defines it as:

“a person centred philosophy; and egalitarian value system concerned with reducing the deleterious effects of structural inequalities upon people’s lives; a methodology focusing on both process and outcome; and a way of structuring relationships between individuals that aims to empower users by reducing the negative effects of social hierarchies on their interaction and the work they do together.” (Burke & Harrison, 2002, p. 134).

This framework informs the methodology of this research, and assists in contextualizing and examining some of the dynamics that the participants and researcher are subject to through their relationships with each other and the systems within which they are entangled. My hope is that the act of committing this research is an act of exploring and challenging power dynamics and inequities.

### ***Critical Race Theory***

The broad category of critical theory mirrors and complements anti-oppressive practice. Critical race theory acknowledges hegemony, recognizes that racism has been normalized and ingrained systemically and must be uncovered structurally, incorporates experiential knowledge, values storytelling, and allows the researcher to make an appearance in the research (Ladson-Billings, 2000). Critical race theory “seeks to analyze, deconstruct, and transform ... the relationship among race, racism, and power” as it “challenges liberalist claims” of objective neutrality and the privileging of a colour blind approach, over race

consciousness (Abrams & Moio, 2009, p. 250). Abrams and Moio (2009) outline some principles of critical race theory, which include the acceptance of the fact that racism is a social construction and the fact that the silencing of voices of colour - the “other” - serves to maintain the power of dominant systems and groups. This theory proposes a rewriting of history to include these voices. It also looks at how dominant social groups racialize “other” groups of people in ways that suit the present ever-changing historical and political context of a particular time and place, it outlines how racism benefits dominant social groups, and it suggests that change only occurs when the interests of these groups coincides with the interests of the “others” (Abrams & Moio, 2009).

Dei (2005) discusses how the critical theory of anti-racism furthers the basic principles of critical race theory. Anti-racism calls for the “practice of identifying, challenging, and changing the value structures, and behaviours that perpetuate systemic racism” (Dei, 2005, p. 4). It also seeks to understand how oppression “helps construct and constrain identities, both internally and externally through inclusionary and exclusionary processes” (Dei, 2005, p. 2). Importantly, critical anti-racism also marks the connection between racial identity and the production of knowledge.

Essentialism is “the assumption that groups, categories or classes of objects have one or several defining features exclusive to all members of that category” (Ashcroft, Griffiths & Tiffin, 2000, as cited in O’Mahony & Donnelly, 2010, p. 444). One principle that is under debate within critical race theory is the importance of recognizing the effects of the multiplicity and intersectionality of oppressions, so as not to essentialize them by focusing only on race (Abrams & Moio, 2009). Not centering race, however, can have the effect of burying racial oppression and devaluing its importance.

This theoretical framework is useful for this research as it serves as a lens that, while recognizing the necessity to map the intersections of oppressions in their totality in order to empathetically understand any one individual experience,

it draws attention to racism as one of the most salient social and political forces permeating this mapping.

### ***Postcolonial Theory***

Postcolonialism is a postmodernist practice approach that has no single definition. It has been defined as “a studied engagement with the experience of colonialism, its past and present effects, both at the level of ex-colonial societies and the level of more general global development thought to be in the after-effects of empire” (O’ Mahoney & Donnelly, 2010, p. 443). Healy (2005), more specifically mentions the “legacy of European colonization” (p. 198).

Postcolonialism can denote the period following colonization where a nation gains independence and some political autonomy, but where economic domination still exists (i.e. through production and administration of third world debt, and inequitable trade relations); and where the dichotomy of oppressor and oppressed remains (Slemon, 2001). Many postcolonialists caution, however, not to make any assumptions about the use of the prefix ‘post’ as meaning that colonialism is a finite historical chapter that has passed (O’ Mahoney & Donnelly, 2010). Colonialism continues to be facilitated through economic, political and cultural means.

Postcolonialism also “refers to a broad range of critical scholarship that seeks to rewrite colonial relations in order to offer alternative insights into the complexities of these relationships in both their historical and continuing forms” (Harrison, 2007, p. 74). Postcolonial theory is used to look at how colonialism has constructed understandings of race, gender, slavery and the representation of the “other”, and facilitates a critique of institutional and structural power imbalances between “advanced” and developing countries (Healy, 2005, p. 198). It also questions the dualism between European and non-European identities in an effort to combat the essentialization of either group, in recognition that race is only one dimension of difference (Healy, 2005). Lastly, in keeping with its postmodern

affiliation, postcolonial theory looks at how language perpetuates forces of oppression, while also potentially offering a site of resistance.

### ***Feminist Theory***

Feminist theory seeks to center experiences of gender oppression. Its most popular tagline is ‘the personal is political’, which summarizes the idea that personal experiences are rooted in political structures and processes (Healy, 2005). It provides a framework to analyze gender, race and class relations and “to examine the production of knowledge from different social and political locations together with a gender and class analysis” (O’Mahoney & Donnelly, 2010, p. 445). An analysis of power and language are endemic to feminist methodologies, as well as the recognition that theoretical frameworks themselves are socially constructed (Neysmith, 1995). Black feminism is based on principles of equality, and focuses on the interconnections among these relations of social inequities and their impact on the individual, family, and community (Burke & Harrison, 2002). This echoes the fundamental feminist principle of working toward social change (Ballou, 2005).

Three key components of feminist frameworks are “accountability, positioning, and partiality” (Haraway, 1988, as cited in Boushel, 2000, p. 83). Equally important along these same lines, is the principle of voice and recognizing “the need for knowledge construction from the perspective of the marginalized female subject whose voice has been muted in the knowledge production process” (Kirkham & Anderson, 2002, as cited in O’Mahoney & Donnelly, 2010, p. 443). Postcolonial feminist principles add to those of feminism, in being critical of the traditional sciences and supposed objectivity of inquiry, and recognizing the importance of researcher positionality (O’Mahoney & Donnelly, 2010).

Feminist research involves the formation of an empathic relationship between researcher and participants, incorporation of the researcher’s experiences and feelings in the research process, and flexibility in research methods (Neuman,



1997). This framework is one of the few that has provided an analysis of the mental health system, and operates in line with the other frameworks mentioned. It will also facilitate an analysis from my perspective as a female research of colour.

## **II. Literature Review**

Because there is almost no available literature on the mental health of Indo-Caribbean Canadians, this literature review draws on related bodies of research to contextualize the Indo-Caribbean experience. This review will facilitate an understanding of issues and processes of power that shape identity construction and positioning of Indo-Caribbean Canadians who are involved with formal mental health service systems. Relevant topics to be summarized include Indo-Caribbean history and identity, West Indian mental health systems and individual problems, positioning within the Canadian mental health system as immigrants and racialized subjects, mental health system engagement, systemic racism and power in the mental health system, related ethno-cultural research of Afro-Caribbeans, and approaches to cultural diversity in the Canadian mental health system. This chapter explores literature that provides an often marginalized critical analysis of dominant systems and discourses, in order to facilitate the examination of the positioning of marginalized identity within dominant systems.

It is important at this point as we begin the discussion of ethno-racial and cultural identity, to discuss the meanings of the terms culture and ethnicity as they were understood in this study. Although the term culture was not defined for participants and both of these terms have contested and multiple meanings in the literature, some assumptions were made about their meanings in this study. One common feature to most definitions of culture is it being passed from generation to generation. Dewees (2001) cites Lum (1999) in calling it a “sum of life patterns” that includes “institutions, language, religious ideals, habits of thinking, artistic expressions, and patterns of social and interpersonal relationships” (p. 34). Maiter (2009) cites Abney (1996) in recognizing it as a “set of beliefs, attitudes, values, and standards of behaviour” (p. 269). And Pumariega, Rothe, and Pumariega (2005) add that it is socially transferred, is shared by members of a

society or social group, and it orients people to expectations of behaviour to be co-ordinated and sanctioned.

The definition of ethnicity is widely contested, and often is conflated with culture, and even race. It is often associated with descent and group memories, histories and language (Keddeh, 2009), as well as the combination of racial and cultural lineage. In psychiatric literature it is referred to as “notions of minority groups within majorities, and interactions and reactions between these groups” (Fung, Bhugra & Jones, 2009, p. 336). An ethnic group can be thought of as “a group of people of the same race or nationality who share a common and distinctive culture” (The Random House Dictionary, 1968, as cited in Maiter, 2009, p. 267).

### **Indo-Caribbean History and Identity**

Razack (2003) points out that theoretical and practice approaches for Caribbean people should be grounded in history. She recognizes that awareness of the colonial and imperialist history of the Caribbean, which includes slavery and indentureship, is crucial to understanding its culture and ethnicity, as such awareness helps correct misconceptions. For the purpose of this research, a historical approach also allows us to examine issues of identity and some of the dynamics of its construction. In this research, the term West Indian refers to people from the Caribbean Commonwealth, which are nations that share a history of British colonization including Anglophone countries outside of the West Indian islands, such as the mainland Caribbean country of Guyana. It is important also to note that the term Indo-Caribbean is not prevalent in the literature or among research participants or the community designated as such; however, it is being used for this research in that it captures a particular historical diasporic context to the identity of East Indian people from the West Indies. Also, Fernando (2010) recognizes the term “the West” as countries that are traditionally European, although the people living in the country can hold non-European traditions. For the purposes of this paper, the term “western” will be used to refer to a set of

traditions, customs, or values, that are Eurocentric in historical origin, which have been transported globally, and are reflected in positivist biomedical approaches to mental health.

The original inhabitants of the Caribbean were native Amerindians. Large numbers of them were eliminated by white European settlers who seized the economy and purchased large portions of land (Razack, 2003). Soon realizing that they needed to increase their labour force, European settlers brought slaves from Africa, who were prevented from maintaining cultural and religious traditions or traditional family values (Razack, 2003). Once slavery was abolished, European settlers moved to supplement their labour force again and brought indentured workers from Portugal, China, and India. By the late 1800's European settlers had brought 400,000 Indians to the Caribbean from India (Razack, 2003).

During the period of indentureship from 1838-1917, most Indians were brought for cheap labour on sugar plantations, and comprised half or more of the populations in Guyana and Trinidad (Plaza, 2004; Razack, 2003; Roopnarine, Krishnakumar, & Xu, 2009). Indentureship in the West Indies involved contracting labourers to work in exchange for the cost of travel, room, board, and food for a fixed period of time. They were not paid wages and were the property of their land owner. After the period of bondage, they were able to pay to become independent and purchase land. Over 55% of the approximately 500,000 Indians that were recruited were brought to Guyana, 33.5% to Trinidad, and the rest to Surinam, Martinique, Jamaica, and other West Indian countries (Khan, 2007). After this period, some East Indians returned to India, but approximately 80% stayed in the Caribbean, starting small businesses or staying in agriculture (Roopnarine et. al. 2009). Alliances between slaves and indentured labourers were undermined by colonial social and economic policies, pushing Indo-Caribbeans to settle in rural areas and Afro-Caribbeans to settle in urban areas (Roopnarine et. al., 2009). The history of settlement and labour distribution created friction between Afro and Indo-Caribbeans, which erupted more violently

after the 1960's when most British colonies began to gain independence. Also, East Indians were more able to retain their cultural and religious practices than people brought as slaves (Razack, 2003), thereby exacerbating this disparity. It is important to note that the culture, music, food, and dialect of all West Indian countries exist on a continuum of hybridity. Colonial systems of education and government often remained intact.

Between the period prior to the introduction of the point system in Canada (1946-1966) and the period after the immigration amendments (1967-1998) the total percentage of immigrants to Canada that were Caribbean increased from 1.1% to 8.3%, the highest time being that of the mid '70's (Plaza, 2004; Razack, 2003). Most Caribbean Canadians settled in Ontario, and some in Quebec and British Columbia and were from all socio-economic classes and professions or trades; although Afro-Caribbean women came as domestic workers earlier and in higher numbers than Indo-Caribbean women (Plaza, 2004; Razack, 2003). Although family separation was more common among Afro-Caribbeans in the immigration process, Indo-Caribbeans also experienced this dismemberment of family structures (Plaza, 2004). Most Indo-Caribbeans came from Guyana and Trinidad, with some from Jamaica and Surinam (Plaza, 2004). Between 1981 and 2002, approximately 302, 900 people migrated from Guyana and Trinidad (Roopnarine et. al., 2009). Much of the impetus for the significant increase in migration may have been due to political strife and policy changes that have resulted in increasing crime rates, decreased employment opportunities, and the deterioration of social structures in the West Indies (Plaza, 2004). Both Indo- and Afro-Caribbean families maintain transnational identities through ties to culture and family, to whom they send aid, in their countries of origin (Plaza, 2004). More recent immigrants are afforded closer ties to home due to greater ease of travelling and technological advances in communication; and they feel more of a need to maintain ties because of exclusion due to racism (Razack, 2003).

The homogenization of Caribbean people in Canada results in the blanket categorization of them as Afro-Caribbean, and most often Jamaican, a category which is made synonymous through the media with criminality and violence (Plaza, 2004; Razack, 2003). As a result, Indo-Caribbean culture has been invisibilized, or is often subsumed under that of South Asian, despite their “creolized” culture being quite different (Plaza, 2004). Plaza (2004) describes creolization as a process of cultural mixing from the colonial plantation settings that includes political, social, and economic experiences of domination, slavery, and indentureship of Africans, East Indians, Chinese and Europeans. These experiences were even further shaped by the cultural, political and historical factors in each individual Caribbean country (Plaza, 2004).

Caribbean Canadians are mostly Christian, with a large population of Indo-Caribbean Hindus and some Muslims in Trinidad and Guyana (Razack, 2003). Religion plays a major role in shaping culture and values and has produced a significant measure of religious understanding and tolerance in West Indian nations. (Razack, 2003). Class differences can dictate acculturation experiences, with those of lower socio-economic status having more difficulty adjusting after migration to Canada (Razack, 2003). Shadism and skin privilege intersect with these other points of privilege and marginalization (Razack, 2003).

A diaspora can be framed as a historical experience of migration (Khan, 2007). The history of a diaspora contributes to identity development in that its legacy leaves a hereditary imprint on the psyche of a people. It is important to consider these characteristics as part of a historical and cultural context of a people, just as relevant and important as any other point of identity. Indo-Caribbeans could be considered a double diaspora, having been brought from India to the Caribbean, and then migrating to Canada and beyond (Plaza, 2004). Murdoch (2007) recognizes Caribbean diasporic identity as including elements of origin, exile, dispersal and return, voluntary and forced migration, transnational and transcultural identities, constant transformation, and “revised patterns of

alienation and displacement” (p. 579). “The diaspora experience ... is defined ... by the recognition of a necessary heterogeneity and diversity; by a concept of identity which lives with and through, not despite, difference; by hybridity” (Murdoch, 2007, p. 579).

Scholars have suggested that a narrative of a people consists of the unwritten, orally transferred, pieces of a people’s history. These narratives constitute a diasporic consciousness (Khan, 2007). Khan (2007) has described one such story as that of the betrayal and trickery into indentureship through false promises of wealth, or outright lies about where they were being taken and for what purpose. Indians were recruited mainly from Uttar Pradesh, Oudh, and Bihar, and arrived as “bound coolies” as subordinated colonial subjects (Khan, 2007, p. 142). Redemption came from the fact that they were able to ‘save’ the sugar industry through perseverance and hard work, while drawing strength from religious practices (Khan, 2007). This story is one that ingrains qualities of loss and hope in its teller, along with a marking of outsider status (Khan, 2007). The narrative of many Caribbeans includes the story of ‘going home’, and while many may not want to move back in a literal sense, there is a feeling of desire for safety and nurturing expressed in this dialogue (Razack, 2003).

### **Mental Health System in the West Indies**

In order to gain some insight into the conceptualization of mental health by Indo-Caribbean people, it will be important to look at formal and informal support structures for mental health issues in the West Indies. Although the literature is limited, there is some information on the history of formalized mental health supports in Trinidad and Guyana, which have historically contained the highest population of Indo-Caribbean people.

In their overview of mental health in Trinidad, Maharaj and Parsaram (1999) note that Indigenous Amerindians in Trinidad in the pre-Columbian period prior to 1498, practiced herbal medicine and addressed mental unwellness through spiritual means. The arrival of the Spanish and French between 1498 and 1797

brought a privileging of Christianity and its notion of demon possession, that combined with native practices to fuel superstition and a form of folk magic or voodoo known as ‘obeah’ in the West Indies. Western psychiatry was brought to Trinidad in the mid-1800’s and resembled British colonizers’ systems of management of the “insane”. The opening of gaols and asylums marked a period of aggressive biomedical treatments in the early 1900’s, followed by psychotropic medications. After independence in 1962, psychiatric wards in hospitals and a national mental health strategy were developed, the most recent of which still focuses on institutional care and intersectoral integration of services. Research in Trinidad has moved from social psychiatry, focusing on issues such as substance use and suicide, to the epidemiology of schizophrenia, depression, and biological psychiatry. The Trinidadian mental health system is currently, to a certain degree, an amalgamation of biomedical psychiatry and indigenous practices around superstition, religion, and folk medicine influenced by African and Indian indigenous practices and beliefs. Disjuncture is still evident, however, as the notion of demon possession has caused some friction between medicalized mental health professionals and local healers, who specialize in obeah or priestcraft (Maharajh & Parasram, 1999). NGO’s and community organizations round out the formal mental health supports in existence in Trinidad. Transcultural psychiatric strategies were being developed in the late 1980’s in an effort to address ethno-specific needs. Currently, other inpatient and outpatient treatments are provided by multidisciplinary teams including electro-convulsive therapy (ECT) and supportive counselling; and diagnosis is guided by the DSM, the Diagnostic and Statistical Manual of Mental Disorders and the ICD, The International Statistical Classification of Diseases and Related Health Problems, which is the international equivalent from the World Health Organization (Maharajh & Parasram, 1999).

In Guyana, formal supports for mental health have developed similarly but less progressively due to economic and political turmoil. Mental health is



currently being addressed through a new Country Cooperation Strategy by the Pan-American Health Organization, a regional office for the World Health Organization (Social issues, 2010). It is to be completed within five years (2010-2015), and will focus on “neuropsychological illness” and training for medical staff (Social issues, 2010). This will overlap with the National Health Sector Strategy (2008-2012) that recognizes depression, anxiety and suicide as serious concerns, and outlines strategies of integration of mental health and primary health care services, increased training for health care professionals, further development of hospital and psychiatric institutions and movement toward decentralization from institution to community-based supports (Ministry of Health, Guyana, 2008). Minister of Health, Dr. Ramsammy, does advocate for holistic interventions, collection of information on mental health, and equitable treatment for people with mental health issues (Decentralisation, 2007). On the ground it seems that this meticulous planning has not been materializing, evidenced in the stalled opening of a suicide center and unpublished research on suicide; although counselling services and NGO’s have offered supports (La Rose, 2004).

Fernando (2010) describes the history of the development of Western mental health services in West Indian countries as psychiatric imperialism. As Euro-American political forces spread through Africa and Asia, so did the practice of psychiatry, which subjugated indigenous systems of healing, and privileged Western medicalized knowledge. This is in part due to the supposed objective underpinnings of the Western positivist system that is assumed to be free of cultural bias (Fernando, 2010). Psychiatric hospitals still existing in countries colonized by the British or French, resemble those in Europe and still operate primarily within systems of biomedical psychiatry. In developing countries, emotional difficulties that were previously being treated by indigenous religious customs or social networks, are now being pathologized and treated through medication (Fernando, 2010).

### **Indo-Caribbean Mental Health**

Razack (2003) outlines mental health concerns common to Caribbean people in general, and notes that mood and anxiety disorders are more prevalent than personality or thought disorders. Research suggests that Caribbean people tend to benefit more from short-term counselling, may be less overt in expressing emotions, and may be more formal with professionals (Razack, 2003). In terms of stigma in this community, someone who needs mental health counselling is stigmatized as being a failure or ‘going mad’ (Razack, 2003).

Suicide is a major problem in Trinidad and Guyana. Guyana’s Ministry of Health (2008) found that suicide is the leading cause of death for 15-24 year olds and the third leading cause of death for 25-44 year olds, pushing suicide rates that are more than double the global average. It is said to be worse in rural areas of Guyana (La Rose, 2004). Maharajh & Parasram (1999) discuss mental health problems in Trinidad, where suicide is noted as being highest among East Indian people. Males have a higher rate of completion, mostly by means of weed killer poison, as well as hanging, while attempted suicide is higher among adolescent females (Maharajh & Parasram, 1999). Some reasons for suicide have been identified as “marginalization and ethnic disadvantage, psychiatric illness, lovers’ quarrel and family dispute, substance abuse, changing role definition, unemployment, religious and cultural rigidity, social stress, transgenerational cultural conflicts, and imitation suicidal behaviour” (Maharajh & Parasram, 1999, p. 177). Other reasons have been cited as matched weddings, and relationship problems among youth, sometimes due to not being able to repay bank loans associated with rice production (La Rose, 2004). According to Maharajh and Parasram (1999), there is inconclusive evidence on the prevalence of depression but they do discuss the local term “tabanca”, described as being love sick over the loss of a love object, which can be seen as an expression of “depression”. Alcoholism was also noted to be highest among East Indian people in Trinidad (Maharajh & Parasram, 1999).

### **Theoretical Underpinnings of Western Mental Health Systems**

The mental health system and research in this area has been dominated by a positivist framework. The ontological basis of this framework espouses fixed universal truths that can be discovered through objective observation, in order to control or predict events (Neuman, 1997). “The emphasis on creating objective knowledge without historical or social context is consistent with the decontextualized, neutralized gaze of a post-positivist framework”, and is “particularly important in psychiatry” (Williams, 2001, p. 236). The basic premises of the ‘psy’ disciplines are the idea of the separation of the mind and body and the commitment to classification of people and their conditions (Fernando, 2010). Features of the medical model include a depersonalized relationship between professional and service recipient, passivity among service recipients, and seeing the body as a machine (Jhangiani & Vadeboncoeur, 2010). The anti-psychiatry movement of the 1960’s reflects the critical analyses of the theoretical frameworks underpinning this research in its basic principles which, include the following: questioning the validity of the biomedical model, normalization of madness, disapproval of decontextualisation in diagnosing, examination of repressive aspects of psychiatric practice, and a critique of positivism, reductionism, and scientific methods (Kecmanovic, 2009).

Hierarchy, patriarchy, and power imbalances are embedded into the medical model (Larson, 2008). In mental health service systems, the professional is the expert, thereby holding the power to define problems and the methods of examining those problems (Williams, 2001). Notions of universalism, individualism, and cultural homogeneity are prevalent also (Jhangiani & Vadeboncoeur, 2010). These positivist ideals translate into standardization in interpretation of behaviours, regardless of cultural differences (Sheppard, 2002). In a study by Gray (2007) that explores narratives of female mental health service recipients, she states that the discourse of biomedicine positions women in static universal ways, thereby fixing identity.

Framing positivist theory using a postcolonial lens, it can be said that the West, as an imperial power, facilitates the classification of societies, creates systems of representation, and provides models of comparison and evaluation (Tuhiwai Smith, 2008). “The division of people to be governed into communities is a ‘time-honoured colonial strategy’ ” (Baumann, 1996, as cited in Fernando, 2010, p. 20). This positivist system of classification and representation “enable different traditions or fragments of traditions to be retrieved and reformulated in different contexts and discourses, and then to be played out in systems of power and domination, with real material consequences for colonized peoples” (Tuhiwai Smith, 2008, p. 128). One of these consequences can be the colonization of knowledge, practice, and inevitably, people.

It is important in these discussions, which at times dichotomize indigenous and western mental health constructions and systems, to recognize that medicalized mental health systems are transnational, but Eurocentric and western in nature and origin. They are institutionalized more systemically in certain ‘developed’ first world countries, a categorization in which Canada can be included. This study falls prey to this dichotomization, but efforts have been made to distinguish medicalized service systems from alternatives without fixing geographical boundaries.

### **Immigrant Mental Health**

There is no single definition for immigrant in the literature. Although European colonial settlers are technically immigrants, this term has often been used to describe the “other”, who initially were European ethnic groups outside of the dominant Anglo-Saxon groups, and more recently, became “Third World settlers in the First World” (Tsang, 2001, p. 236). O’Mahoney and Donnelly (2010) cited the definition by Citizenship and Immigration Canada, which is “a person who has moved themselves (and often their families) to a permanent residence in a new country” (p. 440). One of the participation criteria for this study was having been born in the West Indies, and currently residing in Canada.

This, therefore, was the operationalized definition of immigrant referenced in this study, as citizenship status was not requested. As a result, regardless of status, participants may experience mental health problems as specified in the literature for immigrant mental health. It is important to note the negative racist connotation that can come with the term immigrant (Razack, 2003) that can influence how newcomers experience acculturation and impositions of categories of identity.

Since the 1970's, war, famine, and political turmoil have increased forced migration all over the world (Pumariega et. al., 2005). Hoen & Hayward (2005) note that nearly 20% of the Canadian population are immigrants, 40% of Toronto's population are immigrants, and over 50% are identified as people of colour. The healthy immigrant effect explains the phenomenon of new immigrants appearing healthier than the Canadian-born population, which is in part due to Canada's immigration criteria, that favours those who are in optimal health (Ali, 2002). This disparity is less apparent the longer the duration in Canada (Ali, 2002). While pre-migration stress can predispose people toward emotional difficulties after migration, lack of job security, language barriers, and difficulty pursuing education experienced post-migration can exacerbate these difficulties (Hoen & Hayward, 2005; Pumariega et. al., 2005). Other losses from migration can include identity and status, occupation, social network of supports, family structure, parental authority, financial assistance from home country, social roles, basic needs, and a sense of social justice (Hoen & Hayward, 2005). Social and economic disadvantage, which is often experienced by immigrants, can increase mental unwellness (Ali, 2002; Pumariega et. al., 2005). Acculturation and discrimination are recognized as having adverse effects on mental health (Pumariega et. al., 2005). Lum and Vanderaa (2010) define acculturation as the psychological adaptation to a new culture, but also frame it as the ability of a newcomer to adopt language and cultural knowledge in their new environment. Diagnosable mental illnesses resulting from the stresses of acculturation include

depression, anxiety and post-traumatic stress disorder, substance abuse: and other disadvantages include poverty, low self-esteem and physical health issues (Hoen & Hayward, 2005; Pumariega et. al., 2005).

### **Underutilization**

Research clearly shows that non-European immigrants underutilize mental health services compared to Canadian-born people (Whitley, Kirmayer, & Groleau, 2006). Current mental health systems are not effectively serving ethnocultural populations, and “poor understanding of the interplay of cultural, financial, organizational, and diagnostic factors contributes to inappropriate service utilization, individual suffering, and deep social and economic costs” (Rollock & Gordon, 2000, p. 5).

Different studies attribute underutilization to different causes, ranging from what is pathologized as maladaptive behaviour, to less need, to system failure to engage immigrants of colour. In one study that featured interviews with Afro-Caribbean immigrants in Montreal, participants revealed that their reluctance to engage with mental health services was due to doctors’ overemphasis on medication as intervention, a dismissive attitude by doctors, and a belief in nonmedical and more holistic interventions (Whitley et. al., 2006). Theories on underutilization in this community also include the notion that mental illness is highly stigmatized by this population (Morgan, Mallett, Hutchinson, and Leff, 2004).

A study by Kirmayer, Weinfeld, Burgos, Galbaud du Fort, Lasry and Young (2007) examined service access in the context of Canada’s universal health care system and found that lower socio-economic status was associated with less engagement in psychiatric services, but not primary non-emergency health care. They found that many minority group members are often treated through other primary health care and informal resources. O’Mahoney and Donnelly (2010) deduce, in their research on women’s mental health, that the primary health care relationship affects how immigrant women seek help for mental health. Kirmayer

and colleagues (2007) suggest that patterns of underutilization can be reflective of how people go about seeking help for mental and emotional difficulties, as well as patterns of referral. These researchers go on to point out that help-seeking for mental health issues is a “complex social process that involves culturally mediated interpretation of symptoms, coping strategies, and hierarchies of resort that interact with economic and social structural factors as well as with the organization of health care services and clinicians’ attitudes and practices” (Kirmayer et. al., 2007, p. 296).

Williams (2001) notes that in research on the underutilization of mental health services by ethno-racial groups, the hegemony of Eurocentric privilege is preserved in the assumption that Western mainstream mental health is the desirable treatment for most people, and the further assumption that if they do not access services, the problem lies with the individual. He also notes that research on underutilization invisibilizes race, avoiding structural issues and racism. The language used in an article for psychiatrists produced by the Mayo clinic illustrates this point by describing “the barriers encountered by caregivers” (p. 582), the fact that “non-compliance problems often are due to the fact that the patient and his or her family do not understand the therapeutic benefits of the medication”, and that “it may be beneficial to allow patient and family to retain some control over the situation” (p.591) (Scuglik, Alarcon, Lapeyre III, Williams, & Logan, 2007). Services that are not culturally relevant can create barriers that are both a factor in, and can have an impact on, the construction of the racialized mental health service recipient in the system.

### **Black and Afro-Caribbean Mental Health**

There has been a proliferation of research on black and Afro-Caribbean mental health in the United Kingdom. Indo-Caribbeans have been subsumed under both of these ethno-racial categorizations, as well as others. In Britain, the term BME is used to refer to black and minority ethnic, and black people are considered to include all ethnic minorities; although when specified by ethnicity

in the research, the term “black” seems to translate specifically into Africans and African Caribbeans (Fernando, 2010). In Canada and the U.S. the terms “people of colour” and “visible minorities” are used, and in Europe the term “migrant” is still used (Fernando, 2010). This non-specific designation of “black” in the literature, is problematic for this research in that Indo-Caribbean people, by virtue of skin colour, can be included in this category, although culturally are very different, reinforcing the invisibilization of this group.

Studies show that minority service recipients more often are misdiagnosed, get assigned to less experienced professionals, receive less preferred forms of treatment, are disproportionately represented in mental health institutions, more often disengage prematurely, and report more dissatisfaction with services (Ridley, Chih, & Olivera, 2000). Research in the UK shows that more African-Caribbean mental health service recipients than White service recipients access services through coercive means of police and involuntary hospital admission, which is a deterrent for future engagement (Morgan et. al., 2004). Studies have found that Afro-Caribbeans were involuntarily detained for treatment twice as often as white people (Sheppard, 2002). Other points of entry include general practitioners and social and housing services (Morgan et. al., 2004). Afro-Caribbeans are also less likely to be referred to specialist services and have less family involvement in their care (Morgan et. al., 2004).

Another issue that is featured in the literature is the prevalence and overdiagnosis of schizophrenia with black people - especially young men - and Afro-Caribbeans (Fernando, 2010; Sheppard, 2002). Studies in the UK showed a rate of 12 times higher for Afro-Caribbeans than that of the general population, and U.S. rates are similar (Fung et. al., 2009). This disproportionate representation amongst black Caribbeans has been shown elsewhere in Europe as well, such as in migrants to the Netherlands and Morocco (Fung et. al., 2009). Conversely, prevalence rates of schizophrenia in Jamaica, Trinidad, and Barbados are similar to that of white people in Britain, therefore much lower than the rate of



diagnosis for Afro-Caribbeans (Fung et. al., 2009). One study of Jamaicans noted that the prevalence rate of schizophrenia in Jamaica was one tenth that of Afro-Caribbean immigrants in England and one third that of white people (Hickling, 2005). This does not seem to be an immigrant condition as the prevalence rate of white immigrants to Jamaica did not increase; although they were of higher socio-economic status than Jamaican immigrants to England (Hickling, 2005). There is also a very low rate of psychosis in Jamaica, however there is little information on prevalence of anxiety and depression in the Caribbean (Hickling, 2005).

In Trinidad, the higher rate of schizophrenia reported amongst Afro-Trinidadians than Indo-Trinidadians has been attributed to a history of slavery and forced assimilation (Maharajh & Parasram, 1999). Fernando (2010) has explored the psychological effects of slavery on black people. It follows then that the entrapment of indentureship could yield similar long-lasting intergenerational effects for Indo-Caribbeans. Proposals of causes of this overrepresentation of schizophrenia have included misdiagnosis, lower socio-economic status and education level, trauma, and social isolation (Fung et. al., 2009). It is also possible that “the aggressive, esteem reducing nature of routine racism experienced by Afro-Caribbeans” [through economic, social, educational, and employment disadvantage]... “may well play a contributory part in higher rates of schizophrenia” (Sheppard, 2002, p. 174). It is also possible, as suggested by Fernando (2010) that it is due to institutionalized racism that manifests in erroneous diagnoses.

### **Power and Social Control in the Western Medicalized Mental Health System**

Vatne and Holmes (2006) echo Foucault in noting how religious, intellectual, and medical establishments have become examples of civilizing institutions that teach people how to monitor their own behaviour through making their expectations of behaviour explicit. These institutionalized, and often dehumanizing, mechanisms of social control are evident in the fact that black service recipients experience excessive forcible hospital admissions,

overdiagnosis of schizophrenia and underdiagnosis of depression, excessive administering of medication often by force, enforcement by police, overrepresentation in medium and high-security facilities, and they are less likely to receive counseling or other alternative treatments (Keating & Robertson, 2004). Sheppard (2002) found that in the UK, young black second generation and immigrant Afro-Caribbeans were 29 times more likely than young white men to be subject to forced hospital admissions. In a study by Keating & Robertson (2004) it was found that black people are treated with fear and coercion in mental health systems possibly as a result of racism. They in turn become fearful of using mental health services due to the apprehension of a replication of the same racism that they have experienced in society at large, and of the stigma associated with mental illness that can create social isolation. Participants felt that service responses were similar to some of the controlling aspects of other institutions with which they were involved, and that they were met with resistance in challenging professional decisions in their care. Echoing other studies, service professionals in Keating and Robertson's (2004) study often painted black service recipients as dangerous, used restraint and seclusion more often to deal with this perceived aggression, and felt fear about talking about issues of race in their work settings. These coercive methods have not resulted in any higher success rate of treatment or engagement by black service recipients (Secker & Harding, 2002).

### **Systemic Racism and Mental Health**

The adverse effects of interpersonal acts of racial discrimination have been alluded to in previous sections of this literature review. Another factor in the creation of mental health problems and construction of identity is that of systemic and institutionalized racism. Many oppressions, including racism, have evolved with the development of the mental health system. European philosophies on race espoused the need to civilize the savage other; were based on Darwinism, which designated stages of evolutionary development based on race; and were also based on eugenics, which helped facilitate the extermination of 'inferior' races

(Fernando, 2002). Psychiatrists and psychologists, such as Carl Jung, followed suit in determining that white European cultures were the epitome of civilization, and designating the “other” as uncivilized (Fernando, 2002). British psychiatrist J.C. Carothers concluded that the absence of depression in Africans was due to the fact that they had no long-term goals or initiative in life, an example of how diagnostic categories reflected European values of self-reliance and personal responsibility (Fernando, 2010). With regard to diagnosis, the social construction of mental illness was evidenced in the designations of ‘homosexuality’, and drapetomania (the desire of slaves to run away from servitude) as mental illnesses in early editions of the DSM (Fernando, 2002), which was not created on the basis of any scientific evidence. “Political, social, and ideological pressures current in society always impinge on the diagnostic process by influencing questions of intelligibility, common sense, clinical opinion, pragmatism and tradition... racism acts through these pressures” (Fernando, 2002, p. 103).

It has been widely accepted recently that race is a social construct and not based on biological traits (Maiter, 2009); however when discussing prevalence rates of mental health issues among certain ethno-racial or gendered groups, causality is often implied without any analysis of social location or structural forces. This is the case in a study by Nelsen (2002) where, even though there is a recognition that groups or treatments should not be essentialized, and clients are the best resource for information on their health, gender and sociocultural identity, these groups are still connected to “susceptibility to particular disorders, expression of symptoms, and responses to treatments” (p. 159). Racism is embedded in the psychiatric system through definitions of mental health and illness that subjugate ‘inferior’ groups, assessment and diagnoses that have been developed in ways consistent with concerns of those in positions of privilege, and service delivery not being culturally relevant (Rollock & Gordon, 2000).

Racism itself is perpetuated when ideas of race, culture, and ethnicity are used interchangeably. For example, people who are seen as being racially

‘different’ are portrayed as having different cultures, and as such, assumptions and judgments about race, are transferred to culture (Fernando, 2010). Western diagnoses are assumed to be neutral and not culture-bound, whereas a set of conditions or “symptoms” identified in a non-Western context become a culture-bound pathology (Fernando, 2010). Yee (2005) notes in her examination of the institution of whiteness, that it is the “other” that is constantly classified and categorized, whereas whiteness has power in being unmarked or unnamed.

Tuhiwai Smith (2008) describes the new racism as being the avoidance of race as well as being “aversive, modern, symbolic, subtle, or unconscious, and embraces individualistic, egalitarian, achievement oriented values” (p. 429). Similarly, unconscious racism works through meanings of race to create power imbalances; and, in the development of policy and practice that benefits those in power, unintentional racism becomes institutionalized (Yee, 2005). Institutional racism is the practice of racial discrimination, which is often exacerbated economically and socially, through the operations of societal institutions (Fernando, 2010). It also can be reinforced through the failure of these institutions to recognize and address ingrained and historic racism, or to provide service to people based on their colour, culture, or ethnicity (Fernando, 2010; Hyman, 2009).

Racism itself can contribute to mental health problems. It generates internal stress (Rollock & Gordon, 2000) and can “create anger borne out of desperation and life circumstances” (Razack, 2003, p. 347). Racism directly affects health causing depression, anxiety, lowered self-esteem, substance abuse, self-harm, negative coping strategies, and delays in seeking health care, which all can affect immune system functioning and has an impact on mortality (Hyman, 2009). Social exclusion, which includes racism, is a major social determinant of health as determined by the World Health Organization (Hyman, 2009).

### **Canadian Mental Health System's Response to "Cultural Diversity"**

A key goal of Canada's national mental health strategy is that of responding to the diverse needs of all people in Canada by providing cultural safety and competent practice, through respectful and diverse service delivery (Mental Health Commission of Canada, 2009). While in principle this is a positive approach, its implementation may not reflect these values as they should.

Cultural competence has been developed to address the 'problem' of culture (Razack & Jeffrey, 2002). The National Association of Social Workers (NASW) (2001) defines cultural competency as "a set of congruent behaviours, attitudes, and policies ... to work effectively in cross-cultural situations". One of the most prevalent models is that of the cultural competence continuum scale. On one end of this continuum is the cultural literacy model which positions the practitioner as expert with superior knowledge, essentializes culture, and applies culture-specific techniques (Al-Krenawi & Graham, 2003). Some critiques of the cultural literacy model are that it presents culture as static, confuses race with ethnicity, homogenizes groups, blames only culture for behaviour to the exclusion of other points of identity or marginalization which can then obscure power imbalances, fails to recognize the culture of the systems within which social work is practiced, and attempts to concretely define the fluid concept of culture (Carpenter-Song, Schwallie, & Longhofer, 2007; Dean, 2001). Other critiques include the fact that this approach focuses only on consciousness-raising for workers and not on larger social issues facing service recipients; and it emphasizes method and efficiency (Dean, 2001; Razack & Jeffrey, 2002; Yee, 2005).

The experiential-phenomenological model is a more constructionist approach. It positions the practitioner as learner with humility, who believes in the multiplicity of internalized culture; believes in the uniqueness of the group member as an individual and in critical self-examination; and applies process-oriented techniques (Al-Krenawi & Graham, 2003). One of the drawbacks of the

constructionist model is that it does not lead to a concrete prescription of practice, and does not necessarily draw attention to the structural issues that need to reflect cultural sensitivity (Burr, 1995). Some benefits include the fact that it recognizes the importance of historically and culturally situating constructions of the service recipient, as well as the importance of anti-essentialism and language in the process of construction (Burr, 1995). Symbolic interactionism is the view that people construct their identities through everyday social interactions with each other (Burr, 1995). This is one way in which the interaction between worker and service recipient can create a situation-specific construction of culture that reflects the voice of the service recipient. One caution is captured in Nelsen's (2002) article on prevalence rates of "mental disorders" among marginalized groups which illustrates how cultural competency has been co-opted in that often culture is learned by workers, to get people to accept Western treatment (p. 48).

This literature review provides information on the historical, political, and social forces that can shape racialized mental health service recipients' constructions of themselves, the constructions imposed upon them, and their positioning in the system. The fact that there are a number of different bodies of research that apply to this group but no one in particular, speaks to the multiplicity of identities of Indo-Caribbean Canadian immigrant people, as well as the invisibilization of this group as a distinct ethno-racial and cultural categorization.

### **III. Methodology**

#### **Research Framework**

As a principle of feminist and anti-oppressive methodology, it is imperative to make thoroughly transparent the rationale for one's methods and processes, as a means of addressing power imbalances (Neysmith, 1995). As a result this chapter will describe both my methods and the rationale for them. I begin by explaining why I chose a qualitative approach. I then describe recruitment, the people I interviewed, the interviews, and my analysis. In the section that follows I return again to broader issues of methodology, considering questions of voice, standpoint and representation as they relate to my theoretical framework and the interviews I conducted. I conclude with reflections on my study intentions at the level of epistemology.

Positivist research is based on the scientific testing of ideas and breaking problems down into measurable units (Gibbs, 2001), which explains why quantitative research is best suited to a positivist perspective. As a result of the hegemony of positivist and scientific means of discovery, there still exists a hierarchy of accepted knowledge in that those derived from quantitative methods are privileged (Arnd-Caddigan & Pozzuto, 2006). The authority and supposed objectivity with which this knowledge is delivered renders it an accepted common-sense truth (Ladson-Billings, 2000). However, a critique from social work suggests that this research only discovers problems that exist within an already constructed paradigm (Gibbs, 2001). Therefore, "by design, the scientific method must either ignore the tender qualities of moral, spiritual, imaginative, creative and other subjective experiences, or painfully distort them into quantifiable variables" (Gibbs, 2001, p. 696).

While scientific research does encourage accuracy and reliability of information by not relying on personalized information alone, if it becomes the measure of normality it can be used as a means of social control and often serves to exclude and silence the voice of participants (Gibbs, 2001).

Lastly, it is important to briefly mention the current conditions facing social work services systems. As previously discussed, the positivist methodology is focused on creating clarity and employs causality (Neuman, 1997), which is facilitated by classification and quantification. Gibbs (2001) has documented the rise in social work of outcome-based consumerist research and managerialism, which has as its ultimate goals efficiency, cost-effectiveness, evaluation and monitoring. This often results in compromised service that silences the voice of the service recipient and ignores issues of identity and equity. Engaging in positivist research, therefore, has implications of supporting this service system.

“Western research is more than just research that is located in a positivist tradition. It ... brings to bear, on any study of indigenous peoples, a cultural orientation, a set of values, a different conceptualization of ... subjectivity, different and competing theories of knowledge, highly specialized forms of language, and structures of power” (Tuhiwai Smith, 2008, p. 125).

In contrast to the quantitative positivistic research methods described above, the ontology of qualitative research is based on heuristic principles that “reality is complex and uncontrollable”, and does not hold universal truths (Gibbs, 2001). It is situation-specific and contextualized environmentally, politically and socially. Also, participants’ viewpoints are more valid than the statistical information about them, and there is no objectivity (Gibbs, 2001). Qualitative methods recognize that meanings are fluid, and can focus on the individual or macro issues, and can be exploratory (Luborsky, 1995). They also make it possible to reveal the perspective of those who experience a particular condition (Stamm et. al., 2008), and social work literature states that research participants know themselves, their situations, and coping strategies best (Gibbs, 2001). Qualitative research is about developing a “tolerance for ambiguity” (Anzaldua as cited in Ladson-Billings, 2000). This type of research often takes the insider’s perspective, and espouses that theoretical concepts serve as tools to unearth new issues that emerge through the analysis (Luborsky, 1995). This method facilitates



meaning making, where individuals employ a referencing process of evoking symbols, values, and ideas that shape experience (Luborsky, 1995).

As a result of the aforementioned considerations, and in order to create an open space for participants' reflections and constructions of the topic of mental health and illness, this study employed a qualitative approach, with the primary method being a semi-structured interview. The qualitative approach was deemed to be most useful in acquiring thick descriptions of the meanings that participants attach to constructions of mental health and illness within a cultural context, and assisted in examining power imbalances and systems of colonization. Personal narratives can offer understandings of larger systems, which can facilitate social change that can move the research beyond a simple report (Davison, 2004). In terms of service provision, this interactionist approach can "explicate the internal processes and problems, events, meanings, and situations that make up the interaction between a program and its clients" (Swanson & Chapman, 1994, p. 73).

### **Sampling**

Inclusion criteria for participation in this study included any adult, meaning any person over the age of eighteen, who self-identified as Indo-Caribbean or West Indian of East Indian heritage, parentage, or lineage, or mixed lineage. They also needed to be born within the Caribbean Commonwealth or West Indies, currently living in Canada and receiving service from one or more social service agencies designated as mental health services.

In the first stage of the recruitment process, participants were solicited using purposive sampling through a number of Toronto-based community mental health and social service agencies, as well as informal networks that were known to myself as the researcher to be connected to the Indo-Caribbean community (i.e. academic or employment contacts). Purposive sampling is said to best be used with special less accessible populations that are unique and specific that are to be explored more in depth; and involves selection by the researcher based on

judgment, with a specific purpose in mind (Neuman, 1997). Recruitment was initiated through an initial phonecall or e-mail to the agency or network that explained the purpose and method of the study, and a request to send more information by e-mail. Approximately twenty resources were contacted that included mental health and community agencies, as well as consumer survivor led businesses and supportive housing organizations.

For those agencies that responded in the affirmative to my request, the recruitment flyer (see Appendix A), client brochure (See Appendix B), Letter of Information and Consent Forms were sent via e-mail. A follow-up phone call was then made to the agency within a week to confirm participation in recruitment for the study. The recruitment flyers were posted, either by me while visiting agencies or by agency staff, in client common areas of the agency or on client information bulletin boards. I also attended agency cultural events, such as South Asian Heritage month celebrations, where participants could be recruited directly. Potential participants that were not directly recruited by me were then free to access the information themselves and phone or e-mail me to set up an interview. At this time, as stated in recruitment material, I explained that participation in the study was completely exclusive of any mental health service they were accessing, the purpose of the research, how anonymity in data reporting would be maintained, as well as the fact that they are able to withdraw at any time without penalty. These principles of confidentiality would be explained again just prior to the actual interview. A second stage of recruitment included snowball sampling where participants were asked if they were aware of any peers who would be interested in participating. The crucial feature of this type of sampling draws on formal and informal networks that are connected directly or indirectly, and is operationalized by inquiry into accessing these networks (Neuman, 1997).

The first five participants that responded to the recruitment request, that fit the sample criteria, and followed through to the data collection phase, were selected for the study. The participants were born in countries that had significant

Indo-Caribbean communities and lived in the greater Toronto area. The majority of the participants were born of two Indo-Caribbean parents, with one participant of mixed ethnicity that included Indo-Caribbean parentage. They were all male adults over the age of thirty and have been living in Canada for anywhere from 5 to 45 years. The range of services they had accessed included hospital-based psychiatric services, psychologists, community mental health agencies, medical doctors, addictions services and shelter services, as well as social assistance and housing services.

### **Data Collection**

The chosen method of data collection was face-to-face interviews. Participants took part in a semi-structured interview conducted by me as the primary researcher, having identified as a second generation Indo-Caribbean Canadian.

The interview (see Appendix C for interview guide) was guided by questions regarding participants' understandings of mental health, illness, and treatment, and culturally relevant services, and how this understanding has been influenced by their culture or where they are from, as well as their experiences in Canada. Interviews were audio taped and transcribed with the individual consent of each participant.

Interviews typically lasted one to two hours and were mostly conducted in common public areas or rooms in service agencies. Each participant was given the opportunity to debrief after the interview to talk about how they felt about the process and the information they shared. They were asked if there was anything they shared that they wish to have stricken from the record or not incorporated into the final report. To address any feelings of exposure they may have felt in having shared information about their psychiatric history or life experiences, they were given a list of support referrals that was reviewed with them. Participants were then provided with a \$20 gift card to their choice of Wal-Mart or Shopper's

Drug Mart. They were also reimbursed \$5 for transportation if they took public transit to get to the interview meeting point.

Participants were asked at the end of the interviews if they would like a one-page summary of the study results or a phone call to advise them of the results and potential next steps if further dissemination were to occur, and if so, to provide further necessary contact information that would be discarded after mailing.

### **Data Analysis**

Charmaz (2005) has explicated how grounded theory can be used to surface social justice and equity issues, which is also a principle in the anti-oppression and critical race theoretical frameworks used to anchor this study. This focus can “locate subjective and collective experience in larger structures and increase understanding of how these structures work” (Charmaz, 2005, p. 510). One of grounded theory’s criticisms, however, is that it does not surface issues of power within these structures; but according to Charmaz (2005), this can be rectified by using grounded theory within a social justice and critical inquiry framework. Although grounded theory is often implemented in a positivistic manner to look for an objective reality that can be validated if a number of people interpret data similarly, as espoused by one of its original creators Glaser (Charmaz, 2005), this study employs principles of the theory in a manner that coincides with a major objective in qualitative research in revealing the subjective reality of participants. This constructionist perspective fits with the version of grounded theory that is based in symbolic interactionism, championed by the theory’s other original author, Strauss (Charmaz, 2005).

The ontology of constructivist grounded theory perspectives incorporate reflection on ways of knowing, and values empirical reality as well as location of the subject and self within that reality (Charmaz, 2005). It recognizes the value of the focus on the process of data collection rather than the product, the fact that researchers share in the construction of the data through interaction with the

participant in collecting the data, and recognizes the influence of the lens the researcher uses to interpret the data (Charmaz, 2005). It situates the data and contextualizes the interpretation of these malleable social constructions.

The interviews were analyzed using principles from a constructionist grounded theory approach and methodology. This methodology uses coding to categorize major themes in the narrative yielded from the interviews in an inductive process that allows for simultaneous data collection and analysis (Charmaz, 2005). It refers to both the method and product of inquiry, and allows participants' narratives, as research data, to be disseminated in a manner that is concise (Charmaz, 2005). The process of data analysis involved "developing increasingly abstract ideas about research participants' meanings, actions, and worlds and seeking specific data to fill out, refine, and check the emerging conceptual categories" (Charmaz, 2005, p. 508). The process of coding participant narratives reveals themes that can then be used to support the creation of theories or generalized statements based on this analysis of empirical data that can then be used to facilitate further analysis. Also, the themes that are identified may reveal opportunities for examination of implications, further research, potential social justice concerns, or policy and program recommendations.

### **Representation**

#### ***Voice***

There are a number of relevant issues that are necessary to explore in order to provide a thorough rationale for the methods of data collection, analysis and reporting employed in this study and how these methods are connected to the theoretical frameworks described earlier.

Razack (2003) notes that critical race theory is essential when working with Caribbean Canadian communities for a number of reasons, one of which is the notion of privileging the story of the service recipient, and hearing it from "non-dominant, non-colonizing, non-racist positions" (p. 358). The idea of centering the voices of those who have historically and politically been

marginalized and silenced (Gray, 2007) is a feminist principle. Indeed the concept of voice can be defined as “having the ability, the means, and the right to express oneself, one’s mind, and one’s will” (Reinharz, 1994, as cited in Lord & Dufort, 1996, p.7). The act of breaking silence is a social justice movement, one of the goals of feminist theory, and the first step toward change (Gray, 2007). The goal of centering the marginalized “other” prevents them from being relegated to a position relative to, and separate from, the dominant norm; and, unlike positivist approaches, is an effort to reclaim “human subjectivity and intentionality” (Hill Collins, 2008, p. 113). It also can combat internalized oppression by fostering an inner consciousness of one’s own identity as defined by oneself instead of acquiescing to being defined from a dominant lens that is quite often racist (Hill Collins, 2008). This act of centering voice is not to be confused with giving voice which provides an illusion of comprehensive representation of all who are placed in a particular category of identity (Gray, 2007). “Voice is not simply the story told. Reflecting the interplay of time, place and space of both the telling and hearing of the narrative, voice is very complex and always political” (Gray, 2007, p. 427).

Two important concepts from black feminism that are prevalent in the operationalization of the aforementioned principles are that of self-definition, which involves “challenging the political knowledge-validation process that has resulted in externally-defined, stereotypical images of Afro-American womanhood”; and self-valuation, which is the idea of replacing these stereotypical and externally imposed definitions with more authentic images (Hill Collins, 2008, p. 96). These harmful illustrations (i.e. the angry black woman) can be used to subordinate groups of people, as they are exaggerated images of the aspects of black women’s behaviour that are seen as most threatening to male patriarchy (Hill Collins, 2008). Therefore, simply replacing the images without recognizing this mechanism of social control is not effective in creating change (Hill Collins, 2008). The study outlined in this report aims to expose some of

these mechanisms. One challenge in the notion of self-definition might be how to define oneself outside of existing categories if these constructions are not recognized outside of one's own community or culture, or if one has internalized mainstream standards of definition. This is akin to the difficulty Boushel (2000) notes in having to fit oneself into census information from which her sample was drawn (for example, the ethnic category of Indo-Caribbean, or Caribbean for that matter, does not exist).

In her study of female mental health service recipients, Gray (2007) attempted to create space for the voice of the participants as an act of resistance to being "subject to an objective biomedical gaze" (p. 413), as well as to the professionalized psychiatric labelling and assessment processes that served to obscure true understanding of their diagnoses. The opportunity to voice their opinions served as a means to reply to their objectification. The idea of having women speak their own experience was to combat the notion that mental health service recipients do not have the ability to participate in the production of knowledge because of their "condition" (Gray, 2007).

### ***Standpoint***

A complication of the notion of voice then is who has the authority to speak and on behalf of whom. One relevant and contested principle of feminist standpoint theories is the idea that members of oppressed groups supposedly have a more complete, reliable, and 'objective' perspective of social reality (Janack, 1997). This is because they come from a position that allows them to understand their own oppression as well as the position and worldview of their oppressors, affording them an epistemic privilege (Janack, 1997). As a result, according to Hill Collins (2008), although the herstory of black women can be recorded by others, those who share this identity have a unique and more thorough knowledge of, and perspective on, Black women's experiences (Hill Collins, 2008). It is assumed that this full awareness cannot be possessed by those in dominant groups as their life experiences are based on, and institutionalized in, dominant ideologies

that do not have to acknowledge the “other”; whereas, oppressed groups are forced to construct their reality in relation to these dominant systems of knowledge (Janack, 1997). Black feminist frameworks suggest that “it is impossible to separate the structure and thematic content of thought from the historical and material conditions shaping the lives of its producers” (Hill Collins, 2008, p. 95). Dei (2005) posits the importance in acknowledging that dominant epistemologies most often cannot accurately capture the experience of these voices; therefore efforts must be made to center and consider the epistemological standpoint of marginalized voices.

The related idea of epistemic authority, however, contends that people who are most qualified to speak and be validated are those who have been historically, politically, and socially privileged through class or socio-economic status, such as those who have been afforded formal education or are professionals, and this designation is guided by the historical development of Enlightenment principles of who is in the best position to be rational and objective. This historically has been a Eurocentric designation (Janack, 1997); therefore the people in positions of privilege, in Enlightenment ideology, would be assumed to have epistemic privilege in having the most objective and rational viewpoint. This premise contends that there is a single point of power embodied in dominant groups or ideologies and all other groups are positioned in proximity to this central point, however we know that power shifts.

One critique of standpoint theory is the adoption of constructed narratives by someone in a position of epistemic privilege as static truths (Janack, 1997), which again secures an ontological positioning of positivism through the “Enlightenment constructs of who counts as a rational agent” (Janack, 1997, p. 130). This also creates a risk of homogenizing or misrepresenting experience by generalizing voice to all who share the same identification. At the same time, although there is a commonality of experience within this community, other points of identity and marginalization, such as age, class, sexuality, and others,



can create unique expressions of this commonality that is always shifting; which resists the essentialization of oppressions and identity (Hill Collins, 2008). Janack (1997) claims, however, that this risk can be remedied by historically, politically, and socially contextualizing the voice.

As Dei (2005) notes, “knowledge resides in body and cultural memory” (p. 8). The process of knowledge construction that is facilitated by the conversation between researcher and participant reflects the assumptions that “knowledge is developed in the interactive domains of practical, value laden beings acting in the world” (Arnd-Caddigan & Pozzuto, 2006, p. 427). This means that the position of each party is informed by her or his social locations and life experiences, which will also influence the process of knowledge construction. Once this knowledge and its process has been placed within a historical context, and made transparent through exposure of these locations, exploitation can be minimized, or in the very least addressed. Dei (2005) echoes the importance of the influence of our subjective identities, particularly racial identities and social difference, in this process; and he challenges the extraction of information from the subject to the epistemic community that is often facilitated by a one-sided authority. Locating myself at the outset of this thesis is my way of taking up Dei’s cautions and insights.

Dei (2005) writes that anti-racist research does not espouse that only those who are oppressed have the authority to talk about oppression, but resists attempts to de-racialize the subject, which has the effect of devaluing subjectivity and privileging objectivity. It is not my contention that people in positions of oppression have a more objective view of the world in general, as the knowledge every person holds is a product of socialization and continual construction in constantly changing contexts; and the very notion of objectivity supports positivist principles that fix identity. However in their subjectivity, and as survivors of oppression, I do believe that people in subordinated social positions have the knowledge and authority to speak on their own experiences and create

their own self-definitions so as not to have aspects of dominant identity or belief imposed upon them. This was hopefully addressed in this study in its efforts to create a space for Indo-Caribbean Canadian service recipients to speak about their own experiences and worldviews. It was meant to validate the notion that people have the right, and deserve the space, to define their experience in the way that is most meaningful to them. They also have the right to have the knowledge that is produced in those utterances validated as equally privileged as that from professionalized and socially privileged voices reflecting hegemonic ideology, including that of the medicalized mental health system or the racially and ethnically privileged.

### ***Epistemological Intent***

This research was originally intended to create a space for Indo-Caribbean Canadian mental health service recipients to articulate and construct a notion of mental health that is specific to the participants themselves, reflecting their own social locations, identities, and belief systems. But there exists a pervasive question of what is truth and whether ethnic epistemologies can or will be legitimized (Fook, 2003) as being as credible as positivist or scientific epistemologies. Fernando (2010) believes that indigenous beliefs in developing countries are seen as inferior to those from western ideologies, regardless of their actual efficacy, and are not included in biomedical training of Western mental health professionals. In research on Indigenous people, cultural healers have ended up being used as supplements to the main medical system (Williams, 2001). The authority in the knowledge construction of traditional research is built on the othering of ‘different’ cultural and racial groups (Dei, 2005). A subjugated epistemology is one that is negated as invalid due to its supposed naivety, or lacking in cognitive intelligence or scientific validity, and placed lower on the hierarchy of epistemological credibility (O’Mahoney & Donnelly, 2010). Postcolonial epistemology focuses on location, power relations, and situated knowledge (Wong, 2002). This research study is grounded in postcolonial and

marginalized epistemologies. It recognizes that meaning is produced in a social and historical context (Wong, 2002), and that the purpose of working in and with ethnic epistemologies is not simply to add race into the discussion, but to challenge the hegemonic structures that perpetuate inequality (Ladson-Billings, 2000).

Researchers must avoid the re-colonization of marginalized voices – that is, we must avoid denying people the role of knowledge producer and activists (Dei, 2005). “Critical race and anti-racism research must be presented as a critique, subversion, and unravelling of conventional research paradigms as ‘ideologically determined and culturally biased production of knowledge’ ” (Stanfield, 1995, as cited in Dei, 2005, p. 19). Research must also challenge the exploitation often characteristic in dominant research frameworks to “pathologize, stereotype, label, and re-victimize marginalized peoples” (Dei, 2005, p. 13).

This study is informed by the aforementioned epistemologies but its purpose is not to create a new one. It is an attempt to simultaneously add to, and challenge, existing hegemonic positivist epistemologies that seek to fix identity (i.e. racial, ethnic, service recipient, and the interaction among these) and standardize knowledge construction. My aim is to extend the existing canon of writings on expressions of mental health and illness by particular ethno-racial groups, as well as demonstrate a process of knowledge and service recipient identity construction that creates an open space for self-definition of the group being featured.

### ***Capturing Participant Interviews***

One important consideration in this study was that of representation in reporting participants’ statements or ideas. Through the process of colonization and assimilation, many Indo-Caribbeans speak a dialect of English that has been called patois, creole, or is described as a “broken English”, (very much reflecting Anglo-European hegemony).

Many colonized people have been educated in a second language, which is that of the colonizer and/ or dominant ethnic groups, and language has historically been used as a tool of colonization (Harrison, 2007). Using the language of the imperial power changes the relationship with the self and others. Using the colonizer's language approximates inclusion but difference is maintained. It is this difference that postcolonial writers address in trying to find ways to renegotiate their relationship with English as a representation of the colonial empire (Harrison, 2007). English in many non-Western countries has been established as a necessity and a source of cultural capital that allows access to educational and economic resource (Harrison, 2007). This could lead to an internalization of inferiority. A contrasting viewpoint is that indigenous languages are not like material resources that can be commodified and viewed as items of exchange, and are thus very important to identity (Harrison, 2007). Languages are not just about words and signifiers but reflect their historical, social, and cultural context (Harrison, 2007). Colonization is replicated in that the native/ non-native speaker dichotomy mirrors the colonizer/ colonized dichotomy; this leads to essentialized or fixed social constructions of identities that perpetuate power imbalances. For example, the native speaker is considered expert and non-native speaker as learner and therefore always "other" (Harrison, 2007). Babha talks about creating a third space, beyond these dichotomies (Harrison, 2007). Writers who use the dominant or the imperial language to represent and construct the "other" risk privileging Anglocentric meanings (Spivak, 1993, as cited in Harrison, 2007). In Harrison's (2007) study, which features the narratives of three bilingual and multilingual social workers, one of the workers described speaking and writing as "acts of identity" (p. 79), rather than just communication. A postcolonial analysis of the issue of language allows us to center "other" language identities from the margins, recognizes language as a symbol of identity, points out how monolingualism can limit full understanding, calls for the historical contextualization of language identity, exposes power imbalances in the colonial

dichotomy of native and non-native speaker and in knowledge production, recognizes transnational spaces of identity production as a product of globalization, and sees language as a site of resistance in being able to reclaim history and experience (Harrison, 2007).

Throughout the West Indies, there is a continuum of language between dialects and what is considered ‘proper’ Anglocentric English (Morris, 1999). It is extremely important to mention that dialects vary by country and region, degree of urbanization, and is influenced by colonizing languages such as French and Spanish, as well as indigenous languages native to those that were colonized, such as Hindi and Amerindian languages. They are an “indigenised form of English” (Harrison, 2007, p. 77) that are often interpreted, through the lens of stereotypes, racism, epistemic devaluing, and classism, as the writing or speaking of one that is less educated, and therefore less valid epistemologically. Louise Bennett, a Jamaican writer, responds articulately to the accusation of speaking “bad English” in the following excerpt from one of her poems:

“My Aunty Roach seh dat it bwile her temper and really bex her fi true anytime she hear anybody a style we Jamaican dialect as ‘corruption of the English language’. For if dat be de case, den dem shoulda call English Language corruption of Norman French and Latin and all dem tarra language what dem seh dat English is derived from. Oonoo hear de wud? ‘Derived’. English is a derivation but Jamaica Dialect is corruption! What a unfairity!” (Morris, 1999, p. 4).

Further reference is made to the legitimization of British dialects of Yorkshire and Cockney, and Scottish and Irish brogue, that is not stigmatized in the same manner (Morris, 1999). Morris (1999) concludes his article by stating emphatically “is English we speakin” (p. 14).

The “language issue” was one of particular contention for me in this research due to the understanding of how language constructs, and is constructed by, identity. Proximity to the language of the colonizer can indicate a particular

relationship to that identity, and when conflated with internalized racism, can translate into a feeling that closer proximity indicates inclusion into a more civilized and powerful group. As a result one of the concerns I had was whether or not participants would endorse the use of a “dialect” to document their voices, or if they would see themselves as speaking ‘the Queen’s Englis’, a little ‘differently’, but written ‘properly’. One way of alleviating this dilemma, if time permitted, would be to have asked the participants about this and to have had them make this decision of representation. In the absence of the ability to do this, and for all the aforementioned reason of resistance to the colonization of language identity of participants, all quotes in the findings chapter were kept in their original dialect and/ or “accent” and transcribed verbatim. For presentation in this report researcher minimal encouragers (i.e. yeah, okay, etc.) have been extracted from the quotes for ease of reading.

A further exploration of methodological issues and challenges that position me as a researcher, explore construction of participant identity, and offer some additional reflections, are presented at the beginning of the discussion chapter. It was placed there so as to position my standpoint in the analysis of the interviews. This was also done in an effort to allow readers to more directly engage with participant narratives prior to being subject to the influence of placement of participant and researcher constructions. Having noted this however, for readers who wish to better understand my own standpoint before engaging with the findings, please turn to the first sections of the discussion chapter before continuing.

## **IV. Participant Interview Responses**

This chapter provides a summary of participant responses gathered in the interview process. The interview explored questions around participants' definitions of mental health and illness and how this understanding was influenced by their culture growing up, and then by their experiences in Canada, as individuals and as mental health service recipients. This exploration was continued with inquiry around their opinions of effective treatments and how this has been influenced by culture and experience. Lastly, their opinions on the cultural relevance of the Canadian mental health system as they have experienced it, as well as suggestions for improvements within the system, were explored. As such, where applicable, participant interview responses are organized within each section beginning with an illustration of experiences and information from the participant's culture of origin followed by a comparison of their experience in Canada. The section begins with summaries of responses in the area of identity, followed by definitions of mental health and illness, mental health system involvement, constructions of meaning of mental health labels, life experiences that have contributed to mental health issues, treatment and coping, and finally system evaluation and feedback.

### **Identity**

#### ***Ethnic Identification***

Participants identified as Indo-Caribbean, Indian, and Dougla, or Creole, which is a mix of East Indian and Black ethnicities and racial lineage. One participant responded in the following manner when asked how this mixed culture was different from Indian culture alone:

*"Creole culture people are more lovin. Dey more carin. Dey mo' understandable and dey mo' givin and like to co-operate and dey like to live nice and lovin and,stuff like dat... So we know what is life is all about. But you being a Indian, is deh hard for you to live our life."*

Participants also noted distinctions of identity that conflated ethnicity with religious affiliation, while alluding to colonial racial tensions.

*“Well my country dey got Hindu and dey got mix, black and Hindu. Some a dem are racial but some a dem is okay. But you don’ worry wid dem, just you live you own life, dey live dey life right, so?”*

Immigrant status was also discussed with the awareness of being othered through this labelling, but the term was not necessarily adopted by participants.

*“I don’ know wha’ we call immigrants here, as far as I’m concerned everybody is immigrant.”*

### ***Cultural Affiliation***

Participants varied in how much they associated themselves with what they have constructed as their culture of origin. This was at times expressed with pride, such as in claiming intelligence associated with Indian people. One participant, however, discussed the negative impact of racism on ethnic identification, and its evolution with age.

*“I find in order for me to move forward I have to know where I came from ... As, as a kid, as a kid growing up in the seventies I hated it, you know being Indian ‘cause it was so bloody racist, but now, now I love it. ‘Specially as I’m getting at dis age in my life I’m, I’m digging, digging more where I came from, who I am.”*

One participant problematized the term “background” by marking the diversity within “West Indian culture” as a diaspora in Canada.

*“Da question is not, is not, is not, is not correct either right, because you know same background, means you have, de West Indies right? Dis guy might eat differently from Trinidad, dis Guyana guy might*



*eat differently, you know, de fruits might n', might name different...  
we dealin with, with double culture. And triple culture sometime."*

Reflecting diversity within cultural groups, one participant marked some dissent in adoption of cultural customs in the ethnic group with which he identifies:

*"I will identify myself as a Guyanese but you know da's a be, to be questioned. Right? Dere's certain tings I very well disagree wid dem."*

There was an allusion to transnational identities in the following participant's use of the word "we" that marked his inclusion within cultural and national identities, and between Canada and his country of origin.

*"We call it ghost over here, we call it jumbee over dere."*

### ***Colonial Tensions***

Some participants confirmed in their dialogue the large movement of migration out of the West Indies in the 1970's, the political history, and racial tensions between Indo and Afro-Caribbean people that remained as a legacy of colonization within the West Indies. It must be noted that for the purpose of this study, these ethnic and racial tensions have been captured under the term "colonial tensions" with no further specificity due to the complexity of the historical, political, social, and assimilationist forces impacting this dynamic. While the well established binary of white versus the "other" of colour also surface, one participant positioned most of his discussion of race in opposition to the "black" or "negro" other. Some participants expressed some of their own feelings of disdain or being discriminated against, and noted the prevalence of this tension beyond the borders of the West Indies, extending to their lives in Canada.

*"Well, you see in a', in a', in ancient days, de slavery days, de, de black really, de Indian come from, from India in de ancient days. So*

*de black and de Indian dey used to, like, live together. And dey make chil'ren. Right, but now dese days it do', it does', it don' really happen... you can't take a Indian girl if you is a black man. Da's totally out of de religion."*

Participant responses in this section reflected a multiplicity of identifications, and implicated some of the social, political, and historical forces that shaped their construction of identity, as well as how they take this up. Some of their comments also alluded to issues of inclusion based on ethnicity.

### **Culture**

The meaning of the term culture was not explicitly explored in the interviews. As a result, while issues of cultural difference and inclusion surfaced, it is clear that culture was not bound by geography and is an accumulation of the totality of the participants' life experiences. There were however, some clear distinctions made between participants' culture, based on their upbringing and the cultural values of their families and society of origin, as opposed to what they interpreted as Canadian culture and values. These values can be important in recognizing many issues that can affect service recipients' mental wellness.

#### ***Cultural Beliefs/ Practices***

The value of working was noted by a participant who immigrated to Canada at a young age.

*"That's all you know. You get up 4:30 whatever, you go in the fields work, whether it's cuttin' rice, sugar cane, you know wha' a' mean?"*

*"Here several jobs I went to, de first ting dey talk about is coffee breaks and time off and all, an' I'm like, you know, I'm sayin' to myself what? I don' wanna hear about dat. I wanna hear okay work and make money."*

The ability to work was also cited as an inaccurate measure of wellness.

*“You put in your 40 hours a week, you pay your bills, and that's all that mattered dey don't care whatever, once you put in your 40 hours, they t'ink you're okay... But that's not necessarily, that's not necessarily true.”*

There was a prominent theme of reluctance in accessing health and social service systems. Regarding mental health services, one participant stated:

*“Basically I'm a guy when I have pain I take it on my own ... I just don' abu', don't want to abuse de system. Because I know dere's other, ill people dere wants to use it too.”*

Another value was that of keeping up appearances.

*“Dere's also dat facade where you wanna look like you're, you know wha' a' mean, like you're top cat, so you don' wanna, you know, whatever is behind closed doors is behind.”*

Lastly, religion or spirituality was also named as a cultural value. Some of the naming of cultural values reflects a reconstitution of values in the process of acculturation. The value of work was tied to both culture of origin and Canadian culture in different ways; however the internalization of constructions of a social service system might be the result of becoming acclimatized to Canadian structures and institutions.

### **Canadian Values**

Participants spoke of their experience of Canadian culture. Among others, gender role stereotypes surfaced, as well as the necessity and value of working, which could reflect aspects of the immigrant experience.

*“In Canada you gotta, you gotta hustle. Or else you don’t get anywhere ... Yeah you gotta work. Qualify yuhself.”*

One participant commented on the Canadian principle of multiculturalism and the difficulty of living in pluralistic society.

*“Live in a multi-culture society dere, I’ll tell you someting is more stressful ... You might pass anodda guy wid a culture, or anodda woman wid a culture dere. He or she might not smile wid you... Canadian dem say listen man I’m a Canadian culture. Dis guy gon say okay I’m a Trinidadian culture. And den, maybe conflict gonna clash, maybe dis guys are gon disagree with certain ting.”*

*“Yuh nah dealin wid de Canadian society alone. Yuh dealin wid many many more people around you. Is nah like, is nah like you have a whole bunch a table wid Guyanese, playin one type a game. You know, when dey, when dey finish playin dat game, a card game, dey will enjoy it. but when you, when you play card game, unless dey know it, in deir country, you gotta, dose guys tremblin’, how yuh gonna play? How you gon, you know? Even if he wants to play he wouldn’ enjoy it. Dat’s why I don’ believe in multi-culture.”*

These comments describe a metaphor for social, racial, and cultural tensions that are inherent in negotiating space within a multicultural society, which can affect expressions of identity and mental well being if the anticipation of conflict becomes a source of stress.

Canadian individualism was also a prominent theme with many participants.

*“And den come to a new country is different changes and people, people here, people in Canada don’ give you nuttin ... Because a*

*different life all together here. People just mind dey own business here and dey go, and dey go about dey own life yuh know? Dey don' cares about you, dey don' cares wha problem yuh have, you sick, if you eatin, if you hungry, if you dying, dey don' cares nuttin. You know. So is different, is kinda hard."*

Individualism was also tied to materialism.

*"In Canada, every, everybody, everybody thinking about, material life right?... Peop, people tinkin bou' deyself to get, how to, how to make money, how to make dey own life ... People nah gat time to help you. So is only de government here does give you money to suppport you and ... even though it don' be enough but is still better dan, be on de streēt."*

This was compared to one participant's country of origin alluding to a different sense of community.

*"You see, like back home you can go, back home you can go at your neighbour and you can get food. You can get anyting. But here you can't go at your neighbour and get someting. Dey don' give you. Here you come, you can't do dat 'cau people don' know you."*

These comments reflect a loss of community in migrating to Canada, and the mental or emotional difficulty resulting from this sense of isolation. This can affect the reconstruction of identity in relation to society, and exacerbate the difficulty of being othered. Cultural values and life experiences help to inform constructions of mental health and unwellness.

### **Definitions of Mental Health and Illness**

Participants were asked what the terms "mental health" and "mental illness" meant to them, as well as about causation. This information is useful in

terms of participants' constructions of themselves as potential mental health service recipients. The following are some participants' definitions of mental health:

*"Mental health is a, a sort of a, holistic approach to um ... um... mental health. Like when you, when you try to make, treat de um, body an' de, and de soul, at de same time."*

*"Stability if treated."*

Mental illness was made distinct from physical illness in being located in the mind instead of the body, and was described with a number of different characterizations and terminology, such as "being unwell", "not acting normal", as well as the following from one participant who did not identify as having a mental illness:

*"You can't argue wid a mental case. You know wha' I'm sayin? You gonna lose. I'm sorry. It nah gonna work."*

The idea of being crazy was associated with homelessness and having no support, as well as difficult life experiences, by one participant who had accessed the shelter system.

*"Crazy mean, like you'd a run, like run, mad like, like you'd be on de street walkin like yuh, like yuh have no future like, you, you walkin up, up and dung de road like some a dem, like some people downtown dey homeless and dey walkin crazy like dey got n', have nuttin to do. If you meet dose people on de street dey can tell you deir life, what dey pass through and, and is da make dem, be on de street and, I feel so sorry for some of dem when dey tell you dey story because is like look at, lookin at my story and lookin at wha dey tellin me is like is de same ting. Is like nah dat, dey can't help*

*demself. Dey need help but, dere's nobody dere to guide dem and to help dem, who's gonna help dem? ... Most people um, people don' wanna be on de street because dem want to be on de street. You'd be amazed to, to know how, how dey survivin yuh know?"*

The term crazy was also revealed to have a more benign meaning and made distinct from madness.

*"Well, some people might say is a bad thing, but most people when you use de word crazy, in odder words like, oh, she's drivin me crazy or, or he drive her crazy or someting like. But crazy like, people have lots a problems and dey get... crazy, I, in, de town home dey say crazy right? So dey get like stupid and like dey don't know what to do and sound frustrated like."*

*"When dey run mad is like, dey don' know anyting dey, dey totally, gone. Dey totally blank out like. Nuttin, dey, de brain is nah workin properly and everyting just everyting just, going wrong."*

*"Mad people. Violent. People who are violent. Sometimes you have a setback. But you have a violent case. A violent mental case or mental or mental illness."*

Definitions of mental illness approximated clinical definitions in causing a disconnection from reality, with mental health being the ability to come to terms with reality. Behaviour manifesting from mental illness was discussed. Participants specified body language and speech, along with the following qualifications.

*“I’m nah gonna um... say dat someting wrong wid him. I’m gonna say well, he, de guy doesn’ look right to me... Once you keep a eye you gonna know more, probably.”*

*“Like, some could be hidden. S’, Sometimes de disease is not progressed. So, ah, de mental illness... is not so severe.”*

The ability to deal with the “illness” was surfaced in the inquiry around definition.

*“The biggest definition would be... is just coping. Coping and trying to get a understanding of what’s going on.”*

Helplessness qualified one participant’s experience of mental unwellness as an illness.

*“Yeah because there was nothing that, looking back that I could have done, or not do, to change, to change things.”*

The preceding comments indicate different levels of internalization of “mental illness” and how they construct inclusion within this category. Some of this is based on their perceived ability to cope with their emotional and mental difficulties.

### ***Causation***

In discussing causation, some participants debated its biological origins as being in the brain, a congenital condition, or an acquired physical condition. Some attributed it to difficult life experiences, including family separation, marital conflict and breakdown, homelessness, loss of accumulated wealth, and traumatic childhood experiences such as abandonment by a parent. Participants discussed the effect of those life experiences on their mental well being.



*“Da bring a toll down. Right away, I been downhill from den. Now I’m there. I gotta come up.”*

*Keep tinkin every day regrets livin hopes and wonderin what, what next. What will I ever done to end up like dat and stuff like dat yuh know?”*

*dey get mad and dey take it on too much, some commit suicide some kill dem own self, some of dem just just run crazy like dey get mad yuh know? And de government just put dem in de madhouse.”*

*“Alot of it stems from when I was a child... everything back den was put on me... and I think dat’s one a de reason I, I, I ran so much in my life, you know, because I was told you don’t like it leave. You know, never dealt wid it or anyting.”*

Participants’ values, life experiences, and definitions of mental health and unwellness, can influence constructions around formal diagnostic labels and informal labelling.

### **Constructions of Meanings of Mental Health Labelling**

This section explores signifiers and their meanings, labelling, and perception of mental health issues from participants’ culture of origin that contribute to their understanding of mental health and illness. This is followed by participants’ constructions of meanings of mental health diagnoses in Canada.

#### ***Diagnostic Labels in the West Indies***

A mental health condition in one formal medicalized mental health system in a participant’s country of origin was labelled as “nerves”. Indo-Caribbeans speak a dialect of English that often draws from indigenous languages spoken in

the East Indian countries from which they were colonized. This is reflected in one of the terms that are explained as follows:

*“D’, d’, dey really didn’t talk to, ‘bout no mental, dey would call a person wid a mental illness pagla, or ah, pagli. Pagla is for a man, and pagli for a woman... Dat would be uh, uh... uh, inhabited by, a devil or something... They’re called pagli or pagla by de Indians, East Indians.”*

### ***Mental Unwellness in Country and Culture of Origin***

Participants talked about labelling and stigma, as informed by cultural values.

*“Coming from Indian things, I mean, dey don’t usually label, but once you’re labelled it’s not a very nice, you know, it’s almost like you’re... t’rown out of de group.”*

*“I think the worst label you can give a person dat come from my background is dat you’re lazy, you don’t wanna do anything you know and, or you’re crazy... you don’t wanna do anything. But people didn’t understand, dat’s not what is.”*

*“Dey be stamp. Dey cannot go, and, and, go, a de corna store and look for a job. Guy gon say hey wha de hell is you, kick you to de curb. Because, he know dat you cuckoo. Here [in Canada], dey would deal with you differently, if dey have de time. And you gotta work hard for it. Nah gonna come easy. I could tell you.”*

*“And dey, dey, dey have to, more or less uh, fetch deir uh, diagnosis wid dem. Like if, if dey decide, dey say is a madman. You know, mean de person might be schizophrenic or something but he’s lumped together wid de others as mad.”*

Another common theme in the treatment of mental unwellness in participants' cultures of origin was that it was invisibilized or dismissed.

*“‘Oh dis mental health thing is nonsense, it's laziness', you know, coming back from... an Indian culture.”*

*“You don't speak about it. Unless, like I say, a guy try to kill himself or someting. And even den, it's like a family shame.”*

*“We never dealt with it, you know, at home.”*

Participants also talked about mental health not being a topic of concern when needing to carry on with activities of daily living.

*“Alot of these things dey, dey, dey just think it's silly, because they grew up, you know, they get up whatever, four, five o'clock in the morning go work out in the fields and come back... it was all ignored or pushed”*

*“You know what? You know we had riotin [referring to civil unrest in country of origin in the 1960's] and dat? You know you musse read bout it, sixty-four riot, and all a dat right? Um, we didn' had much talking bout dat, basically. Everybody was goin about in dey chores, dey business, and move along... I don't think people wouldn' notice it. I did not notice dat in my life. I'm pretty sure. May had de odd ones. but I might not had de, de know how or de skill to recognize it. Eh? May had de odd ones. I'm not sayin, you know, I see people cry, you know.”*

*“Yeah, cau dat’s de way how, how my, my family dem lived. Everybody I seen dey had their problems but they was never, you know wha’ a’ mean? You know they had their problems but you never, you never seen it. It was always dressed up with this or that so, you know wha’ a’ mean?”*

Society’s reaction to people with mental health issues in participants’ cultures of origin were explored. Courses of action included family withdrawal once a person experiencing mental health difficulties was of an age to “fend for themselves”. One participant said the following in terms of his immediate family’s reaction to his acquiring a mental health issue:

*“Oh dey were ah, dey were, dey were sad. To know I was once a healt’y boy an’ I en’ up doin’ dese tings. Dey were sad.”*

The following comments about participants’ communities in their country of origin reflect compassion as well as exclusion.

*“Well, dey were treated wid love and uh, respect. But ah, a kind of um, de kind of... leery of getting too close. Because for fear dat de, de illness might have affected dem too. Because dey’re, recognize dis illness, eventually... Not dat dey didn’t want to do anything but, dey didn’t know how to, manage, an ill per’, de person dat was ill so dey tended to uh, you know go, go in de backgrung.”*

*“Well nobody really, ah, got into it... If you are violent from mental illness is different.”*

*“Well uh, like, I w’, I would, I would say dat ah, dese people, dese paglas and paglis were ostracized. Because people wanted to have nothing to do wid dem because dey w’, dey, you, you never knew what, what dey would*

*do. So dese people uh, had no um... psychiatric assessment. So, dey were just written off as uh, mad. Put in de asylum."*

Reaction of participants' ethnic and cultural community influences constructions of mental health in creating expectations and values around behaviour. This will affect how they engage with society as well as mental health services.

### ***Formal Mental Health System Engagement***

Points of entry into the mental health system were mostly in Canada, and happened by means of criminal justice involvement, the shelter system, addiction services, primary health care services for physical conditions, and mental health services. For some, coping mechanisms such as substance use, brought them to the mental health system through the criminal justice system. Although medicalized psychiatric supports were also accessed by one participant in his country of origin, all instances of formal diagnosis took place within the Canadian mental health system. One participant stated that he had no idea how he received his diagnosis of depression. Many were diagnosed with schizophrenia. While many were aware of the condition of mental unwellness prior to coming to Canada, acculturation and acclimatization experiences included those of learning about the mental health system and diagnoses in Canada.

### ***Definitions and Meanings Around Formal Diagnosis***

As previously mentioned, all of the participants' formal diagnoses were received in Canada. The following comments reflect their constructions of these labels as an amalgamation of information by the system from which it was bestowed upon them, along with their own knowledge of their condition and experience.

### ***Schizophrenia***

*"To me is like in your spirit or in your mind yuh know? 'Cause sometime yuh hear voices, sometime you don't. And sometimes could*

*be good, another time it don' really be too nice, yuh know sometimes stuff like dat."*

### **Depression**

One participant questioned the clinical diagnosis of depression and explained it as a natural circumstance of a particular condition of living.

*"Well, hear, if you got a, a room like dis, nothing in it, bare room. Paint wid, one colour, nuttin like dis. And you put a animal in dere, right? He guh wanna exit. Okay? No doors no nothing. If he had to run to dat wall, dere's no exit, no exit, no exit, no exit, no exit, no exit, no exit, wha would happen? Become depressed."*

*"Well I, I figure, right, dat um, you come, a guy lock you in a room, like yuh been locked dung. I'm nah telling you about de jail, de jail is a different ting, da's de lock down, da's depress ... And da's someting dat, is gonna trigga inside a you and probably will stay. Yuh guh always be afraid now. You gonna always say well listen, dis is part I gotta deal wid and I gotta deal wid my regular life behin' it. You know. And, de two and two might not, go together. You know. So, de depression might more, come in inside a you. Faster dan your normal life."*

This participant also qualified behavioural criteria for depression.

*"When a person depress he cannot function like a normal person. Right? He's out there. He's seein things. He's see movin things. 'E know to walk, 'e know to talk, 'e know to cross a light 'e know to go shop. How, how a person could depress, and, and have dose kinda function? How could dey function like dat? Da's nah depression. I don' tink so. Is de way, how you were taught, basically."*

These comments describe the process of reconstruction of mental illness, which involves the combination of personal and cultural values, Canadian experience, and experience of mental health supports, which in turn all affect construction of mental health service recipient identity.

### **Difference in Health Issues in Canada versus Country of Origin**

Many participants talked about the absence of pathologized and diagnosed mental and physical health conditions in their countries of origin as they exist in Canada, and often cited differences in lifestyle, community, and life events as the cause.

*“ ‘Cau when I was back home I was healthy and good I never had all dese kinda, and you never hear bout, I never hear about chizo, schizophrenia or all dese kind diagnosistic and all kinda ting.”*

*“But to me, like since I know myself people back home neva got dis type a problem because dey live happy right? People don’, I mean, I mean, I mean people gah dey own, dey own issues but dey never, dey never have people like complainin and like saying dat, yuh know like, I’m depress ... Life goes on home yuh know you survive you know?”*

*“When I was growing up, all what I know about, maybe is de climate, different and I’m pretty sure is de climate has, a lot to do wid it, we never had problems... De only, de only problem we might have, um, is a little fever... So in a sense, wwe lose something and we gain something. Here also we lose something and we gain something. And wha we losin is worse here, we’re losin our health.”*

*“Because yuh pace is so slow [in home country]. Yuh do yuh own pace. Yuh cook whenever yuh feel likes. Yuh don’ have to answer to*

*nobody. Yyyou soup is comin. Is, is so, is like a routine, dat's your life you know dat's all you know. Yuh come ova here... you have a heart attack. You have high blood pressure. You have, just name it."*

One participant made a direct link between a lack of healthy food and some of his health conditions.

*"Yeah because is, you see, here is de different life all together right because first of all de food is different, de, de lifestyle here are different, de culture here are different. Is nuttin like back home. Back home we get everyting fresh. Fr', yuh get life fresh from, from de sea and like greens and vegetables and stuff like dat and, is mek you mo healthy yuh know? Lots a protein yuh know? Here, sh', f', is frozen fish. Everyting is frozen. Is no good right? When I first came dis country I couldn' eat, I couldn eat um, frozen food yuh know? ... Now I have to do it."*

When asked if the outcome of the life events that led him into the mental health system in Canada would have been the same in his country of origin, one participant said simply that it would not have happened there. Another participant responded as follows:

*"You know what? 'E probably woulda work in. 'E woulda work in because um, aaaah, you know your society. You know your lifestyle. You know what's comin next. You know, you know where, where to go, what to do. Something like dat happen here, you need help buddy. You need help big time. You can't get out your apartment. You can't even get to de friggin doctor sometimes. People suffering here. Strugglin. And I don' see de sense in it."*



It is clear in the preceding comments that diagnosed mental health issues are related to illness by these participants, and made distinct from conditions of mental or emotional unwellness as constructed in their culture of origin. This implies some indoctrination into Western mental health ideology.

### **Experiences Affecting Mental Health and Wellness**

As outlined in the literature review, experiences unique to racialized people and immigrants can affect mental health and wellness. These experiences mark the intersection between racialized and mental health recipient identity constructions. This section will explore how Indo-Caribbean Canadian immigrants experience these issues.

#### ***Racism***

The issue of racism was explored and participants confirmed not only its existence but some discussed the emotional impact of dealing with discrimination directly. One participant noted that its presence was felt more after coming to Canada, and another noted how it has progressed throughout his life in Canada.

*“ Oh, I grew up here. So racist... things have changed so much from when I was a kid to now, I remember de school I was in there was only tree of us da' was black in a shool of eight hundred, nine hundred kids so I mean alot of it wasn't even, you know, as far as... wasn't even understood den for, for Caribbean kids whatever, you know? But now, I don't know and I tink now especially wid dis um, nine eleven thing that happened now, now all of us are judged as, you know? Doesn't matter where you're from you know and, the, I don't know, it's just ah,. You know, by everyone from de cops to whoever, you know? ”*

Racism being attached to allocation of employment was expressed by one participant.

*“Well of course because dey look, alot of dem look like oh, it’s um... a burden on dem, because dey say, oh, our tax money, our, you know wha’ a mean? And, I mean I, most of them are doing, most of dem wouldn’t even go take a two dollar an hour job. You know, it, it’s below dem. And I mean yet still dey will complain about those of us dat wanna work whatever dat oh, dey’re taking our jobs.”*

Significant experiences of racism were described from law enforcement. As males, participants may have been disproportionately subject to this particular system of social control. Some participants also commented on being treated unfairly by police in matters of criminal proceedings, such as in cases of domestic violence. They did not directly attribute this to racism, although this experience can be shaped in particular ways when impacted by constructions of gender and race. One participant did talk about being incorrectly categorized as being Muslim. The following comment alluded to labelling, but did not necessarily refer to mental health labels.

*“I have no respect for cops at all. None whatsoever, I mean. Aaah, sometimes you feel as though you’re a second class citizen, you know wha’ a mean? Anybody can call, say whatever about you, you know wha’ a mean? They say, oh, you have citizenship you have equal rights, dat’s bullshit. You know cause still, dey, dey label you, dey say things, whatever... Dey’re supposed to be de bright ones and whatnot. An’ it hurts the most when you have people like dem dat label you.”*

Another participant commented on the difference between the expression of racism in the U.S. versus Canada, noting that it is easier to deal with when out in the open. This alludes to the “new racism” discussed earlier, which is much more

covert, creating a need to generalize the anticipation of the threat of discrimination.

*“Here it’s like, you know wha’ a mean, dey smile at you and still, piss in your face and say no dey’re not doing it; whereas in de States dey tell you right off, “I don’ like you whatever, you know, so you know where you stand. Over here you don’t know.”*

Although many participants identified with Canadian culture, social exclusion due to religion and other types of othering were felt by participants as well. This impacts a sense of belonging.

*“ ‘Cau’ first of all Canadian people don’ really welcome, welcome too much immigrant in dey country. Dey don’ really appreciated you da much. Some of dem is okay, buh some a dem watch yuh different.”*

*“Well see, come to a country like dis hey you know is, is a white man country, you can’ run away from dat. white people, no matta what, dey still one people. But when you come as a, as a negro or as a, or as a Indo-Guy’, diff, different kinda people, dey look at you different you know dey, regardless what you know dey jus’ look at you different somehow or de odda for some reason.”*

*“I could write about my experiences here. I, personally I mean I, this is my home. But it isn’t my home.”*

*“The main thing is, if you don’ like it go back to where you come from. Dat’s, dat’s deir famous words. You don’ like it, go back... and I turn around an’ I say well, where, where did you come from? I say, I turn it around and say my great grandparents came here raped and*

*pillaged, would you treat me, would you say something different to me?"*

*"It's like oh well you should be grateful dat we let you, you know dat's what dey, dat we let you into our country."*

*"We're de same people. Is nah because dem fair da mean I black. Is de same blood. Is just our, our culture are different, our, our skin colour are different"*

One participant noted how this mistreatment is not reciprocated.

*"But when white man come, come in my country dey treat like, like king and queen yuh know? Dey welcome because we get so excited when we see white people in our country, and we treat dem de best dat we could. So why when you come to dey country, why, why dey can't treat we de same? Why dey treat we like we a prisoners you know?"*

One participant commented on being incorrectly designated to a particular racial category. As discussed earlier, this othering of all people of colour as black can be problematic.

*"Dey lump together de others, dey say black, you paki, or so. So dey say you're coolie, uh, you know, coolie, back home dey use coolie. Here dey use black, and black, mostly."*

This racial designation influenced how some participants were treated by law enforcement.

*"Well, first of all dey callin you a bla', a black person, dey call you black and den dey treat you de same way dat dey would treat a black*

*person which is wid, wid, some violence and so on. Which makes, makes for a, a, sort a, a, an attempt to retaliate on de part a de uh, person dat is receivin de treatment."*

Participants were asked to explore racism within service systems. One participant stated that he had not experienced this at all, yet another noted that despite having the same diagnosis, white people do receive better service. On participant spoke of the difficulty in accessing services in Quebec if one did not have a French name, despite speaking French.

In reaction to discrimination, participants discussed their own vigilance in recognition of the imminent threat of racial discrimination.

*"Um, I don' know you dealin wid de public, you gotta pretend dat way. Could be, you don' know who yuh dealin wid, right? "*

*"Police, mental health, I mean dey got different kinda people you know? So you don' know who is who and who is not who, you know?"*

Their reactions also involved different methods of coping.

*"Nobody's gonna tell me nutting. I'm sorry. You know. I h, I, I, I you know I defend my turf. Dat's me."*

*"And, prejudice, is anodda issue ... I deal wid it all de time. And you know what? I had to. And most people have to. And dis is surpressed too."*

When experiencing racist treatment from law enforcement, a sense of powerlessness and resulting coping strategies were revealed.

*“De first ting dey have on de side deir car is to protec’ and serve.  
Who you protecting and serving?”*

*“Dey can say anything and do anything dat they want. An’ you as a  
person how, you cannot, you cannot defend yourself... But it’s just, I  
just had to accept it. Okay it’s a fact, it’s a way of life.”*

Racism, as reviewed in the literature, can adversely affect mental health and well-being, and cause feelings of powerlessness and shame. It can also perpetuate the pathologized constructions of race and mental health. These various stigmas can in turn reduce engagement with formal support services.

### ***Migration and Acculturation***

As reflected in the literature on immigrant mental health, participants’ experiences of migration did shape their definitions of mental health.

*“Mental health, I would say it’s a s’, it’s a struggle of oneself...  
trying to live, you know, understand, trying to live within society and  
it’s... it’s strange rules.”*

It was confirmed also that certain aspects of migration did have an adverse effect on their mental health and wellness.

*“Well yes, well ‘e have alot to do wid it. Because like, living alone,  
bein alone, living alone, cookin, cleanin, and, and lookin for a job,  
you can’t find de right job you know, is kinda hard you know? Is  
kinda hard den sometime you don’ have de money and you know  
sometimes, ‘cau de money de government give you is like just pay  
rent and just little to, to eat you know? Is kinda hard you know? Is,  
who yuh gonna complain to? You just gotta you know?... See when  
you when you have family here it easier for you right? When you  
don’ have family here is hard and, you can feel it, you knows it.”*

Participants noted difficulties with accreditation, in not having out-of-country credentials recognized in Canada. Some also noticed friends and family assimilating into Western culture and the ideal of individualism, creating divisions of inclusion and exclusion.

*“Yes, and even though when people come from my country to come here, dey change... Yeah, dey turn mo, more, dey turn more Canadian dan who livin in Canada... Well probably when dey come dey see, see how people livin here and de lifestyle probably in work, dey workin a little more, like de exchange and de money and so on dey feel like dey’re s, you know, de king a de castle.”*

*“I have one or two friends but dey’re so busy as I told you when dey come. Back home is different, dey live together, dey l, dey lime together. Do everything together. But when yuh come here everybody just, for demself. Everybody pullin and ting, and dey don’, don’ even have time with you.”*

*“But I find say, de Guyanese, de half of dem, which are de kids, dat, dat born here, I think they’re more, on de Canadian side, of doin tings. An’ de parents is dere now is pullin dem back say here, you stay wid my culture here now, because dis is de way I grew up, I don’ wan’ see you go out dere and, slam bam or whatever right? ... And mind you, most a dese parents, doesn’t make sense to me.”*

Reflective of the aforementioned narrative of many Caribbeans of ‘going home’, described by Razack (2003), most participants expressed wanting to return home.

*“Alot of, alot of sugar cane fields around us, rice, we plant rice in de wet season and you do like watermelon and cucumbers and stuff like*

*that. Yeah so it was, it was nice, it was a nice life. I would give up all dis to go back to someting like dat.”*

*“Right now I want to go back home, but I can’t afford it now. But as soon I get money I’ll go back home yuh know so I don’t want to be here. Is hard.”*

Experiences of migration and acculturation can exacerbate mental and emotional unwellness through the difficulty in creating a life in Canada, as well as in negotiating culture, identity, and processes of inclusion, as is evident in some of the preceding comments.

#### **Experiences of mental illness**

A combination of cultural values, life experiences, and service system experiences, as explored thus far; as well as constructions of health, culture, social norms and difference, and much more, have contributed to this section of participant descriptions of their experiences of their mental health difficulties.

One participant reported feeling “uncomfortable”. Others discussed it as follows:

*“I don’t know what direction dey comin from, basically I might have it, I might not have it. You know, I feel de odd times I’m, I’m, I’m down. I tink da’s normal, right? ... So, if you put your ups and your downs and you put it togedder, it, you know, it, you, you, you might able to get some help from it. And, a lot a people can’t do it my dear. You know, dey, dey bring all deyself down. Why dis have to happen to me? Why you askin de question all de time like dat? Okay, ‘e happen, ‘e happen. Move along.”*

*“Not that you don’t decide not to go to work, you just don’t, you just don’t have de energy to get up an’, and do it. Some days, some days you have all de energy, and you can do w’, whatever, you can move*



*Mount Everest. Den odder days you, you, you can ' even move a cup from de coffee table to de kitchen, you know. Alot of people dey don ' understand."*

One participant talked about the effect of his troubles with addictions and mental health on relationships around him.

*"Oh my God I've done dat so much. Burned down bridges and den have to come back and, you know, to rebuild. And I, I tink it all goes back to have an opening mind and accepting what is going on... more with people than services."*

Understanding how Indo-Caribbeans articulate their experiences of mental unwellness is useful in privileging their description of it, but also must be incorporated in the process of construction that facilitates diagnosis.

#### **Identification with "Mental Illness" and Diagnostic labels**

Another significant reflection of participant's constructions around mental health within the guidelines of community, society, and mental health services systems, is their identification with the condition of "mental illness", and with diagnostic labels. When asked whether or not participants' felt that their diagnoses fit for what they were going through, some respondents responded in the affirmative. As well, some readily identified themselves as schizophrenic or having depression or anxiety. In these instances, dominant constructions did not appear problematic:

*"I don 't, like, alot of, yeah, like alot of people, then again window dressing, an ' I tink it's... I tink it's diverting from what... what de problem really is you know? Like for me I have severe depression... and bipolar and whatnot, but yeah, I want to be known a patient dat has. Ha, I don 't want all this colourful thing."*

In other situations, however, the discourses and labels were ill-fitting. One participant adamantly proclaimed that he had no diagnosis or mental health issues, until well into the interview when he mentioned that he has been on medication for years for a diagnosis of depression. The following excerpts from this participant explain his perceptions:

*“I dunno, me brain is nah tellin me certain tings either. Bu’ I’m nah dat, perfect. I migh’, I might have problems here. But dealin wid society. I’m fit to deal wid society. Dis is de difference here right.”*

*“Now, if you goin back to, to depression, now dey diagnose me... And to me, da’s a line a hogwash. Right? Because, I know de difference between two society now right?”*

This participant had been involved with other services systems as well as criminal justice and mental health systems. He did reveal having had some emotional difficulties; however, as is clear from these quotes, he did not equate this with the pathology of depression. This participant talked about recognizing poverty in his country of origin and how people in Canada complain about their lives despite the excess here. He did not complain of particular ailments or emotional difficulties and saw feeling down as part of living, not a pathology as it is labelled in Canada.

### **Treatment**

Following the exploration of unwellness, is that of a process toward wellness. This is addressed through participant constructions of treatment, or addressing mental health issues. This section begins with a summary of participant experiences of “treatment” in their country of origin, followed by experiences of medicalized treatments.

#### ***“Treatments” and Support in Country and Culture of Origin***

In terms of treatments in participants’ country of origin, the minority of participants mentioned institutions called madhouses or asylums, although one

participant did not know of asylums at all. Medications were administered in these medicalized systems, and one participant did mention music being used, but did not specify how. It was also mentioned that people were not put in an institution unless their condition became acute, such as if they tried to commit suicide.

*“Dey gah place fuh mad, uh back home yuh geh mad people yeah, but dey got a place like ‘e got a place you call madhouse... and dey put dem dere...dey put dem in a place where dey can, be mo’ comfortable until dey can recover or someting.”*

Another private facility was also mentioned.

*“There were some, philanthropic uh, Indians dat uh, built some um, houses to, keep dem. De government, because de government dey didn’t exactly do anything to help. So it was just dese philanthropic Indians dat, helped by building some dharamsalas and so on.”*

Outside of these institutions, it seems people were ‘managed’ and cared for by family and community without formal diagnosis.

*“Dey would just uh, keep de person uh, you know to tow de line and so on and so. Not to get too carried away.”*

*“It sucks! Because... dey don’ have a hospital fi it. Okay. Dey don’, dey don’ have a institution fuh dese people. Like okay yuh born da way, dey plunk you home here. You know yuh parents h’, parents know yuh have problems, either dey get rid a you, some parents do, I’m nah sure... fortunately some a dem grow up to be it, and a’, de parents accep’ it. Dey don’ have no facility dat dey could go dey could get help, or whatever. You know so dat’s, dat’s why we been,*

*we been pushed to de wall and stay dere. We have nowhere to go.  
Dese people has nowhere to go."*

The preceding comments reflect the diversity of experience, knowledge and feelings from participants about mental health supports. It also reveals different feelings about the value of formal medicalized treatments and how this has been incorporated into their constructions around mental health and supports.

### ***Medicalized Treatments***

One participant received traditional medicalized treatments from his country of origin and this continued in Canada. This includes medication as the main intervention, as well as involvement in psychiatric-based services. Others have varied time frames and histories of being on medication. Most accepted it as treatment, but had varying levels of endorsement. Some said it improved their health, while others said it made no difference. All participants saw psychiatrists as part of their treatment and had the following comments in evaluating this support.

*"Dere's a doctor dat really helped me alot ... Dat guy, oh my god.  
Dat guy. I don't think even... I don't think I, I don' know. Dat guy,  
dat guy has done alot above and beyond of his duties for me so..."*

*"She did alot of listening and stuff and. She was the one that  
actually got the right kinds meds for me. So sh, she, she was really  
great.... She saw me and den when it came time she turned me loose  
and I was like, I was kinda angry like why you thing, but den I had to  
accept okay dat's as far as dat and I needed to move on and was  
great. And I, I will always, thank her thank her for that."*

*“Well one time I only saw. If I need to you know. I’m nah, I’m not in a, in a regular um, basis. So like if... I don’t know I’m down, or, I have difficulty to deal wid certain tings den, he might have to kick in. Sort of, you know, but basically I can manage right now.”*

Some participants discussed their initial resistance to taking medication but changed their minds when they realized it was useful. One participant mentioned that it helped keep him calm. They also, however, discussed the harm of medication.

*“Sometimes dey have to experiment. Like dey give you a dosage of two hundred and fifty uh, milligrams of something and den, dey would leave you uh, coming t’, coming here uh, um, unable to speak or you know foaming at de mouth or so on, and uh, not, properly controlling your uh, your uh, mental illness.”*

*“I’m still takin medication fuh it. And I en see no changes. I’m still takin it and taking it and takin it and taking it, and, d, d, my life I was functionin at work very well. My job was a really high, high quality job... I was still functionin like a narmal person. And I was takin dese pills and takin dese pills. I don’ know if ‘e catch up wid me. It could be catchin up wid me... Dat medication did damage to me, now dey givin me one to fix da damage. And de cycle is gonna go and go.”*

### ***Other Formal Supports***

Formal supports outside of the hospital and psychiatric systems were explored. Some participants accessed twelve step programs for addictions, the shelter system, community mental health agencies and off-site programs through these agencies (i.e. camping, etc.). Negative experiences of addictions and hostel

services were disclosed, and one participant revealed feeling “bullied” in an addiction service to which he was mandated through the criminal justice system. Participants were not aware of many alternative treatments, and one participant had the following to say about them.

*“I have a cousin that, she, she, she believes in all these natural stuff and whatnot but you know what? I’m not, I, I’m not about to go experiment with none of that. This is working for me and, you know wha’ a’ mean? I mean if drinking mud water every morning would help me I’d do it.”*

When inquiring about the difference between treatments in Canada versus their country of origin, one participant said that medicalized treatments were similar. This participant did say, however, that the medication in Canada is more “advanced”. He also noted that treatments in his home country are not “curative” but in Canada might be “corrective”. Other participants cited that there are more doctors and “options” in Canada.

### **Coping Strategies Accessed by Participants**

Coping strategies accessed by participants in dealing with emotional difficulties and/or mental health issues are important in terms of individual resources, as well as in their reflection of cultural values, and constructions of mental health. These strategies included gambling, escape in the form of travelling, and a few used substances such as drugs or alcohol to cope. One participant talked about his substance use and striving for material success as masking the emotional difficulty he was experiencing. A couple of participants cited substance use as a coping strategy for dealing with emotional difficulty in their culture of origin. Participants also remarked on the ineffectiveness of these strategies for themselves and those around them, alluding to gendered notions of coping.

*“I mean that’s how I end up doing so much travelling you know, not realizing hey you know, no matter where you are or where you go, sooner or later stuff’s gonna catch up wid you. So you’re not getting away from anything.”*

*“And I mean it’s the whole, the whole thing because den the men never say anything so if there is the one out of de hundred dat talks to de wife, the wife don’t know and her response to it is not in kind so he ends up you know drinking or taking out whatever frustration on her. Because she don’t understand or she doesn’t have the knowledge of, how to relate, to a man.”*

### ***Informal Supports***

In terms of informal supports, many mentioned strained or unstable connections with family and friends. One participant talked about how owning a pet has been instrumental in his healing.

*“Well like I say, family’s all pretty much shot. I have... fff... eh... I don’t know it’s... friends not really, but you know having, having [pet’s name] is, because I used to be so shy I wouldn’t talk or it has broken me out of my shell.”*

One participant talked about support from a community of service recipients.

*“And like I say de acceptance, I, you know and you go and dere are odder people. You don’t feel strange because you know you go dere, dere are odder people dat have de same thing that’s going on with me. The same thing going on with them.”*

Other informal coping strategies and supports included Christmas outings arranged by community agencies; socializing and meeting new people; physical

activity such as biking, running, reading, and swimming; praying; sleeping; and watching adult and children's television programs. A discussion of spirituality as a support, often understood, and sometimes stereotyped, as important in racialized and immigrant cultures, revealed a mixture of feelings.

*"Well nah really helping. Is just keepin me um, you know... keeping me... um, keeping me from, behaving uh, violently toward others. Because I hate p, when people tell me dey Christians and as a Christian you must do dis an' do dat, is like look I don' need religion."*

*"Yeah, w', ah, prayin a lot mek I get through in life continue, constantly prayin and askin God fuh wisdom and health and strength and give me ... de grace to carry on every day in life. 'Cause without, without Him yuh can't do nothing yuh know?"*

### **Acceptance**

Acceptance was a theme for most participants, in terms of accepting their 'illness' and present life circumstances.

*"A big part of coping is accepting; accepting of whatever is going on, you know, Try to make the best of it."*

*"If you can accept then understanding comes after but the biggest thing is accepting this is the way how it is."*

*"Well, I think it's acceptance first of my diagnosis and trusting de meds, and being honest wid dem about de meds dey're giving me, like I said, they've given me so much meds in the past I didn't wanna take any more meds, I got fed up. I overdosed a few times, and... like*



*finally now they got the right combination and not every day is good but there are more good days now than there are bar.. bad days, and, because I'm accepting what is, you know, I'm accepting what is, www... you know de diagnosis dey give an', looking to see what is de best, you know, de best for me to do."*

Some participants talked about not questioning what is currently working for them if they are feeling stable. Some of this acceptance was attributed to age and maturity.

*"I aint, I aint questioning it. I'm not gonna question it ... For once, you know I have a, I have a good home. I have my [pet's name] dat loves me very much. You know, so I'm not... Who, who, who am I to question it? I'm just enjoying it. You know, I just thank, thank my god dere are days like this."*

*"I'm to de, to de point now what works hey, you know wha' a mean? Why take it apart, it's working, I don't need to, you know. An' dat's the kind of person I was younger. Everyting I have to take apart to see how it works and... And now, I just accept that okay it works."*

*"When you were younger you know you were, you were bloomin. You know you're, you're fast. Your blood was hot. You know you were doing, superman things. Now you're slow dung. You think about, and, and is, yeah you're very cautioning, tinkin about it. ... So, yuh go accordin to de, how you feel I guess."*

Acceptance was a prevalent narrative for most participants. It was not clear where this principle originated from, and whether it is a cultural value or was an indoctrination from their experiences as a mental health

service recipient. This will be explored further in the discussion chapter of this paper.

### **Evaluation of Mental Health Treatments**

This area looks at participants' evaluation of their treatment. Most endorsed the need for, and usefulness, of "treatment" which mainly meant the use of medicalized interventions. In terms of the value of other formal support, some participants valued the structure offered by agencies they felt were successful supports. Participants valued agency programming such as cooking classes, music groups, and especially the opportunity to have a place to come and socialize or relax. Approachability and support of staff at their respective agencies was also valued. Some, however, felt they were not offered any concrete support or not the kind of support they needed, including access to resources outside of the mental health system such as housing.

Participants responded ambivalently in inquiring about counselling as an option. When asked if other formal supports would have been useful without medication, some participants responded by stating they would need both to ensure success. One participant found the relationship with his doctor to be integral to his healing.

*"Well I think it was a little bit of trust that she is, you know, that, and I coulda, there was just something about her dat I could tell that dis, dis woman wasn't just... a psychiatrist. It, you, I, I just saw some' dat she, she cared. And I could feel it."*

One participant did mention the preference of being able to come and relax at an agency rather than be subject to rigorous medicalized treatments such as medicine, injections, and pills. Some participants had other critiques regarding medicalized treatments.

*"Seeing a psychiatris"? Mm... I don't um... believe in dem a hundred percent. Might sound strange. Um, she, she want to up my*

*medication, I did not, I refuse it and I'm okay still... I'm nah gonna go and see psychiatrist for dem mess my brain up and mess my health up."*

*"I would say medication da's dat's de key of makin you, where you are. Once you in dat stage. Medication either, either help you, but is not gonna heal you."*

One participant talked about his openness to interventions as being the key to his healing.

*"I had a open mind to everyting and I tried everything. If it didn't work, it didn't work. I moved on to de next. And I think had I not done dat, I would still be where I was on day one. You know? So, no, I h', I have an open mind towards ever', dey say try dis, try dat and ... If I didn't like it I'd say no, let's try someting else so."*

Participants reported mostly positive outcomes to the interventions they received. They talked about success in terms of stability, feeling better, and finding employment.

*"Right now I feel great. I feel great 'cause I've seen so much changes in my life, in dis short time and... and, to me, I can see it can only get better."*

*"I was kinda shocked dat you know like even dis morning how I say hi hello to you. Normally, normally I would just look and I'd have a face like, like if were angry."*

Some participants reported better ability to cope with their situations. The also reported feeling less stigma around their mental health issues.

*“I’m out, come out, come out and say okay dis is what’s happening and what’s going on widout feeling an embarrassment or ashame or whatever, ya know?”*

One participant reported getting involved in outreach by going to schools to talk to students about his experiences. A participant did, however, talk about the barriers his police involvement created in getting a job, despite having gone back to school and earning a diploma. Experiences in the mental health system can impact people’s construction of wellness and healing, and can reinforce a sense of inclusion and acceptance by service professionals and the community of service recipients.

### **Evaluation of Canadian System**

The next areas of inquiry with clients were around feedback on their experiences in the Canadian mental health system, and suggestions for improved service in general, as well as in the area of cultural relevance.

### ***Difference in Characterization of Mental Health in Canada versus in Culture of Origin***

Moving toward structural, or institutional, and systemic issues in the construction of mental health in Canada, a summary of participants’ notions of the characterization of mental health in Canada will be useful. One difference was in the acknowledgment and visibility of mental health issues in Canada.

*“Now, we in a different society here, I, I see, different tings. I see help for dese people. Dey go into a facility and work... Dey’re not being put down.”*

*“In Guyana it, yyyou took it ahm... you took it, like, dey’re a second class citizens sort of... I tink it’s on average here because, is not a easy world over here.”*

*“I really can't complain 'cause dey're still acknowledging this is going on.”*

*“There's alot, alot of work still, still ahead to be done because I mean growing up here in the seventies there was nothing and wha... no... ya know wha' a mean? Whereas now dey're, dey're looking into it and you have people like yourself, and I mean if people like yourself are doing research which means there's a little bit of hope.”*

Participants also explored the issue of stigma around mental health issues in Canada, including the effects of being labelled with a diagnosed mental illness, which yielded mixed reviews.

*“I don't think there really is a stigma here, okay dis is what's going on, okay dis is, ya know, what you can do. Go here or go dere. So I, I t', I tink, I tink it's quite healthy.”*

*“Well in Guyana dey, not really ostracized. Dey ostracized but, de, dey, dere is a scope for dem to heal; whereas here [Canada] dey' t', up, up to a few years ago dey were ostracized... dey have all dese uh, names for uh, psychia', for psychiatric illnesses dat uh, dey lump dem as uh, what to do you call it, uh schizophrenic um, uh, paranoid schizophrenic ... Well it, doesn't exactly make them uh, vicious or so but uh, it keeps dem in a compartment uh, isolated from de general population.”*

*“It's just dat if, if you can, if you can uh, avoid making yourself a nuisance den uh, you're free to, you know, hold on to de fact that you might be uh, schizophrenic or bipolar or so on.”*

Participants endorsed the fact that mental health difficulties were acknowledged in Canada, and connected it to reduced stigma, while still recognizing the global stigma of mental illness. Differences between Canada and participants' country of origin can affect mental health services recipients' constructions of ethnicity and culture, and ultimately race, and how they internalize the value of this.

### ***Ethno-racial Mental Health Services***

Participants were asked to explore their experience and/ or opinion of ethno-racial services in terms of their effectiveness and cultural relevance. Reported benefits of these services included support in different languages, seeing their own culture represented by workers, having recreational activities planned that are familiar pastimes (i.e. forming a cricket team) and knowing "how to treat people". Issue of racism and social exclusion in services were also explored.

*"Well, you can come and, everything dat we're experiencing here as all as minorities, whereas a white would say, if you don' first ting, well if you don' like it why don't you go back where you came from."*

*"Well, dey, dey, dey're able to, you, you're able to uh, relate to de persons ... whereas if you go to a white uh, agency, dey would treat you as a, you know, outsider or so."*

One participant mentioned the benefit of addressing the issue of race at an ethno-specific agency.

*"So like, you come here dey meet everybody togedder so we does have meetin about racialism, how to, how to be one you know? How to, unite as one people. And it lookin at difference of racism, religion, stuff like dat, we got to put dat aside and come together and be, be like, be like one people."*

One participant discussed the benefit of being able to be included in a group with shared values.

*“That’s what I wanna know. What can I do? How can I, improve myself. I don’ wanna, every, every whatever go to get a bloody welfare ch’, you know wha’ a’ mean? Whereas I tink a’, people of colour, dey come an’ dey see opportunities but dey don’t know how to, to get to it, or dey don’t know how to express demselves so, whatever. An’ I tink it’s places like dis is great where you can sit down as a group an’, you can share dese different things.”*

*“There should be a place for, just minorities alone... Because more minorities, we’re not interested in sittin’ down an’ just having a free meal and what’. We need a place where we can go, we can do tings, we can learn. Further ourselves. We just don’t wanna be like stagnant water.”*

One participant noted the benefit of ethno-racial services in combating the colonial racial tensions amongst West Indians, due to the ability to form alliances between Indo- and Afro-Caribbean people based on commonalities instead of focusing on difference.

Ethno-racial agencies not only cater to specific issues and needs, but are integral in the construction of racialized mental health service recipient identity.

### **Creating Cultural Relevance**

#### ***Direct Inquiry***

An area of exploration with participants was the notion of opening up an opportunity for construction of knowledge around racial and ethnic identification within the service relationship. Participants stated that they were not often asked about cultural issues, although it has happened on occasion. When asked about the

value of workers doing so, it was revealed that who was asking and at what point in their lives and journey of healing, would have elicited different responses.

*“I suppose it, it couldn't have hurt [to be asked], but den, at de same time being where my mind was, maybe I would have taken it, de wrong way so... you know, so maybe at de time it wasn't um... you know, de, good for me... 'Cause you know sometime yuh so deep into your crap that, you know, simple innocent question you just blow it out of proportion.”*

*“You know at my stage, at my level, I don't think it matter. Even if dey do ask me, maybe somebody else but not me.”*

When asked if the race of the worker inquiring about their culture would impact their reaction, one participant had equal concerns over being asked questions by both white or black workers but did not specify ethno-cultural background. Some participants, however, endorsed this space for inquiry.

*“Peop, people ask you question right? So is up to you to give dem de response or not. So like you know people come and dey ask me I give dem de answer you know? I'd be honest with them.”*

*“Well it's kinda helpful to me because as I said dey know, dey know, who I am right? So it, it make it mo' easier for me, and it make it mo' easier for them too, so they can co-operate with me, co-operate with them... Yeah and I know who they are you know?”*

*“No, they just ask you because they want to know, where yuh from, wha's yuh background, wha's your religion so dey can know how to deal wid you.”*



While some participants looked at this inquiry about their ethnicity as an opportunity for some empowerment and autonomy, others spoke of it as a space for workers to categorize and place them, as opposed to having an opportunity to construct their own identity.

### ***Having a Worker of Similar Background***

The literature has revealed that ethno-specific services and/ or having workers of a similar background is somewhat successful in engaging service recipients. Some participants agreed that it would be of benefit.

*Well it's like you gonna make curry chicken or someting an' we're all here and you got a white person what does a white person know about it?*

*I'm going around in circles wid dese, wid dese, you know dey different culture. Dey don' know you... Dey don' know your background. They don' know like, how tings a function in your life and dey counselin you. Come on, gimme a break here!*

Some participants stated that having a worker of a similar background did not matter, or that once the service provider was “qualified”, cultural background was not relevant. Another participant talked about a different concern with dealing with a cultural insider.

*“I see a psychology. Again I didn' learn nothing from him. Took my money. And guess who, was who?... My back neighba in [country of origin]... de guy didn' do much because um, he knows me and me know him. And he took me money and run. Because, when I go in 'e office, we talkin pure nonsense. You know, we're back neighbours.”*

This principle of employing workers of colour is often used indiscriminately without recognition of issues of colonial tensions or internalized racism, or, as in the literature, issues of confidentiality. These issues can affect the process of construction of the racialized mental health service recipient.

### **Power**

Power structures can significantly shape construction of identity (i.e. in terms of race, ethnicity and mental health, etc.) in terms of what constructions are privileged and sanctioned and which are discouraged by social exclusion.

#### ***Power of Professional in System***

An underlying issue in the provision of service is that of power. These power structures are embedded within the mental health system through its positivist theoretical and value-based underpinnings. Most service recipients have been indoctrinated into this belief system through its systemic hegemony and pervasiveness, but even moreso when inducted into the mental health system as a “consumer”. Some participants recognized the level of formal education as being indicative of qualification, and some comments reflected ingrained deference to authority.

*“I have to be understanding that these people are the professionals and they know, so I... I try not to insis' on my idea, have a, no what's the word I should say? I try to have a open mind.”*

One participant described an allegedly legally binding rule in his country of origin that one was not able to change doctors. This participant also stated that when he told his doctor that he did not like the medication he was on, he was ignored, and the treatment continued.

In Canada, some participants talked about being mandated to services through the court system, or having service withdrawn if they were not compliant with medication. The following reactions to this gentle coercion were revealed.

*“While I was dumping his medication dat he gave me. It was only when dey start giving me uh, you know like, telling me dat uh, I had to take medication and so on. Den I said okay, I take ‘em. Because I didn’, I didn’ tell dem dat I was dumping, eventually I told dem maybe but dey said keep ‘em, keep on using de medication.”*

*“And even with this, the, the, the psychiatrist that I brought up all that. I told her I didn’t wanna take no meds, I don’t want no more meds no more an’ I was really upset. Uh, and she, she said okay, ‘try this, try this, try this for six months, try for’. And it’s going on about... two years now. And I feel... I feel good... she said try, you know what’s wrong with giving somebody a chance, or giving something a chance?... Because I was, I was really closed. I didn’t want nothing. I was f’ dis, f’ dat’. I gave it a cha’, uh, you know life is, life iss good.”*

In terms of participants challenging doctors in Canada, compliance seemed to be encouraged, with consequences for non-compliance implied but not explicitly enforced; although service recipients often had the option to negotiate which medication they needed to be on.

*“It went alright. It was like ‘okay if you don’ want to do dat we can do dis, you know, and I, I always, I never burned down any bridge for say, I tried to have different options. Ya know? What are, what are my options?’”*

*“And you know, alot of people dey respec’ you too if you say no you don’t wan’ dis you don’t wan’ that ‘cause you know it’s just not a... puppet or whatever dat’s just following blindly. Dat you are,*

*seriously making an attempt to, whatever your situation, to you know, remedy it.”*

*“But in de past de meds wasn’t working whatnot so I said to a doctor and he changed me. Th’, that’s how I always got changed to different meds ‘cause I said it’s not working, this is what happening, okay so let’s try dis.”*

Whether a collaborative or directive relationship, participants clearly acknowledged the power that doctors play in their lives as mental health service recipients.

*“I notice dat, dat de docta have a lot to do in your life, in, in, dis society. Okay. Like he basically direc’in your life.”*

*“If not de psychiatris, is doctor you know you’re lookin at dese guys in dere, dey, dey don’ even have no clue wha medication dey de pun. And dey nah even have wha is it for? Is it gonna get dem better? Is it gonna kkeep dem stable? Wha de psychiatris said give dem, give dem. What de psychiatris say change, change. And, dey life is going back and forth, come on. I see it. I, you know like, is a big money makin. I’m sorry I have to tell you dis. If you in health care, you’ll know.”*

The preceding comments reveal a gently coercive process of indoctrination into medicalized systems of treatment, while offering some semblance of power sharing through the ability to contest the type of medicalized treatment they can receive. One participant noted that this sense of autonomy is endorsed by the system on the condition that their choices reflect that service recipients are genuinely interested in recovery, as it is defined by the service system.

### ***Participant Value on Indigenous Knowledge/ Beliefs***

Following the exploration of power and hegemonic belief systems, is the examination of value placed on indigenous epistemology.

*“You know, in Guyana when I was growing up, I hear a lot a nonsense. No, I hear a lot a stories, now it become nonsense... You know dey believe in, in, in certain voodoo, business, like, ghosts... I don’ know if you got a sayin’ dat um, if you heard de sayin’ people used to say oh, she do dat guy someting ... I’m trying to find de someting out and nobody cannot explain to me, de word something.”*

*“Because as you grow older you educate yourself, you do certain tings. As you go by, But is dose, dose, dose, kinda age, you know, you believe what your, your parents does sayin... dese all, dese ol’ head very hard to change”*

*“I mean we’re, alot of us are illiterate farmers. What do, wha do dey know.”*

How participants articulated their comments in this area reflected their indoctrination into the hegemony of positivist Western knowledge systems, indicative of internalized racism.

### **Suggestions to Create Cultural Relevance**

#### ***Education***

Participants were asked for feedback on what they thought would be necessary, in terms of cultural relevance, to effectively engage service recipients. Education was cited as a useful tool.

*“Is, is better educate dese people than to give dem medication. I believe in it very much ... Educate dese people about, about*

*depression ... Well, educate dem in school. Da should be, da should be, de number one priority."*

### ***Informing Workers of Cultural Values***

Participants were asked to explore how best to accumulate or construct culturally based knowledge with and from the service recipient, and what would be important for workers to know. Some participants said reading and education. Other responses clearly reflect gender role expectations, such as men not talking about emotions.

*"I would say the biggest thing, especially come from a person of Indian background is to talk about your feelings. How you feel. Indian people dey never, and a, dat's, mmmmy last relationship da' was de biggest breakup. I never talk about how I feel ... I mean you talk to the person and tell em', dere is no shame in talking about your feeling because there's always that thing dat men don't, ya' know? That men don't talk whatever, oh whatever botherin' go have a drink and da will settle it.*

*"Well I tink dey need to beee first of all educated by... someone who does know.. You know wha' a mean. It's like, like a mechanic, not necessa', he just don't put him to work on a car and he don't know a foreign car or whatever... I don't think by a person having dat paper dat that... that makes dem qualified."*

### ***Participant Suggestions or Principles for Relevant Service***

Participants listed some general requirements for engaging ethno-racial service recipients, such as "background experience", "genuine caring", having more "God inspired persons" as psychiatrists, as well as the following:

*“You need places where you can go and where you can voice, you can voice your... de way you feel and thing, you know if you don’t feel good, I don’t feel good today I don’t. You can express things and if it’s right, if it’s right, and if it’s wrong, somebody else can say ‘hey dat’s not de right way of tinkin’ or you know, and I, I, and I like dat.”*

*“You know what, you treat everybody de same. And, and dat’s something yuh gon have to live with. It nah gonna happen. You know, and, and, if we start from dat, you know you might see a lot a changes.”*

One participant talked about needing to feel the potential for self-actualization.

*“ You must have odderwise, odderwise you ’rrrre, you’re worse dan a dandelion. At least a dandelion looks pretty, you know wha’ a’ mean, you ’rrre just a, you’re just a shrub dat is of no use, dat doesn’t really particularly matter. You’re expendable, an’ I, I tink dat’s kinda sad for a human being to be, I tink all of us have something to give. But it’s knowing what, you know? ‘Cause I question myself for years what de hell am I put here for? What, you know? And now I can see myself making little changes here and dere an’ it’s, it’s okay.”*

### ***Power Sharing***

Lastly, participants talked about dialogue between service providers and service recipients. This has the potential to address power imbalances.

*“Um, is to, is to meet people needs and to try to talk to people more, and try to ask them wha dey opinion, wha dey like to do, and what you know, and tings like dat.”*

*“Call your doctor and den, they can talk to you and you can, you can communicate, you can share your like, share your opinion, I can share mine, and, and tings like dat.”*

*“Because I ask question too. I, I mean, I don't ask them, like, bad question like you know? I just ask them like, where you from, what's your background, wha's your religion, and they tell me yuh know?... Because you get to know that person better you know?”*

This section has summarized participants' reflections on issues of ethnic and mental health identity, the forces that have impacted these constructions, and their experiences and recommendations for mental health services. The next chapter will explore the themes that have surfaced from these responses further.



## **V. DISCUSSION & CONCLUSION**

This discussion of participant interviews involves a complex process of analysis, due to the many intersecting points of identity constructions, systems of power and marginalization, and research process issues. In order to thoroughly examine these points of analysis, this chapter will begin with an exploration of methodological issues and tensions inherent in this research, followed by an exploration of findings in participant responses framed within a systemic analysis, and ending with implications from this research.

### **Methodological Issues**

This research project, although fraught with tensions, dilemmas of conscience and challenges, was just as valuable for its process as for its outcome. Beginning this discussion with issues and processing of methodology follows its theoretical underpinnings in positioning myself as a researcher, and documents a parallel process of self-reflection in the research that contextualizes the analysis of the findings. This can lead to implications of this research, not only for this topic, but also for the research process.

### ***Researcher positioning***

In its critique of positivist methods of inquiry, feminism requires that the researcher make transparent, their positioning and issues of social location in the research in order to understand how their standpoint, race, class, gender, and culture shape the research and its interpretation (O'Mahoney & Donnelly, 2010). "Highlighting positionality allows the researcher to be aware of his or her own subjective experience in relation to that of the participants, and is key to acknowledging the limits of objectivity" (Deutsch, 2004, as cited in O'Mahoney & Donnelly, 2010, p. 442). It is hoped, in research in general as well as in this study, that this process offers some accountability and insight into the dynamics of construction of identity and experience in research.

### ***Insider/ Outsider status***

The emic perspective is that of an “insider” who is assumed to be more subjective and informed; and etic is the position of “outsider” who does not belong to the group in question, implying objectivity and distance (Kanuha, 2000; LaSala, 2003). Hill Collins (2008) defines insiders as those who have “gone through similar experiences, possess a common history, and share taken-for-granted knowledge” and can have similar worldviews (p. 109). In this research project, I disclosed to participants that I identify similarly to them ethnically as an Indo-Caribbean, thereby attempting to solidify some semblance of an insider identity.

In exploring the risks and benefits of ‘insider’ research, Boushel (2000) explains that for black participants, having a black researcher can make the explication of issues such as racism easier, but that if the experience is one that the participant feels is “just ordinary”, it may not matter (p. 81). Benefits include that qualitative researchers working from an emic perspective may have an extra understanding of importance or meaning in certain disclosures or perspectives, and may have access to the population and their whereabouts. They may, however, fail to notice things about the participants if common knowledge is taken for granted, be biased in emphasizing this emic perspective, or either researcher or participant could have an emotional reaction to the other (LaSala, 2003). Also, participants who identify similarly to the researcher can be concerned with issues of confidentiality within the community (Boushel, 2000). Kanuha (2000), in her exploration of native research, frames the insider researcher as subject and object of the research, walking the margins. She notes that one is differently invested as an insider in that a process of self-reflection takes place that can be distracting. She also discusses the fact that although the type of information gathered as an insider can be richer, she cautions against taking this position as truth. Lastly, she recognized some flexibility in the strict researcher subject boundaries in attending dinner with one of her participants as part of a cultural tradition in which she was expected to partake. Kanuha (2000) and

Razack (2003) talk about the dangers of overidentification with participants in which one is assumed to share a common identity; and Kanuha (2000) also notes that transference toward the researcher can be fuelled by issues of internalized racism. For example, a participant might assign less credibility to an insider researcher, consistent with hegemonic ideals that devalue indigenous epistemologies. In this study, this transference may have been countered by my class status as an academic and someone with a Canadian accent whose first ‘language’ was not a creolized dialect.

It is important not to essentialize insider or outsider roles (Williams, 2001), which can be multi-dimensional and confounding. Boushel’s (2000) concept of experiential affinity recognizes the common experience between researcher and participant, as opposed to simply a common culture, which can be essentialist. The concept of relational positionality describes this idea that the debate on power and position can often become mired in static binaries such as white and non-white, ignoring the fact that people have multiple dimensions of identity and statuses that shift with their changing contexts and relationships (Abrums & Leppa, 2001). The connection of these two concepts results in the hope that by recognizing this multiplicity and intersection of identity and oppression, we can form some common ground upon which to work with each other instead of simply focusing on difference (Abrums & Leppa, 2001). A critique of this “common ground” concept is that it can obscure particular oppressions behind others (Abrums & Leppa, 2001). It can also create different points of inclusion as an insider and exclusion as an outsider. One drawback might be that researchers connect only with the points of identity of the participant that are most salient to us as researchers. In this research, it was our common experience of oppression that created a useful, yet at times blinding, investment in the study, as well as the surfacing of experiences of racism of the participants that may have been more valuable for me than them.

#### *Gender Differences*

One point of difference in this study was my identity as a female researcher working with all male participants. Addis and Cohane (2005) explore men's mental health through the lens of particular theoretical frameworks. A feminist analysis proposes that men, despite holding positions of power, feel subjectively disempowered, due to the following: being unaware of their own privilege, the fact that there are great emotional costs to maintaining power, and the fact that men's social location can create both privilege and disadvantage (i.e. due to racialization). This analysis also suggests that men negotiate help-seeking for mental health issues in a manner so as not to seem powerless or subordinate. Social constructionist theory proposes a "view of individuals as active agents who construct particular meanings of masculinity in particular social contexts" (Addis & Cohane, 2005, p. 639). This may have had some impact on how participants negotiated their interaction with me in terms of having to reinforce their masculinity in particular ways. Also, Razack (2003) talks about the tokenism that comes with being a female researcher of colour representing their ethnic category in the world of academia, where one can get caught up in the power of this role within this institution. This power affords one a particular voice that can eclipse that of participants.

### ***Researcher construction of participants' identity and experience***

What Wong (2002) refers to as "postcolonial epistemology of location" (p. 72) builds on positionality, which looks at the power held in researchers' and workers' social locations in relation to that of the participant and service recipient, as well as how this power imbalance manifests in representing these subjects' experiences. Researchers construct meaning in their representation of participants (O' Mahoney & Donnelly, 2010). Stories get filtered through the lens of the researcher (Abrums & Leppa, 2001; Gray, 2007). From a postcolonial perspective, interpreting participant narratives in a process that does not involve them can re-colonize them (Dei, 2005). Also, "researchers can reproduce the colonizing discourse of 'Other' when their interpretive contributions go unnamed

in ‘data’ purported to ‘speak for itself’ ” (Fine, 1994, as cited in Gray, 2007, p. 415). The colonizer-colonized relationship can be created as aggressive-passive, leader-follower, and dominant-submissive, and it is important to avoid recreating this relationship by addressing the colonial behaviour of deference to authority (Razack, 2003), and positioning the researcher. How we construct participants also can become another tool of colonization if used to paint them as subordinated subjects or minimize the totality of their identities.

A caution in this type of research that could potentially facilitate this colonization, is that of homogenizing culture and its expression, when building information on cultural beliefs, practices, and meanings, especially if there is little existing information on a particular group. This can happen when voice is taken as a stable universal truth (Gray, 2007), and reflects the positivist tendency to create finite categories. Being an ‘insider’ in this research, I had a particular investment in authentically representing ‘my’ participants and my ethnic group, who are often misrepresented in negative ways. I realized through the process of writing, the protectiveness I felt over how they were represented. This consideration of representation fuelled my approach to language as discussed in the methodology section, and how to write participant quotes. It is necessary to recognize how that voice is received by the listener, how and by whom it is taken up, and how it is placed in dominant systems where it can be appropriated by the very forces that rendered them silent in the beginning (Gray, 2007).

“As researchers constantly construct their own identities through social interactions with research subjects, we must be cautious of how we ‘construct our notion of others’ ” (Dei, 2005, p.7). One of the challenges of this research project has been the attempt to create a space to fully explore aspects of ethnic, racialized, and mental health service recipient identity and their interaction, with the recognition that doing so, essentializes identity in a paradoxical manner that conflicts with the study’s theoretical frameworks. In Gray’s (2007) study on the voices of female mental health service recipients, identifying as female and a

mental health service recipient assumed a common life experience and experience of oppression, which centralized their identity around these points of social location; however, the researchers note this may not be the most salient point of identity for them. Sinding, Barnoff, Grassau, Odette, and McGillicuddy (2009), writing on the experience of lesbians with breast cancer, noted that many participants did not make connections between lesbian identity and experiences of cancer. The realization of their erroneous assumption that the experience would necessarily be uniquely defined within these categories, lead them to move toward a recognition of the diversity of experience and narratives. It is important to recognize multiple identities shaped by a myriad of influences, as well as diversity within a chosen identity (Fernando 2010). Equally important is the avoidance of the essentialization of oppressions and creating hierarchies of oppressions (Abrums & Leppa, 2001; Yakushko, Davidson, & Nutt Williams, 2009). With this caution in mind, however, this multiplicity does not preclude people from having a common cause, as it is important not to deny the commonalities in human experiences that are shaped by larger global and historical forces (Dei, 2005; Keddel, 2009). It is this commonality of experience as an Indo-Caribbean Canadian and a mental health service recipient that was the focus of this study, and the points of identity that were being explored.

In answer to this dilemma in this research project, strategic essentialism, which is to feature one identity or oppression for political purposes (Razack, 1998, as cited in Sinding et. al., 2009), was employed, so as to highlight and fully examine the impact of ethnicity and race, and its interaction with mental health conception. One of the issues with strategic essentialism is the creation of binaries of oppression and identity. This can include talking about Westernized medical-based mental health systems versus alternatives as though they were bound by geography when it is clear that the imperialist endeavour has transported these ideals and systems abroad. Another impact of these binaries can include white people not having to be defined in terms of race or culture, which

then perpetuates othering of people of colour (Fernando, 2010). Despite these concerns, it was important to be able to examine particular points of identity. Doing this facilitated the examination of a particular process of construction and looking at social positioning, which “refers to the discursive practice of assigning, individuals or groups of individuals to particular positions in relation to others ... with particular power relations and conditions” (Tsang, 2001, p. 235). The path and outcome of a process of social construction results from the interaction between the constructors (Ryen, 2008), in this case myself as the researcher, and the participants. In this scenario, I represented a common aspect of ethnicity, but also the voice of dominant discourse and privilege as a Canadian born academic.

### *Self-reflection*

My process of self-reflection through this research, as noted in the principles of the critical theoretical frameworks referenced, was both confounding and exciting in confronting some of my strongly held beliefs about oppression and participants’ experiences, which was directly related to my own, seemingly similar experiences. This was facilitated by a reciprocal process of construction and dialogue with people and the material. In this process I realized that I assumed that most racialized people, identifying as I do, have a narrative around an experience of racism, and had some awareness of systemic factors in this, leading me to the paternalistic reflections about whether or not this group understands their oppression. This idea of consciousness-raising is debated in the literature. Razack (2003) notes that while issues of history and migration may not be salient for Caribbean service recipients, it is up to workers to “be able to view how these legacies are ineluctably wrapped around the body of the Caribbean Canadian” (p. 342). Keddell (2009) states that awareness of oppressive discourses is necessary to foster resistance. While this is true and useful, it is important to respect people’s narratives and constructions of their own experiences, and in research, make certain that this is represented.

In conducting this research, I was made more aware of the salience of my ethnic identity and experiences that result from this identification. I engaged in a parallel process to the research, of challenging my identity and in-betweenness being a Canadian born Indo-Caribbean with a diasporic herstory. I also confronted my own issues of inclusion. This involved, taking into consideration my power as a researcher, how my membership in this ethnic group was determined by the participants and impacted by other aspects of my identity (i.e. being born in Canada). There was a process of reflection on where I placed myself and where I was placed by the participant, as well as how these influences, along with many others, shaped the construction of identity and experience. My own process of identification may have aided in the surfacing of a richer analysis or inquiry for participants, but may also have disproportionately emphasized parts of their experience that were not as important to them. One strategy to address this would have been to ask them how they might have positioned me in relation to their ethnic identification, and more direct inquiry as to the importance of their identities as racialized mental health service recipients and experiences of racism, to them. I did feel, however, as though the common identification yielded an increased understanding of cultural values and descriptions of living for participants.

### **Systemic analysis and Participant Narratives**

The purpose of beginning this discussion chapter with methodological issues was to contextualize my analysis of the participant interviews. The literature review explored the topic of ethno-racial mental health from a critical perspective seeking, as informed by the underlying theoretical frameworks, to create a space for marginalized and alternate discourses. Informed by this standpoint, the literature review, and observations through my practice experience, much of the participant interviews were guided to focus on tensions and differences between participants' constructions of race, ethnicity and mental health in Westernized mental health systems, and culture of origin. Following



this method of inquiry, some common threads were revealed that captured the path of these tensions and constructions of meanings.

This section begins with a systemic analysis that combines the critical literature review with a framing of the participants' interviews, and allows these narratives to be explored within the theoretical frameworks that underpin this research. This analysis is rooted in my own understanding of how oppressions are institutionalized, and how this affects constructions of identity. This pathway can be illustrated as follows: when racism becomes institutionalized (for instance, in mental health or law enforcement services), it is reified in the operation of these institutions. Through discriminatory and coercive practices, or reinforcement of assimilation into dominant ideologies, these institutions can become agents of social control, which then re-colonize these subjects as mental health service recipients, in a process of standardization of behaviour as an expectation for membership. Both the racialized being and the mental health service recipient are othered and pathologized in this process. For the racialized mental health service recipient, these pathologized identities intersect, heightening exclusion.

The response of service recipients to this colonization can be further rebellion and deviance, or assimilation and acceptance of these external constructions of identity that may or may not fit. There is also a parallel journey of the intersections of the processes of construction of identity along with this voyage. In exploring this analysis further, this section of the paper will begin by briefly expanding on the examination of race and power from the literature review section, and considering this dynamic in relation to participants' comments.

### ***Systemic Racism in Mental Health***

The first step in the systemic analysis mentioned above is that of racism becoming institutionalized, in this case, within the mental health system. This process is outlined in the literature review section of the paper. This analysis is in line with anti-racist practice, which looks at how institutions reinforce racial, class, gender, and other inequities present in society, focuses on construction of

identity, and implies that the effects of the construction of race cannot be fully understood (Maiter, 2009). Also, as outlined by Fernando (2010) the practices and policies of systems and institutions are based on value systems of those developing and operating them; therefore the mental health systems, having been created within a racist Eurocentric value base, can then be racist. This racism can be perpetuated by individual practitioners who operate from similar, conscious or unconscious, value systems thereby guiding processes such as assessment and diagnosis (Fernando, 2010). It is then supported by social and political systems that have a similar value-base or interest.

In terms of findings in the area of racism, current research was confirmed in that participants acknowledged its existence, and surfaced themes of exclusion and powerlessness. Also confirmed were the adverse effects of racism on mental health. Many of the participants seemed to conceptualize racism as individual acts of discrimination. Hernandez, Carranza, and Almeida (2010) describe this as racial microaggressions which are “brief, everyday exchanges that send denigrating messages to people of colour because they belong to a racial minority group” (p. 203). While direct instances of racial discrimination within mental health service provision were not found, as previous analysis has explored, the insidious infiltration of institutional, unconscious, and new racism can have indirect effects on people, and in subtle ways reinforce the diasporic history of exclusion. Picking up on the aforementioned debate regarding consciousness-raising of service recipients, it is possible that the success of systemic and institutional racism is due to its ability to remain concealed, which is why participants more easily identify racism in these microaggressions instead of the larger systemic or structural forces. This can be explored further with participants by creating an open space that raises these issues within the process of construction with service recipients.

### ***Power and Social Control in Western Mental Health***

A review of power and issues of social control in mental health is presented in the literature review. Following the second step of the systemic analysis outlined previously, systems of social control like mental health services enforce societal expectations and guidelines around behaviour.

All the participants in this study were male. Gender, race, and ethnicity will have an impact on their experiences. Findings in this study confirmed current literature in that for most men of colour, points of entry are often not directly into mental health services, but instead through alternate systems of social control such as criminal justice, as well as addictions and hostel systems. Many participants had experiences with police, having been involved in the criminal justice system. Addis and Cohane (2005) offer an examination of men's mental health, and found that research has shown that "men are almost twice as likely as women to suffer from substance abuse or dependence, and three to five more times as likely to commit suicide" (p. 634). Women are much more likely than men to meet DSM-IV criteria for mood and anxiety disorders. Masculine gender socialization has been linked to increased risk for mental health problems and reluctance to seek treatment, a fact made more concrete by research that confirms that men generally underutilize all health services (Addis & Cohane, 2005). For these reasons, and that of racist practices in mental health systems, pathways into the mental health system through means of coercion seem inevitable.

Nicki (2001) reflects on literature that has discussed the use of the construct of "mental illness" as a means of social control using the mind as the mechanism of oppression. This is done to support the status quo and the oppression of groups based on gender, class, race, sexuality, and ability. Ironically, "the use of the term 'mental illness' to denounce deviant behaviour and problematize women and other oppressed groups is at odds with the term's use to validate medically certain instances of difficulties in social adaption as aspects of legitimate illnesses" (Nicki, 2001, p. 83).

Also noted in the literature review is the legacy of the diasporic identity in the narrative of being tricked and betrayed and, for Indo-Caribbeans, the coercive process of indentureship. Police and mental health systems of social control, whether overtly forceful or insidiously pervasive, can reinforce this problematic narrative for Indo-Caribbean service recipients. Most participants had some experience with police and were particularly incited by racism they experienced by a form of authority that they felt powerless to challenge. Many felt they had been treated unfairly by the criminal justice system as a whole.

#### *A Response to Re-Colonization: Assimilation versus Resistance*

The Oxford dictionary defines colonialism as the practice of acquiring control of another country, occupying it with settlers, and exploiting it economically (Soanes, 2001). Colonization is structured around power imbalances, where “first world theories are applied to third world people” (Harrison, 2007, p. 80). Historically it is marked by the effort to civilize the colonized by instituting colonizer values and “fully maintaining the conditions of their rule” (Razack, 2003, p. 350.) The mental health system, through its systems of classification, much like the finite classifications of race and ethnicity, perpetuates colonization, or re-colonization of racialized service recipients. Psychiatric imperialism, a tool of colonization around the world (aiding in the indoctrination of colonized subjects into Western cultural epistemologies and practices around mental health), continues to affect racialized service recipients in their migration to the West.

Following the systemic analysis described earlier, institutionalized racism is used as a value-base with which to reinforce expectations of behaviour of normalcy and compliance, that are perpetuated within mental health systems. It also reinforces the othering that is endemic to diasporic identity, which, as outlined in the literature review, involves patterns of exile and displacement.

In addition – and especially salient to the analysis that follows – colonization is implicated in the idea of hybridity, and the transformation or re-

constitution that is constantly required when negotiating any conflict between one's culture and external social, political, and historical forces that might impact it. This tension of negotiation of identity, through epistemologies and cultural values, is where the next step of my systemic analysis lies. The next section will explore this idea that participants' responses can take the form of assimilation or resistance. Participants' narratives revealed the presence of this tension at times, and at times, there was none where it was expected.

### ***Ethnic and Cultural Identification***

Findings: In the area of ethnic and cultural identification, there was a reflection of diversity within this ethno-cultural categorization in terms of religion and ways of identifying, but also adherence to cultural customs and values. Participants first identified culturally more with their place of birth instead of Canada, but did identify to a certain degree with both. This was consistent with notions of transnational identity of both diasporic and immigrant peoples. For some, racism affected claiming of their ethno-cultural identity. Participants did not talk about their racial or ethno-cultural identity as the most salient part of their identification but did respond to inquiry around how issues of race impacted their life experiences and feelings of exclusion.

All participants positioned themselves in dichotomous positions opposite white people and Canadians, which did not in itself reflect a source of stress, but rather a negotiation of identity due to racism and acculturation. Adopting labels of "immigrant" and being categorized as black, despite not sharing ethnic or some historical origins, meant accepting their status as "other" in a way that created an exclusion in which they were comfortable. Some of this ease of identification may be because I identified similarly ethno-culturally, so in this respect was an insider. There was an acknowledgment of the diversity within the ethnic classification of Indo-Caribbean, and the difficulty in negotiating this with outside assumptions of homogeneity.

This constant negotiation of identity can be seen as an identity crisis, which in an othered group is usually attributed to problems within that group instead of to the social and political forces to which they are subject (Fernando, 2010). This perpetuates pathology. Tsang (2001) notes that people with similar ethnic backgrounds can internalize cultural practices and beliefs differently, due to the aforementioned influences or level of acculturation. Identity adaptiveness may also be a practice of this group, where individuals shift the salience of their social identity in response to their environment (Yakusho et. al., 2009).

#### *Cultural Values*

Findings: Although distinctions were made between mixed ethnicity (Creole) cultural values and Indo-Caribbean values, overall a distinction was made between West Indian and Canadian ideals. The main difference was a sense of community in their culture of origin that is willing to help people when in need, as opposed to individualism and materialism that results in Canada. The values of work, and not using the system were noted.

This description of a lack of sense of community and materialism was a source of distress for many participants. This ‘cultural value’ is indicative of a neo-liberalist ideology pervasive in Canada that impacts race, and mental health service use. The neo-liberal agenda is based on principles of liberalism, which is based on unadulterated individual freedom to pursue social and economic success, and assigns merit based on ‘hard work’ (Moosa-Mitha, 2005; Razack & Jeffrey, 2002). Participant responses reflect an adoption of the notion of having to work hard in Canada to achieve success, but a tension in the difficulties this presents - not only in having to work so hard, but also having to do this in the face of mental unwellness. A link can also be made here to the diasporic identity of the Indo-Caribbean in being tricked into migration to the West Indies but through hard work, overcoming these circumstances and making a successful life.

Liberalism responds to social difference by either denying or tolerating it, allowing dominant groups to benefit by being able to absolve themselves of

responsibility (Razack & Jeffrey, 2002). Neo-liberalism espouses little government intervention in order to allow freedom for the individual to engage in the market, capital investment, privatization, and lack of investment in community (Noble, 2004). It follows that neo-liberalism individualizes and pathologizes mental health problems, separating them from social contexts and making them the fault of the individual (Morrow, Wasik, Cohen, & Perry, 2009). It is assumed that people are responsible for their own mental health, a premise which casts aside social determinants of health and supports biomedical discourses around illness (Morrow et. al., 2009). Echoing this analysis, some participants articulated the internalized shame of “using the system” and connected this to the cultural value of ambition, and wanting to make something of themselves. Another value mentioned by participants is that of the importance of keeping up appearances in Indo-Caribbean culture. This is a tendency that could be exacerbated by other internalized expectations of behaviour in terms of the active role of citizenship to be productive.

Another value that was mentioned was that of being deserving of citizenship or membership, and service, which also speaks to issues of social inclusion.

#### *Migration and Acculturation*

Findings: The exclusion and isolation due to the process of migration and acculturation confirms the literature on immigrant mental health, of the adverse effects of these processes.
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The way Caribbean people construct their identities after migration is complex and can affect their adjustment to their new environment (Razack, 2003). It involves a reconstruction of their identities in their countries of origin in the context of their placement by their new society (Razack, 2003). They also often “decide to bear as best one can the racist treatment in exchange for access to economic and educational opportunities better than one would face in one’s home country” (Bashi & McDaniel, 1997, as cited in Razack, 2003, p. 348). As Razack

(2003) notes, “The Caribbean Canadian does not ever get to assimilate fully, since skin colour is a marker of identity, and identity in this case may be viewed with negativity and labelling” (p. 350). The aforementioned loss of community, discrepancy in value systems, and the othering and mental unwellness caused by racism was a clear tension for participants. Many spoke a narrative of it being hard to live in Canada and the desire to return home.

Acculturation theory suggests that newcomers can adjust to their new environment in the following ways: assimilation, where one adopts the new culture over their own; separation, where one does not adopt any aspect of the new culture they have come into contact with; marginalization, where one does not retain any connection to their own culture or that of their new society; and integration, where one is able to have a balanced connection with their own culture and that of their new environment (Jhangiani & Vadeboncoeur, 2010). It is assumed that integration is the best type of adaptation, but the theory itself reflects a decontextualized Western gaze that does not acknowledge how issues of discrimination and other social pressures can shape this process (Jhangiani & Vadeboncoeur, 2010). The interaction between newcomer and the host society creates a process of restructuring of community and identity. Some tensions were expressed by participants in the process of adoption of Canadian values that were not shared by family members, as well as the implication of “becoming Canadian” in adopting materialist values and not assisting members of their community when in need. Due to the assimilationist expectations of acculturation, there is a flexibility required by the “other” that is not required by dominance in the same way. Even though integration is constructed as the best form of adapting, the dominant group is not required to integrate reciprocally; therefore, for the othered, it seems the more you assimilate, the easier it will be for you.

### ***Identification With Mental Unwellness***

#### *Definitions of mental health and illness*



Findings: Definitions of mental health and illness approximated those of Western mental health. Participants described affect, and disconnection from reality. There was a clear distinction between diagnosed mental illnesses and life problems that have emotional and mental consequences. Causation was strongly connected to life experiences that led people to involvement with the Canadian mental health system. Responses confirmed current literature on the effects of stressful or traumatic life experiences on mental health.

The fact that personal definitions of mental health and illness resembled those of mainstream Western systems could be indicative of the fact that participants currently are service recipients who have adopted ways of knowing and behaving that fit within those systems. It could also reflect the fact that they come from a colonized country where the few formalized mental health systems in existence reflect Western medicalized structures, so are somewhat familiar with them. Participants described distinctions between mental and emotional difficulties that need to be coped with, which can escalate to madness, still distinct from diagnosed illnesses. Clearly behaviour is not pathologized in the same way through classification and labelling in their cultures of origin, unless it is from Western systems in their home country.

Difficult life experiences were connected to mental health difficulties and diagnosed mental illness, but some participants determined that these experiences would not have resulted in illness in their countries of origin, as the combination of cultural values and community support would shape these outcomes differently. Some of these values, for example in experiences of marital breakdown, may reflect gendered privilege. Depression was described by some participants as feeling trapped or isolated due to difficult life experiences and migration. This alludes to a discrepancy between the role of life experience, such as the adverse effects of acculturation, in creating pathology, and the decontextualized categorization of affect described in DSM classifications.

### *Visibility of Mental Health Problems*

Findings: The lack of acknowledgement of mental and emotional difficulties in participants' cultures of origin was noted, as well as endorsement for the visibility of mental health issues in Canada. Almost unanimously, even for those who were involved in medicalized mental health services in their country of origin, there was a non-existence of "mental illness" in participants' countries of origin due to differences in lifestyle, cultural and social values and practices, and community involvement.

Tensions in this area were found in participants having acquired illness since coming to Canada. This provides support for the long-term trajectory of the healthy immigrant effect in that disparities between newcomers and the Canadian-born population lessen the longer newcomers are in Canada. While participants were pleased that there was a space for the discussion of mental health problems, they distinguished this process of acknowledgment from that of the acquisition of illness, such as schizophrenia, bipolar, and others, and ill health since coming to Canada.

### *Acceptance*

Findings: Most participants clearly articulated a narrative of acceptance of both racial inequities and acceptance of mental illness and medicalized treatment, as a pathway to recovery. For some, this was a mindset connected with the maturity of age.

This narrative of acceptance from participants, for some, created a sense of peace. Acceptance was implied in some participants not contesting being categorized as black by society and mental health systems, despite their own identification in interviews as Indians from the West Indies in the context of their colonial history. Most also accepted their designation as patient, for some because they felt it clearly captured their identity within the mental health system, and for some it was simply a given (being treated in a hospital means you are a patient, as would be due to the process of psychiatric imperialism).

To examine this further in the context of assimilation versus resistance it is helpful to look at the enforcement of societal norms. Although there is a paradox of acknowledgement, resignation, and sometimes endorsement of the othered identity, a desire for inclusivity is still prevalent. Residual rules are those social rules that are unwritten and commonly understood among a social group or society, and separate what is normal from that what is strange (Sheppard, 2002). Freud (1999) presents meanings of normality as follows: a statistical average, the positive value on an ideal of mental health, and conformity to community and cultural standards. Mental health systems regulate abnormality and deviance (Cermele, Daniels, & Anderson, 2001), which have historically been attached to racial stereotypes and cultural practices, as well as behaviours that are pathologized. A feminist analysis of psychiatric disability explores the intolerance of alternate states of mind that denote abnormality (Nicki, 2001). For example, extreme states of emotion can simply be a natural reaction to difficult life events, but can be pathologized and characterized through racist, sexist, homophobic or other discriminatory assumptions (Nicki, 2001). Examples of this could include the stereotype of the “angry black woman” (Nicki, 2001, p. 87) or erratic and violent black man. It follows then, that there are both implicit and explicit rewards and consequences for compliance, mostly in the form of social inclusion, which could prompt acceptance or assimilation, or rejection or resistance. This ‘choice’ can be shaped by the power structures within which one is situated.

*Power in Professional and Medicalized Systems*

Findings: Participants noted the integral role and power that their doctors had in determining a course of action in their lives. They identified the power of medical professionals in their lives, but felt as though at times they were able to have some room to discuss or challenge their treatments (i.e. switching or altering medication, etc.).

As noted earlier in this paper, positivist medicalized treatments place the professional as the expert. In keeping with responses to expectations of compliance with normality, mental health professionals have the power and authority to make these expectations known, and provide consequences or rewards depending on level of compliance. Foucault's panopticon is a system of surveillance that conditions people to self-monitor by making the monitor's presence unpredictable or invisible (Burr, 1995). This system of surveillance combined with the power held within a paternalistic system can guide service recipients' behaviour. This push toward compliance can happen subtly and in good faith in professionals caring about the welfare of the service recipient, guided by the construction of wellness within a biomedical model. Or it can happen more explicitly using the language of compliance ingrained in mental health systems, that outlines the threat of more intrusive methods of support if one does not conform. Both of these types of outcomes were experienced by participants. As a result, "patients" adjust their behaviour to fulfill expectations. This reinforces the act of colonization into a particular epistemology and role.

#### *Responses to Medicalized Treatment*

Findings: Most study participants revealed initial resistance to medication as an intervention but eventually acquiesced and found some success with all their formal treatments. No significant indigenous alternative treatments were brought forward as being preferable to medicalized interventions, although many described harmful physiological side effects of medications.

Much of the literature reveals indigenous beliefs around lack of desire to be treated for mental illness with medication. This essentialized view of indigenous beliefs was not reflected by the majority of participants', although the opinion that medication is not useful was expressed. Interesting in this finding is the eventual compliance with medication despite initial resistance. Some talked about this change of mind resulting from a positive connection with a mental health professional that convinced them to try it, and others talked about the threat

of consequences as noted above. Other consequences, as noted by Keating and Roberston (2004) in the literature review could be fear of racism and confinement in service provision.

Some of the rewards for compliance were noted to be the fact that once the right medication was found, participants did feel better and did not want to question what was working. Another reward may have been the approval from mental health professionals in reinforcing the service recipient's worth. There is research showing a connection of race to forced admission to health care services and poor insight, and poor insight is connected to worse clinical presentation, which then gets further pathologized (Morgan et. al., 2004). This idea of having insight is about recognizing that one is actually ill. The approval and reward that can come from acceptance of this role can create compliance. While overall this can have a positive result, it can possibly perpetuate paternalistic leader-follower colonizer-colonized roles. Lastly, while there is success with medicalized remedies, there are simply no other viable treatments for diagnosed mental illness that are endorsed or practiced in mainstream service systems.

*Difference in System of Care Between Culture of Origin and Westernized Systems*

Findings: Those who had knowledge of medicalized systems of intervention in their country of origin described it as being similar to asylums and institutionalized care in the West years ago, as confirmed in the literature review. Most, however, discussed family and social support systems that take care of individuals who are unwell until they are no longer able to, without engagement in formal supports, thereby only being subject to informal labelling. Informal coping strategies for mental unwellness were discussed and included both successful and problematic resources.

While both mainstream medicalized systems and alternatives can be useful in healing from mental health difficulties, success in the individual journey toward recovery is rewarded in Canadian medicalized systems as long as it is within their parameters. Family care was mentioned by participants, and while

manifestations of mental health difficulties held social stigma, the absence of labelling avoided connection to diagnosed illness. There was no significant resistance to medicalized treatments reported by participants, which may prove that the system is helpful, or may be a result of the fact that they are all service recipients actively engaged in formal supports. This could also be a result of the absence of visibility of mental health problems and treatments in their cultures of origin so there is nothing to which the present system can be compared.

#### *Labelling and Stigma*

Findings: Previous findings around racist labelling, and categorization of Indo-Caribbeans as black people have been examined. Also, all but one participant endorsed the mental health labels they received, and wanted it to be called for what it is. Stigma and social exclusion were recognized in both countries of origin and in Canada, although manifested differently due to labelling.

Despite the lack of obvious tension in mental health labelling, with the opposite feeling around race, discussion of labelling is useful in determining how racialized mental health service recipients are positioned in the system, and whether or not these meanings fit for them. Expectations of behaviour that is ‘normal’ or acceptable are made known through the use of labels. Vatne & Holmes (2006) explain that labels can legitimate discrimination and fix negative characteristics to the person instead of attributing them to interpersonal conflict or other environmental factors. They also note that these processes directly influence how the stigmatized person sees themselves. Being included in the racial category of black was associated with racism and maltreatment from systems of social control for participants, but offered inclusivity within a marginalized group. A distinction was made in being categorized as black in Canada, and “coolie” (a derogatory word for indentured labourer) in their country of origin. Labelling within the mental health system, such as the use of the term patient, implies meaning around a particular role (McLaughlin, 2009). Other terms such as consumer, survivor, client, service user, and others can denote a

particular experience of mental health systems, and can be imposed or self-identified.

In Gray's (2007) study that explored the narratives of female mental health service recipients, she notes that participants described a long-lasting effect of a mental health label that resonated long after the diagnosed experience subsided. This is in part due to stigma and socialization around diagnosis, and can also be due to long-term effects of marginalization. Diagnostic labels can reflect the interests of dominant social groups (Cermele et. al., 2001) and can reinforce marginalization through mechanisms such as racism. This can be internalized in different ways. Studies show that mental illness is highly stigmatized in the Afro-Caribbean community and this may be a deterrent for help-seeking, which confirms research on the connection between cultural beliefs and help-seeking behaviour (Morgan et. al., 2004). Informal and derogatory labelling, such as in the case of the term "crazy" can be as dehumanizing and silencing as other forms of discrimination, and perpetuates the idea that "strong or intense emotion is devoid of meaningful, directive, cognitive content; that people with mental illness are irrational that they are cognitively impaired, and that they are frightening" (Nicki, 2001, p. 86).

Some participants noted the same stigma and social exclusion from informal labelling in their cultural of origin, but behaviour was not pathologized in the same way as in systems of psychiatric diagnosis, which can carry an extra layer of stigma. Freud (1999), paradoxically, talks about the usefulness of labelling in that, while it can pathologize, it can normalize. This was alluded to by participants in their endorsement of visibility of mental health problems in Canada and adoption of the labels to validate their condition. It can also create an inclusivity into a still othered category of abnormality, that although has some drawbacks, can create a community. Some participants discussed the idea of being involved in formal services and engaging with a community of other service recipients, which can help to remedy isolation from ethnic community or family.

### ***Intersections of Processes of Construction***

Having examined constructions of identity and surfaced issues of power, tensions, and learnings from the findings of participant interviews, I now turn to the actual processes of these construction that are shaped by social, historical, and political value systems, and impact how one moves through the world. Understanding the processes of construction as much as the actual constructed identities, can facilitate a critical self-awareness that can in turn lead to enhanced understanding of the racialized Indo-Caribbean mental health service recipient. As it would be impossible to highlight all of these processes of construction that Indo-Caribbean service recipients are subject to, examination of a few relevant ones will illustrate this dynamic further.

Racialization is a process whereby people are categorized by their differences, which is then assigned to race, assumed to be an objective biological categorization, and they are then treated inequitably based on these constructions of identity (O'Mahoney & Donnelly, 2010). This can set up a binary construction of white people as "legitimate citizens, professionals, and service providers, and people who are not white as immigrants, and clients with ethnicity" (Tsang, 2001, p. 239). Another process of construction is that of meaning-making around terms such as ethnicity, race, culture, etc.

It is important to remember that processes of identity construction are fluid and contextual (Yakushko et. al., 2009). These processes of construction are being undertaken by both the researcher or worker, and the service recipient, who will present themselves to each other based on their own contexts, social locations, and the dynamic between them in a process of symbolic interactionism. "Identity functions as 'a junction or hinge concept that can help to maintain the connective tissue that articulates political and cultural concerns' " (Gilroy, as cited in Murdoch, 2007, p. 575). Although the politics of identity can be used to construct people in marginalized positions and maintain privilege (Tsang, 2001), social identity theory explains that ethnic identity reflects one's self-worth as it comes



from the emotional attachment to the membership within a particular social group (Surko, Ciro, Blackwood, Nembhard, & Peake, 2005). This is why it is important to understand the mechanisms of identity construction.

In terms of mental health diagnosis, “responses to illness emerge from a process of negotiating the meaning of symptoms within a social network” (Morgan et. al., 2004, p. 746). Again, power structures can dictate whose constructions prevail and are used in service provision, but these constructions can also be used as a tool of collaboration. “Social constructionists examine the meanings their clients give to various constellations of life” (Deweese, 2001, p. 36). In the constructionist process of the research interviews, participants and researchers are making meaning of things they may not have thought of before, or can make new meanings in the context of the interaction.

Another consideration in these processes of construction, and a prevalent theme arising from participant narratives, is that of social inclusion. This positioning seemed to influence how participants constructed their racial and mental health identities. Sin and Yan (2003) explore this notion, noting that social exclusion is about what has been done to those who are vulnerable and have been dehumanized, and it focuses on difference; whereas social inclusion links life opportunities to social cohesion and reinforces the departure from deficit-based views of people and marginality, and focuses on finding common ground. Both are more concerned with social distance and proximity than who is in and out. The lack of acknowledgment of power imbalances of this theory of social inclusion and exclusion, creates a totalizing effect that can perpetuate essentialization and assimilation into dominant discourses. It can ignore multiple oppressions and forms of domination, and assumes “sameness and universality are necessary and achievable” (Sin & Yan, 2003, p. 31). In resistance, it is important for individuals and groups to position their identities on the continuum of sameness and diversity, within shifting social, cultural, and political forces (Sin & Yan, 2003).

Lastly, in terms of this research, the intersection of the multiple processes of construction of the racialized mental health service recipient can converge in ways that create what I have referred to as “pathologized identities”, if guided by the perspective of dominant discourses. Pathology, which is the nature of disease or deviance, has been explored throughout this paper as a mechanism of racism and mental health diagnosis, and is used to mark social deviance, inferiority, undesirable or extreme behaviour and illness. Essentialist views can pathologize experience resulting in the “other”’s expression of identity being seen as deviant and needing to be remedied (Keddel, 2009). This can be perpetuated through re-colonization, a process of assimilation. The prejudiced pathologizing of culturally diverse communities is based in the disease model, which reflects how power imbalances are translated into pathologizing of behaviour for those labelled with an illness (Rollock & Gordon, 2000; Yee, 2005), as well as those who are racialized. This approach places the individual, not structural issues, as the cause of their own problems (McLaughlin, 2002). The failure to acknowledge the effect of racism can pathologize the resulting anger and fear, often an expression of lowered self-esteem from the internalization of racism, as paranoia (Fernando, 2010). It is hoped that the understanding of these various processes of pathologizing construction can be countered through the normalization of difference.

### **Best Practices: Addressing Issues in Construction and Positioning**

As reflected in the literature as well as participant interviews, there are some considerations that can help to guide the processes of construction to gather a more comprehensive, and less essentialized picture of mental health service recipients, and attempt to address power imbalances and pathology. These considerations include historical and social contexts that can impact identity, situating the worker or researcher, privileging indigenous epistemologies, and creating culturally relevant and ethno-racially specific strategies of service provision.

### ***Historical and Social Contextualization***

Findings: Participants provided some historical information from their countries of origin. They also made explicit racial tensions resulting from colonization and political turmoil in their countries of origin. Issues of multiculturalism and acceptance of racial and cultural difference were also surfaced.

The literature review section of this paper offered some historical and political context for Indo-Caribbean mental health service recipients. This context is integral to the understanding of the service recipients' process of construction, identity, and experience. Also, while it is important not to essentialize identity or experience, understanding some aspects of cultural norms and beliefs can be a starting point for understanding this construction.

Important points of identification for this group of participants were diasporic and transnational identities. Another important issue that surfaced as part of the colonial legacy for Indo-Caribbeans was the racial tensions that resulted from patterns of settlement and labour division, and extended into political divides. This pitting of Afro-Caribbeans against Indo-Caribbeans has created a complication in the binaries of race between white and non-white, creating another point of othering. Some participants centered the tension between these two groups as more salient than that created by the institution of whiteness. In Canada's multicultural society, these colonial relationships and dynamics are important to understand and examine when necessary.

Lastly, historical or social contexts effect the construction of mental health. This is why the historical background on systems of support for mental health in culture and country of origin is important. Exploring the language used, as well as formal and informal systems of support can be useful. For example, shifting from the language of mental illness to well-being, depending on the services recipient's meaning-making around mental health issues, can situate constructions of mental health or wellness outside of dominant pathologizing biomedical discourse (Fernando, 2010).

### ***Situate the Worker***

As discussed previously, it is important to make transparent the worker's positioning, social location, and standpoint so as to address power imbalances. By not making these issues explicit, this silence can assume privilege by not having to be defined, thereby perpetuating re-colonization by only defining the othered racialized service recipient. Critical consciousness is the "process of continuously reflecting upon and examining how our own biases, assumptions and cultural worldviews affect the ways we perceive difference and power dynamics" (Sakamoto & Pitner, 2005, p. 440). This critical consciousness about positionality of both worker and service recipient (Yakushko et. al., 2009) is important for the worker's self-awareness around privilege.

### ***Privilege indigenous epistemologies***

Findings: Some participants discredited traditional ways of thinking and the limited knowledge base of uneducated agricultural workers.

Not only do dominant systems not consider indigenous epistemologies as legitimate, internalized racism among marginalized groups works to further discount this body of knowledge. Oppression can facilitate an internalization of inferiority and mental colonization (Yakushko et. al., 2009). This is an indication of the hegemony and pervasiveness of Western epistemologies, created by oppression as a tool of colonization to instil shame in its subjects. The value of privileging indigenous epistemologies has been discussed in the methodology section.

### ***Cultural relevance***

Findings: While participants were lukewarm on the idea of 'recognizing' culture in mental health service provision, many said they may not have responded favourably to being asked directly about their backgrounds depending on their stage of engagement with the mental health system and who was asking. Despite this reservation, they did surface the benefits of working with someone who is familiar with their culture.

Models and broad critiques of cultural competence, currently the main method of addressing what is often framed as the ‘problem’ of diversity, have been summarized in the literature review. Additional critiques of the critical literacy model of cultural competence from an anti-racist perspective are that it can lead to an oversimplification of the concept of culture and assumes the worker is free of cultural values. Scholars in this area urge us to look at people within their cultural context, recognizing we do that through the lens of our own culture (Maiter, 2009). Also, the focus of this type of support on building competency is reflective of managerialism in social services, which supports positivist inquiry that fixes points of identity.

Based on the approach of this research, the constructionist experiential-phenomenological model is preferred in order to create a space for a more equitable process of collaborative construction. This process of construction, based on participant responses, must be approached with caution, and is not always useful for service recipients that do not center race as a particularly salient point of identity, and who might anticipate racism as a motivation for this inquiry. Social location already predisposes a particular process of construction and positioning. Some participants saw value in this inquiry, but mainly for the purpose of the worker being able to define them and know how to deal with them.

In order to address issues of equity in this construction of culture, the worker must accept the position of not knowing, although it is the responsibility of the worker to learn about culture and be an informed ‘not knower’, so as not to place all the burden on the service recipient to define themselves for the worker (Deweese, 2001; Keddell, 2009). The worker must know themselves and how to ask about culture (Deweese, 2001). It must be understood, however, that this process of self-awareness cannot neutralize worker culture and its influences on the interaction, so we must allow ourselves to be “reconstituted in the presence of the other” (Yan & Wong, 2005, p. 187).

In this reconstitution, it is important not to homogenize culture or experience, which is a principle endemic to cultural competence. One example of an open process of construction in research was in a study by Groleau and Kirmayer (2004) where they successfully created a space for Vietnamese immigrants to name and define in their first language, their categories of mental unwellness. One example of this was *Ua't u'c*, which is suffering of indignation because of injustice, such as the loss of dignity one suffers in a war camp. In the same vein, Wong and Tsang's (2004) study of Asian immigrant women illustrates the danger of operating within assumptions about cultural groups such as the stereotype of Asian collectivism and women defining themselves by their families.

One of the aims of this study was to offer information on some Indo-Caribbean cultural beliefs and practices, but it is important not to homogenize culture by applying this information to everyone who identifies with this ethno-cultural label. For example, the notion that superstition prevails in Indo-Caribbeans' ideas of causation for mental illness is taken up or endorsed differently by different members of this group.

Due to the concerns with positivist aspects of cultural competence, I would like to propose a reframing away from the notion that the degree of cultural responsiveness of a service is evaluated from the perspective of the service provider, who is able to privilege their own processes of construction, and determined by the degree to which they have 'learned', or become competent in, culture. This reframing can be thought of in terms of "cultural relevance", and the determination of whether or not a particular service is culturally relevant for the service recipient. In other words, does the service recipient feel that it fits their constructions of identity and mental health? This can help with the examination of causation for underutilization of services by ethno-racial groups, as well as to combat colonization. This concept is referred to in the literature quite scarcely, but is mentioned by Maiter (2009) who cites Green (1995), in defining a

competent practitioner as one who works “in a way that is congruent with the behaviour and expectations that members of a distinctive culture recognize as appropriate among themselves” (p. 268).

***Ethno-specific services:***

Findings: As reflected in the literature, participants expressed the value of ethno-racial services in terms of feeling comfortable with workers and other racialized service recipients who understood them better because they identified similarly culturally and ethnically and shared similar values; but also stated that having someone that simply understood them and that they had a good connection with was equally valuable.

This finding confirms some of the literature on ethno-racial services. In a study by Secker and Harding (2002) on perceptions of service recipients of an African and Caribbean mental health service, it was found that although having workers of the same background, as well as service provision from an ethno-racial agency reduced their sense of social isolation and affirmed their self-worth by being able to be comfortable being themselves, this alone did not account for positive reviews; but rather the combination of these factors and the genuine connection and warmth they felt was what created success. It has also been noted however, that service recipients sometimes prefer not to work with members of their community due to issues of confidentiality or internalized racism. Also relevant to this research is the possible difference in identity construction in ethno-racial services in terms of understanding who service recipients are, in a historical and cultural context, and what they experience in life in terms of migration, racism and exclusion. Racial tensions can still exist, but race was talked about with service recipients both in the service agencies in the Secker and Harding (2002) study and in this one, which participants found useful.

**Opportunities and Learnings for Next Steps**

*Challenges and Learnings from this Study*

One issue that surfaced as a result of reflection was the absence of inquiry into what culture meant for participants. While it seemed they abided by mainstream definitions, it might have been useful to explore this, as it was such a central concept. As a result, I operated from my own construction of it, which reflects the literature. My assumption that the term culture was understood similarly by participants was likely correct at times, but not always.

Another issue was that of my placement in unstable proximity to participants, which led to what could be seen as the notion of the outside insider. Simply by virtue of being a researcher, one's 'insider' status is jeopardized if one leans too much toward an etic perspective (LaSala, 2003). One of the points of this project was to complicate dominant identifications of racial, ethnic, and mental health service recipient identity. One of the difficulties was in having to use the dominant medicalized language to inquire about a condition of mental unwellness outside of the system of Westernized mental health. This language denotes a theoretical positioning and creates parameters around experience that are not easily transcended or discarded when attempting to create an open unfettered space for defining meanings of mental wellness. It is clear that the relationship between researcher and participant are not always clearly defined (Kanuha, 2000). This ambiguity holds true for researchers as well, who sit in the in-between spaces of having to operate within dominant oppressive discourses and creating new ones (Ladson-Billings, 2000).

Other learnings came from participant characteristics and the need for further examination of sampling criteria. Points of identity for participants that were significant were their age in being well into adulthood, which may have accounted for a certain life experience and attitude. They were not asked to specify diagnosis, which may have been relevant in terms of their experience of the mental health system. Participants had varying levels of cognitive functioning, which at times affected communication and processing of questions. Another extremely significant point is that I interviewed mental health service



recipients who were well enough to engage in an interview. This may have indicated a particular perspective on mental health systems that was useful for their ability to compare meanings of mental health between their culture of origin and medicalized systems, while also missing information on mental wellness in the community, that is not influenced by institutionalized constructions.

Lastly, participants being all male may have reproduced dominant narratives within the Indo-Caribbean community by privileging already privileged voices (Wong, 2002). Even with these particular features, however, the study has produced a depth of information that will assist in learning about the particular experiences and constructions of meaning for this group.

#### *Implications for Future Research*

Due to its broad focus on processes of construction and intersections of identity, this research can be used as a springboard for many avenues of inquiry. Some of these could include looking at research with second generation Indo-Caribbean Canadians, with Indo-Caribbean workers who may have a wider analysis on cultural and systemic issues pertaining to racialization and mental health in the community, or research with non-mental health services recipients who are members of the community that can speak to constructions of mental wellness from outside of the medicalized system. Future research could also focus on different salient points of Indo-Caribbean identity or experience such as gender, sexual orientation, ability, or a larger sample with more diversity of identity; or an examination of the multiplicity of identities within this ethno-cultural group, as there is little existing research. Outside of issues of identity, future research could look at how liberalist and managerialist constraints on practice perpetuate racism and silence voices of colour within the Indo-Caribbean community. If engaging in qualitative research, an example could be taken from Gray's (2007) study in looking at alternate ways of presenting service recipients' stories that were most comfortable and least exploitative for them, such as public speaking, video recordings, or focus groups.

### *Practice Implications*

This research could be seen as a model for centering marginalized discourses and narratives. It can open a space for migration stories and many other overlapping narratives of identity. This research can also serve as a model for critical analysis and contextualizing of specific cultural information. It can also have implications for the reframing of cultural competence toward cultural relevance with the aid of the aforementioned better practices.

One of the aims of this research that was only partially achieved was looking at creating a model for a process of construction with service recipients of what mental health is for them and what informs that definition. This would be to counter the present focus on accumulating cultural information that can be categorized and used to homogenize identity. If the focus is not the information itself, but a method of equitable and collaborative construction of identity, this process could be used in service delivery and generalized to different situations and groups.

### **Conclusion**

The purpose of this research was to critically examine processes of construction in the experience of Indo-Caribbean mental health service recipients, as well as the intersections of racialized, mental health, and service recipient identity. The aim was to create a space for service recipients' voices to be surfaced in the discussion about constructions of race, ethnicity and mental health and the systemic social, political, and historical forces that influenced these constructions. It was also to add to the present canon of literature on particular ethno-cultural and racial experiences of mental health, with a group that reflected my marginalized, in-between, and invisibilized identity, looking at issues of exclusion. This was attempted through a process of inquiry and analysis that involved positioning myself as the researcher in order to make transparent the factors that shaped this process. This was further facilitated by exposing the self-reflective process that informed the research. The background literature

informing this research privileged critical inquiry that problematizes mainstream dominant discourses, in an effort to center the margins. This literature, along with participant interviews, contextualized the identities and experiences of Indo-Caribbean participants. Findings from participant interviews for the most part confirmed existing literature on ethno-racial and immigrant mental health, but thickened these generalizations and provided information on cultural issues relevant to identity as Indo-Caribbeans, and mental health service recipients. Broad findings from the research indicated an overall compliance with and endorsement of the medicalized mental health system, confirmation of system entry through systems of social control such as the criminal justice system, clear distinctions in prevalence and understandings of mental wellness and illness between Canadian culture and culture of origin, confirmation of adverse effects of racism and acculturation on mental health, lack of confirmation of tension between indigenous interventions and Western systems, and endorsement of acknowledgment of mental health problems in Canada, which are invisibilized in participants' culture of origin. The interviews further explored these issues confirming diversity of experience within this group, and provided thick accounts of constructions of identity and experience that did and did not reflect issues of power imbalance and the resulting tensions.

It was my hope in this process to complicate the issue of identity construction and positioning of racialized mental health service recipients. It has been invaluable in mirroring and furthering my own process of inquiry into issues of personal identity and feelings about experiences of oppression, difference, and commonality. It has served to confirm the African proverb that "it is not what you call me, but what I answer to".

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## APPENDIX A



### **RESEARCH PARTICIPANTS NEEDED**

Do you identify as:  
INDO-CARIBBEAN?

OF INDIAN DECENT BORN IN THE CARIBBEAN?

(Including Guyana, Trinidad & Tobago, Barbados, Antigua, The Bahamas, Cuba, Dominica, The Dominican Republic, Grenada, Haiti, Jamaica, Saint Kitts, St. Lucia, or St. Vincent)

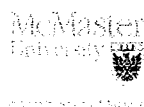
Have you been involved in the  
CANADIAN MENTAL HEALTH SYSTEM?

Be a part of an important study to help explore: your knowledge and experiences of mental health and mental health services and how they have been influenced by culture and your experiences in Canada.

Have your voice valued!

You will receive a Wal-Mart or Shoppers Drug Mart gift card for participating in a 1½ hour interview

For more information, please contact:  
Anjali Upadhyia



Phone: 905-824-4947  
E-mail: [upadhyas@mcmaster.ca](mailto:upadhyas@mcmaster.ca)



## About the Researcher

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I am a second generation Canadian woman of colour, born to parents who emigrated from Guyana, South America. I am currently a student at McMaster University in the Masters of Social Work program, and practicing social worker. My previous education includes degrees in psychology and English and a BSW, and a Human Service Counselor diploma. My practice experience has been mainly in the violence against women and mental health sectors in a number of practice settings. My current research interests are in the area of ethno-racial mental health, and equity issues.

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### Contact Information:

If you have any questions about this study, or **would like to participate**, please contact **Anjali Upadhyas** by phone at:

905-824-4947

Or by email at:

[upadhyas@mcmaster.ca](mailto:upadhyas@mcmaster.ca)

This study has been reviewed and approved by the McMaster Research Ethics Board.

If you have concerns or questions about your rights as a participant or about the way the study is conducted, please contact the McMaster Research Ethics Board Secretariat.

Phone: (905) 525-9140 Ext.23142

Email: [ethicsoffice@mcmaster.ca](mailto:ethicsoffice@mcmaster.ca)

Mail :

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McMaster University

1280 Main St West

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My faculty supervisor, Rick Sin can be reached at (905)525-9140 ext 23785 or [sinr@mcmaster.ca](mailto:sinr@mcmaster.ca)

## McMaster University

## McMaster University

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Exploring an Ethno-racial  
Definition of Mental Health  
and Illness from Indo-  
Caribbean Canadian Mental  
Health Service Users



improving innovation and discovery

Research Investigator  
**Anjali Upadhyas**

Masters Student  
Department of  
Social Work  
McMaster University  
Hamilton, ON

## About this Project

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This project is a result of my interest in anti-oppression work and mental health. It is being conducted as a thesis study for a Masters in Social Work program at McMaster University. The purpose of this study is to explore definitions of mental health, illness, and treatment; and look at how those definitions are framed in mental health service systems.

In this research, I want to learn about the experiences of ethno-racial groups in the Canadian mental health system, and have chosen the Indo-Caribbean community to do this as they are a group that often is not identified in culturally sensitive social service provision. As an adult who identifies ethnically as an Indo-Caribbean Canadian immigrant, or as Indian born in the Caribbean, who is receiving service from the Canadian mental health system, your knowledge and voice will be very valuable in exploring this subject.

## Participant's Role

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Participants would be invited to tell me about their knowledge and experiences of mental health and illness, as well as mental health services in Canada. I am also interested in how this knowledge has been influenced by your culture and life experiences.

Individual interviews will be done at a mutually agreed upon location and time. After an introduction to explain the study more in depth and answer any questions you may have, the interview should take about an hour. You have the right not to answer any questions you are uncomfortable with. With your permission, interviews will be audio-taped.

**As a token of appreciation for your participation in this important study, you will be given a choice of a \$20 Wal-Mart or Shoppers Drug Mart gift card. You will also be reimbursed \$5 transportation costs if taking public transit to the interview.**

## Confidentiality

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**Your participation in this study is voluntary and confidential. As the study is not connected to the agency from which you receive mental health services, your participation will not affect your service. The fact that you participated in the study or the content of the interview will not be revealed to your service agencies or worker.**

Your information will be kept in a secure location and interviews will only be accessed by the research team. No directly identifying information will be used in the final report. Direct quotes will be used, but every effort will be made not to include quotes that could identify you. You will also have a chance after the interview to let me know if there is any part of the interview that you wish not to be used in the final report. Also, you have the right to withdraw from the study at any time without any negative consequences.

## **APPENDIX C**

### **INTERVIEW GUIDE**

1. What is your understanding of mental health and illness?
2. How do you think that this understanding has been influenced by where you are from or your culture?
3. How do you think that understanding has been influenced by your experiences in Canada?
4. What do you think are good treatments or remedies for mental health or illness?
5. How do you think your ideas about mental health treatments have been influenced by where you are from or your culture?
6. How do you think your ideas about treatments have been influenced by your experience in Canada?
7. Do you feel that Canadian mental health services fit for you based on your ideas understanding of mental health and mental health treatment? In other words is it culturally relevant for you?
8. Do you have any suggestions for better recognition of cultural considerations for mental health services?
9. Is there anything else about this topic that you may want to share that we haven't covered?

### **DEBRIEFING QUESTIONS**

How are you feeling about this interview process and what you have shared?

Is there anything that you would like deleted or not used for the study?

Are you feeling like you might need any follow up support regarding the things you have discussed in this interview?