NO SOVEREIGN REMEDY:
DISTRESS, MADNESS, AND MENTAL HEALTH CARE IN GUYANA

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Abstract

This dissertation is an ethnographic examination of how mental distress is read and understood in Guyana. Through semi-structured qualitative interviews, site observations, media analysis, and document analysis (primary, secondary, tertiary, and grey literature), this research investigates (i) competing and complementary discourses and etiologies of distress; (ii) diverse care pathways and practices utilized by Guyanese to address and ease distress; (iii) and the histories, legacy of empire, and socio-politico-economic factors that inform and spring from this exploration. This research commenced in response to deaths and incidents of violence against women and girls who were labelled "mad", "mentally ill", and "demon possessed" in Guyanese news reports. These cases signalled the polyvalent, intersectional, and fluid ways in which Guyanese make sense of and respond to mental distress; thereby prompting research questions on belief systems, modalities of care, and the social relations that are produced, organized, and practiced as Guyanese attend to mental distress on their own terms.

Interviews were conducted in Guyana with 37 helping practitioners, inclusive of medical doctors, nurses, social service agents, civil society/NGO actors, government officials at Guyana's Ministry of Health, and religious/spiritual practitioners belonging to various faiths. Observations were carried out at the country's National Psychiatric Hospital – informally known as the "Madhouse". Participants emphasized how mental distress is colloquially and primarily perceived through the stigmatized and meaning-centred language of "madness". They reported that the general public seldom uses the clinical terms "mental illness"/"mental disorder", which reference the dominant, Western biomedical model of psychiatry. Instead, participants revealed how mental distress is expressed through an array of perceived explanatory models: biomedical; socio-economic/structural; (inter)personal; and supernatural. A major point of consensus among

all 37 participants is how perceived supernatural causality is viewed as an intelligible landscape for understanding distress among the public; therefore, there is a propensity for religious/spiritual practitioners to act as first responders. Per participant accounts, Guyanese appear to embrace plurality and refuse either/or models of care. Consequently, these findings present crucial implications for theory, research, policy, and practice aimed at addressing and reducing mental distress experienced by Guyanese and fostering safe, comprehensive, responsive, and accountable public health systems.

Dedication

Dedicated to:

Vincent Chan

Bringer of jollity[1] and the one to whom my spirit took to, immediately and steadfastly.
多謝晒

[1] Vince: if ever there is music that captures the joie de vivre that you inspire, Holst's "Jupiter" comes close.

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Endless gratitude to my country people who asked, "Yuh gettin' through?"

I am now able to respond, "*We* get through!"

Woi! Woi! Woi!

Table of Contents

List of Figures

Introduction

This research commenced in response to deaths and reported incidents of violence against women and girls in Guyana who were labelled "mad", "mentally ill", and "demon possessed" in the media coverage of these cases, with the language of "disability" also employed to a lesser extent in some reporting. Three cases in particular inspired this dissertation: the murder of a woman named Radika Singh; the death of a fourteen-year-old girl named Sangeeta Persaud (no relation); and the killing of a young woman named Todah Richards. The function of "evil" and the ways in which the imputation (Singh and Persaud) and insinuation (Richards) that diabolical entities – whether rooted in folklore or religion – indwelled in their bodies, engulfed how all three incidents were constructed, rationalized, and reported on in the national media ("Child Dies after Frenzied Attempt to 'Beat out Spirits'", 2010; "Nurse held for Murder after Ritualistic Beating", 2014; "'Old Higue' Murder: Three in Custody", 2007). The reports signalled that violence was enacted with the intention of ridding their bodies of evil. These practices – framed through the language of "exorcism", "healing", and "ritualistic beating" – at times directly mentioned or broadly gestured to Caribbean traditional medicine and healing practices, tied to different religious and spiritual affiliations ("Child Dies after Frenzied Attempt to 'Beat out Spirits'", 2010; "Nurse held for Murder after Ritualistic Beating", 2014; Quan-Balgobind-Hackett, 2007; Tan, 2007b; Seales, 2010; G. Sutherland, 2010b).

The cases themselves and the public outrage sparked by the reports of violence revealed the polyvalent, intersecting, conflicting, and fluid ways in which Guyanese make meanings of mental distress and the array of practices that they negotiate and employ to manage and ease distress. In particular, these horrific incidents offered a small yet insightful and agitating opening, which exposed the worldviews of some Guyanese, namely through language that

signalled competing and complementary rationalities of mental distress, which further revealed gendered, racialized, disabling, sexualized, religious/spiritual, and socio-economic assemblages of power when bodies labelled mad, mentally ill, and demon possessed are the victims of violence. This dissertation moves through and beyond these cases and their initial, individual tellings to explore their collective linkages and, more crucially, to investigate the wider research questions that they catalyze and what they divulge about the material realities of Guyanese society.

Through interviews with multiple and diverse stakeholders working in medicine, civil society, social services, government, and religious organizations, this research exposes the complex interplay of different ontologies, epistemologies, and models of care that shape and inform the lifeworlds of Guyanese people as they reckon with and make meaning of mental distress. This dissertation asks and responds to questions concerned with belief systems, practices, and power. How do Guyanese understand mental distress? To whom do they turn? What are the practices enacted to address and ease distress? How is knowledge and expertise produced and exchanged? How can harm be the outcome in any model of care or healing practice? In asking these questions, I engage explanatory models and pathways to and practices of care. The final question underscores the paradox of healing and harm, particularly how violence is read as an intelligible response because it is perceived as curative. Here and throughout this dissertation, I am specifically thinking through how (neo)coloniality scripts bodies – simultaneously enacting and erasing multiple forms of violence – and the socio-historic ways we can attend to and address contemporary violence against people experiencing distress and labelled mad in Guyana.

This dissertation pays particular attention to understandings of madness as participants reported that this is the primary, stigmatized, and meaning-centred term through which Guyanese understand and engage mental distress, with the biomedical and psychiatric language and labels of mental illness or mental disorder utilized to a much lesser degree. Despite its predominantly negative connotation in Guyana – where it is an abject identity and expression often used to describe a frenetic, threatening, and deleterious state of being and people – the term madness is privileged in this dissertation because of its social purchase and widespread use in the vernacular. Madness is a common lay term in Guyana and is employed by the majority of participants as they contextualize prevailing understandings of mental distress and grapple with its usage and meanings. This project works to understand how madness functions as a culturally intelligible shorthand that captures the socio-politico-economic milieu of the nation.

This research engages the viewpoints of participants within a sphere of influencers that I collectively, and will sometimes generally, refer to as "helpers"[2] throughout this dissertation. I primarily draw on ethnographic fieldwork and semi-structured qualitative interviews conducted in Guyana with 37 participants – inclusive of medical doctors, nurses, social service agents, civil society/NGO actors, government officials at Guyana's Ministry of Health, and religious/spiritual practitioners[3] belonging to various faiths and subdividing denominations. Research conducted in

[2] The vocations of some of the participants (e.g., doctors, nurses, and social service agents) conventionally fall into the category of helping professions (Graf et al., 2014), whose work is usually subject to oversight by private and public regulatory bodies. Others (e.g., NGO/civil society actors, government officials, religious/spiritual practitioners), however, are not always captured by this classification even though their roles, on some level, involve "professional interaction between a helping expert and a client, initiated to nurture the growth of, or address the problems of a person's physical, psychological, intellectual or emotional constitution" (Graf et al., 2014, p. 1). To prevent confusion with the conventionally understood definition of helping professions, I, instead, utilize the term "helpers" to collectively refer to the 37 participants because of how their various professional roles have allowed them to work and interface with people experiencing mental distress and their families, specialist and non-specialist populations, and the general public.

[3] I use the language of "religious/spiritual practitioners" or "religious/spiritual helpers" as general umbrella terms to capture the participants who are often sought out to provide faith-based care and healing modalities across various faiths and subdividing denominations, inclusive of Christian Pastors and a Christian Reverend; Sanatanist Pandits;

Guyana, the wider Caribbean, and in countries with large Caribbean diasporas indicate that these various groups of stakeholders, with which my research engages, appear to be a dominant set of multi-sectoral actors that mentally distressed people and their families tend to interact with, particularly to access an array of service provisions to address and ease distress (Aarons, 1999; Lee et al., 2000; P. Sutherland et al., 2013; Whitley et al., 2006; World Health Organization [WHO], 2008). All of the participants in this study have experience working and interfacing with people experiencing mental distress and their families, specialist and non-specialist populations, and the general public. Significantly, 17 of the 37 participants voluntarily shared personal accounts of how they (n=9) or a family member (n=8) experienced mental distress. These unprompted personal disclosures add layers of nuance, perspective, and texture to this project.

The World Health Organization Assessment Instrument for Mental Health Systems (WHO-AIMS) is the framework utilized to draft the foundational and oft-cited "WHO-AIMS Report on Mental Health System in Guyana" (WHO, 2008). In its executive summary, this report states, "Mental health services are inadequate and not available or accessible to the vast majority of the population" (WHO, 2008, p. 5). It also indicates that there is "little research in mental health" focusing on Guyana, and that "multi-sectoral collaboration in mental health has been poor" (WHO, 2008, p. 31). The report acknowledges that in addition to the voices of "mental health consumers/users, volunteer, family or advocacy groups", a broader range of actors must be engaged:

> There are many non-health professional and non-professional groups in Guyana, including teachers, community leaders, traditional/spiritual healers, herbalists, religious leaders, law enforcement (police), ambulance attendants, NGOs, and the media, who could potentially play a role in the promotion of mental health in their communities. (WHO, 2008, p. 6)

Kali Mai Pujaris; a Faithist Reverend; a Hindu Priestess who performs *Shakti* (goddess) worship; and a Sunni Imam and his wife (Sadia), who is a leader among the women in their small Muslim community.

This dissertation is attentive to these weaknesses and the call for additional research and multi-sectoral collaboration in Guyana.

Fundamentally, this work casts its nets to encompass, analyze, and transcend the limitations of the WHO-AIMS report, whose general framework is embedded in and privileges the biomedical model of mental health; an approach that tends to stress how "mental disorders are brain diseases and emphasizes pharmacological treatment to target presumed biological abnormalities" (Deacon, 2013, p. 846). This framework finds its roots in allopathic medicine or the "broad category of medical practice that is sometimes called Western medicine, biomedicine, scientific medicine, or modern medicine" (WHO, 2002, p. 1, as cited in McKenzie et al., 2011, p. 67). By basing its estimates on "relevant studies in the Americas" – while failing to specify which studies and which countries were studied in such a large region of vast social, cultural, political, and economic variance – this report goes on to estimate that there is "likely a prevalence of 10 to 15% of the population with a mental disorder at any one time, with 3 to 5% of the population having a severe chronic mental disorder" in Guyana as well (WHO, 2008, p. 6). The authors approximate that given Guyana's "population estimate of 750,000, this would predict that 75,000 to 112,500 Guyanese suffer from mental disorders and require some level of mental health care services" (WHO, 2008, p. 6). This report signals the WHO's push for discourses that appear aligned to calls for "world mental health" (Jakubec, 2009) and "global mental health" (V. Patel et al., 2008). These frameworks pedestal the psy-disciplines – a "collective term for psychiatry, psychology, psycho-analysis and other psycho-therapies" (Foucault, 1977, as cited in Petersen & Mellei, 2016, p. 1); they privilege Western-based diagnostic models, which are championed in an effort to universally apply and globalize biomedical psychiatry (Mills, 2014; P. Thomas et al., 2005). The advocacy for and proliferation

of biomedical psychiatry and psy-disciplinary interventions in Guyana is particularly pronounced since the release of the WHO's global suicide statistics, in which Guyana was cited as having the highest suicide rate in the world in 2012 at 44.2 suicides per 100,000 people (age-standardized, all ages) (WHO, 2014, 2017b). Due in part to the legitimization and propagation of psychiatric discourses, local approaches – which have been utilized for centuries to ease mental distress – and other approaches outside of the biomedical model are often rendered ancillary or dismissed, thus Westernizing or "Americanizing the world's understanding of the human mind" and "homogenizing the way the world goes mad" (Watters, 2010, pp. 1-2).

In Guyana – as this research will demonstrate – and in other nations of the global South, the complex human experience of social suffering (Kleinman et al., 1997) and mental distress are not vernacularly understood through universalizing and reductionistic psychiatric labels (Mills & Fernando, 2014). Furthermore, biomedicine has yet to identify a definitive biological or physical cause/marker accounting for mental illness (Deacon, 2013). Billions in research funding has been dedicated to this quest even as "psychiatric drugs haven't improved much in recent decades, and searches for the genetic causes of common forms of mental illness haven't yielded clear answers either" (Regalado, 2015), which is acknowledged by American psychiatrist, neuroscientist, and former head of the US National Institute of Mental Health, Thomas Insel (2022), who was influential in shifting research efforts away from a behavioural focus to those centred on genetics and neuroscience (Barry, 2022; Carey, 2014). Despite what is considered an "intense search for the biological basis of mental disorders", this pursuit, according to Borsboom et al. (2018), "has not resulted in conclusive reductionist explanations of psychopathology". Psychiatric diagnoses, for example, stand in contrast to diseases that are demonstrably traced to microorganisms – also known as pathogens or "germs", as in germ theory – where scientific

evidence demonstrates how particular diseases (e.g., smallpox, cholera, variant Creutzfeldt-Jakob disease) are caused by said microorganisms (e.g., viruses, bacteria, prions). With a known pathology, some diseases can be effectively treated with antibiotics and antivirals or through vaccines, which prompt the production of antibodies that allow for the immune system to recognize and appropriately respond to future exposures.

Instead, psychiatric diagnoses are rendered through clinical observation and symptomology – as outlined by the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM), or the "'bible' of the profession", as it is often described – where a person's stated and observed symptoms are assessed and categorized, and they are given a psychiatric diagnosis based on the subjective understanding of those symptoms by a clinician (Watters, 2010, p. 3). Kwame McKenzie – a prominent psychiatrist, professor, and researcher at the Centre for Addictions and Mental Health in Toronto, Canada – sums it up thusly in an interview for a documentary that, in part, discusses the diagnosis of schizophrenia:

> Because we haven't got the pathology, we can't say what's going on in the brain, or in the mind, or whatever, we try and find the symptoms and cluster symptoms together and we say we've got "this diagnosis" or "that diagnosis" and schizophrenia is a number of symptoms that have been put together to say that "this is an illness". And that's an idea, it's not a thing. (Balazs, 2012)

Like schizophrenia, other psychiatric diagnoses are ideas, even though they are prone to reification (Hyman, 2010).

All of this is not to say that biology plays no role – it does, biology matters; and together with a confluence of psychological factors, social determinants, and other environmental exposures and their combined interplay, we are better able to glean and understand the various roots of mental distress (R. Clark et al., 1999; Engel, 1977, 1980; Ghaemi, 2009; Harrington, 2019; Mental Health Commission of Canada, 2013; Scheid & T. Brown, 2009; R. Smith, 2002;

Sulmasy, 2002; Weir, 2012). An integrative approach may offer greater understanding about the etiology of mental distress in contrast to a siloed, deterministic, and binaristic "battle between biological and non-biological approaches" (Weir, 2012). Nevertheless, it is inaccurate and problematic to solely proclaim biological causality and to point to, for example, the widely popularized theory of chemical imbalances, which is unfounded even though it is often authoritatively cited by doctors and is mainstreamed as a leading cause for a range of psychiatric diagnoses (e.g., depression, bipolar disorder, schizophrenia) (Healy, 2004; Kirsch, 2011; Lacasse & Leo, 2015; Leo & Lacasse, 2008; Moncrieff, 2008). Indeed, and unlike the dominant discourse and practice of biomedical psychiatry, not all of the psy-disciplines (e.g., psychoanalysis and psychotherapy) emphasize a biological explanation in accounting for mental distress, nor do these approaches underscore the use of psychopharmaceuticals. Psychoanalysis and psychotherapy – which mainly utilize talk therapy and behavioural coping strategies – look to the individual's internal, psychological conflicts (both conscious and unconscious) when addressing mental distress. Furthermore, and beyond neurochemistry, scientists have made tremendous strides in gleaning pathophysiological and other neural system insights via investigating links between mental illness and developmental disorders, complex genetic disorders, and brain disorders (Insel, 2009, p. 700). While these important connections and ongoing research in this area are insightful, conclusive biological causal links have yet to be identified (Borsboom et al., 2018; Deacon, 2013).

Biomedical psychiatry – and its accompanying diagnostic tools, labels of mental disorder, and overwhelming focus on individual expressions of illness and pathology – does not capture the intricacies borne out of holistic and country-specific factors (e.g., Guyana's colonial history and multi-ethnic population), which influence how distress is conceived and experienced.

Biomedical psychiatry provides one framework of interpreting mental distress. Its benefits, limitations, and harms will be further discussed in the theoretical section of this dissertation. Despite its mixed record of efficacy, particularly the comprehensive body of literature that evidences the limitations and harms of biomedical psychiatry in addressing mental distress, this allopathic approach is conventionally viewed as the standard-bearer – as the legitimate or primary system of thinking, knowing, and doing to address distress. This sometimes lends to the subordination of other ways of understanding and alleviating distress. This research attends to these aforementioned tensions, impositions, and silences.

The diversity of terms and expressions utilized by the participants, such as madness and others akin to madness (e.g., "running off", "tripping out"), spirit possession (e.g., "*jumbie*[4] deh pon" [spirits/demons are on them], "jumbie gat dem" [spirits/demons have possessed them]), spiritual/supernatural interference (e.g., "somebody do dem something" [employing rituals and spells to cause harm or madness in this context]) and mental illness/mental disorder (e.g., "depression") prompted me to engage with the non-medicalizing umbrella term of mental distress, which is commonly utilized in medical anthropology, cross-cultural psychiatry, critical mental health research, mad studies, and critical disability studies literature to more broadly yet accurately capture different conceptions and experiences that typically elude the dominant psychiatric lens (Beaupert, 2018; Beresford, 2019; Gammeltoft & Oosterhoff, 2018; Lacasse, 2014; LeFrançois et al., 2013; Lovell et al., 2019; Mills, 2018; Nichter, 1981; Read & Reynolds, 1996; Spandler et al., 2015; Whitley, 2014).

[4] *Jumbie* is an umbrella term that references demons, spirits, and other supernatural beings in the Caribbean, which usually, though not always, intend harm. Seymour's (1975) definition states that it is a "ghost, spirit of evil disposition" (p. 37).

When I mention people with experiences of mental distress, I am largely – but not exclusively – referring to individuals who have or were given psychiatric diagnoses/mental illness labels, people labelled or who self-identify as mad, people with psychosocial/mental disabilities, neurodiverse people, patients, ex-patients, consumers, service users, and psychiatric survivors. These categories do not exclusively capture all people with experiences of mental distress because some individuals reject these labels altogether, finding them narrowly individualistic and unable to apprehend the social and structural roots of their distress (Beresford, 2019). Though all of the participants who chose to disclose personal experiences discussed how periods of immense distress and emotional suffering have affected their lives – causing suicidal ideation, debilitating worry, the inability to perform day-to-day functions for prolonged/sustained periods of time – some do not claim any of these identifiers. In fact, there are a few participants who disavowed them, choosing to forgo labels in an effort to clearly spell out their experiences and to discern, in plain and blunt terms, the overall conditions and pain points that gave rise to their distress. It is important to capture the multiple and complex ways that people understand themselves – to meet them where they are, especially when they locate themselves in ways that are outside of existing or common categories.

Chapter One of this dissertation briefly introduces the reader to Guyana and some of the socio-politico-economic complexities of the nation. This first chapter also lays out the interdisciplinary conceptual framework and methods with which this dissertation engages. I explore the theoretical groundings and location of this work in current fields of knowledge, specifically (i) Caribbean health belief systems, traditional medicine, and healing practices, (ii) medical anthropology, cross-cultural psychiatry, and critical mental health research, (iii) mad and critical disability studies, and (iv) postcolonial, transnational, and feminist approaches. This

dissertation speaks to research gaps in the four areas of scholarship. While medical anthropology, cross-cultural psychiatry, critical mental health research, and mad and critical disability studies decentre Western biomedical models and show how cultural conceptions of mental distress and madness differ across space and time, in-depth engagement with Caribbean communities, Guyana in particular, is lacking. Scholarship on Caribbean health belief systems, traditional medicine, and healing practices contextualizes the diverse kinds of worship and strategies in the region related to health and wellness, but does not comprehensively consider questions of mental distress, madness, disability, spirit possession, and how these factors resonate with healing in Guyana. Postcolonial, transnational, and feminist approaches provide an intersectional framework grounded in understanding colonial legacies, structural inequalities, and the politics of identity. While there is a budding subsection of this literature that is beginning to engage the dimensions of mental distress, madness, and disability in the Caribbean, additional and sustained scholastic engagement is necessary, especially as it relates to countries such as Guyana and other categories of difference like religion and spirituality.

Chapter Two explores the case studies of Singh, Persaud, and Richards in greater detail; the published media reports, op-eds, and letters to the editor related to each case are analyzed. This chapter also engages with relevant aspects of Guyana's history and provides context as related to major themes of this research, spurred by these cases – namely questions of gender-based violence and race – and the ways in which ethnic gendering (Williams, 1996a) operated historically and persists in the contemporary moment to make violence possible. Chapter Three outlines the formal mental health care system in Guyana, namely the relevant infrastructure, laws, and policies that come to constitute it – the majority of which are colonial inheritances that date back to the 1930s. These mechanisms are rooted in the British lunatic asylum system, which

centred colonial psychiatry, and continue to wield power in the contemporary moment. Considerable attention is paid to the deplorable conditions at the National Psychiatric Hospital (NPH) and decades-long government inaction and neglect; these discussions are predominantly based on the accounts of NPH staff. Chapter Four specifically addresses the phenomena of suicide in Guyana, some of the effects of its criminalization, and the proliferation of biomedical psychiatry and the psy-disciplines more generally in the country.

Chapter Five maps and analyzes the aforementioned meanings of mental distress as worked through by the 37 participants. Of import in this research are the disclosures from 17 of the participants detailing their experience or a family member's experience of mental distress. These accounts speak to the humanity and complexity of distress, particularly understandings of madness. More often than not, these stories insist that mental distress and madness do not diminish or erase one's dignity and worth. The participants talk through the many intersecting factors that come to shape their experience or a family member's experience of mental distress, refusing to be flattened by the perceived abjection of the mad subject. There is a lack of research and a dearth of theorization that substantively investigates the nuanced understandings of mental distress and madness in Guyana, let alone at the intersections of (dis)ability, gender, race, class, religion/spirituality, and sexuality. The personal accounts in Chapter Five lay bare some of these connections and crossings; they insist that the stigmatized perception of madness is the delusion because it is divorced from the profound range and intricacies of the human experience.

In Chapter Six, participants reveal how mental distress and madness are perceived and attributed through an array of explanatory models: biomedical; socio-economic/structural; (inter)personal; and supernatural. All of the participants cite a multiplicity of perceived drivers that traverse at least two explanatory models. They place greater emphasis on (inter)personal,

socio-economic/structural (e.g., violence, poverty, racism, sexism, homophobia), and supernatural (e.g., spiritual interference, spirit possession) models. Crucially, this research maps and analyzes praxis and the various methods – inclusive of the biomedical, psychosocial, and traditional medicine and healing approaches – utilized to ease distress. As cited by all 37 participants, common articulations expressing perceived supernatural causality of mental distress and madness are a part of the intelligible landscape that the helpers must maneuver and negotiate across the various occupational categories represented in this research. Specifically, socially sanctioned idioms of distress (Nichter, 1981) citing supernatural attribution include "somebody do dem something" (malevolent religious/spiritual rituals are performed against a targeted recipient to cause harm or mental distress in this context) and, to a lesser but still common extent, "jumbie deh pon" or "jumbie gat dem" (demons/spirits are on them or have possessed them).

The first section of Chapter Seven explores the propensity for religious/spiritual practitioners to act as first responders when distress is understood through this prevalent supernatural explanatory model. This research concerns itself with people's beliefs, and significantly, people's practices; practices that are sometimes considered default behaviours. This is not to say that these practices are mechanical or uninformed. To the contrary, the participants explain the competing logics and common grammar at play when Guyanese attend to mental distress and solicit different care approaches. For example, several participants across the different helper categories cite referral practices whereby distressed people and their families were advised by medical professionals to seek "outside" help or assistance from "outside doctors". They allude to traditional medicine and healing practices associated with various religions and spiritualities, with "outside" and "outside doctors" used as stigmatized terms that

often, though not always, connote Obeah and Kali Mai practices and practitioners – forms of worship that are of African and Indian (specifically Hindu) origins respectively – which have historically been ostracized in Guyana and the Caribbean (Case, 2001). According to most participants, the general public continues to view both sets of practices and the spiritualities related to them (e.g., Faithism) with suspicion and contempt. The majority of the religious/spiritual helpers – including those of Christian, Hindu, Muslim, and Faithist religions/spiritualities – said that some people who experienced mental distress specifically solicited their care because medical doctors referred their patients to them. Some participants cite that this is done because the referring medical professionals believed that the patient's mental distress was either caused by supernatural interference; or that the medical professionals believed that they did not have the confidence of their patient – whereby the patient believes that biomedical treatments are unable to address their distress and may, instead, place greater trust in traditional medicine and healing practices. These narratives reveal that some medical practitioners gave ear and engaged their patients' supernatural understandings of mental distress as they either suggested or passively supported patients' decisions to seek the care of religious/spiritual helpers if the patient felt it necessary. Divergently, other medical practitioners, while acknowledging how the general population and some patients seeking their care cite supernatural etiology, refuted and outright dismissed patient narratives of perceived supernatural etiology and the use of traditional medicine and healing practices.

The practice of seeking out religious/spiritual helpers as first responders and, in some cases, as medically referred second opinions speaks to the powerful perception that they possess the ability to heal and alleviate mental distress. Chapter Seven also specifically examines how religious/spiritual practitioners assess, respond, and intervene to provide care – detailing their

approaches to ensure that distressed, help-seeking people, according to one Hindu religious leader, "come back good" (Deonarine, Interview). Religious/spiritual helpers, in narrating how they assisted people experiencing distress, detail how they act as interlocutors of care. They cite three main connections. Religious/spiritual practitioners are bridges between mentally distressed people and (i) medical and social service professionals; (ii) the supernaturally interfered body and the spirit world; and (iii) kin and kith. They are influential mediators who intervene on multiple levels, but they also appear to recognize their limitations when they, too, advise distressed people to consult other helpers, specifically doctors and social service agents. Dominant cross-referral practices (e.g., medical professionals ➔ religious/spiritual practitioners; religious/spiritual practitioners ➔ medical and social service professionals) cited by participants underscore the plural approaches to care that come to constitute an intelligible landscape of belief systems and practices in Guyana.

This research functions as a multifocal critique (Mani, 1998; Siddiqui et al., 2014). It interrogates imperialism and Western hegemony via the imposition of colonial psychiatry in Guyana, and considers the provincialization (Chakrabarty, 2000) of biomedical psychiatry as it pertains to assessing, diagnosing, and treating mental distress. Biomedical psychiatry is but a single approach to care in addressing mental distress, especially in global South nations; it is not *the* approach to care. To be sure, and for many, biomedical psychiatry is a necessary component in an arsenal of plural approaches and wellness practices. It should, therefore, be considered as one important and potential element of care only insofar as the person experiencing mental distress finds this approach useful. Safety and utility from the perspective of the individual receiving care for mental distress – where practices centre human rights, informed consent (as an initial and continuous process), transparency, accountability, and harm reduction – are

paramount and are fundamental principles of this dissertation. People possess the ability and deserve the dignity to make sense of their distress and to determine what constitutes "help" in attending to their distress (Pitt, 2018).[5] Simultaneously, this dissertation is critical of government inaction in addressing the failures of the formal mental health care system in Guyana, especially the conditions at the NPH as outlined by the helpers who work there. It is the patients at this hospital who bear the greatest burdens of risk, harm, and violence.

Importantly, this dissertation is not a hagiography of that which is considered "traditional". This research questions cultural particularism in relation to traditional medicine and healing practices in Guyana – with the caution here being the "national conceit and unthinking glorification of everything in *our* culture" (Bhattacharya, 1954 [1931], p. 107, as cited in Siddiqui et al., 2014, p. 286). Caribbean traditional medicine and healing approaches, too, are models of care which may work for some but not others, similar to biomedical psychiatry. Nevertheless, a consideration of the use of Caribbean traditional medicine and healing approaches in care does not amount to an uncritical and unflinching deference to these practices, particularly when harms are committed or may result in the name or enactment of these practices, similar again to biomedical psychiatry. The crucial difference here, however, being the authority and legitimacy that is extended to one approach (biomedical psychiatry) compared to the historical denigration and broad stroke associations with maleficence and "witchcraft" (Grieve, 2010, pp. 492-494; F. Mohammed, 2015; Monty, Interview) imputed on the other (Caribbean traditional medicine and healing approaches). Both approaches often rely

[5] This point springs from discussions arising from a presentation given by Kendra-Ann Pitt (2018) at the roundtable event, "Whose community is it anyway?", which was a part of the Community Perspectives on Mental Health and Well-being series hosted by the Toronto Metropolitan University in Toronto, Canada. Pitt's (2018) talk asked important questions about who defines "help", what that "help" looks like, and how it varies across communities and different groups.

on theories and belief systems that are unproven or inconclusive, even though research outlines the utility of them because they sometimes – not always – produce positive outcomes in alleviating distress. None is a universal, sovereign remedy; there are no cures or miracle treatments in the existing toolkit of approaches. Instead, each method – in their own way – may offer degrees of utility and relief. With this understanding, this dissertation, in part, ends by asking: what might it mean to bring the "outside" *in*? This work also concludes by reorienting the "dem" in "somebody do dem something" and poses questions about what these findings mean for the collective, for "us" or "we" (per Guyanese Creolese[6]) – "somebody do *we* something" – in order to source best practices, nurture shared solutions, and cultivate better public health outcomes.

[6] Guyanese Creolese is an English-based creole language that is spoken by Guyanese people in Guyana and in the diaspora. Some of its vocabulary and expressions draw on various African, Indian, Chinese, Indigenous, and European languages. It is considered the "vernacular of the community" (Gibson, 1992, p. 49).

Chapter One:
Place, Theory, Methods, and Me

The first section of this chapter introduces the reader to Guyana, its people, and important socio-economic-politico facets of the nation. The next section engages with this research's theoretical groundings and its location in particular fields of knowledge. This interdisciplinary dissertation works with and across four areas of scholarship: (i) Caribbean health belief systems, traditional medicine, and healing practices, (ii) medical anthropology, cross-cultural psychiatry, and critical mental health research, (iii) mad and critical disability studies, and (iv) postcolonial and transnational feminist thought and approaches. I discuss foundational scholarship from each area, which come together through a syncretic and transdisciplinary reading practice to arrive at a conceptual and methodological framework that captures and attends to Guyanese belief systems, practices, and experiences. In the third section of this chapter, I discuss research methods and my research process. Finally, I reflect on my positionality and praxis as a scholar born in Guyana, living in Canada, and engaged in research in Canada, Guyana, and the wider Caribbean and its diasporas.

Place: Guyana

Guyana is an ethnically diverse nation with a population of around 750,000 people, who are spread out across three counties and ten administrative regions (Bureau of Statistics of Guyana, 2016a; Pan American Health Organization [PAHO], 2017). The main ethnic groups include Indians (40%); Africans (26%); Indigenous[7] societies (11%); people of mixed ethnicity

[7] The various Indigenous peoples of Guyana are widely referred to as "Amerindians" by the general population; however, an emerging and growing segment of these communities prefers the term "Indigenous" to describe themselves and their diverse societies (Casimero et al., 2020). In 2020, a petition was created to oppose the renaming of the Ministry of Indigenous Peoples' Affairs back to the Ministry of Amerindian Affairs ("Keep it 'Indigenous'", 2020). Romario Hastings, an educator from the Kapon' Akawaio Nation who started the change.org petition, states: "The generalized ethnic label 'Amerindian' or 'American Indian' is now an acknowledged

(20%); and Chinese, Portuguese, and White European populations (non-Portuguese, mainly of British and Dutch origin) (<1%) (PAHO, 2017).[8] Guyana is also a country of great religious diversity, whose population identifies with Hinduism (Sanatani, Arya Samaj, Kali Mai[9]), Christianity (Catholicism, Pentecostalism, Seventh-day Adventism, Anglicanism, Methodism, Jehovah's Witness, Spiritualism or Faithism, Lutheranism, Presbyterianism, Mormonism, and others), Islam (Sunnism, Shi'ism, Ahmadiyya), Bahaism, Rastafarianism, and a range of other faiths (Bureau of Statistics, 2016b).[10] While Guyana is geographically a part of continental South

misnomer resulting from the erroneous geography of Christopher Columbus, a label which has been perpetuated without the consent of Indigenous Peoples; a label which will continue to distort our histories and search for our lost and hidden Indigenous identities. This historical blunder must end with us" ("Keep it 'Indigenous'", 2020). Though participant narratives and research sources cited in this dissertation may use the word "Amerindian", I use the term "Indigenous" in my analysis when referring to Guyana's first peoples.

[8] Guyana has a history of colonial conquest, slavery, and indentureship. With this in mind, it is important to briefly contextualize Guyana's multi-ethnic composition. Indigenous peoples are the first inhabitants of the land; there are nine Indigenous nations (Wai Wais, Macushis, Patomonas, Arawaks, Caribs, Wapishanas, Arecunas, Akawaios, and Warraus) living across the country, particularly in hinterland communities (International Work Group for Indigenous Affairs, 2019). Afro-Guyanese are the descendants of people who were enslaved and forcibly taken from Africa to Guyana in the early 1600s by European colonizers to work on the sugar plantations and whose labour was fundamental in the establishment of the colony and its economic viability (Merrill, 1992). Indians, Chinese, and Portuguese are the descendants of people who were brought from India, China, and Portugal respectively to Guyana as indentured labourers in the 1800s, particularly after the abolition of slavery and when total emancipation came into effect in two stages throughout the British Empire (apprenticeship from 1834-1838; full emancipation in 1838) (Merrill, 1992); these groups were contracted to fulfill a labour shortage when formerly enslaved Africans sought opportunities away from the plantation system (Rodney, 1981). White Europeans (mainly British and some Dutch) are settlers and the descendants of colonizers. Portuguese people were historically "considered economically powerless (that is, compared to other European groups)", and "they were therefore not in the same category as planters and landowners and were not considered 'white'" (Brereton, 1981, as cited in Ferreira, 2006, p. 73). Of Guyana's sizeable mixed-race population, one prominent group are *dougla* people who are of mixed African and Indian descent. Dougla is of Bhojpuri origin describing a "person of impure breed" (Regis, 2011), a "bastard" or "mutt" (Bahadur, 2015a). Though initially read as pejorative in meaning, dougla has been reclaimed and is utilized as a self-identifier among Caribbean people of mixed African and Indian heritage (Barratt & Ranjitsingh, 2021; Kempadoo, 1999).

[9] The Kali Mai sect of Hinduism and Kali Mai *Puja* (Hindu religious/worship ceremony and rituals) in Guyana and the Caribbean refer to practices that are associated with the Hindu deity Kali – the dark-skinned mother goddess (A. Khan, 1977; Vertovec, 1993). Indian indentured labourers brought these practices to the Caribbean from southern India; these specific workers from the south were sometimes collectively called "Madrasis" (Tsuji, 2009). Kali Mai Puja is considered a healing ritual. A. Khan (1977) explains: "This is particularly true in the small South American country of Guyana where it is not surprising to hear of the sick or infirm seeking help at 'the Kali Church'" (p. 35). Like Obeah, Kali Mai worship is stigmatized (Tsuji, 2009). Christian colonial powers and Hindus who subscribe to more orthodox and Brahminical (Sanatani) forms of worship repressed these practices. Kali Mai worship is sometimes considered "an untrue representation of Hinduism" given its worship elements of animal sacrifice and spirit possession/trance states of being, which are sometimes seen as illegitimate forms of practice by other Hindus and non-Hindus alike (Tsuji, 2009, p. 72; Vertovec, 1993).

[10] Bureau of Statistics (2016b) data, based on results from the 2012 census, indicate that the distribution of the population on account of religious affiliation in Guyana are as follows (rounded to the nearest tenth): Hindu

America, the country is more socially, economically, politically, and culturally aligned with English-speaking Caribbean nations. It is a founding member state of the Caribbean Community (CARICOM); a regional intergovernmental organization intended to foster cooperation and economic integration among its 15 full member states and five associate member states (CARICOM, 2021). Most of Guyana's population resides in towns and small villages along a ten-mile coastal belt of habitable land, which is approximately six feet below sea level. Guyana is a former British colony and was known as British Guiana until May 26, 1966. Guyana removed Queen Elizabeth II as its head of state and became a republic on February 23, 1970. Before the British, Guyana was a Dutch colony and was also influenced by Spanish and French colonial policies. In this dissertation, I refer to Guyana as Guyana, before and after it achieved independence from the British on May 26, 1966.

In low- and middle-income countries like Guyana, difficult histories and complex socio-politico-economic relations must be engaged in a study focused on capturing how mental distress is understood, experienced, and the accompanying practices that are utilized to foster relief. Guyana continues to grapple with its history of colonization and the social, political, and economic consequences borne out of that history (Canterbury, 2007; Fletcher, 2010; Mars, 2001; Peake & Trotz, 2002; Williams, 1991). The country's experience with neocolonialism and neoliberal structural adjustment programs compound the pressure on demands for already limited resources (C.Y. Thomas, 1993; Walker, 2017). Guyana is one of the poorer countries in the Caribbean region and among its South American counterparts (World Bank, 2021a, 2021b).[11]

(24.8%); Pentecostal (22.8%); other Christians (20.8%); Roman Catholic (7.1%); Seventh-day Adventist (5.4%); Anglican (5.2%); Methodist (1.4%); Jehovah's Witness (1.3%); Muslim (6.8%); other faiths including Bahai, Rastafarian, and others (1.4%); and none (3.1%) (pp. 33-37).

[11] Per the World Bank (2021a), Guyana's GDP per capita in 2019 was approximately $6600 USD. This figure is projected to triple in the coming years given Guyana's emerging oil and gas sector (Tharoor, 2020); however, the COVID-19 pandemic and move to renewable energy sources may stall or hinder GDP growth.

The nation had a poverty rate of "41.2% in 2017, based on a poverty line of US$ 5.50 a day using data from the Guyana Labor Force Survey" (Inter-American Development Bank, 2020, p. 19). The high emigration rate of skilled workers ("brain drain"), including medical professionals, is a persistent problem of national urgency (Matera et al., 2020; Mishra, 2006; PAHO, 2011). The International Monetary Fund reported that 89% of Guyanese with a tertiary-level education left for economic opportunities in member countries of the Organisation for Economic Co-operation and Development (OECD) from 1965 to 2000 (Mishra, 2006, p. 16), representing the highest emigration rate in the world of an educated labour force between 1970 to 2000 (p. 17). The ramifications of these economic realities, with decades-long implications, are reflected in the social service sector and public health care system – including formal mental health care – which are under-resourced and rank poorly on global indices (Fullman et al., 2018; Goede, 2014; Misir, 2015). The findings outlined in Chapters Three to Seven of this dissertation especially speak to these challenging social and economic realities. Guyana's political landscape and history of ethnic conflict is briefly discussed in Chapter Two given the broader connections to themes of gendered and racialized violence, which are outlined in that specific chapter.

Theoretical Framework

Caribbean Health Belief Systems, Traditional Medicine, and Healing Practices[12]

What happens when people do not view ill-health, in part or entirely, through the gaze of biomedicine and look to supernatural or spiritual rationalizations? This is one question that is investigated in a study describing the "folk medicine beliefs" and practices of mothers in the treatment of childhood illnesses in the twin-island nation of Trinidad and Tobago (Aho &

[12] By Caribbean traditional medicine and healing practices, I refer to the complex mosaic of remedies and techniques grounded in the knowledge of ancestral medicinal herbs and plants, and constitutive of cultural and religious cosmologies of care and ritual with holistic and integrated understandings of the self and universe (P. Sutherland et al., 2013). These knowledges and practices in the Caribbean spring from Indigenous, European, African, Asian, and Indian cultures (P. Sutherland et al., 2013).

Minott, 1977, p. 349). Like Guyana, Trinidad and Tobago is also a part of the English-speaking Caribbean and shares a historical experience of British colonialism, similar ethnic demographics, and related socio-cultural characteristics. In their study, Aho and Minott (1977) felt it necessary to designate sections of their paper to describe "a supernatural cause of illness" because they found that some of the 77 mothers that they interviewed believed in *maljo*[13] (pp. 349; 352-353) – or ideas more widely and cross-culturally known as "evil eye"[14] in parts of the global North and South (Dundes, 1992b; Gershman, 2015; Lykiardopoulos, 1981). The mothers were firm in their convictions, with one poignantly describing the loss of her child and attributing the death to maljo:

> "One of my children died from maljo. The doctor said it was 'gastro' (gastroenteritis), although he didn't put anything on the death certificate. Symptoms were vomiting, going off (diarrhoea), and fever. I took him to an Indian Pundit, who said was maljo. He prayed and in order to test the maljo he took the baby to a coconut tree; the tree died. True, true thing." (Aho & Minott, 1977, p. 535)

Admittedly, this is a loaded narrative outlining an experience of perceived supernatural illness, which, on its face, is inexplicable – impossible to test through the scientific method. Yet, it is also one that – as this dissertation will reveal – is recognizable to Guyanese and other Caribbean societies because of its intelligible relationship with common conceptions of holistic health and the enactment of Caribbean traditional medicine and healing practices, which tend to engage the many religions and spiritualities practiced in the region and among its diasporas (Asantewa, 2016; Austin & Bourne, 1992; Bisnauth, 1989/1996; Case, 2001; De Barros, 2004; Gibson,

[13] *Maljo* – as it is known in Trinidad and Tobago – comes from the Spanish meaning *mal de ojo*, which references ideas of "evil eye" and literally translates to "bad eye" in English; it is known as bad eye in Guyana (Jainarinesingh, 2014).

[14] According to Dundes (1992a), evil eye is "a widespread, but by no means universal folk belief complex according to which the gaze or praise of one individual at or for another may cause illness or even death in the second individual or to an object belonging to that individual" and is a particularly prevalent belief in Indo-European and Semitic societies (p. vii).

2001; Guppy, 1958; Harrison et al., 1913; A. Khan, 2013; McKenzie et al., 2011; Pedersen & Baruffati, 1985; Peretz, 2020; Reinders, 1993; P. Sutherland et al., 2013; Waldron, 2003).

Utilizing the Aho and Minott (1977) case study as an entry point throughout these first few pages of this section, I work to explicate Caribbean health belief systems, the role of traditional medicine and healing practices, and the wider research resonances and implications for this dissertation. For an uninitiated Western audience, unacquainted with the Caribbean's history and socio-politico-economic complexities – particularly its religious and spiritual multiplicities (Edmonds & M. Gonzalez, 2010; P. Taylor & Case, 2013) – the idea of maljo and the competing rationalities and paradigms of health and how to address ill-health, as expressed by this mother in the study, might appear confounding and utterly absurd. I want to emphasize that this dissertation does not set out to debate the existence of God(s), spirits, demons, or other supernatural entities – which are features of global North (e.g., Christianity) and South (e.g., Kali Mai worship, Vodou, Christianity) belief systems – or whether or not said understandings are rational. It is the beliefs about the etiology of the child's symptoms in the narrative and, more critically, the practices enacted with the aim of bringing about relief that are of significance in this telling. This experience evokes the uncanny; it serves as one window into a single aspect of Caribbean life that is at once frightening as it is familiar to specific regional and global audiences. In fact, the mothers in Aho and Minott's (1977) study are not alone as research conducted around the world on parental health beliefs and caring practices show that evil eye is cited as a supernatural etiology of childhood illnesses (Bradley & Corwyn, 2005). This is found among Mexican and other Central American communities (Krajewski-Jaime, 1991; Mikhail, 1994; Murguía et al., 2003); European-Americans – specifically Irish, German, Italian, and Jewish populations (Jones, 1992); Spaniards (González et al., 2012); Greeks (Hardie, 1992);

Turks (Hizel et al., 2006); Indians (Choudhry, 1997; Spiro, 2005); and Kenyans (Abubakar et al., 2011), in addition to numerous other societies.

Maljo, as it is referenced in Trinidad and Tobago, is widely and colloquially known as "bad eye"[15] or *najar* (or *nazar*)[16] in Guyana (Deolall, 2019; A. Khan, 2013). In addition to Trinidad and Tobago (Aho & Minott, 1977) – evil eye is analogously referenced as such, with some linguistic variations, in the Caribbean countries of Haiti (Kirkpatrick & Cobb, 1990), St. Vincent and the Grenadines (Mulcahy, 1973), Cuba (Potterf, 2006), and Suriname (Vossen et al., 2014). Maljo is believed to be "a fairly common childhood illness felt to be caused by supernatural forces" when "someone born with a blight in the eye… looks admiringly on a child" (Aho & Minott, 1977, p. 352). The *Dictionary of Caribbean English Usage* (R. Allsopp & J. Allsopp, 1996/2003) expands on understandings of bad eye and defines it as "an evil spell or bad magical influence caused by looking with envy or a false show of goodwill… (esp. at a baby or a flourishing plant)" (p. 65). Others, however, have also concluded that bad eye or evil eye and the ill-health that may accompany it may be unintentional, where "people bestow the evil eye without malice" as they are unable to consciously control the power of their affected gaze (Jones, 1992, p. 158). Symptoms of maljo or bad eye, especially in children, include but are not limited to constant crying and irritability, the inability to urinate or have bowel movements, diarrhoea, green or extremely foul-smelling stool, stomach discomfort/cramps, cough, and cool and/or dry skin (Aho & Minott, 1977; Mans, 2020).

Like maljo, described by Aho and Minott (1977) as "a supernatural cause of illness" (pp. 349; 352-353), spirit possession and cognate beliefs are sometimes linked to ill-health in

[15] Refer to footnotes 13 and 14.
[16] *Najar* or *nazar* is from the Arabic meaning "sight" or "gaze" and also translates to mean "evil eye" in some contexts (A. Shaw, 2000; Spiro, 2005).

anthropological literature (Bourguignon, 1976); though, and it must be underscored, this is only one general understanding among many possible interpretations of possession and trance states. To be clear, spirit possession and cognate beliefs, which constitute regular and normalized phenomena and aspects of religious worship among various faiths (e.g., Vodou, Comfa [also spelled Komfa], Kali Mai), may or may not relate to ideas of "evil" or understandings of health and/or illness. Anthropological research in this area points to the manifold understandings and geographic and cultural pervasiveness of these beliefs (Bourguignon, 1976; Keener, 2010). A cross-cultural study of 488 societies – conducted by anthropologist Erika Bourguignon, a specialist in the area of possession trance and altered states of consciousness – found that 360 societies (74%) held spirit possession beliefs (1976, pp. 17-26). And while these beliefs are not universal, with varying context-specific interpretations ascribed to them, "no anthropologist today denies possession trances and the like" (Keener, 2010, p. 217); such refutation is viewed as the anthropological equivalent of "being a 'flat-earther'" (Burridge, 1969, p. 2, as cited in Keener, 2010, p. 217).[17] With these complexities in mind, several studies show how perceived spirit possession/interference – cited as a specific supernatural explanatory model – is attributed to ill-health among diverse societies (Bourguignon, 1976; Cohen, 2008), and to mental distress as well, leading to the application of psychiatric diagnoses (Castillo, 1994; Kua et al., 1993; I. Lewis, 2003; Razali et al., 1996; Ward, 1980). Spirit possession/interference is also cited as a perceived cause of mental distress in Caribbean communities (Alonso & Jeffrey, 1988; Gopaul-McNicol, 1998; Edge, 2013; Kiev, 1961; Maharajh & Ali, 2006; Mantovani et al., 2017; Moodley & P. Sutherland, 2010; Schwartz, 1985). Guyana is no exception (Lee et al., 2000; Singer et al., 1980).

[17] See Kenelm Burridge, *New Heaven, New Earth* (Oxford: Blackwell, 1969), 4 η. 2, as cited in David C. Lewis, *Healing: Fiction, Fantasy, or Fact?* (London: Hodder & Stoughton, 1989), 321-22 n. 15.

Returning to Aho and Minott's (1977) study, a significant proportion of the mothers utilized traditional medicine and healing practices when their children became ill, with some visiting folk healers and/or utilizing "plants, home-made oils, ointments, and teas" (p. 354). The authors found that religious and spiritual rituals play an important role in folk healing, especially when mothers believed that their children had maljo. Some mothers reported that they sought out an "Indian Pundit", "Hindu woman", and "Spanish folk healer" to perform rituals intended to "cut", or penetrate and break, maljo (Aho & Minott, 1977, p. 350). Moreover, practitioners of religions and spiritualities that have historically been maligned and equated with the practice of "magic and sorcery", with specific reference to Obeah[18], are consulted and "are all involved in healing" (Aho & Minott, 1977, p. 350). Medical doctors cannot cure maljo; as a general belief, "only people who know prayers can 'cut' the maljo" (Aho & Minott, 1977, p. 353). Aho and Minott (1977) interviewed two of the healers who the mothers consulted. The authors describe how the "Hindu woman" healer used prayers and rituals to "cut" maljo:

> In Laventille, mothers often consulted a Hindu woman who would "*jaray*" [19] [emphasis added] (prayer/healing ritual) the baby or child in a temple at the back of her house…

[18] According to Bilby and Handler (2004), Obeah "encompasses a wide variety of beliefs and practices involving the control or channelling of supernatural/spiritual forces, usually for socially beneficial ends such as treating illness, bringing good fortune, protecting against harm, and avenging wrongs" (p. 153). Others cite the ambiguity that comes to mark the practice of Obeah: "A hard-to-define term, Obeah can, in one breath, connote religious healing, spiritual harm, African tradition, cultural mixture, herbal medicine, legal intervention, and illegality" (Crosson, 2015, p. 152). As partly demonstrated in the Aho and Minott (1977) text and depending on how the term Obeah is employed, by whom, and for what ends, there exists potential for subterfuge and open interpretations of this practice, the specific rituals that come to constitute it, and the outcomes.

[19] According to A. Khan (2013), *jaray* or *jharay* comes from the Hindi word *jhara* and means "to sweep away, remove, clean off, or drive away, either with fire, bush brush, or a bramble broom", and alludes to the "idea of hocus-pocus as in juggling, or magic and conjuring up" by referencing the notion of "waving a wand or stick to drive away or expel evil" (p. 11). A. Khan (2013) mentions that jaraying is used as a means of "curing of snakebites and disease, or driving off evil spirits, or undoing charms and spells as in the evil or bad-eye" (p. 11). This custom of healing is shared and predominantly practiced by Indo-Caribbean people, particularly those living in Guyana, Trinidad and Tobago, and Suriname; Hindus and Muslims alike utilize it, even though specific understandings of jaraying may vary (A. Khan, 2013; S. Mohammed, 2016; Sharma, n.d.). While referenced as jaray, because of the "fluidity in customs, religious practices and beliefs at the quotidian level among many adherents of the two religions", it may involve different performative acts among Hindus and Muslims (A. Khan, 2013, p. 5; S. Mohammed, 2016). According to S. Mohammed (2016): "To jaray is to heal by stroking with broomsticks (Hindu custom) or to blow on the person three times after reciting Quranic verses (Muslim custom)" (p. 274). A. Khan (2013) details how jaraying involves the burning of "some bramble sticks (as in six-inch pieces of a pointer from a

> When the interviewer visited the Hindu woman in Laventille, she said, "Yuh baby have maljo? Bring him nah, ah can cut it." In a Hindu temple this healer uses a pinch of salt, five bird peppers, five grains of garlic, five mustard seeds, and five cocoyea broom sticks. These ingredients are passed over the baby from head to toe five times. Each time she repeats in Hindi, "Who maljo this is. Go back to them. Leave my baby alone." At the end of this prayer she throws all the ingredients into a nearby fire made especially for this purpose. It is important that the parents, who must accompany the child, not look at the fire while the ingredients are being burned. If they do, the maljo will follow them. Even spectators were advised not to look. The ritualized fire symbolizes the burning up of the maljo inflicting the baby. (p. 353)

The mothers placed great confidence in the folk healers because it is believed they are the trusted authorities with the appropriate knowledge to counteract and cure the perceived supernatural causes of illness (Aho & Minott, 1977). Moreover, mothers in the study held unfavourable attitudes towards "doctor medicine", expressing distrust of biomedicine and its practitioners (Aho & Minott, 1977, pp. 349, 354); but it was also not uncommon for some women to hold what the authors call "neutral responses", whereby they employed the dual use of biomedical and traditional medicine and healing practices (p. 354). These nuances, so insightfully captured by Aho and Minott, only scratch the surface of the expansive ways in which Caribbean people conceptualize health and ill-health, and the practices that they employ to elicit healing and restoration. Importantly, Aho and Minott (1977) assert that folk medical beliefs and practices,

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coconut broom), wrapped in a piece of brown paper that contains also onion and garlic skins, seven mustard seeds, and small peppers (bird peppers), and salt" (p. 11). The wrapping that holds the ingredients are passed around the body of the individual seeking healing five to seven times and, according to different interpretations, may be burned during or after the encirclement of the wrapped ingredients (Aho & Minott, 1977; Deolall, 2019; A. Khan, 2013). Depending on the religion and knowledge of the healer, verses springing from religious texts (Bhagavad Gita, Quran) may be recited, but incantations are not always a part of the ritual, especially if lay people – particularly mothers – are conducting jaray rituals (Aho & Minott, 1977; Deolall, 2019; A. Khan, 2013). This wrapping of ingredients into a bundle, encircling of the affected body, recitation of religious texts, and burning of the bundled ingredients is similar to another healing ritual of *ouchaying*, to *ouchay* (Deolall, 2019; Sharma, n.d.). Ouchaying and jaraying may be used interchangeably (Deolall, 2019). Like A. Khan's (2013) and Aho and Minott's (1977) description of jaraying, Deolall (2019) describes both ouchaying and jaraying as "five or seven pieces of coconut/cocoyea broom, bird peppers, the skin of garlic and onions, and salt were among the ingredients passed over an affected child as certain prayers and mantras were recited, with the entire lot burnt to ashes." Furthermore, A. Khan (2013) states that jaraying is often confused and equated with the Islamic practice of *dam karna*, or "blowing of the breath over the body or its ailing part but only after words of the Quran have been recited" (p. 13). This confusion may be linked to the cultural fluidity and fusion between Indo-Caribbean people of Hindu and Muslim faiths as cited by A. Khan (2013).

"far from being a hodge-podge of superstition, are more effective and systematic" than those unfamiliar with these views and phenomena would conceive (p. 350).

In the Caribbean, traditional healing practices have historically played a vital sociocultural role in maintaining the wellbeing of the diverse and dynamic communities that make up this region. The history of colonialism in the Caribbean is one of violence and marked by European conquest and the genocide of Indigenous communities; the enslavement of Africans who were forcibly transported to the region to work on sugarcane plantations; and the indentureship of Asians (predominantly Indians and Chinese) who arrived to work on the sugar estates under oppressive bonded labour contracts after the Slavery Abolition Act of 1833, with the first two ships of Indians arriving on the shores of Guyana in 1838. The distinct spiritual and healing practices of these various groups were birthed out of knowledge of ancestral medicinal herbs and plants, cultural and religious cosmologies with holistic understandings of the self and universe, and the desire to survive and thrive during the colonial period, where the health and wellbeing of racialized bodies was of ancillary concern to European planters and settlers (P. Sutherland et al., 2013). Along with mainline Christian denominations (e.g., Catholicism, Lutheranism, Presbyterianism) and Brahminical forms of orthodox Hindu worship (e.g., Sanatani), "sideline" faiths and charismatic spiritualities such as Obeah, Vodou, Shango, Spiritualist Baptist, Pentecostalism (and other evangelical forms of Christian worship), Winti, Comfa, Santeria, and Kali Mai worship are only a few of the syncretic, religious and spiritual formations in the Caribbean today (Olmos & Paravisini-Gebert, 2011).

The belief in the supernatural – God(s), spirits, ancestors, demons, and other mystical entities that are workers and bringers of favourable or malicious outcomes – is common in this religious and spiritual milieu, in addition to Christianity's influence and scriptural teachings of

angels and demons (Maharajh & Parasram, 1999). In particular, the practice of Obeah and Vodou in the Caribbean is viewed with suspicion based on colonial and Christian assumptions, even though they include good works meant to yield positive outcomes and healing (Bilby and Handler, 2004; De Barros, 2004; Crosson, 2015; Paton & Forde, 2012). It is not uncommon for people of Caribbean origin experiencing mental distress to believe that illness or misfortune is caused by malevolent spiritual or religious practices, especially in relation to Obeah (James et al., 2014). The belief that one Obeah practitioner can heal and undo/untie what another Obeah practitioner has cursed is partly explained by Dale Bisnauth (1989/1996), noted scholar of Caribbean religions: "The belief that healing was the work of the divine order was the corollary of that other belief that human disorder or sickness was brought about by the operations of the spirit world." Healing practices intended to intervene in the spiritual world by casting out spirits and demons from bodies of the affected – rituals that are sometimes referenced as exorcisms – are routinely performed in the Caribbean (Bisnauth, 1989/1996; Glazier, 1985; Marina, 2016; Mustapha, 2013). People of European origin also employ the practice of exorcism in the West. Around the world, every Catholic diocese is expected to have a trained priest who is able to perform exorcisms (Brennan, 2012); this includes Guyana ("If it is Diabolical", 2009). Similarly, the Church of England has a "network of diocesan exorcists" (Stanford, 2013) and experienced a resurgence of interest in performing exorcisms (Milner, 2000). The West appears to use both exorcism and biomedical psychiatry to address mental distress without appropriately acknowledging the former. Biomedical psychiatry is mainstreamed and privileged, while there seems to be some apprehension about the ways in which understandings of mental distress, madness, spirituality, religion, healing, and allopathic medicine are enmeshed in unimagined and, sometimes, complimentary ways in the global North (S. Persaud & Trotz, 2015). This

project engages with and analyzes these multifaceted approaches, their legacies, and the social and cultural purchase of this nexus in Guyana.

Since 2018, there are 170 WHO member states that acknowledge the use of traditional[20] and complementary medicine[21] in their societies (WHO, 2019b, p. 10). Of the WHO's (2019b) 194 total member states, 98 crafted national policies on traditional and complementary medicine, 109 developed national laws or regulations, and 124 reported having laws or regulations related to the use of herbal medicines as of 2018 (p. 5). Guyana is one of the 170 WHO member states that acknowledges the use of traditional and complementary medicine (WHO, 2019b). Per the WHO (2019b): "There is no national policy or regulatory system for traditional and complementary medicine in Guyana. However, the Government recognizes the important role played by traditional and complementary medicine" (p. 94). The WHO (2019b) also recognizes the significance of Indigenous traditional medicine[22], which is important in Guyana, especially given the nation's diverse Indigenous societies. In Guyana, Indigenous traditional medicine is a constitutive part of the knowledge base and practices used to solicit positive health outcomes, particularly as it relates to ethnobotany and the use of medicinal herbs and plants – or "bush medicine" – which are widely accepted and utilized across different ethnic groups and are commonly sold in local markets throughout the nation (Austin & Bourne, 1992; Dial, 2019;

[20] Per the WHO (2019b): "Traditional medicine has a long history. It is the sum total of the knowledge, skill and practices based on the theories, beliefs and experiences indigenous to different cultures, whether explicable or not, used in the maintenance of health as well as in the prevention, diagnosis, improvement or treatment of physical and mental illness" (p. 8).

[21] The WHO's (2019b) definition of complementary medicine is also inclusive of alternative medicine and refers to a "broad set of health care practices that are not part of that country's own traditional or conventional medicine and are not fully integrated into the dominant health care system. They are used interchangeably with traditional medicine in some countries" (p. 8).

[22] According to the WHO (2019b), Indigenous traditional medicine is defined as "the sum total of knowledge and practices, whether explicable or not, used in diagnosing, preventing or eliminating physical, mental and social diseases. This knowledge or practice may rely exclusively on past experience and observation handed down orally or in writing from generation to generation. These practices are native to the country in which they are practised. The majority of indigenous traditional medicine has been practised at the primary health care level" (p. 8).

Lachman-White et al., 1992). Bush medicines of Indigenous, Indian, African, and Chinese origins are all prominent in Guyana, reflecting the country's diverse populations (Dial, 2019). These various approaches have maintained their individual integrity, and, in some cases, they have also syncretized with their counterparts (Austin & Bourne, 1992; Harrison et al., 1913).

Experts also cite the positive value of Caribbean traditional medicine and healing practices, calling for the consideration of its integration with conventional biomedical health care systems in the Caribbean and in Western nations with large Caribbean communities (James & Peltzer, 2012; du Toit, 2001; McKenzie et al., 2011; Mitchell, 2011). Its utility and potential to yield positive outcomes when combined with biomedical approaches, particularly to address mental distress, is also emphasized according to research studies conducted by Jilek and Draguns (2008), Moodley et al. (2008), Sussman (2008), Thachil and Bhugra (2009), and Wintrob (2009) (as cited in McKenzie et al., 2011). And while Aho and Minott's study was published in 1977, research published in the last 25 years on the Caribbean and countries with significant Caribbean diasporas show that these belief systems and healing practices persist (Aarons, 1999; Edge, 2013; James et al., 2014; James & Peltzer, 2012; Lacey et al., 2016; Mantovani et al., 2017; P. Sutherland et al., 2013; Upadhya, 2011; Whitley et al., 2006). Furthermore, research recommends that these health beliefs and practices must be engaged, interrogated, and potentially integrated towards the creation of responsive approaches and to arrive at equitable outcomes in treatment and care for Caribbean populations (Chaze et al., 2015; McKenzie et al., 2011; Mitchell, 2011; P. Sutherland et al., 2013).

Caribbean traditional medicine and healing practices must not be romanticized either; they are not without their failures. These practices – like some dehumanizing psychiatric practices in mental health institutions (Bedi, 2019; Goffman, 1961); psychologist-designed

torture tactics in the US "War on Terror" (Borger, 2020; Bray, 2009; Rabbani, 2020); and well-intentioned, yet damaging social interventions (Sapien & Jennings, 2018) – are not immune from wielding power in ways that enact grievous harm against vulnerable populations, particularly people experiencing mental distress. In Guyana, people have been assaulted and killed as a result of practices ascribed to traditional medicine and healing rituals ("After failed 'Exorcism'… Manslaughter Convict 'Mother Alves' now on Attempted Murder Charge", 2015; Gibson, 2001, pp. 44-45; "*Pandit*[23] to face High Court Trial for Rape", 2014; Juan, 2019). While the intent to heal is emphasized, harm may be the corollary in any model of care that decentres the rights of the recipient receiving said care. This dissertation does not glorify the "tradition" in Caribbean traditional medicine and healing practices. As sacred as these practices are or may be perceived, they are not sacrosanct. They must be rigorously interrogated and must not be used as an alibi to legitimize harm and abdicate responsibility. Conversely, the three cases of reported violence (i.e., Singh, Persaud, and Richards), which generated curiosities that allowed for this dissertation, should not be viewed as a monolithic representation of all practices and outcomes – as though harm is the only consequence of traditional medicine and healing approaches. That is too basic a thesis. When these approaches are poorly understood, it is exceedingly easy to brand them as totally nefarious. Violence and other harmful outcomes, however, must solicit reflection, critical engagement, reorientation, and a push for safe, informed, transparent, and accountable practices. It is violence that prompted this dissertation, but it is ultimately the complexities borne out of that violence in which this dissertation concerns itself.

[23] A *pandit* is a Hindu priest who, among other duties, performs worship/religious ceremonies known as pujas. Pandit means "learned" or "wise"; it is also a "generic term for a teacher or a scholar", often signalling Brahminism and Brahminical forms of Hindu worship (W. Johnson, 2009).

The theoretical framework of this dissertation begins with Caribbean health belief systems, traditional medicine, and healing practices as a gesture of acknowledgement and in recognition of the right to dissent and critique hegemonic systems – like biomedical psychiatry – which were not designed with the wellbeing or interests of Caribbean societies in mind. Traditional medicine and healing practices have historically played a vital role that enabled Caribbean communities to survive and thrive before, during, and after the indelible experience of colonialism (De Barros, 2004; P. Sutherland et al., 2013). The mothers' accounts in the Aho and Minott (1977) study come to represent a postcolonial narrative of belief systems and practices that historically endured the brutality and terror of European conquest and imperialism. Some of these mothers are proponents of Western biomedicine even as they simultaneously place confidence in traditional medicine and healing practices. For others, they judged that biomedical interventions were unsuitable, and, therefore, unable to address their children's symptoms. Through what I contend was a customary act of Caribbean maternal care (i.e., seeking a village healer to address childhood ill-health attributed to supernatural causality), these mothers did what many mothers before them have done: they utilized the immediate community resources available to them to respond to their child's health crisis. In doing so, they returned the gaze and troubled the universalizing and omniscient claims of the biomedical model in their decision to use traditional medicine and healing practices to provide care, which they believed produced health-giving effects. Indeed, it can be persuasively argued that the resolution of some of the children's symptoms after rituals such as jaraying was nothing more than placebo[24] – the "holy

[24] My use of the term "placebo" extends here to mean the "broad array of nonspecific effects in the patient–physician relationship, including attention; compassionate care; and the modulation of expectations, anxiety, and self-awareness" (Kaptchuk, 2002, p. 817). For this specific example springing from the Aho and Minott (1977) article, instead of the patient-physician relationship, I mean the patient-healer relationship, which Kaptchuk (2002) analyzes in his discussion of the placebo effect and healing rituals in alternative/unconventional medicine.

trinity of belief, expectation, and hope" (Begley, 2010). Having said all of this, the mothers' perceptions that these rituals provided therapeutic utility also matters because of precisely what it tells us about the belief systems and practices of some Caribbean people, offering key insights about what they might do, why they choose to do it, and how it is done in anticipation of relief.

The social purchase of Caribbean traditional medicine and healing practices – perceived as powerful and curative as they are also thought fraudulent and demonic – led to them being outlawed in favour of Christianity in Caribbean countries under colonial regimes (Crosson, 2015; De Barros, 2004; Paton, 2009) and later marginalized by the dominant, Western biomedical model (Waldron, 2010). Although some phenomena – like evil eye and spirit possession – might seem uncanny, they come to constitute the ordinary and comprehensible landscape of health, illness, and corresponding care practices among Caribbean populations and societies across the world. Caribbean traditional medicine and healing practices are sometimes marked by stigma, considered quackery, and praised for their ability to heal; they are treated with ambivalence – as open secrets that are performed in comfortable shadows by "outside" practitioners. They play an important role in a larger ensemble of belief systems and practices – frequently competing to be recognized and heard over the piercing and presiding presence of the Western biomedical paradigm; at other times, they participate in concert, complementing or integrating with biomedicine and the psychosocial model; and sometimes, they play unaccompanied as a centred soloist, as the sought after and primary expert in care. No matter how they are adjudged, they are familiar instruments in the orchestra of Caribbean life, and they must be engaged in open and honest conversations.

Medical Anthropology, Cross-Cultural Psychiatry, and Critical Mental Health Research

This project integrates literature from the areas of medical anthropology, cross-cultural psychiatry, and critical mental health research. In doing so, this dissertation returns the gaze by engaging with and critiquing the authority of biomedical psychiatry in specifically addressing mental distress in the Guyanese context. Guyana's multi-ethnic populations each possess disparate origin stories and worldviews that influence the ways in which they conceive of health and ill-health. Biomedical psychiatry is one system of interpreting mental distress; and its benefits[25], limitations[26], and harms[27] are extensively documented. As a framework, biomedical psychiatry does not account for or capture Guyana's history, population composition, and the aforementioned socio-politico-economic intricacies outlined in previous sections.

Leading medical anthropologist and psychiatrist Arthur Kleinman's (1978, 1980, 1987) germinal research on explanatory models grapples with how people and communities understand illness and distress within their social and cultural contexts. Kleinman (1978, 1980, 1987) suggests that there is often a disjuncture between the doctor's clinical knowledge and the patient's lived experience and understanding of illness within their socio-cultural framework. Explanatory models (Kleinman, 1987) document the meaning-making process of illness by asking information-seeking questions: what does the patient believe caused it (illness/ill health); what does it do to them; how does it work; what should be done about it, and so forth. Critiques of explanatory models cite the inherently unequal relationship between the doctor and patient (Scheper-Hughes, 1990), and the inferred authority of biomedicine, which for some scholars

[25] See: Cipriani et al., 2018; Gøtzsche et al., 2015; Shedler, 2010; Kendell, 1975; Kendell & Jablensky, 2003; US Preventive Services Task Force, 2019; and Ward-Ciesielski et al., 2018.
[26] See: Anestis et al., 2011; Fournier et al., 2010; Horowitz & D. Taylor, 2019; Kirsch, 2011; Lecomte et al., 2012; Perkins et al., 2018; and Wilson, 2018.
[27] See: Burstow, 2015; Beaupert, 2018; Bedi, 2019; Fabris, 2011; Fabris & Aubrecht, 2014; Frances, 2013a, 2013b; Gøtzsche et al., 2015; LeFrançois et al., 2013; Reaume, 2009; and Szasz, 1961.

remains an unquestioned regime of truth (Foucault, 1970, 1975). Gaines and Hahn (1982, 1985, as cited in Ember & Ember, 2004, p. 96) further explode the general supposition of biomedical power and its claimed universality in arguing that biomedicine is a historically constructed "sociocultural system" (1985, pp. 3-4, as cited in Ember & Ember, 2004, p. 96). It is saturated with its own subjective beliefs, mores, regulations, and practices belonging to "just another ethnomedical system" (Gaines & Hahn, 1982, p. 215, as cited in Ember & Ember, 2004, p. 96). Their foundational work decentres Western biomedicine, which is commonly thought of as modern, unbiased, professionalized, and evading the influence of a cultural framework (Ember & Ember, 2004).

Mills & Fernando (2014), in turning their attention to biomedical psychiatry, argue that it is an imported, imposed, and detached Western-based system that context-strips, distills down, individualizes, and pathologizes the human experience and complex problems of living. They contend that this approach medicalizes, and more specifically psychiatrizes, social problems. Biology-based theories of mental disorders are often utilized to argue for the proliferation of the biomedical model (Mills & Fernando, 2014; Mills, 2014), which is usually positioned as the primary, if not only, approach to capture and treat experiences of mental distress. Biological theories, which are constitutive of biological psychiatry, predominantly focus on genetics and the anatomical structure and functioning of the brain; they theorize that there is a biological basis for disorder. For example, the Canadian Mental Health Association (n.d.) – even as it acknowledges various causes of mental illness – privileges and points to the brain as the main site of illness/disorder: "The brain is the most complex organ in the human body. Mental illness occurs when the brain, just like any other organ such as the heart, or the kidney, is not working the way it should." Previous WHO publications have made similar claims through the assertion that

mental disorders have "'a physical basis in the brain...they can affect everyone, everywhere' and are understood to be 'truly universal'" (WHO, 2001, pp. x, 22-23, as cited in Mills & Fernando, 2014, p. 188). These claims are exhaustively critiqued and refuted (Joseph, 2004; Mills & Fernando, 2014; Watters, 2010). A 2021 WHO publication, *Guidance on Community Mental Health Services: Promoting Person-Centred and Rights-Based Approaches*, presents a more nuanced and updated position on addressing mental distress:

> In order to successfully integrate a person-centred, recovery-oriented and rights-based approach in mental health, countries must change and broaden mindsets, address stigmatizing attitudes and eliminate coercive practices. As such, it is critical that mental health systems and services widen their focus beyond the biomedical model to also include a more holistic approach that considers all aspects of a person's life. Current practice in all parts of the world, however, places psychotropic drugs at the centre of treatment responses whereas psychosocial interventions, psychological interventions and peer support should also be explored and offered in the context of a person-centred, recovery and rights-based approach. These changes will require significant shifts in the knowledge, competencies and skills of the health and social services workforce.
>
> Furthermore, as mental health research has been dominated by the biomedical paradigm in recent decades, there is a paucity of research examining human rights-based approaches in mental health. A significant increase in investment is needed worldwide in studies examining rights-based approaches, assessing comparative costs of service provision and evaluating their recovery outcomes in comparison to biomedical-based approaches. Such a reorientation of research priorities will create a solid foundation for a truly rights-based approach to mental health and social protection systems and services. (pp. xxi-xxii)

As briefly touched on in this WHO publication, biomedical psychiatry benefits tremendously from extensive research prioritization, institutional endorsement, and billions in dedicated funding (Regalado, 2015) focused on the "search for genes that create vulnerability to mental illness, affect the course of illness, and impact treatment" (National Institute of Mental Health's Genetics Workgroup, 1997). As a result, researchers have identified specific genes and gene activity which they hypothesize create said "vulnerability" for the development of mental illness (National Advisory Mental Health Council Workgroup on Genomics, 2018); however, and as

previously mentioned, we have yet to clearly identify any definitive biological cause(s) accounting for mental illness since the search commenced in the late 1800s and greatly accelerated in the previous decades (Borsboom et al., 2018; Deacon, 2013). Despite the technological strides of genome mapping and the identification of DNA variants, no genetic marker is able to identify or predict mental illness, nor can any blood test or brain scan detect it. Woolfson (2019), in a *Nature* book review, summarizes the present situation and states that "biological causes remain elusive, and biomarkers nonexistent" (p. 181).

Currently in its fifth edition, the DSM medicalizes "significant changes in individuals' memory, identity, and mood" (Lafrance & McKenzie-Mohr, 2013, p. 120). Depending on the diagnosis rendered, psychiatric medications are often prescribed, which are intended to therapeutically alter the chemical makeup and interactions in the brain. It is theorized that chemical imbalances may cause mental illness; however, this hypothesis remains unproven (Healy, 2004; Kirsch, 2011; Lacasse & Leo, 2015; Leo & Lacasse, 2008; Moncrieff, 2008; Moncrieff et al., 2022). A recent systemic review published in *Nature* by Moncrieff et al. in July 2022 on the serotonin theory of depression states: "The main areas of serotonin research provide no consistent evidence of there being an association between serotonin and depression, and no support for the hypothesis that depression is caused by lowered serotonin activity or concentrations." Psychopharmaceuticals, often used and intended to correct said hypothesized chemical imbalances, have a checkered history of efficacy and may cause adverse side effects (Fava, 2007; Gøtzsche et al., 2015; Healy, 1997; Kirsch, 2011, 2014; Kirsch & Sapirstein, 1998; Whitaker & Cosgrave, 2015). The overall benefits and limitations of psychiatric medications, alongside issues of patient rights violations (e.g., manipulative and coercive administration) and financial conflicts of interest between doctors and the pharmaceutical industry, are extensively

questioned and contested by researchers, practitioners, and consumers of these drugs (Burstow, 2015; Cipriani et al., 2018; Fabris, 2011; Fabris & Aubrecht, 2014; Fava, 2007; Fournier et al., 2010; Gøtzsche et al., 2015; Healy, 1997; Kirsch, 2011; Mad in America, 2011; Whitaker & Cosgrave, 2015; Wilson, 2018). Having said all of this, the accounts of people who report that they have immensely benefitted from psychopharmaceuticals (particularly antidepressants) – that these drugs are lifesaving, life-affirming, and essential – must also be acknowledged (Kramer, 2016). These interventions are part of the many and necessary ways in which people require care and find relief. Nevertheless, some controlled studies demonstrate that the efficacy of these drugs is no better than placebo (Kirsch, 2014; Kirsch & Sapirstein, 1998), or the "medical benefit you get from an inert pill or other sham treatment" (Begley, 2010). One recent and lauded, meta-analysis of antidepressant trials by Cipriani et al. (2018) claims that these drugs are more effective than placebo; though reanalysis of this study by other researchers conclude that methodological limitations and flaws, particularly in the evidence base and use of "response" rates, did not conclusively establish that antidepressants were more efficacious than placebo (Moncrieff, 2018; Munkholm et al., 2019). Continued and sustained research in this area is essential in the ongoing process of establishing best practices.

The DSM is a creation of the West. The diagnoses therein are based on symptomology and the clinician's subjective understandings of mental distress (Watters, 2010). It is argued that the previous iteration (DSM-IV) rendered Western-based understandings of distress as universal and subject to no cultural proviso, while classifying the distress experienced by some societies in the global South as "culture-bound syndromes" (Kleinman, 1997). Critics contend that the authors of the DSM and its successive editions are "reluctant to see their creations as historical, cultural, ideological products rather than as scientific documents" (Phillips, 2013, as cited in

Ecks, 2016, p. 142). To be sure, the authors of the latest iteration of the DSM – currently in its fifth edition – observed this criticism and recognized that it is a cultural and changing product of the West. The DSM-5 states: "The current formulation acknowledges that all forms of distress are locally shaped, including the DSM disorders… Like culture and DSM itself, cultural concepts may change over time in response to both local and global influences" (American Psychiatric Association, 2013, as cited in Ecks, 2016, p. 142). Despite pronouncements in the DSM-5 that the Manual itself is a cultural product intended to display "greater cultural sensitivity", this engagement often rings shallow because most of these revisions are only found in the introduction and appendices of the current edition, while the Manual continues to rely upon ethnocentric and superficial understandings of culture (Bredström, 2019, p. 347; Jacob, 2014). Of these shortcomings in the DSM-5, Jacob (2014) notes:

> Social and cultural context, patient beliefs about causation, impact, treatment and outcome expectations are never systematically elicited as they were not essential to diagnosis and classification. Patient experience and narratives are trivialized and the biomedical model is considered universal and transcendental. (p. 89)

Furthermore, the cooption of these cultural critiques in word, however, has not changed psychiatric practice where there is continued reliance on diagnostic labels and advocacy for the prescribing of psychopharmaceuticals (Ecks, 2016), whose use is mainly intended to correct hypothesized, though unproven, chemical imbalances. The failure to substantively view Western-based diagnostic labels of mental distress as cultural formations in and of themselves lends to hegemonic, ethnocentric, and imperialist ends, which reify these diagnoses and biomedical psychiatry; thus, also refusing to acknowledge how global South communities have historically cared for themselves outside of the biomedical gaze.

Moreover, the unreliability of psychiatric diagnoses remains a persistent problem in the field (Aboraya et al., 2006; Goodman et al., 1984; Kitamura et al., 1989); therefore, and based on

the prominence of disorder-specific treatment within biomedical psychiatry (Deacon, 2013), people may be misdiagnosed and prescribed psychopharmaceuticals, which are unable to address their symptoms due to said unreliability of psychiatric diagnoses. Other research refutes the validity of these diagnostic labels altogether, rendering them "scientifically meaningless" (K. Allsopp et al., 2019, p. 15; "Psychiatric Diagnosis", 2019). In a comprehensive study of five significant chapters from the DSM-5 on schizophrenia, bipolar disorder, depressive disorders, anxiety disorders, and trauma-related disorders, lead author, K. Allsopp et al. (2019), concluded:

> Although diagnostic labels create the illusion of an explanation, they are scientifically meaningless and can create stigma and prejudice. I hope these findings will encourage mental health professionals to think beyond diagnoses and consider other explanations of mental distress, such as trauma and other adverse life experiences. ("Psychiatric Diagnosis", 2019)

While it is understood that the DSM's diagnostic labels are constructs, "where all forms of distress are locally shaped" (American Psychiatric Association, 2013, as cited in Ecks, 2016, p. 142), it is argued that the labels might be useful in offering clinicians "information about outcome, treatment response, and etiology that they convey" (Kendell & Jablensky, 2003, p. 4). As well, these labels may allow people experiencing distress to access services and benefits (Perkins et al., 2018). Other research, however, also conclude that these diagnoses are arbitrary and dogmatic – operating at the whims of those in positions of power with the capacity to make authoritative pronouncements (e.g., clinicians, employers, governments) – and may do more harm than good in fueling stigma, poor health outcomes, curtailment of civil liberties and individual autonomy, and other adverse material consequences (K. Allsopp et al., 2019; Borsboom et al., 2018; Davies, 2013; Gorman & LeFrançois, 2017; Knaak et al., 2017; Mills & Fernando, 2014; Nyblade et al., 2019; Szasz, 1961).

Internal critics have also emerged. Allen Frances (2013a, 2013b), psychiatrist and chair of the DSM-IV taskforce leveled major criticisms against the DSM-5. He and others (Horwitz & Wakefield, 2007, 2012) argue that the current edition of the DSM pathologizes everyday forms of distress, including expected forms of sadness and grief after the death of a loved one, where "people who experience completely normal grief could be mislabeled as having a psychiatric problem" (Frances, 2010). He explains:

> Turning bereavement into major depression would substitute a shallow, Johnny-come-lately medical ritual for the sacred mourning rites that have survived for millenniums. To slap on a diagnosis and prescribe a pill would be to reduce the dignity of the life lost and the broken heart left behind. (Frances, 2010)

The practice of psychiatry – from its roots in the early 1800s, to the development of the first edition of the DSM in 1952, to the technological advancements and strides of genome mapping – is a relatively new approach whose search for the conclusive biological roots of mental illness is ongoing. Psychiatry is, as stated by Frances (2010), the "Johnny-come-lately" approach when compared to the millennia-old and heterogeneous practices, rites, and rituals of various societies intended to address mental distress. Furthermore, the DSM is intended to serve as "a common language among clinicians" (American Psychiatric Association, 2012, as cited in Lafrance & McKenzie-Mohr, 2013, p. 120). This "common language" among clinicians in the West is normalized and popularized among lay populations of the West (Lafrance & McKenzie-Mohr, 2013); however, and as stated by the majority of this study's participants, the language of the DSM and biomedical psychiatry – while utilized to a much lesser degree by everyday Guyanese – does not hold the same cultural and linguistic purchase in Guyana. Instead, all participants of this study indicate that socially sanctioned idioms of distress (Nichter, 1981), such as "somebody do dem something", are employed because they are attentive to Guyanese-specific worldviews

and experiences – a Guyanese psychospiritual, if I may call it that, which is deeply attuned to the complex relationship between the mind, the human experience, and spirituality.

This dissertation is also in dialogue with scholarship that analyzes racism and psychiatric models of illness. As a practicing psychiatrist and revolutionary in French Algeria, Frantz Fanon rejected the common discourse of colonial psychiatry, which maintained that North Africans were primitive, criminal, and lacked higher brain function when compared to Europeans (Cherki, 1975/2006). Fanon (1952/1967) argued that colonization is inherently racist and is, in itself, a driver of mental illness and distress among colonized populations. Before Kleinman wrote about the need to engage with culture and healing practices to better understand experiences of mental distress, Fanon was utilizing Algerian understandings of spirituality as an integral component of treatment and recovery as a psychiatrist in Algeria's Blida-Joinville Psychiatric Hospital (Sikuade, 2012; Bhui, 2002). Inspired by the pioneering work of Fanon, Frederick Hickling – the late Jamaican psychiatrist, who was an advocate for deinstitutionalization (as with Fanon) and a champion of community mental health care in Jamaica – emphasized how the mental distress experienced by Caribbean populations, particularly in former British colonies and countries with large Caribbean diasporas, cannot be divorced from the legacy of slavery and colonialism (Hickling, 2006, 2012, 2020; Hickling et al., 2013; Hickling & Griffith, 1994; Hickling & Hutchinson, 1999, 2000). Hickling (2012) privileges a psychohistoriographic approach, which is a "postcolonial model of psychoanalysis" that is rooted in the experience of the Caribbean and its peoples. This approach challenges European conceptions of mental illness and "vigorously negates the Cartesian-based Freudien-Viennese-based epistemic model of psychoanalysis that has shaped the emergence of psychology and psychiatry in the 20th century" (Hickling, 2012, p. viii). Psychohistoriography is an important tool because, as Hickling states, it compels us to

"reconsider our world view and the way in which we consider the future" (p. ix); it challenges us to ask and engage what those futures might look like when we centre and hold space for Caribbean experiences.

Also building on the work of Fanon, transcultural psychiatrist Suman Fernando (1988), whose germinal mental health research intersects with areas of mad studies (Mills & Fernando, 2014), asserts that psychiatry is inherently ethnocentric because it was borne out of inherited, nineteenth-century racist stereotypes that emerge based on European conceptions of the other. Fernando (1988, 2003, 2010, 2014), a UK-trained psychiatrist and researcher who has done extensive work in the areas of racism and mental health, argues that people of colour – particularly Black men of Caribbean origin living in the United Kingdom – encounter both subtle and overt forms of discrimination as a result of migrating to and living in institutionally racist societies where these attitudes are also reproduced in biomedical psychiatry (Fernando et al., 1998). Fernando's (2014) approach in deciphering best practices begins at the grassroots level by prioritizing wellbeing – not just of the individual but also of the family and community as a whole – in addressing systemic barriers. Participatory methods acknowledging that communities may already hold some of necessary keys to solve their problems are emphasized; however, this understanding does not exclude the benefits that might be rendered from outside approaches and biomedical psychiatry if individual people and communities self-determine that these options may also be helpful in addressing mental distress (Fernando, 2014). This dissertation underscores the importance of meeting people where they are by highlighting the gravity and utility of plural systems – inclusive of biomedical, psychosocial, and traditional medicine and healing approaches – in understanding the unique lifeworlds of people living in Guyana and the ways in which they understand and make meaning of mental distress and madness.

Mad and Critical Disability Studies

Mad and critical disability studies supply crucial frameworks from which to draw. These approaches, which scholars argue are not simply "a subject-oriented area of study…" (Schalk, 2017), can be thought of as methodologies, epistemologies, and wider perspectives from which to understand our world (LeFrançois et al., 2016; Gorman & LeFrançois, 2017; Minich, 2016). These fields, in part, attend to the ways in which madness and disability are constructed within normalizing regimes (Anders, 2013; L. Davis, 1995; Foucault, 1977; LeFrançois et al., 2013; Titchkosky & Michalko, 2009) and the multiple systems of oppression (e.g., saneism, ableism, racism, neoliberalism) that come to define the centre, while madness and disability are simultaneously cast outside of notions of normalcy to the margins of society. This casting out is particularly discernable when examining horrific incidents of violence and the ways in which bodies labelled mad and disabled are considered unnatural and abnormal in Guyana; these bodies are constructed as deviant, and they are brutalized and murdered as a means of purging difference. It is, however, the insidious nature of normalizing regimes – and their sustained, dull hum of repression – that systematically constitute an everyday framework, creating habituated conditions that make possible these (un)surprising spectacles of violence. As hooks (2000) reminds us, it is from the margins with which the centre is defined and consolidated in an ever-shifting reproduction of exclusion.

This dissertation relies on a coalition of critical discourses in its exploration of disability and madness. In thinking through how to strengthen theorizing within disability studies, Sleeter (2010) argues that an alliance of critical methodologies and theories across, but not limited to, feminist, postcolonial, critical race, and queer theories is necessary if we are to substantively understand the phenomena of disability in all its complexities and from the standpoint of different marginalized perspectives. Disability studies in its early, widely recognized formation

in the global North was a White, masculinist endeavour, mainly attuned to distinguishing and analyzing medical and social models of disability with little examination of the multiple imbrications of difference and disability. Feminist disability studies scholar Morris (1991) outlines this thinking:

> The disability movement has argued against the medical model of disability which health and social service professionals (and the general public) tend to apply... Within this model, disabled people are reduced to the medical condition (or impairment), which accounts for their physical and/or intellectual characteristics and there is little or no account taken of the social and economic context in which people experience such medical conditions. Disability activists have therefore developed a social model of disability, arguing that it is environmental barriers and social attitudes… not the inability to walk which disables someone, but the steps into the building… However, there is a tendency within the social model of disability to deny the experience of our own bodies, insisting that our physical differences and restrictions are entirely socially created… A feminist perspective can help to redress in so doing give voice to the experience of both disabled men and disabled women. (pp. 9-10)

Morris (1991) challenges both models and insists that while the social model is crucial in its call for basic civil rights, it negates experiences of the body when met with a range of experiences like "physical or intellectual restrictions, of illness, of the fear of dying" (p. 10), and of chronic pain. For Morris (1991) and others (Crow, 1996; Meekosha, 1998; Hughes, 1999; Paterson & Hughes, 1999, 2000) it is critical to bring the body back to disability studies discourse, with an understanding that "disability is experienced in, on and through the body, just as impairment is experienced in terms of the personal and cultural narratives that help to constitute its meaning" (Hughes & Paterson, 2006, p. 101, as cited in Loja et al., 2013, p. 191).

Feminist disability studies scholars Garland-Thomson (2005, 2011), Morris (1991, 1996), B. Smith and Hutchison (2004), C. Thomas (1999), and Wendell (1996) intervene in these early theorizations of disability, while also tackling the omissions of mainstream feminist discourse in addressing the experiences of disabled people. This scholarship in feminist disability studies also birthed ideas that universalized a particular disabled identity as it carved out space for White,

disabled women. Ideas about how "disabled people, across the broadest spectrum of disability, have solidified as a group", establishing "the foundation of a clearly identified disabled community" (Linton, 1998, p. 5) or the notion that disability is "the most universal of human experiences" (Garland-Thomson, 2005, p. 1568) are overgeneralized and over-determined. Disability studies has long ignored and displaced the imbrications and implications of race, class, gender, sexuality, and the socio-historical conditions that affect racialized, poor, and queer disabled people, including women of colour, in the global North and South (Bell, 2006, 2011; Das & Addlakha, 2001; Dossa, 2009; Erevelles, 2011a, 2011b; Gayle-Geddes, 2015; Gorman, 2005, 2013, 2016; Grech, 2015; Grech & Soldatic, 2016; Harry, 2020; Kennedy & Newton, 2016; Nguyen, 2018; Meekosha & Soldatic, 2011; Parekh, 2007; Singal, 2010). These exclusions are considered an "intellectual crisis" (Meekosha, 2011, p. 667) and represent major scholastic gaps within the field (Ejiogu & Ware, 2008; Erevelles & Minear, 2010; Goodley, 2010; Gorman, 2013). Asking questions about *which* disabled people and their material conditions is of import in this work, especially when the mainstreamed disabled subject emerges as a White, Western body given these sparse inclusions of racialized, class-based, queer, and transnational perspectives and realities.

Anti-racist, postcolonial, and transnational responses pose questions about how to conceive of the body and the social differently, particularly so since disability within a Western framework does not necessarily speak to the experiences of racialized, non-Western subjects. Erevelles (2011b) contends that while feminist disability studies critically interrogates the ableism of mainstream feminism, "it falls prey to its own critique of normativity by failing to seriously engage 'difference' along the axes of race, class, ethnicity, and nationality" (p. 119).

She levels central critiques concerning these omissions, which are characteristic of feminist disability studies:

> Although I agree with Garland-Thomson that the analytic category of disability is useful in destabilizing static notions of identity… I argue that the effectiveness of much of feminist disability studies remains limited because of its overreliance on metaphor at the expense of materiality… In order for feminist disability studies to realize its transformational potential, it must move from mere discursive intervention to deep interrogation of the material constraints that give rise to the oppressive binaries of self/other, normal/abnormal, able/disabled, us/them… While Garland-Thomson fundamentally challenges feminist concepts of the (ab)normal body, her argument relies on an unexamined assumption that disabled identity always occurs outside of historical, social, and economic contexts. This assumption is especially problematic given the intersection of race, class, gender, sexuality, ethnicity, nationality, and disability… How can acquiring a disability be celebrated as "the most universal of human conditions" if it is acquired under the oppressive conditions of poverty, economic exploitation, police brutality, neo-colonial violence, and lack of access to adequate health care and education? What happens when human variation (e.g., race) is deployed in the construction of disabled identities for purely oppressive purposes (e.g., slavery, colonialism, and immigration law)?... Unfortunately, feminist disability studies has provided few responses to these questions." (Erevelles, 2011b, p. 119-120)

Erevelles (2011b) explains her approach and practice, what she has termed a "transnational feminist disability studies perspective" (p. 119). When Erevelles (2011a) talks of materiality, she means the "actual social, historical, and economic conditions that influence people's lives, conditions further mediated by race, ethnic, gender, class, and sexual politics" (p. 119). Her work locates and unpacks "privileged material contexts" (Erevelles, 2011b, p. 119) as it situates "disability not as the condition of being, but of becoming, and this becoming is a historical event, and further, it is its material context that is critical in the theorizing of disabled bodies/subjectivities" (Erevelles, 2011a, p. 26). The acquisition of disability within a historical context and how we talk of disabling processes is crucial, while remaining attuned to the dangers of this association because disability is conceived as an abject identity (Kristeva, 1982, as cited in Erevelles, 2011a, p. 26). Building on the work of Erevelles, this dissertation also engages with Gorman's (2016) interventions in calling for "a relational/reflexive methodology to reveal the

social relations of disability beyond the immediate narrative that the subject evokes; one which can attend to both the social organisation of disablement and the situated knowledges of and resistance to these social relations" (p. 251). As Gorman (2016) points out, there is no coherent or universal disabled identity/subjectivity because social-embodied relations differ across space and time (p. 255). Gorman (2016) asks us to think through strategies, which will allow us to "contextualise disablement as an assemblage of political-cultural-economic processes" (p. 258). Erevelles' and Gorman's calls for specificity and sustained engagement with materiality are of central concern in this research project.

As a scholar whose work extensively engages both mad and critical disability studies, Gorman's (2005, 2013, 2016; Gorman & LeFrançois, 2017; Gorman et al., 2013) work provides a necessary bridge between the two approaches. Mad studies is an emergent field that embraces the adage "*nihil de nobis, sine nobis*" or "nothing about us, without us", which is a common refrain in disability rights movements and critical disability studies (Charlton, 2000). Gorman and LeFrançois (2017) recognize how mad studies entered academic spaces through critical disability studies and also on its own merits as a distinct transdisciplinary field (p. 108). Gorman and LeFrançois (2017) understand mad studies as a space to "center the knowledges and theorizing of those who have been deemed mad" and where "much focused attention has been placed on the retrieving, documenting, understanding, revisiting and teaching of mad people's history" (p. 107). They conceive of mad studies as:

> A space of social action and theorising about oppression and psy-violence that centres the histories of psychiatrised bodies, particularly because those psychiatrised bodies have been suppressed and erased within other disciplines and bodies of knowledge, including those bodies of knowledge that critique psychiatric oppression. In addition to this innovative way of studying and teaching mad people's history, mad studies provides a systemic critique of psy-violence, epistemic injustice (Donskoy 2015; LeBlanc and Kinsella 2016) and sanism (Fabris 2011; Poole et al. 2012). (Gorman & LeFrançois, 2017, pp. 108-109)

In acknowledging the omissions, erasures, and other failings of critical disability studies scholarship regarding the inclusion of diverse perspectives and marginalized voices, "transnational, critical race and postcolonial understandings have been integral to mad studies from its inception" (Gorman & LeFrançois, 2017, p. 108). This aspect of mad theory works to centre the stories of colonized and racialized mad people; challenge the erasure of their subjectivities and histories; and contest their disproportionate representation in psychiatric institutions (Gorman, 2013; Gorman et al., 2013; Gorman & Udegbe, 2010; Haritaworn, 2013; Kanani, 2011; Mills, 2014; Nabbali, 2013; S. Patel, 2014; Tam, 2013; Voronka, 2013, as cited in Gorman & LeFrançois, 2017, p. 108).

As recognized by Gorman and LeFrançois (2017) there is potential for mad studies to valourize and emphasize the experiences of middle-class and less dominant White mad identities in the West without tackling the intersecting and co-constitutive oppressions at play in racialized and other marginalized communities in the global North and South. As this research will explore, madness is not an identity that is claimed by any of the participants who reveal and describe their personal experiences of mental distress (n=9). While some participants recognized that their behaviours appeared mad – where they behaved "like ah [I] mad" (Navindra, Interview) – madness is too abject and indelible to self-identify with when compared to the ways in which it is claimed in mad communities, mad studies, and mad theorizing in the West. Instead, the participants in this study extensively talk through social-embodied relations – or their understanding of the acquisition of mental distress – and mainly identify interpersonal, socio-economic, structural, and supernatural explanations; with biomedical narratives featured to a lesser degree, but nevertheless implicated. Interestingly, even when some of these participants personally disavow mad and madness as identity-based descriptors to capture their experiences

of mental distress, they still utilize these words as proxy terms of engagement in their personal accounts and as descriptors of third-party experiences of mental distress. In doing so, they offer nuanced and polyvalent narratives that disrupt and broaden our understandings of madness as they articulate disabling material conditions and outline possibilities for alleviating distress through the enactment of broad social and economic supports and diverse and holistic care practices.

This project poses questions about how to conceive of the mind and body in alternative ways and as inextricably bound. This work troubles Cartesian dualism, particularly so since disability and madness within a Western framework are not always conceptualized congruently in Southern spaces because of diverse historical, cultural, economic, political, and social-embodied relations in countries like Guyana. Disability and madness, branded as abject subjectivities, are not necessarily afforded to, claimed, or desired by racialized, non-Western subjects, particularly so when bodies are readily labelled spiritually-interfered, evil, or possessed. An analysis of these phenomena in former colonial nations like Guyana intrinsically starts by detailing and analyzing how different bodily and behavioural ways of being and expressions are read on their own terms and in their particular contexts (S. Persaud & Trotz, 2015).

Postcolonial, Transnational, and Feminist Thought and Approaches – Caribbean *Rasanblaj*: Towards a Politics of Reconstitution

Postcolonial, transnational, and feminist scholarship play a foundational role in examining the histories and legacies of European conquest and colonialism (Alexander & Mohanty, 1996; Alexander & Ulysse, 2015; Bannerji, 2000; Chakrabarty, 2000; Fanon, 1952/1967; Grewal & Kaplan, 1994; Kempadoo, 2004; Loomba, 2005; Mani, 1998; Mohanty, 2003; Narayan, 1997; Rodney, 1981; Said, 1978; Silverblatt, 1987; Spivak, 1988; Taussig, 1980, 1987; Yuval-Davis, 1997). An important subsection of this literature articulates the emancipatory

possibilities, volatility, invisibility, and erasures connected to gendered understandings of a "woman's place" in Guyanese and other Caribbean societies (Alexander, 1994, 2005; Barriteau, 2003; Hosein & Outar, 2016; Kanhai, 2011; P. Mohammed, 2002, 2012; Mohapatra, 1995; Reddock, 1994; Robinson, 2000; Trotz, 2004). Barriteau (2003) underscores the use of gender as a central analytical node: "Using insights from social relations of gender means that men no longer occupy a transcendental, epistemological position. Like women, they are constructed through relations of gender" (p. 43). Aligned with the concept of intersectionality (Crenshaw, 1989, 1991), developments in the literature consider how meanings attributed to other, interlocking identity categories of social difference (race, class, sexuality), not only gender, also come to inform women's positions in Caribbean societies (Alexander, 1994, 2005; Hosein, 2012; Kanyeredzi, 2013; Kempadoo, 2004; Trotz, 2004; Safa, 1995; Wekker, 1993, 2006). There is a burgeoning segment of the literature that has begun to pursue considerations of madness, critical mental health, disability, and the socio-politico-economic and cultural meanings that are consequently enmeshed within these categories in the Caribbean and among its diasporas (Chouinard, 2012; Gayle-Geddes, 2015; Gramaglia, 2008; Harry, 2020; Hall, 2005; Kennedy & Newton, 2016; F. Jackson & Naidoo, 2012; Josephs, 2013; Lee et al., 2000; S. Persaud, 2019, 2017, 2015, 2014; S. Persaud & Trotz, 2015). This project builds on and intervenes in this emergent area as it attends to how Guyanese conceive of mental distress and the associated practices that are enacted to solicit relief, with emphasis on the ways in which spirituality plays a central role in care; this line of inquiry has not been substantively pursued in the literature.

Jacqui Alexander's (2005) *Pedagogies of Crossing: Meditations on Feminism, Sexual Politics, Memory, and the Sacred* considers the spiritual as a mechanism for survival, as a

resource and restorative strategy in response to the destructive effects of colonialism. Of these effects, she writes:

> Since colonization has produced fragmentation and dismemberment at both the material and psychic levels, the work of decolonization has to make room for the deep yearning for wholeness, often expressed as a yearning to belong that is both material and existential, both psychic and physical, and which, when satisfied, can subvert and ultimately displace the pain of dismemberment. (Alexander, 2005, p. 281)

This dissertation is rooted in making space to foster the "deep yearning for wholeness" that is underscored by Alexander (2005, p. 281). This work also labours toward what Gina Ulysse (2015) calls Caribbean *rasanblaj* – which in Haitian Kreyòl means "assembly, compilation, enlisting, regrouping (of ideas, things, people, spirits. For example, *fè yon rasanblaj*, do a gathering, a ceremony, a protest)". Rasanblaj (Ulysse, 2015) is directly informed by Alexander's (2005) interventions, and common ground is also found in assemblage theory (Deleuze & Gautarri, 1980/1987) and Caribbean theories of relationality (Glissant, 1990/1997). In conversation with Alexander, Ulysse further describes rasanblaj as "a quest to identify and recognize manifestations of this dismemberment with the aim of ultimately subverting and displacing its pain" (2015). This journey for reconstitution and resonance is grounded in historical specificity, where theory and praxis live as equals to address the fragmentation, disablement, and traumata of colonization and neoliberalism. It can be argued that the biomedical gaze functions as a tool of the neoliberal project. The neoliberal propensity to sever community, where people are distilled down and removed from their collectives as a way of individualizing systemic repression without a study of its operational logics and structures must be examined alongside the biomedical tendency to individualize and arbitrarily pathologize mental distress while reducing or outright erasing the gravity of relational, structural, socio-economic, and other environmental problems of living. Alexander and Ulysse (2015), who

together penned a piece on the potentiality of rasanblaj, emphasize that it is a process of reconstitution; rasanblaj can be read as a linkage, and is marked by interdisciplinarity; rasanblaj is the regroupment for multiple ways of doing, thinking, and being. In relation to this research, rasanblaj is the necessary (re)assemblage of singular methods and the pushing of disciplinary boundaries to build existing fields of knowledge and practice anew, with the promise of restoration at the psychic and physical levels of being.

Caribbean rasanblaj is at the same time a process of confrontation, of facing terror. Alexander and Ulysse (2015) tell us:

> To recognize terror is an important recognition. Audre [Lorde] would urge us at this very point to dig deep down inside ourselves in order to see the face that terror wears. It's a necessary piece of work; it's one that troubles terror. Not paradoxically, it's also a beautiful one. What else could be more beautiful than coming to know, or coming to see, the wholesomeness of who/what you are. What more beauty is there in coming to recognize yourself in your full expression of your possibilities, the full expression of your birthright?

Terror is a critical conceptual tool in understanding that which is materially and psychically feared – the phantoms of colonization and their socio-politico-economic hauntings in the time of neoliberalism. Interaction with this terror ultimately reveals itself to be a process of reckoning and reconciliation and is a constitutive encounter that enables one to experience the wholeness that Alexander (2005) yearns. In conversation with terror, rasanblaj is the (re)collection of fears, anxieties, and ancestral injuries; it is the confrontation and bringing together of the terror to transform those entrenched harms and experiences of horror so that one may come to know restoration and healing.

This dissertation confronts the terror that is conjured and made real when bodies labelled mad, possessed, and evil are made central in the examination of how mental distress is experienced in Guyana. I contend that doing the work of exposing and destabilizing terror happens on multiple fronts. Researching how Guyanese make meanings of madness and the

connections to supernatural etiology in particular must speak to the material and psychic consequences of colonial regimes of terror that were enacted on colonized bodies and the intergenerational legacies of this terror, while at the same time addressing the terror that is socially accepted, legislated, institutionalized, and violently performed on distressed bodies labelled mad, possessed, and evil in Guyana today. This work troubles European colonialism and its brand of imperial biomedicine, which characterizes mental distress as pathology, unsettling how colonial legacies of biomedicine have reproduced and promoted violence against bodies labelled mad, possessed, and evil in the present. One must also hold accountable the cultural patrimony of the nation; the gendered and racialized ghost stories that promote violence against women and implicate us all when these tales are uncritically retold from one generation to the next (S. Persaud, 2011, 2019). Guyanese must stare deeply into the mirror of their own acts of harm against bodies labelled mad and possessed and the ways in which we are all implicated and complicit in reproducing terror and fragmentation. An encounter with terror must necessarily challenge the harm produced by violence in all its forms and at all levels. At the same time, this dissertation considers how Guyanese, through the process of rasanblaj and the "spirit of reassembly" (Alexander and Ulysse, 2015), can seek out possibilities of renewal and reunion by confronting that which continues to terrorize; by reorienting the "dem" in "somebody do dem something" to thinking about the collective "us" or "we"; to consider the restorative effects of working through "somebody do *we* something"; to process historical and present-day wounds and then ask, "What are *we* going to do about it?"

In employing a transnational feminist framework, rasanblaj becomes an important concept that is employed in my reading of all four areas of theoretical engagement. Why a rasanblaj of these approaches? I employ this practice precisely because of its commitment to

assemblage, to interdisciplinary inquiry, and to the building of a rhizomatic relationship between these four areas of scholarship. The disciplinary strands of each of these fields sprout, stretch out, reach across, and become entangled. Sometimes they will graft to each other as they develop together and apart in the messiness of their outgrowth, while remaining firmly rooted in doing the work of decolonization and deinstitutionalization.

Methods and Process

This dissertation is an ethnography that utilizes semi-structured qualitative interviews, site observations, media analysis, and document analysis (primary, secondary, tertiary, and grey literature). Fieldwork was conducted in Guyana spanning two research visits in 2014. On my first visit from February to May 2014, I conducted primary and secondary source research – mainly at the Walter Rodney Archives (National Archives of Guyana), the Caribbean Research Library at the University of Guyana, and the National Library of Guyana. A wealth of resources – including historical archival materials, government policies and legislation (and other grey literature), and newspaper reports – were located, and through document analysis they provided necessary information that helped define and anchor this dissertation. Through my affiliation with the Inter-Guyanas Feminisms Project, spearheaded by Kamala Kempadoo, and in collaboration with York International, I partnered with the Georgetown-based NGO Red Thread Women's Development Organization (Red Thread) and the University of Guyana's Institutes of Gender Studies (formerly the Women's Studies Unit) and Development Studies. My relationship with Red Thread spans over 11 years, well before I commenced doctoral studies. During this initial visit and through my established connection with Red Thread and contacts within the University of Guyana, I also began to have casual conversations with doctors, nurses,

NGO/social service actors, and religious/spiritual helpers about the ways in which mental distress was being addressed in the country.

Through these informal chats it became clear that interviews were necessary in order to capture the nuances of how mental distress is understood. Moreover, I realized that this sphere of helpers was my target interview population because of how their occupations allowed them, in part or in full, to engage with people experiencing mental distress, the families of those experiencing distress, specialist and non-specialist populations, and the general public. In these casual chats, a few helpers briefly alluded to their own personal experiences of mental distress. None, however, elaborated in great detail during these first meetings; nor did all of these helpers who I initially spoke with on this first trip come to constitute the participants with whom I conducted formal, ethics-approved interviews. These contacts spoke primarily about their professional experiences because the general direction of these informal meetings centred on their role as helpers, not as persons with experiences of mental distress. In particular, these exchanges apprehended the colloquial – the familiar, cultural, and social dimensions of how mental distress and madness are talked about every day and the associated practices, which were not meaningfully captured by the primary and secondary sources. Qualitative research interviews became a necessary method to explore these complexities; thus, necessitating a future, second research trip to Guyana after the completion of ethics and participant recruitment.

Conducting qualitative semi-structured interviews required the completion of dual ethics applications through York University and the Government of Guyana's Ministry of Health, both of which were approved before my second visit to Guyana from November to December 2014. On this trip, I collaborated with Red Thread and the Guyana Foundation, which is a not-for-profit based in West Coast Demerara, Guyana, and whose central mandate at the time was

focused on understanding pressing mental health concerns in Guyana and issues related to the country's high suicide rate. I reconnected with some of the helpers that I had informal chats with on my first visit. Some were able to participate; those who were unable to assist recommended people in their professional circles who were interested in participating. Through my existing network of contacts and referrals to others (snowball method), I was able to fully constitute the group of 37 helping participants to interview.[28]

Participants were required to have at least two years of experience working and interfacing with people experiencing mental distress, the families of those experiencing distress, specialist and non-specialist populations, and the general public. Many had decades of experience within their respective fields. Of the participants, there are 11 medical professionals across public and private health care systems: three medical doctors, five nurses, one nurse aide, and two aides working in a physician's office. Eleven social service and civil society/NGO actors participated and were a mix of helpers working with disabled populations, human rights and women's groups, and in mental health, LGBTQ, and youth activism organizations. There are 13 religious/spiritual helper participants: four Christians of various denominations; six Hindu leaders of two main subdividing denominations (two Sanatanists; four practitioners of Kali Mai and *Shakti* (goddess) worship, who are often maligned as Obeah/occult practitioners); two Muslim leaders (Sunni); and one Faithist (often maligned as Obeah/occult practitioners). Two government officials at the Ministry of Health were also interviewed.

Interviews were carried out in rural and urban settings throughout three administrative regions of the country, specifically Demerara-Mahaica (Region Four); Essequibo Islands-West Demerara (Region Three); and East Berbice-Corentyne (Region Six), which is where some

[28] Interview data is anonymized. Individual pseudonyms were assigned to each of the 37 research participants and are utilized in this dissertation.

interviews and visits were conducted at the country's psychiatric hospital – colloquially known as the "Berbice Madhouse" or more generally as the "Madhouse". These three regions are the most populated of the ten regions in the country, accounting for over 530,000 people of the country's approximately 750,000 inhabitants (Guyana Bureau of Statistics, 2012; PAHO, 2017). The interviews were expected to last no more than two hours, but some participants chose to extend their interview beyond the two-hour mark. Never did I expect participants to share personal experiences of mental distress; nonetheless, 17 of the 37 interviewees detailed how they (n=9) or a family member (n=8) experienced distress. It was completely presumptuous of me to assume that these participants would not be willing to share or talk through personal experiences of distress given the scope of this dissertation. On one level, this presumption was influenced by a flawed generalization that the helpers themselves were not or had not been service users as well; some were. I, having worked for over ten years in social services, should have known this and known better, but I was quickly able to re-orient when personal disclosures were made. I remain grateful to the participants who openly shared profoundly private details of their lives with me – the raw stories of distress, madness, and illness. These disclosures continue to remind me of that evergreen saying: nothing about us, without us. While the participants engaged with the terms mad and madness as identity descriptors for third-party experiences of mental distress and as a proxy for their own experiences, they did not personally claim the language of mad/madness in the ways that it is taken up in Western-based mad studies and mad pride movements, nor did they claim the disability studies language of impairment (social model of disability), which was the term that I initially engaged in the interviews. Impairment seemed incoherent and was sparsely utilized by the participants. Decisions around terminology shifted throughout this process but it was my discussions with participants that moved me to privilege

the language of mental distress. The participants talked through their professional and personal experiences of dealing with mental distress, owing it to perceived socio-economic/structural, (inter)personal, supernatural, and biomedical causes. It is for these and other aforementioned reasons that the umbrella term of mental distress – not the dominant and medicalizing language of mental illness or disorder – is privileged in this dissertation to negotiate and capture this broad range of diverse conceptualizations, experiences, and ways of being.

Returning to Canada, I began the process of transcribing and coding 37 interviews that, on average, spanned two hours with some nearing the three-hour mark. Transcribing proved to be an onerous exercise. There were ebbs and flows, starts and stops that prolonged this process. The accounts themselves were sometimes difficult to listen to again and again because of how they often engaged with different forms of violence. I am still making sense of the secondary, emotional unease that I feel from hearing, re-hearing, reading, and re-reading these particular accounts. I am sometimes asked why I chose not to hire and use transcription services. I am acutely aware of the sensitive data that I am entrusted with, particularly the very raw and personal narratives of spirit possession/interference, institutional harm, physical violence, and suicidal ideation that were confidentially revealed to me by the research participants. Also, as a researcher who was born in Guyana and grew up speaking Guyanese Creolese, I have an insider's understanding of the ins and outs, maxims, and particularities of the local tongue. These are the main reasons that I opted to solely transcribe all 37 research interviews.

The sheer amount of data was, at times, overwhelming and seemed insurmountable to organize. Some individual interviews equated to over 30 single-spaced pages of transcriptions. In personally doing the transcribing, however, I honed an adept familiarity with the content of the interviews, which made coding more manageable. I looked for common language and meanings

and made rudimentary notes on my initial survey of these transcriptions. The importance of oral literature, narration, and idiomatic expressions in shaping the discourse of mental distress and madness became apparent through the varied perspectives of the interview participants as I analyzed and coded reams of transcriptions and field notes. For example, the local idiom of "somebody do dem something" (Winnifred, Interview) or "somebody do meh" (Nicole, Interview) – the belief that incantations and supernatural works are performed which cause harm or in this context cause a targeted recipient to experience distress or to become mad, or to "trip out" (Lionel, Interview), "run off" (Samuel, Interview), and become "*paagli*"[29] (Hafsa, Interview) or "stupid" – is one that is primarily exposed through interviews and engagement with Guyanese Creolese. Written language does not always or adequately capture this spoken complexity, which is a central component in understanding Guyanese experiences of mental distress. What were endless rounds of coding finally began to come together as general and specific themes of analysis when put in conversation with the previously collected primary and secondary source materials, allowing for the drafting of this dissertation.

Me: Who Am I?

I am a proud daughter of Guyanese sugarcane cutters. I was born in Guyana and migrated to Canada when I was a child. Depending on the day – and I write this with sincerity and a spritz of jocosity – I see myself as a Guyanese-Canadian or a Canadian-Guyanese. "Home" and my sense of belonging reside where my navel string was cut and buried (West Bank Demerara, Guyana) and where jerk chicken shawarma poutine is not only a reality (Toronto, Canada), but is

[29]*Paagli*, *pagli*, or *pagali* comes from the Hindi word meaning mad or crazy (Sharma, n.d.). In Guyanese Creolese, paagli also comes to mean stupid, hysterical, and silly. Seymour (1975) defines the variant *pagla* as an adjective meaning, "deformed person, mongoloid, mentally handicapped" (p. 49).

better tasting than the classic Québécois dish from where it derives some of its inspiration. I have stopped arguing with myself about which one comes before or after the often-vexatious – though still useful (for me) – hyphen because these geographies and the people belonging to them jointly and inextricably shape who I am. These places – intimately and forever entangled – mark the joys, pains, and liminalities of my life. There is a tension that characterizes this space of betweenness that is sometimes difficult to maneuver but always instructional, especially in the ways that it dispels the myth and arbitrary certitude of "authenticity"; a narrative in which I do not subscribe because it largely refuses to recognize the relational and ever-developing self within ever-changing, mutually constitutive societies and the contradictions, glories, flaws, and failures of the human experience across time and space. Ideas of authenticity are illusory and couched in an impossible purity test and vacuous notions of identity absolutism and essentialism for which the amalgam of my working class roots, Canadian upbringing, and mixed-race Guyanese heritage will not sufficiently provide satisfactory responses. Paul Gilroy's teachings in *The Black Atlantic: Modernity and Double Consciousness* (1993) reverberate with me as I write this. Importantly – and in full embrace of these complex, shifting, syncretic, and imperfect places that inform my constitution – it is in and through Guyanese, Canadian, and Caribbean geographies that I strive to learn from, listen to, and centre the messiness and abundance of different, often peripheralized, experiences and perspectives.

My journey to this research started as a volunteer in Guyana with Red Thread, a collective of agentive, working class women. It is here that I cut my teeth on and experienced the dynamism of Guyanese women's activism. Red Thread is a multiracial, non-governmental organization whose goals are to "organize with women, beginning with grassroots women to cross divides and transform" their conditions (Red Thread, n.d.). Red Thread provides "services

to women and children exploited in unequal power relations and simultaneously works to change those relations" (Red Thread, n.d.). In the summer of 2009, I had just completed my third year as an undergraduate student at the University of Toronto, where I also worked as the lead research assistant to D. Alissa Trotz, a Guyanese-Canadian scholar. I had the opportunity to accompany her on research trips to Guyana, and it was during that first trip that I established what would become a lasting and generative volunteer relationship with Red Thread.

At Red Thread, I was tasked with the assignment of creating a database documenting daily, weekly, monthly, and annual reports of violence against women as captured by the newspapers. Guyana does not have a centralized government body or system to account for these statistics on violence against women and intimate partner violence when they are reported. With the exception of child marriage statistics (30% prevalence rate in Guyana), the UN Women's Global Database on Violence Against Women indicates that official national statistics are not available to fully account for the "prevalence data on different forms of violence against women" in Guyana (UN Women, 2019). A 2019 qualitative study, however, found that one in two women in Guyana have experienced intimate partner violence in their lifetime (Contreras-Urbina et al., 2019). Guyanese NGOs like Red Thread and Help and Shelter largely assume the task of assisting victims of domestic violence and collecting and summarizing prevalence data in the country, with Help and Shelter re-emphasizing that "studies of domestic violence in Guyana estimate that between one and two in every three women are victims" (Help and Shelter, n.d.).

That summer, I also campaigned with the Coalition to Stamp Out Sexual Violence Against Children. As a member of the Coalition, Red Thread volunteers, like me, took to the streets to raise awareness about children's rights. Nearly 200 Guyanese from all walks of life stopped and shared their reflections, writing messages in support of children's rights on three-

inch square pieces of colourful cloth, which were then pinned together to create "a large patchwork in protest against violence against children and in the promotion of human rights" (S. Persaud, 2009). I would go on to serve as a courtroom observer with other Red Thread women at a pre-trial hearing related to the alleged sexual abuse of children. We stood with these children and their families, and I witnessed the everyday ways in which Red Thread supported victims of violence. I went on to assist village women from Buxton, a community on the East Coast of Demerara, in making demands to the government through letter writing campaigns for the establishment of effective community health care facilities. Editing these letters under the guidance of Andaiye[30] – the late Guyanese women's rights activist, Red Thread coordinator, and most patient of elders and mentors – was a lesson on intersectional feminism and humility. I distinctly remember a revision for diction that I made: replacing the women's use of the words "high blood pressure" with "hypertension". Andaiye reviewed the edits. Wearing a kind and maternal smirk, she instructively remarked, "Don't change people's language." She asked that I reinsert "high blood pressure"; and she patiently and generously explained that it was important to ensure that the women in the Buxton collective – working class Afro-Guyanese women – were able to express their concerns in words that made sense to them. Their words gave them a sense of ownership of their demands and equipped them with the confidence and agency to push forward and make claims against the state. I was gently and immediately made aware of how my role was to facilitate their message, not to insert my own. This is a lesson that I have carried with me and worked to learn from as I conducted research for this dissertation. It is also a fundamental teaching that I actively draw on and remind myself of as I enter new spaces and encounter the richness of difference in the interactions of my daily life.

[30] Aunty Andaiye passed on May 31, 2019. Her work and memory live on: https://andaiye1942-2019.com/.

As I compiled data on media-reported incidences of violence against women in Guyana and delved in the NGO's archives – its massive collection of newspaper clippings – I happened upon the first of the three cases that partly instigated this research, the murder of Radika Singh. At the height of the case's newspaper coverage, Red Thread (2007) issued a statement condemning the murder of Singh, an elderly woman with a history of receiving psychiatric services and who was labelled mad in the media reports. Singh was killed after she ventured into a neighbouring community and was misrecognized as a monstrous creature of Guyanese myth ("'Old Higue' Murder: Three in Custody", 2007). In Canada, I have worked in social services as a frontline staff for over 13 years assisting people with a range of disabilities. The murder of Singh stayed with me as I returned to Toronto and considered the ways in which my work in these different home places intersected. I began to think about the lives of women like Radika Singh; the conditions that made violence not only conceivable but permissible; and approaches to reckon with and stamp out this violence. These questions led to the pursuit of graduate research across master (S. Persaud, 2011) and doctoral projects. My experiences with Red Thread and later the Inter-Guyanas Feminisms Project and the Guyana Foundation motivated this research and fuel my desire to continue organizing with grassroots women and underserved communities. It is this work and these collective experiences that have brought me here.

Chapter Two:
Introducing the Cases: Points of Entry, Paths of Departure[31]

This chapter captures the complexities and identifies the connections that run parallel across the three individual cases of violence in Guyana that inspired this dissertation: the murder of Radika Singh; the death of Sangeeta Persaud; and the killing of Todah Richards. Importantly, this writing can never capture their untold narratives and cannot articulate the fullness of their lifeworlds, nor does it aim or strive to do so – to stand in and speak for two dead women, a dead girl, or the countless others who are deliberately silenced. Instead, I present the three cases as the points of entry that motivated me to pursue this research and set this work on a trajectory to explore the meanings of mental distress and the practices intended to foster relief, some of which may result in grievous harm, violence, and death. This chapter reads these cases side-by-side and maps their connections. I also explore major thematic resonances of this research that were prompted by these cases, specifically questions of gender-based violence and race. I contextualize the violence across these three cases in the contemporary period by connecting it to Guyana's colonial history and the ways in which colonizers instigated racial animosities, especially through the bodies of differently racialized women (Trotz, 2003).

[31] Sections in Chapter Two – primarily the subsection that outlines the media reports and facts of the Radika Singh case study, aspects of the section "The Ordinariness of Violence Against Women and Girls: Historicizing Gender, Race, and Politics in Guyana", and other smaller portions in Chapter Two – are a slightly modified version of sections from my chapter, "Madness, Myth, and Masquerade: Cultural Patrimony and Violence Against Disabled Women in Guyana," from *Unmasking the State: Politics, Society, and Economy in Guyana 1992–2015*, edited by Arif Bulkan and D. Alissa Trotz (Kingston: Ian Randle Publishers, 2019). Reprinted by permission of Ian Randle Publishers.
These aforementioned sections in Chapter Two draw from my earlier master's thesis, "Of 'haunting' and old higues: An intersectional analysis of violence and the female-gendered body in Guyana" (2011). Also see the student journal article of the same name in the Caribbean Studies Students' Union's (CARSSU) *Caribbean Quilt* (2012), volume 2, pp. 16-46.

In the first section of this chapter, I examine each of the three cases and synopsize important aspects and published commentaries. These cases rouse the terror that Alexander and Ulysse (2015) so fittingly describe, and they instinctively spark a sense of dread and lingering curiosity. Sensationalist reporting punctuated by discursively violent descriptions and images characterize the media representations of Singh, Persaud, and Richards. I draw predominantly from the three main national dailies in Guyana – the *Guyana Chronicle*, *Kaieteur News*, and *Stabroek News*. To a lesser extent, reports from large international news organizations and smaller local media outlets are also cited. The three cases are laid out chronologically based on when each transpired (Singh, Persaud, and Richards) and, coincidentally, in order of the amount of information made public and the extent of newspaper coverage that each case received. Reporting on Singh and Persaud was extensive, while the Richards case received minor coverage.

The second section of this chapter identifies common threads that connect and cut across these cases. They reveal much more when we think of them as multiple points of divergence. They are sociological phenomena that disclose how Guyanese understand mental distress and the gendered, racialized, and violent material realities that are made possible when people experiencing distress are othered through imputations of evil. In the third and final section, I consider the climate of gender-based violence in Guyana, given the reported physical and, in the case of Singh and Persaud, alleged sexual violence against the female victims that so explicitly traverses these cases. I make the argument that while these incidents of violence against Singh, Persaud, and Richards are appalling, they are not spectacular nor are they anomalous. Rather, they are commonplace in the long history of violence against women and girls in Guyana, which continues to beset the nation. These cases are prosaic because they can be read together with

other incidents that share similarities and alongside this larger and long history of violence against women.

Case Studies

Radika Singh

> "'Old Higue'[32] have to dead and I believe if she was an 'Old Higue' she had to dead." – Unnamed resident of Bare Root, East Coast Demerara, Guyana ("'Old Higue' Murder: Three in Custody", 2007)

On the morning of April 28, 2007, the remains of an elderly woman were discovered near the community of Bare Root, East Coast Demerara, Guyana ("Two Held in 'Old Higue' Murder", 2007). According to newspaper accounts in all three of Guyana's major dailies, the unidentified woman's body bore marks of violence and her hands and legs appeared to be broken ("Villagers Allege Dead Woman was an 'Ole Higue'", 2007; "Residents Beat Suspected 'Old Higue'", 2007; "'Old Higue' Murder: Three in Custody", 2007). The three newspapers published accounts from the residents of Bare Root citing a common imputation that became a shorthand reference for this case, namely that the woman – whose body was unidentified days after her death – was an "old higue". The old higue is one of several and similar female vampiric figures in Caribbean folklore (Anatol, 2015); she allegedly preys on infants and young children because their blood is said to sustain her (Seymour, 1975, p. 48). The old higue is a feared and reviled figure of Guyanese mythology and is the subject of various ghost stories in the nation (McAndrew, 1966; M.W. Carter, 1951). Throughout the continued and extensive coverage of this case, and even after Singh's identity was revealed, the newspapers repeatedly chose not to mention Singh by name in their headings and referred to this incident of violence as the "Woman

[32] I spell and refer to the old higue as old higue; however, the term is also commonly spelt "ol' higue" and "ole higue", or "old haag" and "old hag" to a lesser extent (Seymour, 1975, p. 48).

in ‘Ole Higue’ Affair” (2007), “‘Ole Higue’ Killing” (2007), and “‘Old Higue’ Murder Victim” (2007). The body of this dead woman, whose personhood became interchangeable with the old higue figure of folklore, was later identified as Radika Singh – a fifty-five-year-old Indo-Guyanese housewife and domestic worker with a mental illness diagnosis (“Bare Root Murder”, 2007). The papers later specified that Singh had experienced a “mental breakdown” and received psychiatric care from Georgetown Hospital (“Bare Root Murder”, 2007; “‘Ole Higue’ Killing”, 2007).

Though reports vary and may be conflicting, one central allegation that surfaced was that Singh – at some point and as a supposed old higue – purportedly sucked the blood of an infant, which was then cited as one of the main reasons that led to her murder in an apparent act of mob and community violence (“Two Held in ‘Old Higue’ Murder”, 2007). Villagers allegedly closed in on Singh; doused her with kerosene in an attempt to burn her; and struck her repeatedly with a manicole broom[33] and pieces of wood, namely paling staves (“Two Held in ‘Old Higue’ Murder”, 2007). It was later revealed that objects were pushed up into her vaginally (Red Thread*,* 2007). A post-mortem concluded that Singh died of haemorrhaging caused by blunt trauma (“Three Remanded for ‘Ole Higue’ Murder”, 2007). According to police, while it was rumoured that a child “get suck”, no evidence surfaced nor were formal reports made to support this claim (“‘Ole Higue’ Killing”, 2007).

On May 1, 2007, newspapers indicated that Singh’s body had been identified; her family quickly began an appeal to the public for justice and insisted that she was not an old higue (“Woman in ‘Ole Higue’ Affair”, 2007; “‘Ole Higue’ Killing”, 2007; “‘Old Higue’ Murder

[33] A manicole broom, widely known as a pointer broom, is made from fronds of the manicole tree and is commonly used to sweep in Guyana and in other parts of the Caribbean. The manicole broom is also a specific implement that is used to beat an old higue, as prescribed by the folklore (Seymour, 1975, p. 48).

Victim", 2007). This appeal, in part, began by publicly disclosing Singh's history of diagnosed mental illness and psychiatric treatment, which caused her to unknowingly maunder to adjacent communities ("Bare Root Murder", 2007). Three individuals were remanded and charged with the murder of Singh – Roland Spencer, Rayon Bobb, and Aletha Roberts ("Trio Charged with Murder", 2007). All charges were eventually dropped against the three due to insufficient evidence. According to *Stabroek News*, "the prosecution's star witness in the case had not been attending court" ("Relatives of Murdered Good Hope Woman", 2008).

The murder of Singh was also the subject of international reporting (Associated Press, 2007). At the local level and at the height of the case's coverage – from April 29, 2007 to May 18, 2007 – over 50 reports, editorials, and letters to the editor were published in the three dailies, with letters to the editor accounting for the vast majority of publications in the three major newspapers. In the reports, most of the interviewed Bare Root residents asserted that Singh was an old higue who was deserving of a beating death ("Villagers Allege Dead Woman was an 'Ole Higue'", 2007; "Residents Beat Suspected 'Old Higue'", 2007; "Two Held in 'Old Higue' Murder", 2007). Taking into account the opening quotation of this case study section, several villagers vehemently accused Singh of being the mythical creature and relayed their suspicions to reporters:

> "She look evil." ("Residents Beat Suspected 'Old Higue'", 2007)
>
> "I know 'Old Higue' deh [exist]." ("Residents Beat Suspected 'Old Higue'", 2007)
>
> "Is de fuss [first] time I see one." ("Residents Beat Suspected 'Old Higue'", 2007)
>
> "My mother always tell we about it, and she use to tell we when 'Old Higue' sucking you girl child, you does know." ("'Old Higue' Murder: Three in Custody", 2007)
>
> "But you think about it this way if you wake up and see 'Old Higue' sucking you baby what you go do? You have to do something. You ent go stand up and watch it do dat to you child." ("'Old Higue' Murder: Three in Custody", 2007)

Each of these interviewees in the village was of the unshakeable opinion that the old higue exists and that Singh was she. Faced with her alleged wickedness and nefarious intentions, they believed that they had a duty to protect their children – particularly their girl children. As a consequence, vigilante violence appeared justifiable – according to the interviewed villagers – through the evocation of the old higue. Only a minority of villagers who were interviewed seemed to deviate from this position; one elderly woman registered dismay and anger about Singh's death and disagreement about the old higue accusation: "I don't believe in that and I don't believe she was any 'Old Higue'. They were wrong; they should not have killed the woman. They could have chased her out of the village" ("'Old Higue' Murder: Three in Custody", 2007). For this aged villager, the myth of the old higue is purely fiction. She condemned the murder of Singh – perhaps because she understood that the old higue accusation can also be directed at elders like her given her years. She recommends that an appropriate call to action would have been to run Singh out of the community. Opposing opinions from Bare Root received little coverage, perhaps because they appeared to be rare among those who chose to be interviewed by the newspapers. Common to both sets of opinions – the belief that Singh was the old higue deserving of death and the lone objection raised by an elder in disagreement with the old higue imputation – is the shared understanding that Singh's presence, whether old higue or old and mentally ill Indian woman, was rejected. According to media reports, Singh was recognizable to the Bare Root residents only as an outsider who did not belong to this community.

Along with considerations of Singh's mental illness diagnosis and the old higue imputation; race, gender, and community allegiances are also important facets of this case, particularly given the nation's difficult history of racialized and gendered violence, which will be

further discussed in the third section of this chapter (Red Thread & Help and Shelter, 2008, p. 12; Trotz, 2003, 2004). Bare Root, where Singh was killed, is considered to be a community comprised of constituents who are "predominantly Afro-Guyanese". Singh was an Indian woman from Good Hope, which is thought to be a "primarily Indo-Guyanese" village. While the reporting and editorials did not fully and substantively engage with the gendered and racialized dimensions of Singh's murder, some letters to the editor and op-eds speculated that Singh's race, her gender, and the location of her murder in Bare Root contributed to the violence that she experienced and, ultimately, her slaying (Khan, 2007; Kumar, 2007; L. Lewis, 2007). A member of the public, Khan (2007) (full name not stated), writes in their letter: "Where is the outrage? It is not coincidental that the woman killed on the East Coast was Indian. We all know that this has been happening for years." In a column for *Stabroek News*, Sociologist Linden Lewis (2007) writes:

> One should also be mindful of the racial and gendered nature of this murder. The violence of this attack was meted out on an Indo-Guyanese woman, who became the focal point of an essentially African legend. In addition, the three persons charged in connection with this crime – one of whom is a woman – are all of African descent. In a racially polarized society, the implications are worth pondering… In a region and a country, with high rates of violence against women, Radika's death underscores the way such acts continue to be played out on the text of the body of women.

The sentiments expressed above by Khan and L. Lewis regarding the murder of Singh direct us to historicize and consider the documented cases of gender-based, racialized violence against Indian women in particular. The violence of crossing the *kala pani*[34] to the shores of Guyana and

[34] *Kala pani* comes from the Hindi meaning "black waters" (Bates & M. Carter, 2021). For Indians who were indentured and made the voyage to the Caribbean and other regions of the world, the journey to and experience in these new lands was often difficult and marked by immense hardship. The crossing of the kala pani may be read as a metaphor representing taboo (Bates & M. Carter, 2021) and a process of disruption (P. Mohammed, 2002). According to Bates and M. Carter (2021), as a trope, kala pani "is said to derive from long-held notions that sea crossings were antithetical to Hindu culture, entailing a separation of the traveller from the holy Ganges, thereby breaking the reincarnation cycle and engendering a loss of caste" (p. 37). The crossing is transgressive and may also be interpreted as a metaphor for new beginnings and the (re)negotiation of identity.

other Caribbean nations (Bahadur, 2013; Shepherd, 2002), the "wife-murders" during the indenture period (Bahadur, 2013; Mangru, 1987; Mohapatra, 1995), the gang rape of Indian women during the disturbances of 1965 (Wismar Report, 1965), and the sexual assaults committed against Indian women during the 1997 and 2000 elections (Red Thread & Help and Shelter, 2008; Trotz, 2004) are turbulent moments in Guyanese history that played out on the bodies of Indian women. Singh was rendered an outsider; her Indianness, mental illness diagnosis, and threatening femininity – as the old higue – made her humanity unrecognizable in the village of Bare Root. Singh's murder was not exceptional. Her death cannot be divorced from this history of violence and substantive considerations of race and gender.

While the majority of interviewed residents in Bare Root did not challenge the idea that Singh was an old higue, the general public and wider community seemed, by and large, to recoil in horror. The letters written by the public in response to the murder of Singh were vociferous in condemning the violence. Many expressed disbelief and shock, remorse and anger, disgust and pity:

> I read it but I don't believe it… This is how cheap life has become; a woman is killed because she wandered into the wrong place and was regarded as the mythical "Ole Higue". (George, 2007)
>
> Now, outrage and shame follows the dastardly murder of a defenseless middle-aged woman whose attackers are claiming she was an "Ole Higue". (de Freitas, 2007)
>
> I was sickened to learn about this poor insane woman's untimely and brutal death… and the dirty, vicious hands that carried out the execution. (Tan, 2007a)
>
> This poor helpless creature was guilty of Guyana's two greatest crimes. One, she was of unsound mind; and two, she was poor… Oh what pity! I am sure Radika must be telling the Maker, "Forgive them Lord, they know not…" (North, 2007)

Some readers cited linkages made between the stigma of mental illness and perceived supernatural attribution ("demon possession"; "Dutchman"; "jumbie"; "mermaid"; "bad eye")

and relayed how such connections lead to the "underfunding of mental health care institutions" and are indicative of "backward" societies that choose to live under "primitive times", instead of "marching forward":

> For too long there has been a social stigma attached to mental illness. This stigma has fuelled the superstitious belief that mental sickness is somehow different from physical sickness and that the mentally ill have brought such sickness upon themselves. Some even believe that mental illness is "demon-possession". This particular belief resulted in the beating to death of a young woman by a self-styled exorcist a few years ago. It is social attitudes like these that have led to the underfunding of mental health care institutions in countries like Guyana. (Quan-Balgobind-Hackett, 2007)
>
> With this incident and a few others in recent years, it seems that a certain section of the Guyanese community is still living under "PRIMATIVE [*sic*] TIMES" … Next thing we know these people will be telling us that they killed so and so because, "de man de possessed by Dutchman or jumbie" or that, "de lady was a mermaid" or that, "he bad eye me". Please, Guyanese people MARCH FORWARD PROUDLY, NOT BACKWARD INTO STUPIDITY. (Tan, 2007b)

Ultimately, Singh's subjectivity folded into the legend of the old higue in a sensational narrative that initially painted her as a predacious creature of myth. The folklore then became one element of an evolving discourse that further constructed her as a "poor insane woman" of Indian descent (Tan, 2007a). Singh's subjectivity was locked in this duality that failed to acknowledge her full humanity.

<u>Sangeeta Persaud</u>

> "As soon as he [Pastor Ewart Cummings] come, he start fuh holler, 'Get out! Get out!' But Sheena [legal name: Sangeeta Persaud] de done helpless already. Dem ah squeeze she and so like dem ah tek out jumbie from she. 'Get out! Who send you?' But de pickney [child] can't talk… Dem a squeeze dis child belly, all ah she privates. De momma dem ah sing and ah clap… Me tell de mother when she recover me nah want am back because jumbie hold am ah me place. So dem throw anointed oil ah she mouth then dem tek lime[35] and salt… Me live forty years and me nah know bout jumbie, me mek four pickney me nah know bout jumbie, me husband dead and he nah come fuh

[35] In Guyana, lime is sometimes used in specific spiritual and religious practices as a "'cutter' to cleanse evil" (Gibson, 2001, p. 50); its uses are particularly documented in Comfa (Gibson, 2001) and Kali Mai practices (Younger, 2002, p. 137).

> visit me." – Chaitranie Ramotar, maternal grandmother of Sangeeta "Sheena" Persaud ("Child Dies after Frenzied Attempt to 'Beat out Spirits'", 2010)

On March 31, 2010, *Kaieteur News* and *Stabroek News* were the first publications to report on the death of fourteen-year-old Sangeeta Persaud, who was known to her family by the call name "Sheena". Both reports cited extensive accounts from Persaud's grandmother, Chaitranie Ramotar. Ramotar detailed how the child was taken to the local church – Christ Ambassadors Church – in their Canal Number Two Polder, West Bank Demerara community to have an exorcism performed when she became distressed and started experiencing convulsions, which were believed to be caused by the indwelling of a jumbie ("Child Dies after Frenzied Attempt to 'Beat out Spirits'", 2010; "Canal Girl Dies after 'Exorcism'", 2010). Ramotar told reporters of how Persaud had lived with her on-and-off for more than five years since she was nine years old (Seales, 2010). The child's mother, Nandkumarie Jaikissoon, was unable to care for Persaud and her other children, some of whom once lived in an orphanage (Seales, 2010). On the morning of Sunday, March 28, 2010, Ramotar explained that Persaud exhibited sudden symptoms of physical and mental distress:

> "Me sit down pon de bed and de gal come and grab me. Me thought was joke she ah mek. But me see she eye ah roll up and she ah juck up [shake up] in de whole house… Me ask she if she belly ah hurt, she say no, you back ah hurt, she say no. Me ask she wha' wrang with you Sheena [Persaud]? She drink lil more of the tea and she start again. She had [*sic*] a twist up and she ah holler like if something ah frighten you. She face start get dark and she turn up she eye." ("Child Dies after Frenzied Attempt to 'Beat out Spirits'", 2010)

In a panic, Ramotar contacted Persaud's mother who arrived shortly after with Pastor Ewert Cummings. Conflicting accounts from Ramotar, Jaikissoon, and Pastor Cummings were reported in this case. *Kaieteur News* (2010) initially stated that Ramotar first suggested that Persaud was possessed by a spirit ("Child Dies after Frenzied Attempt to 'Beat out Spirits'"), but Ramotar

later maintained in a *Stabroek News* (Seales, 2010) interview that it was Jaikissoon, the mother, who first concluded that Persaud's behaviour was indicative of demonic possession.

Before taking Persaud to the church, Ramotar detailed how Pastor Cummings allegedly spent three hours in her house "tekking out jumbie from the girl" (Seales, 2010). She explained that Pastor Cummings "bring a small bottle with anointed oil and he throw some in she mouth and then he give me daughter to rub it on Sheena [Persaud] and he keep praying and so over she" (Seales, 2010). When Persaud's condition failed to improve, she was taken to the church and placed to lie at the altar. Other church members were called. Ramotar described how she sat and prayed silently while another man named Pastor Gulab and his wife arrived and, along with other worshippers, allegedly went about applying physical pressure all over Persaud's body, including her face and genital area until she began to bleed vaginally (Seales, 2010); it was unclear whether or not she was experiencing a menstrual cycle (Seales, 2010). Ramotar recounted how Pastor Gulab allegedly attempted to exorcise the demon:

> "Was this same man Gulab that start calling out for these Hindu spirits Hanuman, Kali and so and then he tek he hand and put it by my granddaughter private part and de Amerindian woman put she hand on he hand and dem start applying pressure down there [Persaud's genital area] and is like dem been trying to get the demon out from she womb." (Seales, 2010)

Community members also alleged that worshippers at the church believed that Persaud was possessed by a "*Nowraatri*[36] jumbie", which was apparently conjured during a recent Hindu function in the village ("Child Dies after Frenzied Attempt to 'Beat out Spirits'", 2010). During the exorcism, Ramotar said that the child's mother (Jaikissoon) made a lime juice and salt concoction, which was allegedly given to Persaud to drink:

[36] "*Nowraatri*" references *Navaratri*, which is a nine-night, ten-day Hindu festival in celebration and worship of the deity Durga. Each of the nine manifestations of Durga is honoured on their respective night of devotion during *Navaratri*, culminating in the *Vijayadasami* victory celebration of good conquering evil on the tenth day (Simmons et al., 2018).

> "She [Jaikissoon] come back with two green skin lime she get from a boy and she wring it in a cup and dem mix in salt and dem thrown in Sheena [Persaud] mouth but meh cyant [cannot] tell yuh if Sheena swallow it or if she vomit it out… I remember that everything dem been trying to throw down she throat she was spitting out." (Seales, 2010)

Ramotar recounts that one of the women then advised her that Persaud might be menstruating or on her "thing" as they were cleaning her up to go to the hospital when the girl's state did not improve after the exorcism (Seales, 2010). It was at West Demerara Regional Hospital that Persaud later died ("Child Dies after Frenzied Attempt to 'Beat out Spirits'", 2010).

For their part, Jaikissoon and Pastor Cummings acknowledged that rituals intended to exorcise spirits were performed but rejected Ramotar's claim that violence was visited on the body of Persaud; Jaikissoon remarked: "Nobody beat her. No body do her nothing. She was lying there and everybody was praying" (Seales, 2010). Both Jaikissoon and Pastor Cummings agreed that after Persaud experienced convulsions, they believed that she was demon possessed and took her to the church for prayers intended to cast out the spirit; it was during the prayer sessions that Persaud began to "behave like an animal" (Seales, 2010). Pastor Cummings described Persaud's behaviours and defended his actions:

> "I saw her squeal like a pig, I saw her face turn to like a monkey, her eyes, her mouth… I act according to what I believe, the Bible says if there is anybody sick then they should send for the elders of the church and the elders should come and pray for them and use oil and anoint them and if they commit any sin, the sin shall be forgiven. So I did that… I just put some oil in her forehead." (G. Sutherland, 2010b)

He explained why he invited others, particularly Pastor Gulab, to join in prayer and how they responded to the situation:

> "Since Pastor Gulab saw the girl he knew right away that this girl had a demonic problem because this is something that he normally deals with all over Guyana… We don't beat nobody. We don't squeeze no lime and give nobody. I did not give her lime neither did the other pastor give her lime… I said look we need to take this girl to the hospital. I recommended it and I took her myself to the hospital. I stayed with them until this girl died." (G. Sutherland, 2010b)

Pastor Cummings indicated that he prayed for Persaud from 10:30 a.m. to 3:00-4:00 p.m., insisting: “When you are dealing with the demon case there is no timeframe” (G. Sutherland, 2010b). Pastor Cummings mentioned that he conducted exorcisms on other family members related to Persaud (G. Sutherland, 2010b). Jaikissoon said that she does not know whether her daughter died as a result of illness or demonic possession: “I experienced that same thing at age 12… That is why I did not rush her to the hospital. My heart did not tell me to rush her to the hospital” (“Exorcism Pastor says He did Nothing Wrong”, 2010). Ramotar continued to insist that the exorcism performed on her granddaughter was physical and played a role in her death (Seales, 2010). No charges were laid in this case (“14-year-old Dies after Exorcism”, 2010).

The results of the first post-mortem examination were inconclusive in determining the cause of Persaud’s death (G. Sutherland, 2010a). Despite an inconclusive autopsy report, Persaud’s funeral was permitted to go ahead. She was buried on April 1, 2010; the funeral service was officiated by Pastor Cummings (G. Sutherland, 2010a). Persaud’s community was divided as villagers exchanged insults and accusations, arranging themselves into two camps – one in support of Persaud’s mother and Pastor Cummings, and another denouncing the exorcism (G. Sutherland, 2010a). At Persaud’s funeral service, there were persistent calls for her mother, the pastor, and all involved in the exorcism to be arrested and jailed (G. Sutherland, 2010a). Police were later summoned to the funeral and warned Persaud’s father, Chinee Persaud, after he twice attempted to storm Jaikissoon’s home, accusing her of neglecting their daughter while other villagers also shouted him down for largely being an absent parent in Persaud’s life as well (G. Sutherland, 2010a).

In speculative accounts by other family members, readers are also told that Persaud’s stepfather (Jaikissoon’s current husband) believed that Persaud was possibly involved with a

local boy: “I ain’t know if she and the boy had any relationship or what” (G. Sutherland, 2010b). He alleged that Persaud was “washing and cooking” for the boy, and in exchange she “used to receive some money… cause lately she used to start buying gifts for the grandmother, the mother and even the pastor” (G. Sutherland, 2010b). Persaud’s stepfather claimed that he and Jaikissoon only learned of the relationship after Persaud’s death. The stepfather accused Persaud’s grandmother, Ramotar, of upholding the arrangement and suggested that she was aware of the money (G. Sutherland, 2010b). While not explicitly stated, there is a veiled assumption here of sexual immorality. As a fourteen-year-old unwed Indian girl, Persaud should not have been allowed to engage or interact with the boy in a capacity that suggested that they were in a conjugal relationship, where she appeared to regularly carry out domestic duties for him in exchange for financial benefits. Questions of Indo-Caribbean girlhood, sexuality, and respectability also come to define the Persaud case.

Persaud’s death stirred great controversy in Guyana and made regional (*Antigua Observer*) and international (*The Telegraph* and *CBS News*) headlines (“Guyana Death”, 2010; “14-year-old Dies after Exorcism”, 2010; “Guyana Girl, 14, Dies after Exorcism”, 2010). From April 2010 to July 2010, over 60 reports, editorials, and letters to the editor were written in the three national papers connected to the death of Persaud. After Persaud’s funeral, the rift in her community grew, fuelling religious tensions along racialized lines, particularly in light of the way Hinduism and Hindu deities were invoked as the alleged cause of possession, which manifested as convulsions (“Hindu Organizations demand thorough Investigation”, 2010; “Hindu Organisations urge Probe”, 2010); claims of a “conversion agenda” of particular Christian sects that is used to sway disenfranchised Indians in Guyana, enticing them to abandon the Hindu faith in favour of Christianity (Misir, 2010); and the racialized, gendered, and

sexualized optics of an Indo-Guyanese girl killed through an allegedly violent exorcism performed by a pastor who is a Christian, Afro-Guyanese man running a church in a predominantly Indian community with a significant Hindu population ("ERC, Family to put Demon Possession", 2010; G. Sutherland, 2010b). In Guyana, understanding the colonial roots of strained, and sometimes violent, relations between Indo- and Afro-Guyanese is crucial in accounting for and mapping racialized relationalities within the communities along the coastal strip of the country.

The Government of Guyana's Ethnic Relations Commission (ERC) involved itself with the case. The ERC is a constitutional body mandated to "promote ethnic harmony and security" across the different ethnic groups of Guyana.[37] The ERC supported Pastor Cummings and Jaikissoon's position when its then Chairman, Bishop Juan Edghill, held a press conference maintaining that no violence was committed against Persaud:

> "It was just prayers being said in the presence of the mother, grandmother and church members… It is very distasteful that a religious group is being vilified because of the death of a child and a community is in disquiet because of unsubstantiated reporting… I don't like the spin as it carries with it the potential to create confusion and disquiet in communities, especially since the pastor is an Afro Guyanese and his wife is indo [*sic*] Guyanese." ("ERC, Family to put Demon Possession", 2010)

> "Everyday in mandirs [Hindu places of worship], masjids [mosque or Muslim places of worship] and in churches Guyanese are people of faith, take their relatives there for prayer to relieve from evil spirits, from sicknesses and disease. It's an everyday practice all across Guyana and it's not limited to any sect that is taking advantage of poor people in Guyana." (G. Sutherland, 2010b)

When asked if people should be trained and qualified to perform exorcisms, Edghill responded: "The Bible teaches these signs shall follow them that believe in my name you shall cast out devils. Casting out of evil spirits in Christianity is not just for pastors. It's for every person who believe" (G. Sutherland, 2010b). The sentiments expressed by Edghill, a government official

[37] For the Ethnic Relations Commission's mandate, refer to: https://www.erc.org.gy/whatwedo.

representing the ERC, were alluded to and criticized by members of the public, who wrote to the newspapers (Aksharananda, 2010; Totaram, 2010). The vast majority of the letters to the editor – some explicitly citing religion and race – expressed outrage, condemned the practice of exorcism, denounced Persaud's family and Pastor Cummings, and criticized the involvement of the ERC.

> I can make a racist comment and the ERC can get on my case, but in the name of religion I can call any one a sinner, heathen, and demon-possessed and get away with it. If I hit someone on the road and the person dies I can be charged for murder. But if you take a 14-year-old in a church and pound her abdomen until blood comes out of her vagina and she dies, all in the name of casting out demons, then this act is excused and covered up. Indeed, it can even be doing God's work. (Aksharananda, 2010)
>
> It should be made clear that Sangeeta Persaud's tragedy demonstrates a failure on us, as adults and parents, to protect our young and vulnerable children. (Maharaj, 2010)
>
> Where is the justice that Sangeeta deserves? (Marcus, 2010)

Other readers, citing Western biomedicine and psychiatric illness models, wrote in with concerns about Persaud's mental health, specifically connecting her convulsions and behaviours to psychological issues or mental illness, not demonic possession:

> We now know that what people called "demons" centuries ago are today known as psychological and mental disorders. Thanks to Sigmund Freud and others who ushered in a new discipline called psychoanalysis… Today in Guyana, no matter what the specific cause of the mental and psychological problems the individual suffered, Bishop Edghill and pastors Gulab and Cummings would be only too quick to diagnose it as demon-possessed. (Totaram, 2010)

This public uproar, which coincided with impassioned sentiments and debates over Persaud's death and cause of death, prompted an investigation by the Ministry of Health. The Government of Guyana later called for the exhumation of Persaud's body in order to conduct an independent autopsy, to be carried out by an external pathologist from Trinidad and Tobago ("Sangeeta's Body to be Exhumed", 2010).

On July 3, 2010 – over three months after Persaud's death – the Government of Guyana released findings from the external autopsy, which concluded that Persaud died of acute meningitis caused by inflammation of the brain coverings ("Sangeeta Died of Meningitis", 2010). Earlier reports indicated that Persaud had a longstanding tuberculosis infection, which could have contributed to seizures, inflammation of the brain (meningitis), and other neurological and psychological symptoms (G. Sutherland, 2010b; "Sangeeta's Body to be Exhumed", 2010). While the second autopsy report also indicated that Persaud's body "did not reveal any evidence of trauma of any kind or poisoning", her grandmother was unwavering in alleging that the exorcism was a violent and physical ritual that involved "prodding, squeezing, and palming" ("Sangeeta's Body to be Exhumed", 2010). Community members insisted that Persaud might have lived had she been taken to the hospital instead of the church ("Sangeeta Died of Meningitis", 2010; "Sangeeta Died from Meningitis", 2010).

Aside from the multiple and conflicting accounts, the commonalities that register in these different retellings of Persaud's death are that she experienced sudden symptoms of physical and mental distress, which led some of her family members to believe that she was possessed by demonic forces. Prayers and rituals were initially conducted in the home that she shared with her grandmother to cast out what her family considered a jumbie or Hindu deities. When those attempts were unsuccessful, Persaud was taken to her church where an exorcism was performed – it is unclear if this ritual was violent – and she later died in hospital. The first autopsy investigating her death was inconclusive; the second autopsy conducted by an external pathologist ruled that she died of meningitis. In light of all of this, the terms of power in this case wrested in the hands of the authority figures – her grandmother, her parents, her pastor, her community, and government and state officials – who were accountable for the care and

wellbeing of this child. The politics that were forged and played out over the details of her short life reveal the enmeshed and complex ways in which this girl's subjectivity is erased and rendered in a perpetual state of lack, hysteria and possession, dependency, and utter irrationality. Persaud, as an Indian girl, was subject to the shifting expectations of Indo-Caribbean girlhood in terms of the respectability politics centred on her sexuality and the cautions of creolization that her body came to bear (Hosein, 2012). Her dignity and humanity were marginalized in favour of a narrative that depicted her death as a warning flare. On its surface, the case was constructed to present the hazards of interracial and interfaith interaction in a country that continues to struggle with racial and religious divisions. Persaud's body became a site of contention through which gendered, racialized, sexualized, and religious stakes were laid; where schismatic debates interrogated notions of normalcy, belonging, humanness, and spirituality in Guyana.

Todah Richards

> Persons in the community informed this publication that the church is one where after praying they beat the demon out of their believers. ("Nurse held for Murder after Ritualistic Beating", 2014)

On November 27, 2014, *Kaieteur News* reported on the death of Todah Richards – a young Afro-Guyanese woman who was described as a "mental patient for the past five years" ("Nurse held for Murder after Ritualistic Beating", 2014). According to subsequent reports from other media outlets, Richards, age 20, was found dead and tied to a bed with a belt hooked around her neck; she had lacerations and other marks of violence about her body ("Dental Nurse Remanded for Manslaughter", 2014; "Linden Woman Charged with Killing Goddaughter", 2014). A post-mortem cited "compression of injuries to the neck" as Richards' cause of death ("Ritualistic Beating of 20-Year-Old", 2014). The woman who was arrested and later charged with manslaughter was Richards' godmother, Kelly Sandiford, a dental technician who Richards

lived with in Wismar Housing Scheme, Linden ("Linden Woman Charged with Killing Goddaughter", 2014).

It is alleged that between November 16 and 17, 2014, Sandiford tied, "ritualistically" beat, and killed Richards in the home that they shared after a heated argument ("Linden Woman Charged with Killing Goddaughter", 2014; "Nurse held for Murder after Ritualistic Beating", 2014). Earlier reports stated that Sandiford had confessed to police that she was responsible for Richards' death ("Nurse held for Murder after Ritualistic Beating", 2014). Sandiford's lawyer refuted this claim and asserted that Sandiford was only attempting to help her "very ill" goddaughter by offering her a place to live ("Linden Woman Charged with Killing Goddaughter", 2014; "Nurse held for Murder after Ritualistic Beating", 2014). Sandiford was a member of the Holy Ghost Movement Church under the leadership of Pastor John Richards, the victim's father. According to locals, the Holy Ghost Movement Church has a history of beating demons out of its believers ("Ritualistic Beating of 20-Year-Old", 2014). It was also reported that John Richards claimed that his daughter ended her life by suicide because of her diagnosed history of mental illness, which led her to believe that her deceased mother was "coming for her" ("Nurse held for Murder after Ritualistic Beating", 2014). Sandiford was refused bail ("Linden Woman Charged with Killing Goddaughter", 2014). A 2016 news report indicated that the case appeared to be working itself through the court system ("Manslaughter Accused makes Court Appearance", 2016). While Sandiford's name appeared on the High Court of the Supreme Court of Judicature's trial list for manslaughter in January 2020, signalling that her case continued to work its way through the court system; her name did not appear on the January 2021 list (Office of the Director of Public Prosecutions [DPP], 2020, 2021). Since then, no new updates have been published, which appear to be searchable online through the DPP's website, nor have any

searchable online articles by any of the major news outlets surfaced; the judicial outcome of this case is unknown.

Outside of the initial five newspaper reports written on the murder of Richards ("Nurse held for Murder after Ritualistic Beating", 2014; "Linden Nurse Charged", 2014; "Linden Woman Charged with Killing Goddaughter", 2014; "Ritualistic Beating of 20-Year-Old", 2014; "Dental Nurse Remanded for Manslaughter", 2014), only one additional article with a minor court proceeding update was published by *Guyana Times* ("Manslaughter Accused makes Court Appearance", 2016). The *Guyana Chronicle* apparently did not report on Richards' death, and no letters to the editor were published in any of the three major dailies; however, some readers did take to the online message boards that accompanied specific *Kaieteur News* and *Stabroek News* reports to express their views:

> What's wrong with that society? – username: Danita ("Nurse held for Murder after Ritualistic Beating", 2014)
>
> They believe in superstitions thinking it's innocent, like putting a broom in certain position, bathing with blue, walking with garlic etc. But please remember the spiritual church is not associated with Pentecostal or holy ghost movement. Spiritualis [*sic*] practices beatings and worshipping images all part of Satan plan. – username: rajlindenlove ("Linden Woman Charged with Killing Goddaughter", 2014)
>
> Simply horrible. – username: OBSERVER ("Linden Woman Charged with Killing Goddaughter", 2014)
>
> This woman looks scary [referencing an image of Sandiford]. I wouldn't shut my eyes and open my mouth for her in a dental chair. If looks could kill… No wonder her godchild is no longer with us R.I.P. – username: stardust ("Linden Woman Charged with Killing Goddaughter", 2014)

Commenters were particularly interested in the role of religion and referenced what they believed were appropriate and blasphemous ways of worshiping within the Christian faith: "What a tragedy! So many counterfeits out there by Satan, on how to serve God!" – username: Burch01 ("Linden Woman Charged with Killing Goddaughter", 2014). One reader responded,

"Counterfeits? Then which is the real 'how to serve God'?" – username: C I Lewis ("Linden Woman Charged with Killing Goddaughter", 2014). To which others answered by posting lengthy passages from the Bible; and, in turn, some rebutted by arguing that these scriptures are a "tool that was used to enslave and strip your/our ancestors of their culture and today you blindly accept this as being sacred" – username: BORAPORK ("Linden Woman Charged with Killing Goddaughter", 2014).

The murder of Richards, a young Afro-Guyanese woman with a diagnosed history of mental illness and who died after an alleged ritualistic beating, was lost in this exchange. While there was no public engagement with the dimensions of gender, constructions of Afro-Guyanese girlhood and womanhood are important facets of this case. Brackette Williams (1996a) analyzes the interconnections of race, class, and gender, and the conflations in this matrix of ethnic gendering within the Afro-Guyanese community. Williams (1996a) discusses the ethnic gendering of Afro-Guyanese women and how, in the pre- and post-emancipation periods to independence, colonial overseers viewed African women as resistant and riotous when they were slaves, and how they were later depicted as defiant by Afro-Guyanese men when they became freedwomen who were expected to become dutiful wives (pp. 129-131). Black femininity, throughout Guyanese history, is typecast and scripted as disorderly (Williams, 1996a). Indo-Guyanese women's identities are also ethnically gendered and co-constructed in ways that often stand in opposition to Afro-Guyanese femininity, whereby Indian women are stereotyped as submissive and malleable (Trotz, 2004). Returning to the Richards case, her mental distress is entangled at the intersections of Blackness, femininity, and religiosity. Her body was potentially perceived as unruly – a body that apparently required discipline as she was reportedly tied and lynched to a bedpost. The stereotypical constructions that read her gender and race as

domineering, simultaneously read her mental distress as threatening, dangerous, and unhinged. Richards is perceived as a body that needed to be checked, tamed, and made lucid – no matter how violent the intervention and how severe the alleged ritualistic beating. No advocates – family, friends, or community allies – came forward to give voice and demand accountability for the killing of Richards. Unlike the Singh and Persaud cases, Richards' kith and kin were absent in calls for justice. Her death and the way in which she was killed – the claim that she was beaten and the fact that the autopsy reported that she died of compressions to her neck, that the air was choked out of her – received minor attention. Instead, the debates centred not on Richards but on the role of religion, particularly within the Afro-Guyanese community, and defined or perceived authentic and acceptable ways of worship within different sects of Christianity in Guyana.

Arrivals, Connections, Departures

I arrived at these cases at different times in my academic career, across undergraduate and graduate experiences. As previously mentioned, I first encountered Radika Singh's case as an undergraduate student when I volunteered with Red Thread; this case prompted me to pursue graduate research and served as the basis for my MA work (S. Persaud, 2011). When the death of Sangeeta Persaud was announced in the papers in March 2010, I had accepted an offer by the University of Toronto to pursue a Master of Arts in Women and Gender Studies. Persaud's case, which I was unable to address in any capacity in my MA work, forced me to latently consider the scope and discourse of spirit/demonic possession and religious/spiritual interventions. The Singh and Persaud cases signalled how female-gendered bodies – particularly subjects whose behavioural and bodily expressions are rendered outside the dominion of prescribed notions of femininity, normality, and humanness – are demonized as ghastly figures as a means of

expunging difference. And while the confines of a master's research paper primarily allowed me to explore the Singh case through the prisms of gender and race (S. Persaud, 2011), with no mention of Persaud or any substantial intersectional engagement with mental distress, madness, and religion/spirituality, I continued to think on the shared themes of these two cases and the meanings that they made together and separately. It was the inability to engage with the Persaud case, its similarities to and differences from the Singh case, and its intricacies posed by the new questions of religion and spirituality that prompted my decision to pursue doctoral research; I wanted to build on my prior MA work because I sought to make sense of these two cases and other similar incidents. It was this desire to think broadly, both conceptually and materially – through and past the effects of the alleged violence of these two individual cases – that I wanted to analyze what contributes to and may cause violence. Crucially and beyond this, I desired to know how Guyanese understood mental distress and the practices they enacted, which they believed fostered relief. These cases together and other similar incidents gave insight into one aspect of these practices where violence is central, considered remedial, and has heinous outcomes. These cases also glaringly signalled an array of belief systems and practices that are often publicly maligned – in part because they do not conform with biomedical psychiatry or neatly align with notions of Caribbean respectability or, what is considered, acceptable religious worship/rituals – even while they are, nonetheless, facts of Guyanese life that do not always or normally involve violence. This scholastic yearning bought me to the Graduate Program in Social and Political Thought at York University to pursue doctoral studies.

Todah Richards' killing happened in late November 2014 while I was conducting research interviews. On my first day of interviews, November 27, 2014, I spoke with Samuel, a Christian Pastor, who brought the Richards incident to my attention after he read the initial

article published on the case in that day's *Kaieteur News*. In his summary of the news report, Samuel explained how "the mental patient [Richards]… was given a sound beating to drive out the supposed demons she possessed" and how she later died. This case resonated with Samuel and others who I met and interviewed in Guyana. Richards' death troubled them, and they felt the need to flag her murder in our interviews as they expressed their disapproval of violence and the religious teachings and practices of particular Christian churches. One of the more striking features of the Richards case, however, is how little media attention it received. Despite how sensational Richards' murder appeared and was initially made out to be by the media, it disappeared from the headlines after no more than two weeks of receiving minor coverage in a total of five articles. Alongside reports of spirit/demonic possession and the practice of exorcism in Richards' father's church, the discourse around religion and respectable ways of worship and ritual that were expressed by the public rang familiar with the Persaud case in particular, and later came to animate the narratives presented by the interview participants.

I chose these cases as the primary points of departure because of their cohesions and complexities, and what they revealed and might disclose about Guyanese society and its relationship with madness, mental health/illness and wellbeing, disability, traditional medicine and healing practices, religion, gender, and violence. Something must be said for the fact that the three people who died in these cases were two women and a girl; that violence was alleged across these cases; that distress, madness, and other adjacent colloquialisms, mental health/illness, and disability were referenced – albeit in different ways – in each incident. The discourse of spirit/demonic interference and possession was tied to the bodily and behavioural expressions of Singh, Persaud, and Richards. Appeals to superstition, religion, and spirituality were referenced in all three cases. Race and ethnic gendering (Williams, 1996a) played a central

role in how their bodies were perceived, especially in relation to specific forms of religious worship (Persaud and Richards) and the violence of misrecognition and unbelonging in communities that are thought of as predominantly Indo- or Afro-Guyanese to the exclusion of the other (Singh and Persaud).

To this end, the murders of Singh and Richards and the death of Persaud pose questions about the nature of inter-community/intra-community violence (based on geography, specifically village residence) and inter-ethnic/intra-ethnic violence (expressly between and within Afro- and Indo-Guyanese populations), which prompted public discussions about race, gender, and religion in Guyana. The Singh case registers at the level of inter-community and inter-ethnic violence, where, in the media's most rudimentary representations, an Indo-Guyanese woman from an Indo-Guyanese community was slain after mistakenly venturing into an Afro-Guyanese community, Bare Root. The three people who were charged with Singh's murder were of Afro-Guyanese descent and lived in Bare Root. The Persaud case, however, presented the angst of alleged inter- and intra-community violence, and inter- and intra-ethnic violence. Persaud, an Indo-Guyanese girl, lived in a primarily Indian village. She was a parishioner at the community's Christian church, which was headed by an Afro-Guyanese pastor who did not reside in her village. A reportedly violent exorcism, led by her pastor and a group of multi-ethnic worshippers (Indigenous, Indo- and Afro-Guyanese), was performed on Persaud at the behest of her Indo-Guyanese mother. Those who participated in the exorcism were members of Persaud's community and also resided in neighbouring communities. Richards' killing, on the other hand, is presented as a case of intra-community and intra-ethnic violence. Richards, a young Afro-Guyanese woman, lived in a predominantly Afro-Guyanese community. She was killed after an alleged ritualistic beating at the hands of her Afro-Guyanese godmother, with whom she lived.

These cases, as presented by the media, do the work of ethnic gendering (Williams, 1996a), but also simultaneously mark women's bodies as racialized community boundaries. Distinguishing the multiple layers of violence (i.e., inter-community/intra-community and inter-ethnic/intra-ethnic) and the intricacies of community affinities (Williams, 1996b) and race relations in Guyana play a significant role in how differently racialized girls' and women's bodies are regarded and how, based on ethnic gendering, they are treated.

Crucially, my attention to and use of these three cases as my points of departure is not to say that these events alone should come to stand in for the other reported incidents with similar contexts. To the contrary, other cases citing madness, disability, mental health/illness, and the spirit possession of women and children in Guyana have been reported by newspapers over the past two decades. In 2002, the murder of Kamille Seenauth and the charges brought against Patricia Alves, also known as Mother Alves or Sister Pat by her Spiritualist Church followers, was one such case that riled the Georgetown community and is a crime that is remembered by residents as the "shallow grave murder", alluding to the brutality of how Seenauth was allegedly bludgeoned to death during an exorcism and buried in Alves' backyard ("Spiritualist on Murder Charge", 2002; Campbell-Lowe, 2012; "After Failed 'Exorcism'", 2015). The case of schoolgirl possessions and "attacks" of "evil spirits" in the Indigenous community of Santa Rosa in 2008 prompted the Roman Catholic Church of Guyana to request a psychological evaluation of female students, which was later conducted by an American psychologist (Siepel, 2009). Other incidents of spirit/demonic possessions at the primary, secondary, and tertiary school levels – predominantly affecting female students – were reported in 2012 and 2013 (Macklingam, 2012; Vickerie, 2013). All of this is to say that reports of violence are not restricted to the deaths of Singh, Persaud, and Richards. Indeed, these three cases only scratch the surface of reported

incidents, never mind the incidents that go unreported. And while there have been few reports of adult men in similar situations, the bodies of women and girls continue to feature more prominently in the national media. This dissertation, in part, accounts for these gender dynamics and the multiple ways in which Guyanese make meanings of mental distress.

The Ordinariness of Violence Against Women and Girls: Historicizing Gender, Race, and Politics in Guyana

The murders of Singh and Richards, and the death of Persaud – mainly constructed as singular and isolated events by multiple media outlets – only typify the brutality of life in Guyana for many women and girls. In her germinal work with the United Nations Development Fund for Women analyzing violence against women in the Caribbean, Roberta Clarke (1998) outlines state and non-state responses to gender-based violence; an examination of the Guyanese context is included in her report. Clarke (1998) contends that violence against women is rooted in a framework of cultural and socio-politico-economic power relations, which are further splintered by race and class dimensions, and are structured around unequal gender power relations where the authority and dominance of men lead to the economic and social vulnerability and deprivation of women. In Clarke's survey of the available literature in the region, the 1989 classic study conducted in Guyana by George Danns and Basmat Shiw Parsad, is heavily referenced. In their study, Danns and Shiw Parsad (1989) surveyed African and Indian women in Guyana on marital violence and concluded that violence against women in conjugal partnerships is widespread within both populations. Ninety-nine of the 120 Indian women surveyed, or 83%, were physically abused by their partners (Danns & Shiw Parsad, 1989, p. 42). Of the Black women surveyed, two out of every three, or 66%, experienced violence (Danns & Shiw Parsad, 1989, p. 71). In Indian and Black households that were male-headed, women were

more likely to experience violence; however, conjugal violence is equally frequent in households headed by women, particularly Black women (Danns & Shiw Parsad, 1989, pp. 55, 80, 103). Their research also found that the cycle of intergenerational violence against women persists if male spouses have experienced violence as children. Seventy-one percent of Indian male partners and 96% of the African male partners who experienced childhood violence reported that they were violent towards their spouse (Danns & Shiw Parsad, 1989, pp. 57, 83). The majority of Indian and African female partners also believed that a man "has the right to hit his wife" under certain circumstances, with 53% and 66% agreeing respectively (Danns & Shiw Parsad, 1989, pp. 58, 85). Circumstances under which violence was deemed acceptable include "infidelity, disobedience, lying or deceitful behaviour, and failure to attend to household chores and the family" (Danns & Shiw Parsad, 1989, pp. 59, 85). In this widely cited and foundational study, the authors conclude that conjugal violence is prevalent in Guyana because men and women exhibit "socialized role orientations to violence" within a culture that tolerates and supports gender-based violence and exalts male domination (Danns & Shiw Parsad, 1989, p. 99).

Other more recent studies on violence against women in Guyana reference alarmingly high and similar statistics. A 2019 qualitative study found that one in two Guyanese women have experienced intimate partner violence in their lifetime (Contreras-Urbina et al., 2019). In 2011, Guyana's Ministry of Labour, Human Services and Social Security (MLHSSS) commissioned a report analyzing gender-based violence in the country. The report, "Gender based violence in Guyana – An overview of incidences and drivers", states "domestic violence is the most pervasive form of interpersonal violence in Guyana" (Myers, 2011, p. 1). Domestic violence accounted for 82% of the 6222 incidents related to "kindred social matters" reported to the Ministry in 2009 (Myers, 2011, p. 1). Of the child abuse cases, 56% of the perpetrators were

listed as the mother or father (Myers, 2011, p. 1). In a survey conducted in 1998, 360 women from the Greater Georgetown area were interviewed; of the 216 who were in a relationship, 64% reported one form of physical, verbal, or sexual abuse committed against them by their partners (Myers, 2011, pp. 1-2). Seventy-six percent of the total respondents believed that family violence was a common occurrence in Guyana (Myers, 2011, pp. 1-2).

In 2007, the Ministry also published the consultation paper for its "Stamp It Out" initiative, focused on strengthening protections against sexual violence and reforming legislation. The consultation paper, using statistics based on a study conducted by the Guyana Human Rights Association in 2007, indicated that women and girls were victims in 92% of recorded rape cases, where 69% of the victims are below the age of 16 (MLHSSS, 2007, p. 5). Indeed, a published report in 2016 found that girls between the ages of 13-15, who experienced sexual abuse, were the largest group in state and institutional care ("Sexually-abused Girls, Ages 13-15", 2016). The "Stamp It Out" consultation paper also found that in three out of every four cases, the victim knows the accused; in 25% of the cases, the accused is related to the victim (MLHSSS, 2007, p. 5). Two-thirds of the reported sexual offences have occurred in the victim's home or in the home of the accused (MLHSSS, 2007, p. 5). Only 1% of reported rapes lead to a conviction (MLHSSS, 2007, p. 5).

The "Stamp it Out" consultation paper contained small sections on violence against disabled people. There is recognition that "people with certain mental and physical disabilities can also be vulnerable to sexual abuse" (MLHSSS, 2007, p. 1); however, the paper also indicates "no statistics are available in Guyana" (p. 5). Chouinard (2012), whose work investigates the acquisition of disability among women in Guyana as a result of domestic violence, also finds that research on disability and violence is sparse, asserting that little is written on the lives of disabled

people in the country more generally (Hall, 2005). One early report, "Women with Disabilities: The Guyana Situation" – commissioned in 1998 by the National Commission on Women in Guyana – found that women and girls with disabilities tend to fair worse than their non-disabled counterparts (J. Lewis, p. 4). The authors maintain that in the absence of reliable statistics and studies that they, as non-disabled women, must rely on the experiences of disabled women in drafting the report (J. Lewis, 1998, p. 1). Overwhelmingly, the report cites that poverty and economic dependence, accompanied with experiences of violence, are major factors that negatively affect the lives of disabled women and girls in Guyana (J. Lewis, 1998, pp. 12, 28). More research on the lives of disabled people in Guyana is necessary.

Importantly, the factors of race and narrowly drawn village fidelities are key to any meaningful engagement with gender-based violence in Guyana. When examining how Guyanese communities become racialized spaces, one must survey scholarly debates that analyze the ways in which colonial powers created racial anxieties and conflict between Africans and Indians in Guyana; and later how British and American interventionist foreign policy during the Cold War era perpetuated these racial animosities, especially within the context of Guyana's socialist, anticolonial movement for independence in the 1950s-1960s.[38] I engage with these historical events because it is crucial to grasp the colonial fountainhead of racial conflict as a driver of gender-based violence in Guyana. During the period of colonization and after the abolition of slavery throughout the British Empire, Asians (predominantly Indians and Chinese) were brought over to Guyana under the scheme of indentureship to assume work on the sugar

[38] Given the scope of this chapter and dissertation, please consult the following sources for detailed accounts of these historical periods and the social and political relations between Indo- and Afro-Guyanese: Walter Rodney's *A History of the Guyanese Working People, 1881-1905* (1981); Basdeo Mangru's *The Elusive El Dorado: Essays on the Indian Experience in Guyana* (2005); Brackette Williams' *Stains on My Name, War in My Veins: Guyana and the Politics of Cultural Struggle* (1991); Ralph Premdas' *Ethnic Conflict and Development: The Case of Guyana* (1995); Thomas Spinner Jr.'s *A Political and Social History of Guyana, 1945-1983* (1984); British Guiana's Report of the Wismar, Christianburg, and Mackenzie Commission [Wismar Report] (1965).

plantations just as freed Africans began their struggle for better working conditions, often preferring alternatives to estate labour (Rodney, 1981, pp. 180-183). Colonial divide and conquer tactics – the suppression of wages and planter-mediated perceptions of the other through stereotypes – ultimately served the capital interests of European overseers; discord mounted between Indians and Africans and resulted in violent clashes (Rodney, 1981, pp. 180-183).

Despite this early history of racialized tensions, Guyanese lived harmoniously in diverse, multi-ethnic villages such as Golden Grove, Buxton, Wismar, Christianburg, and Mackenzie as the colony began its campaign for independence (Wismar Report, 1965, p. 4). The anticolonial movement – initially a multi-racial, socialist endeavour led by Indo-Guyanese Cheddi Jagan and Afro-Guyanese Forbes Burnham, both of the People's Progressive Party (PPP) at the time – quickly became a cause for concern for British and American powers during the Cold War period (Spinner, 1984, p. 57). In 1953, the Churchill Government declared that Guyana was in "crisis", suspended the constitution, and dispatched troops to the country in an effort to overthrow the democratically elected PPP Government; PPP leaders were arrested, and so continued the internal and external destabilization machinations to partition the core of the PPP along ethnic lines (Spinner, 1984, p. 57).[39] Eventually, Burnham would go on to form the People's National Congress (PNC), whose supporters were mainly Afro-Guyanese; Jagan would lead the PPP, whose base was largely Indo-Guyanese. Through covert CIA operations, the US Government – under the leadership of Kennedy and later Johnson – worked with UK officials to sew political discord and install pro-West leadership in Guyana (Bahadur, 2015b; United States Department of State, 2001). The editorial note on the US Department of State's (2001) archives

[39] See the Robertson Commission Report, which was tasked with investigating the "crisis" of 1953 (Spinner, 1984, p. 57).

website summarizes the declassified documents related to the CIA operations in Guyana during that period:

> The Special Group/303 Committee approved approximately $2.08 million for covert action programs between 1962 and 1968 in that country. U.S. policy included covert opposition to Cheddi Jagan, the then pro-Marxist leader of British Guiana's East Indian population. A portion of the funds authorized by the Special Group/303 Committee for covert action programs was used between November 1962 and June 1963 to improve the election prospects of the opposition political parties to the government of Jagan's People's Progressive Party. The U.S. Government successfully urged the British to impose a system of proportional representation in British Guiana (which favored the anti-Jagan forces) and to delay independence until the anti-Jagan forces could be strengthened. Through the Central Intelligence Agency, the United States provided Forbes Burnham's and Peter D'Aguiar's political parties, which were in opposition to Jagan, with both money and campaign expertise as they prepared to contest the December 1964 parliamentary elections. The U.S. Government's covert funding and technical expertise were designed to play a decisive role in the registration of voters likely to vote against Jagan. Burnham's and D'Aguiar's supporters were registered in large numbers, helping to elect an anti-Jagan coalition.
>
> Special Group/303 Committee-approved funds again were used between July 1963 and April 1964 in connection with the 1964 general strike in British Guiana. When Jagan's and Burnham's supporters clashed in labor strife in the sugar plantations that year, the United States joined with the British Government in urging Burnham not to retaliate with violence, but rather to commit to a mediated end to the conflict. At the same time, the United States provided training to certain of the anti-Jagan forces to enable them to defend themselves if attacked and to boost their morale.

With CIA-backing, Burnham and his allies would go on to win the 1964 elections and continued to receive covert funding from the US Government (United States Department of State, 2001). It was not until after the outbreak of violence during the civil disturbances of the 1960s that the ethnic composition of these communities greatly shifted, leading to the perception that the coastal villages are either predominantly Indo- or Afro-Guyanese (Wismar Report, 1965, p. 4). After a series of fraud and rigged elections from 1968 to 1985 and PNC dictatorship under Burnham, free and fair elections were held in 1992 and resulted in the election of Jagan and a PPP Government (Bahadur, 2015b).

Since these events, the country has tried to address the ethnic divisions; however, racial tensions persisted and erupted in violence again during the 1997 and 2000 elections. The 23-year period (1992-2015) of consecutive PPP Governments ended in May 2015 with the election of a new multiracial coalition government, the APNU-AFC – comprised of the parties A Partnership for National Unity (APNU) (an alliance between the PNC and other minor parties) and the Alliance for Change (AFC). While racial cleavages endured in Guyana, the election of the APNU-AFC was considered a pivotal moment that for some harks back to the partnership forged by Jagan and Burnham in the early 1950s. The APNU-AFC has since lost the broad-based support that propelled them into forming the government in 2015, with constituents divided and again mainly voting along ethnic lines (Kurmanaev, 2020). The general elections in March 2020 also proved highly contentious after alleged attempts by members of the election council, the Guyana Elections Commission (GECOM), to manipulate the outcome – namely Region Four (Demerara-Mahaica) results – in order to install the APNU-AFC's leader, David Granger, as President on the basis of fraudulent results ("Golding Exposes Electoral Fraud", 2020; "Lowenfield Accused of Fraud", 2020; "Mingo Arrested by Police", 2020; N. Marks, 2020a, 2020b; "Western Envoys Voice Deep Concern", 2020; Wintour, 2020). This attempt and the machinations that followed were condemned by CARICOM (Charles, 2020; "'The Truth Hurts'", 2020), the ABC nations (United States, Great Britain, and Canada), and the European Union (N. Marks, 2020a, 2020b; "Timeline of Legal Cases", 2020; "Western Envoys Voice Deep Concern", 2020). After nearly six months and protracted legal battles between the APNU-AFC and the PPP in collaboration with a contingent of newly formed small parties, Irfaan Ali, leader of the PPP, was declared President with his party having received the most votes. Ali was sworn in on August 2, 2020 ("Irfaan Ali Sworn In", 2020; "Timeline of Legal Cases", 2020). It

is within this context of historical and continued racialized divisions that women and girls in Guyana come to stand in as symbolic gatekeepers of their communities when violence is perpetrated against their bodies (Red Thread & Help and Shelter, 2008; Trotz, 2003, 2004).

The killings of Singh, Persaud, and Richards happened within this environment of gender-based and racialized violence in Guyana; and while the soul of this inquiry is inspired by these cases of violence, the crux of this thesis concerns itself with the possibilities of what is to be learned if we rigorously examine their departures – or the conceptual and material questions that must be reckoned with if we are to understand how these deaths were made possible. These cases should be thought of as the catalysts that allowed me to enter and unpack how Guyanese contend with and make sense of mental distress and the various attributed causes; how it is talked about; and the practices enacted to alleviate distress. The findings chapters that follow intend to address these pressing resonances because it is in these departures, which were prompted by the cases, that I believe we can arrive at vital connections that allow us to work towards engendering consiliences and creating a more equitable Guyana.

Chapter Three:
Guyana's Formal Mental Health Care System (1842 – April 2022)

Biomedical psychiatry, as the privileged site of understanding mental distress, organizes and informs the foundation upon which the formal mental health care system in Guyana is built and how it operates in the country, with the National Psychiatric Hospital (NPH) – idiomatically known as the "Madhouse" – at the centre of this system. The Mental Hospital Ordinance of 1930 – the chief piece of colonial legislation that outlines the provision of care for distressed people utilizing services at the NPH – exerts substantial, material influence in dictating mental health care practices in the nation. As this chapter will show, the NPH and these inhumane, antiquated laws are a monument of colonial biomedicine, or the ways in which "medicine served as an instrument of empire as well as an imperializing cultural force in itself" (MacLeod & M. Lewis, 1988, p. x, as cited in S. Marks, 1997, p. 207). These are structures of continued and sustained colonial power and violence in the contemporary moment; their survival is also a consequence of government inaction and unaccountability. They are living anachronisms that operate today with the full backing and force of the Guyanese state. Successive governments across the political divide have failed to enact substantive changes to an archaic mental health care system that its own representatives deemed inadequate and, in the words of then APNU-AFC Minister of Public Health, George Norton, "not fit for human consumption" (Handy, 2016) and "disgraceful" ("The National Psychiatric Hospital", 2017). In view of this, it is ultimately the NPH patients who bear the heaviest burdens of these colonial inheritances and the accompanying institutional failures, which directly impact the provision of services and delivery of care.

This chapter outlines and analyzes significant features of the formal mental health care system in Guyana. The first section of this chapter provides an abridged history of the NPH and specifically discusses the influence of the British lunatic asylum model and colonial psychiatry

in Guyana. The second section exposes how the legacy of this antiquated model, coupled with inadequate government responses, have led to the failures of the present system. This section exposes the inner workings of the institution, predominantly based on the detailed accounts of NPH staff. This project necessitated interviews and observations at the NPH, which were conducted in December 2014. The seven frontline helpers – Colleen, Wendy, Indra, Teke, Salima, Monty, and Violet – who were employed at the NPH and chose to participate in this study are all medically trained professionals. They openly expressed how NPH stigma, the abandonment of patients by their families, and severe resource and operational deficits, including understaffing, overcrowding, poor sanitation and unhygienic conditions, basic supply and equipment shortages, and environmental hazards on the NPH grounds stifled or made their work difficult or near impossible. The participants also spoke of incidences of workplace violence and injury and past allegations of patient abuse, all of which will be outlined in this section. The third and final section of this chapter analyzes the single most important piece of legislation that dictates mental health care in Guyana, the Mental Hospital Ordinance of 1930. Throughout all three sections of this chapter, I discuss other relevant infrastructure, laws, and policies that influence and inform Guyana's formal mental health care system. Importantly, this chapter was completed in April 2022; it should be noted that given the scope of this research project, this chapter cannot possibly account for all aspects of the mental health care system in Guyana from 1842 to April 2022; however, it does strive to highlight important features, issues, and debates.

The "Berbice Madhouse": A Brief History and a Seething Colonial Presence

No institution is more emblematic of the Guyanese mental health care system than the colloquially known "Berbice Madhouse", which, as mentioned before, is presently and officially

referenced as the National Psychiatric Hospital, and previous to that, as the Mental Hospital. "Berbice" references the geographical county location of the institution, which is in Region Six (East Berbice-Corentyne). Before the establishment of the current NPH in Fort Canje, Berbice, a basic treatment facility in Georgetown – then referred to as the Lunatic Asylum and modelled after the British "lunatic hospital" archetype – was built in 1842 with the intended purpose of treating the local "insane" and "pauper lunatics" (Gramaglia, 2010, p. xii). Per the *Anti-Slavery Reporter* of 1st April 1851, the poor conditions of the facility were denounced by Messrs Alexander and Chandler on their tour of the colony and the West Indies in 1849-1850 (Gramaglia, 2010, p. xii). In response to this and other criticisms that followed in subsequent years, a new building was constructed near the General Hospital in Georgetown in 1859; however, "the general and particularly the hygienic conditions of the new Asylum still failed to meet acceptable standards and were harshly condemned in the Digest of 1864" (Gramaglia, 2010, p. xii).

The institution was moved to its present site in Fort Canje, Berbice in 1866, and despite some improvements, it again continued to experience "considerable defects and overcrowding", where "water supply, bathing arrangements, and sewerage were all inadequate" (L. Smith, 2014, pp. 97-98). Robert Grieve, one of the more prominent physicians to take charge of the Lunatic Asylum, is credited with implementing progressive reforms at the institution from 1875 to the end of 1885 (Gramaglia, 2010); however, the lack of political will to fund and implement structural changes meant that the institution continued to experience sanitation and operational problems, especially so as there were substantial increases to the patient population, which saw numbers grow almost fourfold from 170 to 640 patients over fifteen years (1875 to 1890) (L. Smith, 2014, p. 98). Though not fully remedied, some of these issues were alleviated when the

Fort Canje complex was expanded in 1885 after acquiring the buildings and lands of the adjacent general hospital, which relocated to New Amsterdam, Berbice (L. Smith, 2014, p. 98). These conditions at the Lunatic Asylum were not singular. Problems persisted throughout the colony's hospital system when a formal report by the Medical Inspector, Alfred D. Williams – who also fulfilled duties as the Immigration Medical Inspector – revealed "unsatisfactory conditions of the hospitals provided for the care of Indian immigrants", which "were found to be overcrowded, badly designed, not sufficiently ventilated and generally lacking in provisions" (Gramaglia, 2010, p. xix). The birth of the nation's Lunatic Asylum in 1842 occurred less than five years after the full emancipation of the enslaved and the implementation of the indentured labour system. Its founding cannot be separated from this historical context, namely the capitalist imperatives of the colonial project, which demanded a managed and compliant labour class. At the same time, the dismal conditions of the Lunatic Asylum and the estate hospitals were part and parcel of a larger, broken health care system where the economic interests of British imperialists and the White planter class outweighed the public health obligations of the colonial state, particularly in its duty and delivery of effective care to Guyana's colonized, multi-ethnic population (Misir, 2015).

In his study analyzing the history of colonial lunatic asylums in the English-speaking Caribbean, L. Smith (2010) presents how the British imperialists who did this work were executing a "civilizing mission" (p. 1). The creation of laws, policies, and protocols governing these institutions in the Caribbean were also influenced by racist ideas about colonized people who were thought to lead "wild and savage" lives (L. Smith, 2010, p. 20). Thomas Allen, a British doctor who is credited with "apparently enlightened approaches to asylum reform and

treatment" (L. Smith, 2010, p. 20) and also assisted in the establishment of lunatic asylums in Barbados and Jamaica, made the following observation:

> Looking to the normal standard of intellect of the negro peasantry of the West Indies, it must be evident that many are so brutal, and low in their intellectual scale as to be little more than "thinking automata" and that their ungovernable feelings, passions and emotions may render many fit subjects for a Lunatic Asylum, when there is little or no decided intellectual aberration. The want of education and civilizing influences fails to secure the least power of self-control. (p. 20)

Allen vouched for the building of separate wards for White "respectable Patients of the middle and upper class" who, at the time, lived in shared spaces with, per Allen, "criminals and debased pauper negroes" (L. Smith, 2010, p. 20). According to Allen, the former group – upon entering the asylum for treatment and "brought into relationship with negroes or others of such savage habits" – would suffer "more a misfortune than a blessing" (L. Smith, 2010, p. 20). Charles Hutson, superintendent of the lunatic asylum in Barbados in the mid-1870s, was "disparaging in his descriptions of some Black inmates whilst adopting a more sympathetic approach to White patients" (L. Smith, 2010, p. 19). Grieve (2010), the celebrated reformer at Guyana's Lunatic Asylum, engaged pseudo-scientific discussions comparing and contrasting the weight of the brains among different races and made race-based observations about intelligence and risks for an "insane brain" (p. 49). He journaled the following:

> But if there be any doubt about Hindoo brains, there can be none about those of Africans, for amongst these in every brain weighed the right hemisphere of the cerebrum was heavier than the left and when the much larger series of insane brain weights come to be examined it will be found that in the vast majority of instances this is the case, so much so that this preponderance of size in the right cerebral hemisphere may be looked upon as a distinctive character of the negro race. (Grieve, 2010, p. 49)

As well, Grieve (2010) believed Obeah or "Obeahism" to be a "local witchcraft" akin to other "diabolical craft" (pp. 492-494). These practices – which were outlawed during the colonial

period in Guyana, but remain on the books at present, though unenforced – were adjudged wholly objectionable and "horrid" by Grieve (2010, p. 494). He observed:

> From time to time, circumstances arise which bring into prominent notice the mischief done by "Obeah" the local witchcraft. Though it be only occasionally that its working can be openly traced, one is perfectly conscious that all the time it is present and interferes with discipline. The following statement may appear strong but nevertheless it is one, of the truth of which there is little doubt namely that there is not now, and there never has been an attendant of the asylum who does not believe in obeahism. (Grieve, 2010, p. 493)

Grieve goes on to say: "This implies that the same belief is universal amongst the labouring population of the colony… In short the asylum servants may be taken as representative of the creole working man and woman" (pp. 492-494). Obeah is challenging to define because it does not constitute an indivisible or monolithic set of practices, nor have people historically self-defined their own practices as Obeah (Paton & Forde, 2012). It is inaccurate to assume that all Guyanese believed in Obeah during the time that Grieve is writing. Today, while Guyanese acknowledge and are generally aware that practices ascribed to Obeah are carried out in the country, not all believe in or subscribe to these belief systems and practices. Even if all Guyanese believed in Obeah, what is also of concern here are Grieve's negative value judgements of this supposed "universal" belief system and practices. His blanket statements appear to brand Obeah as entirely problematic and irredeemable, and his account of Obeah fails to consider its utility or benefits among Guyanese or other colonized Caribbean populations at that time (Bilby and Handler, 2004; De Barros, 2004; Crosson, 2015; Paton & Forde, 2012). White medical superintendents charged with overseeing the lunatic asylums were not immune from the dominant British stereotypes that persisted about Black and racialized people living under colonialism in the Caribbean (L. Smith, 2010). This historical pretext – Britain's "civilizing mission" (L. Smith, 2010, p. 1), in part, via management of the colonial lunatic asylums – produced conditions that still seethe, influencing the formal mental health care system

of Guyana today. When paired with decades-long government underfunding and unaccountability, the state of care – especially at the NPH – appears to be marked by deprivation and neglect.

Now, as then, similar deficiencies – many of which are colonial inheritances (regressive institutions and archaic laws) – persist in Guyana's underfunded public health care system, which ranks poorly on global indices (Fullman et al., 2018; Goede, 2014; Misir, 2015). These weaknesses are felt in the formal mental health care system, where biomedical psychiatry is the imported, inherited, dominant, and unquestioned, state sanctioned model of care in capturing and addressing mental distress. The oft-cited and internationally recognized "WHO-AIMS Report on Mental Health System in Guyana" (WHO, 2008) provided a synopsis of the situation in its executive summary:

> The current mental health system in Guyana is fragmented, poorly resourced, and not integrated into the general health care system… There are no national or institutional standards for mental health care, facilities or human resources. The National Psychiatric Hospital (NPH) is in substantial disrepair and significantly below the standard of facilities that provide for physical health care, raising concern about equitable treatment of the mentally ill. There are no standards, protocols, policies or guidelines for the use of psychotropic medications; the assessment, treatment, monitoring, and ongoing evaluation of patients with mental disorders; the charting of patient information; or the maintenance of health records. There is little national mental health data available for mental health service monitoring and evaluation. As a consequence, datasets of sufficient quality are not available to inform service utilization or to provide quality assurance for mental health care. (pp. 5-6)

Since the publication of the WHO-AIMS report in 2008, many of the cited conditions – particularly around the lack of national and institutional standards and updated legal frameworks for effective mental health care and the recognition and codification of patient rights – remain the same at the time of the final drafting of this chapter in April 2022; however, some changes were made, which largely bolstered biomedical psychiatry and psy-oriented interventions. These changes were mainly prompted after widespread criticisms and calls for reform with the 2014

release of the WHO's international incidence rates of suicide in which Guyana topped the 2012 list (Rawlins & Bishop, 2018; "Desperate Measures", 2014; Handy, 2016; F. Mohammed, 2015; WHO, 2014). Guyana's high suicide rate – especially the climate after the release of the WHO's suicide numbers in 2014 – will be discussed in Chapter Four.

The poor conditions at the NPH, mentioned in the WHO-AIMS report and in multiple newspaper articles, and the violent deaths of five patients at the institution between April 2009 to June 2021 are widely documented (Alleyne, 2015; "Almost Three Years After", 2018; Bhagirat, 2021; Campbell, 2014; Handy, 2016; "Mental Hospital Patient Charged", 2009; "Five National Psychiatric Hospital Patients", 2021; Oosman, 2021; "Police Probe Death of Psychiatric Patient", 2019; WHO, 2008). While there is a psychiatric clinic affiliated with Georgetown Public Hospital – which primarily serves as an acute care outpatient facility with a six-bed capacity for short stays – and efforts have been made to establish outpatient satellite clinics in other regions (Ministry of Health, 2016), the NPH in Berbice continues to be the largest, centralized institution for psychiatric treatment in the country with 200 beds ("Mental Health Laws to be Broadened", 2017). Per the state's Department of Public Information, some improvements were made to the NPH in 2018 (Raikha, 2019), which will be discussed nearing the end of this first section. In October 2019, however, reporting indicated that conditions at the NPH, particularly in the patient wards, remained poor and substandard; this is according to accounts from local NGOs and a sixteen-year-old girl who was involuntarily committed to the institution after she "attempted to take her own life on numerous occasions because she was sexually molested but relatives did nothing to help her" (Carmichael, 2019b). In an August 2021 news report, further improvements were made to patient wards and were nearing completion ("$26M Upgraded Psych Ward", 2021); however, three separate fires broke out in a specific

patient ward in June, August, and November 2021, which caused varying degrees of damage ("Patient Sets Fire to National Psychiatric Hospital", 2021). These incidents and the violent deaths of five patients at the NPH since 2009 will be discussed in section two of this chapter.

According to Jamaican psychiatrist and academic Frederick Hickling (2020), whose work in Jamaica and the Caribbean spans several decades, these custodial institutions are arbiters of colonial power in contemporary mental health care systems and, as was then, they remain woefully unfit to respond to the needs of the populations that they purport to serve. Speaking about his work in psychiatry and the relationship between colonialism and its impact on the Jamaican experience, Hickling (2020) explains:

> The psychiatrist in Jamaica today is forced to deal with different issues within a profoundly different context. Murder, rape, and crimes of all varieties face psychiatrists as they make their weekly rounds from hospital to prison to public and private clinic and into the community. Confronting deep-seated rage, anger, violence, and hostility are part of the daily routine. The soul murder of abuse and deprivation (Painter, 1995; Shengold, 1989, 1999), linked to the history of slavery and colonialism, is the origin of the conflict and stress, tension, anger, anxiety, sadness, and despair that characterize the postcolonial experience. My experience as a third-generation African Caribbean psychiatrist has given me insight into this intergenerational process and led to the conviction that we all have to own our madness. (pp. 27-28)

While Guyanese and Jamaican contexts are not identical, these nations do share a similar history of British colonialism and comparable, present-day socio-economic struggles (e.g., structural adjustment, remittance dependence, high emigration rates of skilled workers or "brain drain", high incidences of gender-based violence). Both have also endured the "civilizing mission" (L. Smith, 2010, p. 1) of colonial psychiatry through the implementation and influence of the British lunatic asylum system and the accompanying legislative frameworks. Borrowing from the insights of Hickling (2020), space must also be created and nurtured for Guyanese to reckon with intergenerational trauma and the consequences borne out of these colonial inheritances and their complexities in order to "own our madness" (p. 28). The NPH, as it currently functions, and as

the rest of this chapter will illustrate, appears unequipped to address the complex needs of Guyanese; and, as mentioned in a November 2021 address given by Bhiro Harry, one of Guyana's leading psychiatrists, the NPH is "a sad place, very sad place" (Bhagirat, 2021).

Into the "Madhouse"

Institutional Stigma

> I was very fearful of the Madhouse when I went with my family during school breaks to Berbice. It's almost as if, you know, it's worse than jail. You don't want to do anything wrong [chuckles]. Or else you'll just be placed in there. As you're a child you don't want to be placed in there [chuckles]! Even from the outside, I mean I've never been, the property itself, the outside looks abandoned. It doesn't look like a health facility. It looks abandoned. (Nicole, Interview)

> Growing up, that's what children got threatened with: "If you misbehave, we're going to send you to the Madhouse or somebody from the Madhouse is going to take you away." That was the phrase, "Madhouse". (Hafsa, Interview)

In these passages, Nicole and Hafsa, two civil society/NGO helpers, articulate a familiar refrain; they speak of the foreboding and morbid associations of that "worse than jail"-like place, the "Madhouse". They, and other participants who spoke frankly of the facility, point to the stigma that engulfs the space – the palpable feelings of apprehension and dread that are immediately triggered by any mention of the institution. David, a Christian Pastor, sums it up this way with pointed rhetorical questions: "Who wants their family member to be sent to Canje [referencing the specific location, Fort Canje, in Berbice where the institution is situated]? Who wants their family member to be sent to a madhouse? The stigma attached!" These sentiments are characteristic of the public's general perceptions (Foster, 2018; Raikha, 2019), which entrench madness to notions of complete abjection (Kristeva, 1982) and construct tropes of a "haunted and scary" establishment ("Residents Differ on Demolition", 2011) with layered,

cliché-ridden assumptions that the "patients are raving lunatics who need to be restrained" (Conway, 2011). As this chapter will show, it is not the patients who are to be feared, but the entirely man-made and abysmal institutional conditions themselves.

Nicole and Hafsa's tellings, in particular, illustrate how the institution is trapped in an intergenerational and uncritical framing, which engenders feelings of fear, loathing, and desolation. The Madhouse is assembled as a theatre of terror and, as such, is constructed as a disciplining mechanism; it is a place where the threat of incarceration is wielded against children whose behaviours contravene the expectations of their caregivers. As adults, Nicole and Hafsa carry these childhood memories of the scolding and risk of imprisonment, even as one of them points to these recollections with breaks of laughter. And, perhaps, these memories stick because they, as helpers, know that the institution is a place that predominantly houses adults; thus, serving as a disciplining apparatus for all Guyanese, not only children. Importantly, Nicole, Hafsa, and David identify a basic Guyanese shorthand – they affirm to us the way in which the institution is widely referenced by the general population, particularly when Hafsa says, "That was the phrase, 'Madhouse'" (Ahamad, 2011; Rawlins & Bishop, 2018; Campbell, 2014; Conway, 2011; Foster, 2018; Suseran, 2012).

The Impact of NPH Stigma

The staff spoke of how the stigmatized perception of the NPH, as the Madhouse, is common. They cited how it plays a major role in dissuading people from seeking psychiatric treatment and negatively influences the NPH's ability to recruit and keep medical staff:

> I think most people when they hear about over here, like Madhouse or mental or whatever, it's like this is not somewhere nice to be. They probably don't realize that it's people just like me and them are here. They are just challenged in a different way. They would view it in a total negative way. Most people don't want to come and work over here. (Salima, Interview)

> To be honest with you people have a stigma about working here. They can't come and work at the Madhouse. They can't come and look [take care of] mad people… They don't want to work with mad people. (Monty, Interview)

> The general population, as soon as they see the people walking to come here or they hear the patient takes treatment… [They say,] "Well, you are a mad person." (Teke, Interview)

> Nobody wants to be here… You know, the stigma attached to it. So, some persons, to avoid persons knowing that they are in here, as soon as they get better, they leave. (Wendy, Interview)

Building on Wendy's response and the sentiments of her colleagues, the stigma attached to the NPH ensnares itself to all bodies who occupy the institutional space, whereby any person observed entering the facility – for treatment, to work, or otherwise – is viewed with suspicion and labelled mad. The stigmatized perception is felt materially when other medical professionals "don't want to come and work over here" (Salima, Interview) or "don't want to work with mad people" (Monty, Interview). The NPH stigma is symptomatic of the larger stigma tied to the overall perceptions of madness and people labelled mad, which will be discussed in Chapter Five.

"Dumping Ground": Patient Abandonment

It is, in part, this stigma, coupled with the abandonment of patients by their families that contributes to another common epithet referencing the NPH, which is bluntly captured by Monty: "Here is the *dumping ground*." Other staff utilized similar language, which appears to align with Monty's sentiment:

> If you make a full assessment of all the patients that are here, I think maybe three quarters of them can go back home…What I find is that persons just want to bring their relatives and just *dump* them here. (Colleen, Interview)

> Their relatives just bring them and *dump* them here and they disown them. And that would even make them become more and more sick knowing that their family just *dump* them and leave them here… In Guyana, most of the times that is what most of the relatives does. It could be rich people, poor people. Wherever they come from, they do that. They just bring the patients here, as long as they are mentally ill to that extreme

> where they have to be admitted, most of them bring them and just *dump* them here… We would inform the relatives they are discharged. Knowing that the patient is discharged, they wouldn't show up at all. As much as most of them get accustomed to here, some of them just can't stop thinking about home and going out of here. Eventually they get a relapse of their condition, especially our depressed patients. They get a relapse and back to basic again, starting the treatment all over again for the acute condition. (Salima, Interview)

Indra has a slightly different, though principally similar, take: "We are the *burden house*." This suggests that the patients themselves are viewed as "burdens", who are abandoned or "dumped" because caring for them is viewed as too onerous a responsibility by their families. When families neglect and abandon their relatives, some of whom are assessed and deemed ready for discharge, this contributes to overcrowding at the NPH. There are no government mechanisms or programs in place to enable supported or independent living if and when a patient is ready to be discharged; therefore, and in the absence of family support and stable accommodations, the NPH continues to house people who would otherwise be discharged because they may experience homelessness as a consequence of leaving the facility.

Moreover, staff indicated that families will conveniently show up at selective times of the year to accompany discharged patients back home, only to reappear just before holiday periods commence and abandon them at the NPH:

> It have a season… With the fluctuation you would find it between the month of March to April coming into the Easter season, then there will get decline [in the patient population] then it going to be fill up again between the second to last week in June, into July to August, between the Emancipation period. And then it gon' decrease again and it gon' increase again in the last week in October straight into December… Some of them, some of the relatives now, around this time of the year they would come and pick them up because now they know the house got to paint, who may have a trade, or the house got to wash, or the back interlock or the gutter gotta dig out. These are some of the advantage [as in "taking advantage of" or the family exploiting the labour of the patients]. I wouldn't call it challenges. I would call it advantage! And when they finish with them, return to sender. (Monty, Interview)

> Especially during this time of the year [December]… We will see the increase [in the patient population] because a lot of families they will bring the patients. They will say

> whatever they want just for us to keep the patients here and have a quiet holidays. It's really sad but this happens. It happens. (Teke, Interview)

These cyclical fluctuations in the patient population, particularly during holiday periods, create untenable conditions for which the NPH and the government have not adequately addressed.

Institutionalization

The staff underscore that prolonged stays at the NPH lead to the institutionalization (Goffman, 1961) of many patients, which is also acknowledged by government officials ("Efforts Must be Made to Eradicate Stigma", 2016). The NPH is a total institution, and similarities can be drawn between it and a prison; it is "a place of residence and work where a large number of like-situated individuals, cut off from the wider society for an appreciable period of time, together lead an enclosed, formally administered round of life" (Goffman, 1961, p. xiii). Furthermore, and with reference to the comparisons between psychiatric institutions and prisons, two of the seven hospital staff referred to the patients as "inmates" (Violet and Salima, Interviews). The language of "inmates" is employed in reporting across the major dailies, including the *Guyana Times* ("Patient Commits Suicide", 2020), *Kaieteur News* ("Psychiatric Patient Killed", 2019; "The National Psychiatric Hospital", 2017), *Stabroek News* ("Mental Hospital Patient Charged", 2009), and *Guyana Chronicle* (Van-Keric, 2009).[40] In a June 2021 article on a fire at the NPH, *Stabroek News* led with the headline "11 Inmates Suffer Burns in Berbice Psychiatric Hospital Fire – Search Underway for 5 Escapees". The term "inmate" is used in the Mental Hospital Ordinance of 1930 and was historically employed to describe inpatients at colonial lunatic asylums in several English-speaking Caribbean countries during the 19th century (L. Smith, 2010, p. 28). During this period, and before the establishment of asylums, jails often

[40] Consult the body of these articles by the various newspapers for the use of the term "inmates" in reference to NPH patients.

functioned as institutions for "dangerous or disorderly lunatics" in the Caribbean and throughout the British Empire (L. Smith, 2010, p. 6). The contested usage of "inmate" and its general carceral meanings at present is not lost on people (Marshall Project, 2015). The PAHO and WHO country representative for the Guyana Country Office, William Adu-Krow, disavowed the term and its use at the NPH. According to reports, he "cautioned staff that patients should never be seen as inmates" ("National Psychiatric Hospital Re-commissioned", 2017). He is quoted as saying, "We should begin to see this place as a hospital. We have 'in patients' and we have 'outpatients'. We use the word inmates in other settings" ("National Psychiatric Hospital Re-commissioned", 2017). The use of "inmates" signals the continued and constitutive, colonial and carceral features of the NPH, some of which also echoes NGO/civil society helper Nicole's perceptions of the Hospital at the beginning of this chapter of not just a "jail", but a "worse than jail"-like place.

The staff detailed the nature of long-term stays and unpacked how the NPH becomes a "home" (Indra, Interview) for many patients:

> We got one woman in the Ward C… She has been at the hospital for more than 50 years. We don't have any relative or no contact information for her. What you would have had has probably expired so long ago… She came at 45 and she is now 95… Some of them come as children, not small, maybe about 15 and so on and they end up remaining here because after a time, they [patient's family] abandon them… They [patients] are here for 50 years and 20 years. This is their home now. They know the routine. (Indra, Interview)

> A little more than half of the population at the hospital, they are what we call long-term patients and chronic patients and most of them, even if they are stable, they have to remain in the hospital for different causes. Some of the cause is because family migrate to different country and they left here. Others because the family forgetting to bring back them to the family. The family just cut, sever the relationship with the patients… Some of them have more than 30 years [at the NPH]. (Teke, Interview)

> You have patients who don't want to leave. We say that they become institutionalized because some of them have been here since they were children. All they know is being in here. So those patients are left here for years until they die. Then you might see relatives coming to find out about them. (Wendy, Interview)

> Some of them has been here like over 20 years. We even have some about 40 something or 50 years [at the NPH] you know, about 40 something years. Some of them died of old age. A few of them, since I have been here, die from old age… Most of them are like institutionalized. They get so accustomed to here that they don't even want to go home. Some of them are like that. They don't want to go home. They prefer to be here… They are long-term. They eventually become live-in. They do regular things like go out, go to church… If they want to go to the market and buy something for themselves, some of them get public assistance, they would go collect their money and transact their business and those kinds of things. (Salima, Interview)

The staff cite a diversity of reasons that result in long-term stays, which then contribute to institutionalization. It is the understanding of a few staff that some patients, after years of being institutionalized, "don't want to leave" (Wendy, Interview) or "don't want to go home" (Salima, Interview). Colleen reaffirms this perception:

> We have patients who can take care of themselves, wash their own clothing, get themselves tidy, take care of themselves. Yeah, we have patients that go out. Every day they go out on the road and come back. Some patients would go to their family and come back. These are patients that can go home but because so many years they've been in the institution, they call here home. Even if they go home [to their family], they are telling their relatives, "I have to come home [to the NPH]." … So many years in the institution, this is their home… By afternoon the patient would tell the family, "I have to come home [back to the NPH], ya know."

When asked about the meaning of "home" and notions of family, Colleen says that the patients see their peers – other patients – as family: "They does say, 'Dat is meh sistah.' They say, 'Meh goin' wid meh sistah or brudah [brother].' They say, 'Is meh sistah, man, is meh sistah'." More research that focuses on and centres the experiences of patients at the NPH is necessary in order to comprehensively understand patient experiences and the nature and consequences of total institutions and psychiatric institutionalization in Guyana.

Understaffing and Overcrowding

Understaffing is another major operational and health and safety concern expressed by the medical professionals at the NPH:

> Sometimes it can be really limiting in terms of staffing… When there's a shortage of staff we would find that you cannot or you don't achieve your goals. It affects patient care at the hospital… We cannot actually do what you really want to do for the patients especially in the admission wards… You find that you cannot do a proper assessment on the patient… If we have to do any shifting around like for the admission ward, it's overcrowded, what we do is we do some shifting around… Those [patients] who are well… we could send them to other wards so that we can have the space to accommodate the new ones. That is how we manage. We just shift around. That is how we manage. (Colleen, Interview)

> Sometimes it's hard when you have to be in the wards with so many patients. Sometimes we have like 25 or 30 patients. Sometimes one staff is being left and it's a junior staff sometimes. That's how we're short of staff. Sometimes it's just two staff. All like today, it was just two of us. I had to go over to do the ECT [electroconvulsive therapy] with the doctors, and just one staff, a junior staff, was left with the 23 patients… For an admission ward, I think the maximum is about 15 we could house in there. Sometimes, most of the times, we have about 20, 25, or 30 up to 35 in the female unit…. That's too much patients for one unit… If we are over 20 something patients, we don't have enough beds. They have to double up on a bed and that would sometimes erupt fights with them. They are fighting over beds. (Salima, Interview)

> The pressure is too much on one staff because one staff cannot work two and three units, yuh understan'. It is very hard. I can't be working at the admission ward and then you're going to ask me to look over at the post admission ward. What are you doing to me? Instead of taking on responsibilities of 23, now you're putting me with one that have 24… Now you increase my stress load by how much? (Monty, Interview)

Understaffing and overcrowding were mentioned together. The staff felt unsupported and unable to provide the necessary care for a growing number of patients in already overcrowded wards (also referred to as "chalets"), particularly in the admission wards, where the act of "shifting around" (Colleen, Interview) patients is a temporary measure that does not, in aggregate, create new and necessary spaces to provide essential services. The staff felt pressured to solely assume care responsibilities that should be assigned to two or more health professionals. When conflicts arise between patients in overcrowded wards, this creates additional health and safety concerns for other patients and the staff who are in no position to address structural issues such as the lack of beds.

According to staff, the admissions wards are mainly affected by overcrowding. They mentioned that over the years they have witnessed a sharp increase in the admission of patients – primarily men – experiencing substance and alcohol use challenges, which are usually compounded by interactions with the criminal justice system, homelessness, and situations of precarious housing:

> The men, is drugs. Most of them is drugs. Most of the men just keep smoking ganja and using cocaine and all of these things. They eventually end up in here. Most of them are like that. (Salima, Interview)

> It's 23 patients that I have in there and you might find it like 18 or 17 of them are drug abuse, majority of them are drug abuse. They are young men. They are saying that there is no place for them to go and get proper jobs and then you have the peer pressure… Most of them would be very psychotic. (Wendy, Interview)

> The males in particular… If we have 25 males in the admission ward, about 15 to 20 are there because of drugs. The majority, the males… Mostly I'm concerned about the drug addicts. Remember, here is a psychiatric hospital and as I said before, we have these drug addicts come in and because of the drugs, they are having psychosis, so drug-induced psychosis… I think we should have some place for these drug addicts, some rehabilitation, some place where they can go. (Colleen, Interview)

> Majority of the new patients that are coming are not mentally ill, as a mental condition, they are more drug addicts… Georgetown [Psychiatric Clinic] have a system where they admit them for seven days and if they don't feel well, they send them down [to the NPH]. Even if you send them back [to the Georgetown Psychiatric Clinic], three quarters of the time they go back right on the street and they coming and going steady… When they are in the street and they get sick and so on, they gone back to Georgetown [Psychiatric Clinic]. Seven days they spend there [at the Georgetown Psychiatric Clinic], and Georgetown bring them down [to the NPH]. That's the system… We are housing [chuckles]. (Indra, Interview)

For Indra, substance and alcohol use challenges are not considered a mental illness or "mental condition", though the DSM captures and creates labels for what it calls "substance use disorders" (Hasin et al., 2013). Per the National Institute on Drug Abuse (2018) and generally accepted biomedical understandings of addiction and dependence in relation to substance and alcohol use, "Addiction is defined as a chronic, relapsing disorder characterized by compulsive

drug seeking, continued use despite harmful consequences, and long-lasting changes in the brain. It is considered both a complex brain disorder and a mental illness." Scrutiny and concerns, however, have arisen about how the DSM classifies and addresses "substance use disorders" (Hasin et al., 2013). This led to the creation of the DSM-5 Substance-Related Disorders Work Group, which was tasked to address the issues stemming from these and similar debates (Hasin et al., 2013). The accounts by some participants from this study pose additional questions about stigma and staff attitudes/perceptions about specific patient populations and how patients with substance and alcohol use challenges are cared for at the NPH. Further research is necessary to understand this, particularly from the perspective of people receiving services and/or admitted to the NPH with substance and alcohol use challenges.

Like Colleen, Indra indicated that the NPH is not able to provide specific, differentiated care to address substance and alcohol use challenges, which are prevalent among newly admitted male patients: "We just don't have a system for it." She explains that rehabilitation centres designed to address these specific issues are scarce and expensive in Guyana: "We have one rehab place in Georgetown, and people have to pay a lot of money to go there" (Indra, Interview). In 2012, it was reported that a patient at the NPH was arrested after being charged with "possession of narcotics for the purpose of trafficking" when they attempted to sell cocaine to other patients ("Mental Patient Found with Drugs", 2012). Conditions at the NPH created circumstances that potentially triggered or exacerbated the substance and alcohol use challenges of this patient and other patients; this is in stark contravention of the NPH's role as a place of care and recovery. It is unclear what mechanisms were put in place to prevent future incidents of this kind. According to staff, the NPH does not have the resources or capacity to adequately accommodate the "coming and going" (Indra, Interview) of patients – particularly this subset of

patients with substance and alcohol use challenges. This results in ward overcrowding and safety concerns for all patients involved; it raises the potential for compounding, adverse health outcomes. In 2014, the government promised that the NPH would be "converted into a complex, with three components – one for the elderly, the second for addicts and the third for people with psychiatric problems and need care", which was intended to "reduce overcrowding at the institution" ("Mental Health", 2014). This has not yet materialized as plans "fell apart" (Bhagirat, 2021). Experts and families of people experiencing mental distress and substance and alcohol use challenges continue to lament the paucity of specialized facilities, programs, funding and resources to assist Guyanese in these circumstances (Dhanraj, 2021; "Samantha Young: Looking Towards Better", 2019).

Concerns related to unfulfilled promises of wage increases and promotions being commensurate with additional training were cited as reasons for staff departures; thus, contributing to persistent understaffing, particularly of specialized medical professionals. Three NPH staff indicated that there were some professionals who received additional training and were promised new job titles/appointments and salary increases upon successful program completion. According to Indra, the government did not follow through; none of these previously agreed upon advancements materialized for the medical personnel who completed the training:

> They had some training and they too were promised to be licenced as psychiatric mental health nurses… They were licenced but they were never appointed. The government didn't appoint them. They are not being paid for that for psychiatric mental health. They are just being paid for a registered nurse salary… They are not receiving the payments. And you know, if I ent receiving the payment, I ent functioning in that capacity... They train them and say, "We gon' appoint you," and nothing happen. People get discourage. They go away now. Five of them had training and we only got three. Two went away… But all-in-all nobody has been paid for anything… They train the people, and they lose them. They give them nothing to keep them. When people young, they gone.

Patrick, a Ministry of Health official, understood the discontent expressed by Indra and believed that more needed to be done:

> I could understand that concern. They're not just nurses, they become specialist nurses and it's something that we have to pay attention to, to ensure that we keep them... A lot of times, it's not finance you know, it's facilities. Sometimes you might not be able to find the finance ready but if you offer other facilities like transportation to and from their job and so, benefits, there are several things that we can do that we should do. We are looking at those matters. Of course you know funding is always, everybody got up priority in every agency. I could understand the nurses there saying they are trained as specialist nurses. I have no difficulty with that.

As will be discussed in Chapter Four, Guyana has since ramped up mental health training programs (Ministry of Public Health, 2014; Bishop, 2017) after the release of the WHO's 2012 suicide statistics where the country recorded that highest rate of suicide in the world per 100,000 people (age-standardized, all ages) (WHO, 2014). If mental health initiatives are a government priority, as has been repeatedly articulated by elected officials, then they may want to heed concerns of NPH staff in order to retain their services and expertise; otherwise, they may continue to "train the people, and they lose them" (Indra, Interview).

Poor Sanitation and Unhygienic Conditions

> "It is my fairy godmother's wish to bulldoze that structure," Dr. Norton [Minister of Public Health] told the Guyana Chronicle in an interview. He contended that the hospital is one "you wouldn't want to put anyone in" due to its deplorable state. From visits to the hospital, he found it to be "filthy, damp, humid and just unfit." Dr. Norton asserted that the condition of this hospital is "scandalous." (Ragobeer, 2016)

"You cannot deny reality. You walk here, you see the condition," said Teke, one of the medical professionals, after I was given a full and extensive tour of the institution. Salima, another frontline staff, also commented similarly after realizing that I had walked through the NPH facilities and grounds: "The facilities suck. Well, you took a tour and you see what it's

like." Salima's co-worker, Wendy, summarized the conditions: "Well, since I've been working here… things have gotten worse. The environment in the whole, I do not think it's conducive for patients and for staff." The staff candidly talked through the NPH's poor sanitation and unhygienic conditions, basic supply and equipment shortages, and environmental hazards, some of which I also observed during my time there.

The medical staff provided great detail when asked to outline the day-to-day working conditions at the NPH. They emphasized how the NPH's poor sanitation and unhygienic conditions made their work unbearable:

> It's filthy. It's very smelly. It's hard to be in. When you look at it from the patient's point of view, it's heartbreaking to know that you have to come to work every day and these patients have to be in this all the time. You're just there for a few hours but these patients have to be there most of the time. Sometimes there is water, sometimes there is not, so the patients… they don't brush their teeth. So they are left filthy all day sometimes. I've recently encountered a problem with my superior because I went to report the condition of my ward. So I had a problem with that where I walked off. I was going home but I was told not to… There was no water. The ward was smelly. I couldn't work, and then we have to eat our lunch and so it's not healthy because once you have the smell in the air you know it is bacteria present around. (Wendy, Interview)

> In my opinion the compound needs more sanitation workers. That's number one… Environment is very poor as you see. (Monty, Interview)

> You need to do handwashing often. You don't have water steady. Certain times I think the pipes stop running. The maid has to finish cleaning by then. If not the ward is left unclean if there is no water. The patients wouldn't get to bathe. They would smell terrible. (Salima, Interview)

Hospitals cannot perform the most basic of functions or adhere to sanitization protocols without running water. Access to potable water, not just running water, appeared to be an issue. In 2015 reporting on the murder of a patient by another patient at the NPH, then Minister of Public Health, George Norton called conditions at the facility "inhumane" and denounced the absence of potable water at the Hospital (Alleyne, 2015): "It is pitiful to see the conditions where we have our Guyanese brothers and sisters dwelling… The wards are being cleaned with water from

the drain and persons are bathing with and even drinking" ("Accountability to Patients", 2015). Salima lamented the situation of drinking water at the NPH: "Plus water to drink. They [patients] don't have proper water to drink... They drink it right off the tap. They don't really have much of a choice. The situation is terrible."

When staff like Wendy complained and opposed working in these outlined conditions ("I went to report the condition of my ward. So I had a problem with that where I walked off"), her calls for change were ignored and met with resistance. This prompted her to protest by threatening to withhold her labour. Wendy laments: "The environment on the whole, we cannot do anything about it because our superiors, if you go to them, it is left to them and nobody makes the effort to improve on it." Salima also found that her calls for change were disregarded: "If you complain to the management, it's like they behave like it's for yourself that you're doing it, but it's for the patient. We fight but sometimes it's no use. We are still trying." For Wendy, the conditions at the NPH are untenable: "You have people leaving and to be truthful, I myself am leaving because I cannot work in this condition all this time." Asked when she intends to leave, Wendy responds, "Next year. I can't… This compound is deteriorating by the minute. It's getting worse and worse every day." If given the chance, Salima would also resign: "If it wasn't for the patients, I don't think I would've been here. And, yes, if I do have the opportunity, I would run [chuckles]. I'd seriously run because of the working situation. I'd run." According to the staff, NPH management and the government's inaction to correct these failings created hazardous conditions for them and the patients, further fueling staffing shortages and affecting patient care.

While touring the NPH facilities and grounds, I noticed that mattresses soiled with feces and urine were placed on the grass and dirt patches outside of the wards (see Figure 1.0). Many of the mattresses appeared worn with tears to the fabric or plastic, exposing their foam interior.

Wendy stated that the practice of placing the mattresses outside is a common occurrence and explained why:

> They would put them [mattresses] out to have sun because those wards would have the geriatric patients. Some of the very old patients, who really can't move very fast, so you would find some of them wetting the beds and those things. Being in that all the time, you have to sun them [mattresses] out to prevent another illness from occurring.

When the mattresses are put out to sun, the bare metal bedframe or a wooden board atop the metal frame is all that is left for patients inside of the wards to lay on based on my observations. It is unclear whether basic supplies such as mattress soaker pads, intended to capture moisture from urine and feces, are available at the NPH given the constant shortage of basic supplies, which is subsequently discussed.

Figure 1.0: Soiled mattresses are strewn across the overgrown grass and dirt patches to dry outside of one of the patient wards.

Basic Supply and Equipment Shortages

Supply and equipment shortages were another major failing frequently cited by NPH staff:

> We have diabetic patients in the wards. We don't even have a proper diabetic meal for the patients at times. When it comes to checking the blood sugar even, we don't have strips to check the blood sugar. We don't have a choice. Sometimes you have to just go with the flow… We don't have a proper blood pressure machine to check the patient's blood pressure. Like I said, we don't have a glucometer. Each ward is supposed to be provided with a glucometer and a BP apparatus, but we don't have that to check the patient. We have diabetic patients, especially in the geriatric wards. If you have diabetic patients, your blood sugar is supposed to be checked at least every day. They don't do that. We don't do that because we don't have the resources yet. We recently had a patient, she had ulcers on both of her feet, and she's a diabetic. She is on a sliding scale with her insulin. Her blood sugar is supposed to be checked three times a day but there were no strips available so we couldn't even check it sometimes… If we don't have a glucometer to check her blood, she can go in hypo or hyper and we wouldn't even know. How can we administer the medication if we don't have strips to test the sugar? So she is at a disadvantage there. She doesn't have a proper diabetic meal. Sometimes the kitchen doesn't prepare a diabetic meal for her. (Salima, Interview)

> Especially when it comes to transportation, and I would stand up for that because sometimes you would have a patient who would have to go do his chest x-ray, a patient who has to go get his appointment based on his HIV-status, a person whom I got to go to the foot clinic or whenever clinic they might have across there. Sometimes when you call, there is no vehicle. Sometimes for two or three days. These are some of the setbacks. (Monty, Interview)

The lack of blood pressure and blood glucose testing machines and materials, failure to provide appropriate meals for diabetic patients, and the inability to transport patients to vital and required appointments due to vehicular unavailability further demonstrates the institutional inadequacies in the provision of service and care to patients. In 2019, reporting indicated a shortage of diabetic test strips across health facilities in Region Six, where the NPH is located (“‘Region Six Health Services’”, 2019). Other complaints citing supply shortages stretch back to 2011 when NPH staff flagged their concerns to *Kaiteur News* (“Poor Treatment of Patients”, 2011). One unnamed NPH staff member interviewed for the *Kaieteur News* article is quoted as saying:

> "Two weeks back, we had 31 patients and we were given two cakes of soap to last for those two weeks… We had to cut one of the cakes of soap in two and toilet paper and so, if patients can't have their own, we just give them a piece. A lot of old stuff they have there. Some of the patients might be irritable at times, behaving badly and so, so they would have rooms in which they would seclude them… Now, those rooms, they don't have—it's just the bare concrete; the cold concrete those patients does gotta be on. They urinate sometimes defecate in the same room without anything there… All these people are aware. They know what's happening but nobody is making an effort to complain or to do anything about it… And the food, they really need to improve on the food. Not because these patients have a mental problem, means that they can't eat properly or they don't know what good food is. And greens [vegetables] and those things, you don't even see greens; it's curry, channa, chowmein, fried rice, and when you go in the kitchen in there you would see all these things they have stocked up. So what are they doing with the stuff? None of it is coming to the patients." ("Poor Treatment of Patients", 2011)

In 2017, there were also allegations of impropriety when it was reported that an investigation was launched after "supplies of nutritious foods were not reaching the patients of the National Psychiatric Hospital", including 4500 lbs of chicken, with patients instead "given bread, sausage daily" ("4500 lbs Chicken Disappear Weekly", 2017). Per *Guyana Times* reporting, "In some instances, four patients are forced to share one sausage… This newspaper was told that inmates at the psychiatric hospital can be seen in the town of New Amsterdam asking for money to buy food, or eating out of bins" ("4500 lbs Chicken Disappear Weekly", 2017). The article continued, "There were reports that cheese, chicken and fish were being pilfered from the kitchen. Security personnel were tasked with the responsibility of checking the bags of those who work in the kitchen as they exit the compound" ("4500 lbs Chicken Disappear Weekly", 2017). Based on participant accounts and newspaper reporting, these issues appear to be longstanding.

One of the medical professionals in this study, when talking about patient diagnoses, said, "We don't even have the DSM. You better believe." They indicated that, at the time of these interviews, the NPH relied solely on a donated and outdated pocketbook DSM, functioning without a full, current edition of the Manual – the "'bible' of the profession" (Watters, 2010, p.

3). They hoped for another act of charity by foreign medical volunteers who promised to send the current version of the Manual. The DSM – the quintessential, diagnostic tool of biomedical psychiatry – is foundational in establishing psychiatric diagnoses based on listed symptomology, thus allowing clinicians to render diagnoses and devise treatment plans that usually include the use of psychopharmaceuticals. The absence of a current DSM at the nation's largest, institutional hospital – whose main mandate is the provision of biomedical psychiatric care – appeared to be unacceptable from the perspective of this NPH staffer and indicative of the want for greater resources.

Environmental Hazards

According to the staff, environmental hazards on the NPH grounds made for dangerous working conditions:

> Because of the large bushes at the back especially, we have snakes in the ward. It's not safe to work here, honestly. It's not safe to work here. And sometimes you get frustrated and you just want to leave and go somewhere else other than here. The environment is not safe. At night you would get people walking around and you don't even know is who in the compound. (Salima, Interview)

> It's a lot of bushes… We've had a lot of snakes. Mostly it's snakes in the ward. Some of them you don't know what snakes they are. (Wendy, Interview)

> The other conditions are like the bushes… Despite they have prisoners who will come in here and do the work. Enough is not being done because some of the areas are just to the front that they are concentrating on but at the back it's been left unattended and that is where the hazard is. (Monty, Interview)

Several staff expressed how the NPH grounds are poorly maintained, particularly around the back areas of the compound where there is overgrowth resulting in the overrun of snakes and other reptiles, which enter the wards. Infestations like this pose health and safety concerns for patients and staff. As mentioned by Wendy, these factors contribute to understaffing: "The smell.

The bushes. The snakes… People [prospective staff] don't want to come." Further, and according to Salima, areas of the compound are also prone to flooding:

> The walkway to go to our wards is muddy sometimes. We don't have a toilet in our ward for staffs. If you need to use the toilet, you have to walk all the way out. Suppose you are one staff in the unit and you really need to go to the washroom?... When it rains it floods there. We try to do our best. We still have to go to the wards.

These environmental hazards only compound the poor sanitation and unhygienic conditions at the NPH. I also witnessed the burning of garbage on the NPH grounds and inquired about it. Salima provided context:

> The garbage collector comes, I don't know if it's every day, but a couple times per week but they don't sometimes go to all of the wards and collect the garbage. They just come in front and pick up what they have to pick up and that's it. For the rest of the garbage, rather than having it flying around the compound, we try our best. The patients assist in sweeping them up and we have to burn them. We don't really have any other choice. Rather than leaving it there and it getting smelly, we burn them.

Salima states that garbage from each ward is sometimes not picked up and is instead burned on the compound to prevent odours. It is unclear if human waste and other biohazardous materials are a part of the garbage left behind in the wards and if it is also burned on site. According to accounts from government officials, some areas of the NPH compound were "being used as a storage bond with vehicle tires, electrical equipment and other items" (Alleyne, 2015). Per my observations, some of the wards located to the back of the grounds were littered with garbage and what appeared to be a rusted barrel and timeworn equipment that had fallen into disrepair and disuse (see Figure 1.1). These outside areas were unkempt and surrounded by overgrown grass and bushes, with soiled mattresses also placed outside to dry.

Figure 1.1: Overgrown grass and bushes surround some wards. Garbage, a rusted barrel, and old equipment are scattered around the perimeter of a ward (chalet five), with soiled mattresses in the background.

Salima also mentions that patients assist in sweeping up garbage. Indra confirms that patients will “assist the maid”. Wendy also states that “patients would assist in cleaning”. Asked if any of the patients are paid for their labour, staff indicated that patients are not formally remunerated. Salima explains: “No, they don't get paid. But the maid would probably give them something, a biscuit or something just to assist. And it's a form of therapy for them in a way, getting back to doing things for themselves.” And while Salima and another staff (Indra) view cleaning as “therapy”, it is uncertain to what extent patient labour is therapeutic or to what extent it is meant to substitute staffing shortfalls, especially when Indra states the following: “Each unit got one maid so when she is not there, they [patients] would assist for the day.” Wendy’s response is similar: “We have a cleaning staff but it's only one person allocated to a ward so

sometimes you would have nurses helping out along too to get things done or sometimes those patients that are able to do it, they would assist us in doing it too. But staff on the whole is limited." In these specific examples, patients appear to actively assume some maintenance and custodial duties alongside maids and medical staff when there was a shortage of cleaning staff, and for which the patients were not formally remunerated. The patients were instead given the nominal "biscuit" (Salima, Interview) or other small tokens for their labour, which is also affirmed by Monty: "Well staff do give them [patients] a little something." Staffing at all levels appeared to be severely strained or inadequate, which may ultimately affect patient care.

Workplace Violence and Injury

As they talked about their experiences at the NPH, some staff spoke about the prevalence of workplace violence and injury and how the NPH fails to provide adequate support and compensation in the event they are injured on the job:

> We had episodes where staff was hit [by patients] and had to be hospitalized. Our risk allowance here is only $500, $500 Guyanese dollars. That is our risk allowance. And that can't do anything. (Wendy, Interview)

> I've never been hit [by patients] before but I had a cup of tea thrown on me twice. It's a good thing it wasn't too hot. (Salima, Interview)

> I know of many other staff who have been attacked [by patients]… The risk allowance is $500 per month, $500 per month risk allowance… Then when you have to go into the ward now to do your work, you are at risk. What $500 can do? (Monty, Interview)

Colleen states that incidents like these "occur very often" when patients "act out" or exhibit "aggressive" behaviours, which she says is common among men admitted to the NPH who are experiencing "drug-induced psychosis". These behaviours, she says, are a consequence of mental illness: "They are ill and that's some of the manifestations of illness" (Colleen, Interview). According to Colleen, staffing shortages only compound emergency and crisis situations, increasing the likelihood of violence and injury: "They [patients] would break the ward… If it's

one or two staff, they can't do nothing… because you don't want to put yourself in harm's way. If the staff is there, the staff would ask for help… It can be hard for one person or two persons to stop them." Based on Colleen's account and explanations by other NPH participants, it appears that staff feel unsafe and unsupported when tasked with intervening in crisis situations and physical altercations among the patients, which can lead to violence, threatening the safety of all patients and staff present.

At the time of these interviews – December 2014 – a monthly risk allowance of $500 Guyanese dollars (GYD) converted to approximately $2.75 Canadian dollars (CAD) or $2.43 American dollars (USD) based on historical foreign currency exchange data.[41] This amount was barely enough to cover the cost of a small meal in Guyana, let alone stand to cover living and medical expenses in the event of workplace injury, which, as per the participants and newspaper reporting, frequently occur ("Mental Patient Assault", 2009; "Psychiatric Hospital Staffers 'Sit Out'", 2017). In 2017, a nurse at the NPH was injured after reportedly being attacked by a patient who, according to an unnamed source, "break the wall of the entire room and attacked the staff with a big wood" ("Psychiatric Hospital Staffers 'Sit Out'", 2017). After NPH staff protested via a "sit out" action, government officials said that NPH security would be "beefed up"; however, staff had reportedly "grown weary of the 'promises' made to have increased security" and, in this news article, also complained of other unacceptable working conditions such as a "shortage on vitamins" for patients and a "severe shortage of drugs 'to restrain patients'" ("Psychiatric Hospital Staffers 'Sit Out'", 2017). The drugs mentioned in this article appear to be rapid tranquilizers – usually antipsychotic drugs – which are utilized in biomedical psychiatry to sedate patients, particularly patients displaying "violent", "aggressive", or

[41] These approximate conversions from December 2014 are based on historical data from XE Currency Converter: https://www.xe.com/currencytables/.

"challenging" behaviours (Allison & Moncrieff, 2014; Currier, 2003; Dubin & Feld, 1989; Hirsch & Steinert, 2019).[42] Per this reporting, the NPH experienced shortages of these drugs, which seem to be used to chemically "restrain" patients exhibiting said behaviours ("Psychiatric Hospital Staffers 'Sit Out'", 2017). The use of rapid tranquilizers – as a form of chemical restraint – is a controversial practice, where there is "no consensus among clinicians or policy makers whether such use of medications is a form of coercion or a form of patient-focused intensive care" (Currier, 2003, p. 59).

Moreover, the $500 monthly risk allowance is viewed as an inadequate figure by the participants, with one staffer rhetorically asking, "What $500 can do?" (Monty, Interview) in the event of workplace injury. Based on reporting, the $500 monthly risk allowance remained unchanged from at least May 2009 to November 2019, when it was finally increased to $5000 (approximately $30 CAD or $24 USD as of December 2020)[43] ("Linden Nurses Heartened at Hike", 2019; "Mental Patient Assault", 2009). The increased monthly risk allowance was necessary after remaining stagnant for over a decade; however, nurses and their union called for more to be done in the event of workplace violence and injury, with a union representative stating, "The allowance is good, but we must have some kind of addendum if they are injured, their medical bill and so forth, must be taken care of" ("Linden Nurses Heartened at Hike", 2019). Increases to the monthly risk allowance seem insufficient if the "risk" is not mitigated in meaningful ways, which may be done by enacting structural change measures to fix the issues

[42] The use of antipsychotic drugs as rapid tranquilizers emerged in the 1970s, where antipsychotics were "portrayed in psychiatric literature and advertising as a therapeutic and diagnosis-driven endeavour" (Allison & Moncrieff, 2014, p. 57). According to Allison and Moncrieff (2014), "Research suggests that antipsychotics became the mainstay of rapid tranquillisation strategies because of beliefs about their specific therapeutic properties in psychosis and schizophrenia, and not because of demonstrated superiority over other agents (p. 57)."
[43] These approximate conversions from December 2020 are based on historical data from XE Currency Converter: https://www.xe.com/currencytables/.

(e.g., staffing shortages) previously outlined by the NPH medical helpers. The state elides and abdicates its responsibility to remedy these structural failings when, in this article, the state paper (*Guyana Chronicle*) chooses to focus primarily on the long overdue risk allowance increase with little attention paid to the dire conditions throughout Guyana's health care system and at the NPH itself ("Linden Nurses Heartened at Hike", 2019). Blame appears to be largely shifted to the patients, instead of understanding and remedying the underlying institutional conditions that may create contexts of conflict and violence (e.g., overcrowding of patient wards).

Past Incidents of Alleged Patient Abuse

Wendy indicated that she has heard about past allegations of patient abuse, which were reported. No actions, according to Wendy's knowledge, were taken when these past allegations were brought forward: "Some patients would have complained about it but we have never seen or nothing, never heard of anything being done about it or so." When asked about who the alleged perpetrators were in these past incidents, Wendy said, "By other patients and by staff." While it is possible that actions were taken to address these reported and alleged complaints of past abuse, this is unknown. It is also unclear if the NPH has a formal system in place or an oversight body to investigate and respond to incidents of alleged patient abuse. The Mental Hospital Ordinance of 1930 – which governs practices at the NPH – provides no provisions to ensure or safeguard the rights of patients, which is often cited as a major criticism of this and similar legislation in the English-speaking Caribbean (Moss, 1999). In relation to patient abuse, or what the Ordinance (1930) calls "ill-treating patients", s. 26 states:

> Any person employed at the Mental Hospital who strikes, ill-treats or neglects any person of unsound mind confined in the Mental Hospital, shall, on summary conviction thereof, be liable to a penalty not exceeding ninety-six dollars or to imprisonment with or without hard labour for any period not exceeding six months.

The $96 GYD penalty is a paltry sum (approximately 60 cents CAD or 45 cents USD)[44], yet this fine is supposedly intended to discourage these acts. These measures, however, have no teeth or capacity to serve as deterrents in part because they do not present any mechanisms of accountability and redress. They are not comprehensive; they are completely unsuitable to address the present and changing needs at the NPH; and they provide no substantive protocols or procedures for handling or preventing patient abuse as they are constrained by and imbued with the stigmatized values and beliefs of the time (circa 1930) about people diagnosed with mental illness, or "persons of unsound mind" as the legislation brands (Mental Hospital Ordinance, 1930). This archaic colonial law is eight years shy of being one hundred years old at the time of the final drafting of this chapter in April 2022. Its age is indicative of the historically deprioritized status of mental health care in the nation and the social weight that stigmatized perceptions (e.g., "persons of unsound mind") hold and wield in Guyanese society.

Patient Deaths

Based on newspaper reports, the NPH failed to prevent the deaths of five patients under its care between April 2009 to June 2021: the 2009 murder of Harriram Nauth ("Mental Hospital Patient Charged", 2009); the 2015 murder of a patient identified as "Eda" (Alleyne, 2015; "Almost Three Years After", 2018); the 2019 assault and death of Stephan Francis ("Police Probe Death of Psychiatric Patient", 2019); the 2021 assault and death of Ryan Sunthgolam (Oosman, 2021); and the 2021 post-fire death of an unnamed patient ("Five National Psychiatric Hospital Patients", 2021; "Patient Sets Fire to National Psychiatric Hospital", 2021). In the reporting on the murder of Nauth in April 2009, NPH patient Jermaine Benjamin – who was

[44] These approximate conversions from December 2020 are based on historical data from XE Currency Converter: https://www.xe.com/currencytables/.

"said to be suffering from psychotic disorder drug dependency"– allegedly "went berserk" and attacked his peers in the dining area, which resulted in five patients sustaining serious injuries (M. Johnson, 2009). Nauth, age 75, succumbed to his injuries eight days after the incident ("Mental Hospital Patient Charged", 2009). NPH staff indicated that at the time of the incident this ward was short staffed with only two nurses on duty to oversee the care of approximately 30 patients (M. Johnson, 2009; "Mental Patient Assault", 2009). A NPH source expanded on the staffing shortage: "'This is two wards in one – the male admission ward. The ideal figure is six nurses but only two usually work in this double ward'" (M. Johnson, 2009). When this incident happened "staff members managed to escape unharmed and locked the mentally ill patients in the ward where a bloody mess followed" ("Mental Patient Assault", 2009). According to one NPH source:

> "It was plenty blood all over the place. People suffered fractured skull, broken jaws, and some would loose their eyes and teeth. It was a scene of blood all over… He ripped out a double door to the dining hall and one to come out of the ward. The double door was stamped out completely. He used pieces of the door to beat the other patients. The door was full of blood. Them doors had plenty nails." (M. Johnson, 2009).

Participants of this study, Colleen and Indra, indicated that while the NPH must admit patients with substance and alcohol use challenges – similar to the diagnosis of the alleged attacker in this incident – the facility is not equipped to provide specific, differentiated care to these patients ("We just don't have a system for it" [Indra, Interview]). These patients, therefore, do not appear to receive the appropriate supports that are necessary to facilitate recovery. This incident is also similar to examples of violence mentioned previously by Colleen, where understaffing means that staff do not feel safe or adequately supported to respond to crisis situations of this kind ("If it's one or two staff, they can't do nothing"). In the circumstances surrounding the death of Nauth, when NPH staff fled out of fear for their safety, the alleged perpetrator, Benjamin, was

deliberately locked into the ward with other patients; thus, endangering the lives of every patient that was shut into that space. Per reporting, it appears that the patients in this ward were left without any NPH staff intervention ("Mental Patient Assault", 2009). They were imprisoned in a situation of imminent danger and violence without any means of escape. In this regard, and according to the newspaper accounts, NPH conditions contributed to this gruesome violence. In this instance, the state failed in its duty to protect these patients under its care.

This kind of violence is not unique; this incident belongs to a pattern of similar, past occurrences that sources at the NPH discussed with reporters. In a *Kaieteur News* article on the death of Nauth, staff complained of the frequency of these attacks, poor conditions at the NPH, and their $500 monthly risk allowance at the time:

> "In 1989 a patient threw five other female inmates out of a window on the Victoria Block. One of them died. There are regular attacks on staff. Staff always getting attacked and is only $500 risk allowance we getting. The cooks, telephonist, maids, laundresses, dispensers and all other persons working here are not entitled to risk allowance only the nurses. We ain't going back to till they give us $5,000… We are very much short of staff and only one doctor attached at the National Psychiatric Hospital, Fort Canje." The sources pointed out that there is an insufficient water supply – no water was had on Saturday. The situation, they said, has been going on for the past nine months and still no relief. Lighting at the institution and its environs is also not good enough. "Reptiles are being seen, found, caught and killed in the wards especially labaria and alligators." (M. Johnson, 2009)

After the killing of Nauth, NPH staff staged a protest action – sitting-out and withholding their labour – as they demanded a meeting with then PPP Minister of Health, Leslie Ramsammy ("Mental Patient Assault", 2009). Benjamin was later charged with the murder of Nauth ("Mental Hospital Patient Charged", 2009), but it is unclear what lasting steps were taken to prevent incidents of this kind, especially given the future acts of violence subsequently outlined.

In August 2015, a patient in her 30s known as "Eda" was murdered after an altercation with another patient in the same ward (Alleyne, 2015; "Female Patient Killed", 2015).

According to reports, the suspect – Dudwattie Fari – and Eda were both placed in a single isolation room after separately exhibiting "aggressive behaviour" ("Female Patient Killed", 2015). A fight ensued between the two, and Fari allegedly "climbed on the other woman's head (Eda) and stamped on her neck" ("Female Patient Killed", 2015). Eda was pronounced dead shortly after (Alleyne, 2015; "Female Patient Killed", 2015). It is, however, uncertain if police were informed of the incident when it happened. According to *Kaieteur News*, the police only became aware of the murder after reading about it the day after in their publication ("Murder of Patient", 2015). At the time of the killing, the ward housed 22 patients with only one nurse on duty ("Female Patient Killed", 2015). Per reporting: "Nurses at the National Psychiatric Hospital continue to express fear for the conditions under which they work. A number of times one nurse is assigned to a ward which houses as many as 31 patients. The place is very bushy, there are hardly any lights, and sometimes there are no guards working" ("Female Patient Killed", 2015). An investigation into Eda's death was launched according to then Minister of Public Health, George Norton (Alleyne, 2015). In a *Stabroek News* editorial appearing after Eda's death, there were calls for greater accountability to patients receiving care in the public health system ("Accountability to Patients", 2015). The editorial outlined that at the start of Minister Norton's tenure, he first visited the NPH in June 2015 and witnessed the abysmal conditions at the institution, which necessitated urgent attention, yet "it appeared that nothing substantial was done between that visit and the end of August when a patient known as Eda was killed" ("Accountability to Patients", 2015). The editorial called the NPH conditions "sub-human and the antithesis of what care in a mental facility should be like" and pushed for greater government responsibility and action:

> The death underlined the point that instead of simply criticising, as the person in total charge, Minister Norton was one who could have ensured that immediate changes were

> made to improve the conditions and circumstances of patients like Eda at the institution. It was clear that the conditions at the facility posed a grave threat to the well-being of patients there. ("Accountability to Patients", 2015)

In June 2018, nearly three years after Eda's murder at the NPH, the official findings from the investigation remain unknown, and it is unclear whether a probe was ever fully carried out as promised ("Almost Three Years After", 2018). There were calls from the public to publish the findings in promotion of transparency and accountability, yet no government report from the investigation into Eda's death seems to have materialized ("Almost Three Years After", 2018).

Stephan Francis was a patient who died after an alleged assault at the NPH in June 2019 ("Psychiatric Patient Killed", 2019). Initial reports indicate that a fight ensued between Francis and two other patients; during the altercation, and according to NPH administration, Francis "fell and hit his head" and died of his injuries ("Psychiatric Patient Killed", 2019). Francis' aunt, Samantha Young, said that she was informed by NPH staff that the fight "stemmed from an episode in which some items were about to be stolen from her nephew" and that "when he tried to defend his property, he was attacked by two other inmates resulting in him getting injured and he subsequently died" ("Psychiatric Patient Killed", 2019). When she and Francis' mother arrived in Berbice and requested a full report of what had transpired during the incident, authorities were unable to provide details ("Psychiatric Patient Killed", 2019). She protested and directed her criticisms at NPH administration:

> "An incident occurred more than 12 hours ago and you don't have the facts nor any report, is saying something is very, very terribly wrong with the system. If you are the man on this ground in charge and 12 hours after you have to be asking persons here who was the person that did this, and who was the person that did that, then something is definitely wrong… This is slackness, this is slackness. When that fight broke out last night, they were supposed to have systems in place. They have persons in there saying that they did not even render simple first aid… The fact remains, my nephew is dead and the system in here could not protect him from that." ("Psychiatric Patient Killed", 2019)

When newspaper reporters from the *Guyana Times* tried to access the NPH for answers, the administration "instructed the guards on duty to ask the media to leave the compound after which the gates were locked" (Carmichael, 2019a). Administrators later apologized and reaffirmed that the NPH and the services provided at the institution are public; the facility must, therefore, be made accessible to the media (Carmichael, 2019a). After an autopsy, the post-mortem report indicated that Francis' cause of death was bronchoaspiration, which likely occurred when he "allegedly choked on a piece of food which he had in his mouth at the time of the fight" ("Psychiatric Patient Dies", 2019). A statement from a regional health official was issued: "We at Regional regret this incident very much and we will work close with the police and other staff to find out why an incident of this nature did occur and to ensure that this is a one-time thing and does not happen again" (Carmichael, 2019a). This does not, however, appear to an isolated incident given the history of the NPH – with a record of previous violent occurrences, particularly stemming from conflicts between patients ("Female Patient Killed", 2015; "Mental Hospital Patient Charged", 2009).

It was also reported that Francis and one of the alleged attackers who was taken into police custody, Jason James, were admitted to the NPH as "substance abuse patients" (Carmichael, 2019a; "Psychiatric Patient Killed", 2019). Per sources at the NPH, "it was not the first time that Francis or the suspect were involved in fights at the institution", and "several reports were lodged at the New Amsterdam Police Station pertaining to fights involving the now dead man and the suspect" (Carmichael, 2019a). Recall that participants of this study, Colleen and Indra, mentioned that the NPH is not equipped to provide specific, differentiated care to address the needs of patients experiencing substance and alcohol use challenges. Furthermore, and according to Guyana's draft National Mental Health Strategy 2015-2020, the country does

not have a forensic psychiatric[45] facility, nor are there any beds designated as forensic mental health beds at the NPH (Ragobeer, 2016). Per reporting:

> Forensic cases are sent to the national Public Health Hospital where they are admitted to the general wards on order of the court for psychiatric assessment and treatment. As the hospital is not equipped to provide secure facilities, forensic cases admitted on order of the court are provided assessment and acute stabilization treatment and are then discharged to the prison system. (Ragobeer, 2016)

According to a 2021 report, there are now two forensic mental health beds in the prison system (Bhagirat, 2021). No patient is at fault if they are remanded to an institution that is ill-equipped to provide specific necessities of care, such as adequate forensic facilities or measures to ensure that their particular health needs are met. The NPH has an obligation to these patients. The impassability of this situation (no forensic psychiatric facility/beds at the NPH) – noted years earlier in the draft National Mental Health Strategy 2015-2020 (Ragobeer, 2016) – is detrimental for all NPH patients and staff and serves to catalyze crisis and violent situations, as seen with the death of Francis in 2019 and the patient deaths and injuries that occurred prior to the Francis case and later in 2021, which will subsequently be discussed. Acknowledging structural inadequacies is an imperative first step; these NPH deficiencies are identified time and time again by politicians. Over time, however, these acknowledgements are only as good as the actionable steps taken thereafter to remedy the failings; otherwise, and in this specific context, the situation may devolve into repeated crises. In June 2020, it was reported that the family of Francis are still awaiting justice as the case file sits with the Director of Public Prosecutions while "police are currently awaiting information from the court on when a recommended inquest is to begin" ("Mother Still Waits for Justice", 2020).

[45] According to Arboleda-Florez (2006), "Forensic psychiatry is the branch of psychiatry that deals with issues arising in the interface between psychiatry and the law, and with the flow of mentally disordered offenders along a continuum of social systems (p. 87)."

In 2021, several major incidents occurred at the NPH causing grievous harm: the violent death of a patient named Ryan Sunthgolam (Oosman, 2021); and three separate fires (June, August, and November 2021), one of which led to multiple casualties causing one patient to succumb to his injuries ("Five National Psychiatric Hospital Patients", 2021; Patient Sets Fire to National Psychiatric Hospital", 2021). In June 2021, *Stabroek News* reported that Sunthgolam died as a result of injuries sustained from an alleged assault when another "patient pulled out a window and grill mesh, which he used to inflict the injuries on Sunthgolam" (Oosman, 2021). Another patient was also injured during this incident (Oosman, 2021). Sisters of the deceased patient questioned "why their brother was placed in a ward with violent patients given that he was not violent" (Oosman, 2021). A relative of the injured patient immediately requested that he be discharged to her care and lamented that the NPH "need more security and nurse there", apparently signalling to staffing inadequacies (Oosman, 2021). There have been no recent updates related to the investigation into Sunthgolam's death.

In June 2021, just days after the killing of Sunthgolam, a fire was set by patients in the male admission ward, which resulted in 11 injuries, with one patient later succumbing due to smoke inhalation ("11 Inmates Suffer Burns", 2021; "Five National Psychiatric Hospital Patients", 2021). In August 2021, a patient in the male admission ward set a mattress on fire, which damaged a section of the ward ("Patient Sets Fire to Mattress", 2021). Per *Kaieteur News*, "the patients of that ward were unsupervised at the time the fire begun" as "the nurse who had ended her shift left before the other nurse took over" ("Patient Sets Fire to Mattress", 2021). Patients fled the ward, and news reporting made no mention of any injuries ("Patient Sets Fire to Mattress", 2021). In November 2021, again in the male admission ward, another fire was set by a patient, which damaged the roof of the building ("Patient Sets Fire to National Psychiatric

Hospital", 2021). These fires beg several questions: what lasting measures were put in place following the first fire in June 2021? How were two other fires, just months a part in the same ward, made possible? What measures were enacted following the August and November 2021 fires? All of the patient deaths and fires mentioned in this subsection raise serious concerns about the NPH's capacity to care for patients and prevent harm and violence at the institution.

Government Response

In 2016, government representatives pledged that efforts were going to be made to combat the stigma attached to the NPH ("Efforts Must be Made to Eradicate Stigma", 2016). In 2018, the Department of Public Information reported that a nutritionist was hired; a new switchboard was installed, replacing the older one that was defunct for over three years; and some abandoned buildings – which laid empty for years, appeared "condemned", and contributed to NPH stigma – were finally demolished (Raikha, 2019). According to NPH administration, bushes and drains were also cleared regularly; as explicitly mentioned, this was done to improve the public image of the compound (Raikha, 2019). Per the report, the employment of the nutritionist was viewed as a welcomed improvement as the NPH witnessed a decline in malnourished patients from 25 to 12 (Raikha, 2019). This hire is a necessary and beneficial development; however, the fact that there were still 12 malnourished patients at the NPH at the end of 2018 remains a point of concern, especially so because reporting in 2011 and 2017 specified that patients were not receiving adequate nutrition ("4500 lbs Chicken Disappear Weekly", 2017; "Poor Treatment of Patients", 2011). Participants in this research study also called for increased resources and specialist personnel in 2014 when it was indicated that diabetic patients were not provided with appropriate meals.

The previously discussed assault and death of Stephan Francis occurred in June 2019 ("Psychiatric Patient Killed", 2019), after these improvements to the NPH in 2018. The death of Francis poses questions about what kinds of substantive improvements were made to the NPH wards and the impact on patient care. Moreover, it was reported that conditions at the NPH were "inhumane" based on the account of a sixteen-year-old patient in October 2019 (Carmichael, 2019b). The girl – who was involuntarily committed to the institution – attempted to take her life after her allegations of sexual assault were ignored by her family (Carmichael, 2019b). According to the report, the girl was distressed by the conditions in the ward: "She was reportedly placed there with only a piece of sponge to sleep on, which she said is smelly and the surroundings are unsanitary and inhumane" (Carmichael, 2019b). Referencing NPH conditions, the girl is quoted as saying, "I am not going to be able to live here. I can't live under these conditions" (Carmichael, 2019b). This teen's mental distress appears to be amplified by the poor ward conditions. Two local NGOs responded after the girl began "pleading for assistance" (Carmichael, 2019b). One NGO representative expressed that given the report of sexual assault, the Child Care and Protection Agency of Guyana should have been immediately informed and involved in the case; however, when the director of the Agency was contacted, she was unaware of this case and said that an investigation would follow (Carmichael, 2019b). According to the WHO's (2017a) Mental Health Atlas Member State Profile for Guyana, the nation does not have a facility specifically for children and adolescents, nor are there any beds designated for children and adolescent mental health care in the country. Suresh Sugrim, the head of another NGO who was asked to comment on this case, opposed the move to hold the sixteen-year-old girl at the NPH:

> "These are teenagers who are in need, should be handled and taken care of differently from adults. The human rights activists need to be called in to remove that child from that

> institution immediately… Without proper sleep, attention and professional medical help, nothing is going to change in the mental state of these adolescents! Isn't a mental institution partly medical? Why is this place dirty and smelling? Why is it lacking the proper necessities a mental institution should have?" (Carmichael, 2019b)

It is unclear what additional measures were taken by the NPH and the Child Care and Protection Agency to ensure the safety and wellbeing of the child in this case after the newspaper report. The Department of Public Information praised the government's 2018 measures to improve and maintain "the appearance of the facility's compound to the public", all of which are necessary developments; however, nothing is mentioned in this report about improvements to or upkeep of patient wards (Raikha, 2019). Based on the 2019 reporting in the case of this sixteen-year-old girl (Carmichael, 2019b), it appears that patient wards either did not reap the benefits of these improvements in 2018; or, if there were unreported positive developments, it seems that the conditions in patient wards lapsed and did not experience continuity from those changes. After the contentious 2020 general elections that brought the PPP to power, the government tabled its first full budget. The government indicated that in 2021 it will allocate $70 million GYD to "address the shortage of essential medication for psychiatric patients" ("Special Allocations", 2021), with another $18 million GYD designated to the construction of an 18-bed mental health ward at the NPH ("Mental Health Boosted", 2021), which was nearing completion in August 2021 reporting ("$26M Upgraded Psych Ward", 2021). The three fires at the NPH in 2021 resulted in damage to an existing patient ward. Given these repeated incidents, it is important to question to what extent existing or enacted measures are effective in preventing future, similar incidents.

Many of the conditions laid out in detail by NPH participants – some of which I witnessed – harken to the abysmal conditions of the colonial lunatic asylums of yesteryear, including Guyana's, and which have been carefully captured in L. Smith's (2010, 2014)

historical research and also analyzed in Hickling's work (2020). The participants of this study expressed serious concern for NPH patients, and throughout their interviews, appeared demoralized about their working conditions. Few held out fleeting hope that conditions would be remedied, while others conveyed considerable doubt about reform and were resolute in their desire to leave. Their accounts and the various examples cited in this section cut to the heart of the structural failings at the centre of the NPH. Based on staff narratives, some of the conditions at the NPH are cruel and inhumane, existing in an institution that intends to serve as a place of care and recovery. Incidents of deprivation, neglect, and violence are an indictment of the state's inadequate response and mishandling of institutional mental health care in the country. Successive governments and leaders across the political divide acknowledge these horrific conditions, yet patients and NPH staff have paid for theses failures with their mental wellbeing, bodies, and lives. The grievous conditions at the NPH are, in themselves, drivers of mental distress and represent safety concerns. Incremental developments are noted (Raikha, 2019), but this gradualism does not appear to be enough. These developments are woefully inadequate in view of the larger structural shortcomings mentioned previously, and they appear to temporarily whitewash systemic failures until the next major crisis (e.g., patient murder, assault, fire), mainly operating to distract the public and grant the state impunity from liability of the harms that occur at the NPH. All NPH staff emphasized their commitment to their patients as they called for sweeping changes to fix and transform these institutional conditions.

The Mental Hospital Ordinance of 1930

> While Guyana became independent in 1966… we inherited all of the provisions that were made under British Guiana. Most of the health laws continued from the 1930s. (Vishnu, Interview)

In this brief but transparent statement, Vishnu, a Ministry of Health official, captures present-day legislative inadequacies as he acknowledges the unchanged colonial inheritances – the legal ordinances – that remain on the books in Guyana. The Mental Hospital Ordinance of 1930 is one such law and was enacted to "make provision for the care of persons of unsound mind and for the administration of management of the Mental Hospital, Berbice". The WHO (2008) describes the legal landscape as it pertains to mental health care in the country thusly:

> Care of the mentally ill is provided under the legislative framework of the Mental Health [*sic*] Ordinance of 1930, which is antiquated and fails to make provisions for the protection of the rights of people with mental disorders. Persons with mental disorders are reported to suffer discrimination in their communities, the workplace, educational institutions, judicial services and the health-care system. Safeguards to protect individuals with mental illness from involuntary admission and treatment and mechanisms to oversee treatment practices within health facilities are lacking. There are no independent review bodies established to protect the human rights of users of mental health services. (p. 5)

Guyanese NGOs, such as the Guyana Foundation and the Caribbean Voice, have advocated for increased budgets, improved mental health services, the decriminalization of suicide, and the repeal of this colonial ordinance (Caribbean Voice, 2020, 2021; Rooplall, 2018). The Caribbean Voice (2020), in a published letter, urged the newly elected PPP Government to take action: "Cognisance will also be taken of the need to update the 1930 Mental Health [*sic*] Ordinance not only to protect the rights of the mentally ill as the WHO pointed out, but also to ensure that outdated practices will no longer have legislative support." Criticism of Guyana's antiquated legislative framework on the "care of persons of unsound mind" is not new and can be compared to similar colonial ordinances presently on the books of other English-speaking Caribbean nations (Moss, 1999).

Along with the 2021 budget announcement, the PPP Government vowed to conduct a "review and revision" of the Mental Hospital Ordinance of 1930 ("Special Allocations", 2021). Per the Minister of Health, Frank Anthony, this law is "a sorely overlooked and outdated piece

of legislation" ("Mental Health Boosted", 2021). The previous APNU-AFC Government also acknowledged the deficiencies of the law (Ragobeer, 2016). Minister Anthony indicated that the PPP would revisit a draft bill to replace the Ordinance, continuing with stakeholder consultations in 2021 ("Mental Health Boosted", 2021). Per reporting, "He [Minister Anthony] said he hopes to get the Bill to Parliament as soon as possible so that a new legal regulatory framework can be established" ("Mental Health Boosted", 2021). Notably, the PPP governed Guyana for a 23-year period (1992-2015) without implementing new mental health legislation. This proposed legislation was written in 2010, when the PPP were last in power; however, it was not actioned by the PPP during their previous two terms (2006-2011 and 2011-2015), nor was it taken up by the APNU-AFC when the coalition formed the government from 2015-2020. Politicians of all stripes allowed this draft bill to sit idle for over ten years since its creation. Per Stabroek News reporting on April 14, 2022, the government tabled the Mental Health Protection and Promotion Bill, and it was first read in parliament on April 13, 2022 ("Gov't tables Mental Health Protection", 2022). The Bill intends to replace the Mental Hospital Ordinance of 1930 ("Gov't tables Mental Health Protection", 2022). It will need to go through the parliamentary process before it becomes law, which may take several months or longer.[46] This government is taking steps to repeal and replace the Mental Hospital Ordinance of 1930 with new legislation, which promises to address the nation's contemporary mental health issues ("Gov't tables Mental Health Protection", 2022); however, until the Bill is passed in parliament, the Ordinance remains in full legal effect and does nothing to affirm the human rights of people experiencing mental distress,

[46] Since the finalization of this chapter in April 2022, there have been new legal developments in Guyana that are of consequence to this work and which must be acknowledged. In August 2022, while arrangements were being finalized for a September 2022 oral defence of this dissertation, Guyana passed the Mental Health Protection and Promotion Bill on August 8, 2022, which repeals and replaces the Mental Hospital Ordinance of 1930 ("Mental Health Bill Passed", 2022; Smith-Thomas, 2022). It is my intention to analyze this new legislation in future research.

nor does the Ordinance lay out legal protections for Guyanese in their interactions with the country's mental health care system and its institutions.

The provisions in the Mental Hospital Ordinance of 1930 are largely based – substantively and almost word-for-word – on the Lunatic Asylum Ordinance of 1905; therefore, and overwhelmingly, Guyana's legislation regulating the NPH and patient care resonates as far back as the early 1900s. Substantively, this means that the NPH is legally regulated under terms that are over 115 years old. In marking the renaming of the Lunatic Asylum to the Mental Hospital in 1930, the word "lunatic" – used in the Lunatic Asylum Ordinance of 1905 – is substituted for "person of unsound mind", "person", or rarely "patient" in the Mental Hospital Ordinance of 1930. The substance of the provisions across these laws, for the most part, remained the same and are mainly concerned with the adjudication of "lunacy" or "insanity" and custodial protocols; obtaining payment for services rendered at the institution; asserting the primacy and authority of a central institution; and enumerating offences, yet lacking a human rights framework and providing no substantive legal protections for patients. For example, section 12(1) of the Lunatic Asylum Ordinance of 1905 intends to address matters related to the "adjudication of lunacy and the committal of lunatic to Asylum". It states:

> (1) Where upon such enquiry it appears to the Magistrate that any person is a lunatic and a proper subject for confinement, and the registered medical practitioners appointed to examine him have given their certificates, or where only one such practitioner has been so appointed, he has given his certificate as required by this Ordinance of the lunacy of such person, the Magistrate may adjudge such person to be a lunatic and a proper subject for confinement, and may proceed to make an order for the care and custody of such lunatic, and by warrant under his hand in Form No. 3, in the schedule to this Ordinance, commit such lunatic to the Lunatic Asylum, there to be taken charge of.

In comparison, section 12(1) of the Mental Hospital Ordinance of 1930 on the "adjudication of insanity and commitment to the Mental Hospital" reads:

(1) Where upon such enquiry it appears to the magistrate that any person is a person of unsound mind and a proper subject for confinement, and the registered medical practitioners appointed to examine him have given their certificates, or where only one such practitioner has been so appointed, he has given his certificate of the unsoundedness of mind of such person the magistrate may adjudge such person to be of unsound mind and a proper subject for confinement, and may proceed to make an order for the care and custody of such person, and by warrant under his hand in Form No. 3 in the schedule commit such person to the Mental Hospital to be taken charge of.

The meaning and consequence of section 12(1) is consistent across the 1905 and 1930 laws, as are most of the other provisions. Under both pieces of legislation, there is no provision to expeditiously appeal any decisions made by a magistrate who declares a person "insane" and orders that a person be committed to the Mental Hospital, usually based on certificates signed by two but sometimes only one registered medical practitioner(s) with relevant authority. Under these Ordinances, declarations of "insanity" and orders of commitment essentially strips a person of their freedom and incarcerates them to the institution with no time limitations or mechanisms/oversight bodies to mandatorily and automatically revisit and reassess these decisions without application.

Any additional examination with the intent for discharge – under section 15 of the Mental Hospital Ordinance of 1930 and, previous to this, section 16 of the Lunatic Asylum Ordinance of 1905 – is triggered only by request and application to the Governor of Guyana. Note that Guyana, as an independent republic, has a President who is the current head of state, not a Governor – who, under British colonial rule, was the head of state representing the monarchy and primarily tasked with maintaining order in the colony. Who, then, assumes the responsibilities of the Governor per this Ordinance, despite the Ordinance being enacted to reflect and legislate Guyana when it was once a colony? Nevertheless, under section 15, the process is as follows:

(1) An order for the examination of any patient in the Mental Hospital by any two registered medical practitioners authorized by the Governor may be obtained from the Governor, upon the application of any person, whether a relative or a friend or not, who satisfies the Governor that it is proper for him to grant such order; and on the production to the Governor of the certificates of the medical practitioners so authorized certifying that after two separate examinations with at least seven days intervening between the first and second, they are of the opinion that the patient may without risk to himself or the public, be discharged, and the Governor may, in his discretion, order the patient to be discharged at the expiration of ten days from the date of the order.

(2) All the costs of and incidental to any examination made under this section shall be borne by the person applying for such examination. (Mental Hospital Ordinance, 1930)

Important aspects of section 15, like others, are vaguely written. For example, it is unclear what criteria one must meet to satisfactorily demonstrate that it is "proper" for the Governor to grant a discharge. Even after fulfilling these stringent requirements, the Governor may ultimately choose not to issue a discharge because the law allows for this decision to be made at the Governor's discretion alone. Based on the law, it appears that the inpatient cannot trigger this examination process. It is initiated at the whim of others and is ultimately and subjectively decided by the Governor. This anachronistic legislation – open to broad interpretation, unilateral decision-making, and no oversight – creates conditions for abuse, misconduct, and conflicts of interest, inherently serving the state and vesting arbitrary and autocratic power in the head of state. This legislation is an affront to justice; an attack on human rights and civil liberties; and, as a consequence, its constitutionality may also be brought under scrutiny if this Ordinance is ever challenged in a court of law. This archaic legislation – utilized particularly as it relates to the adjudication of one's mental state and custodial protocols – is as dangerous as it is a gross injustice and assault on the individual freedoms of Guyanese.

Both Ordinances provide a section for "civil remedy" allowing one to seek redress in the event of "injury or wrong" but "only that such act or omission is an offence punishable by" said

Ordinances (Lunatic Asylum Ordinance, 1905; Mental Hospital Ordinance, 1930). In the Mental Hospital Ordinance of 1930, under sections 22-29, there are only eight offences listed – including "false medical certificates", "ill-treating patients", "rescue of person of unsound mind", and "trespassing" – but the sentences and fines attached to most of these offences are minor and, at present, cannot be thought of as measures of mitigation or deterrents. If/when actions for redress are brought, they must wind themselves through Guyana's legal system, which is described as "dysfunctional" and "backlogged" ("A Dysfunctional Justice System", 2018; "Caribbean Judicial Systems", 2020). If, for example, a person adjudged "insane" and involuntarily committed to the NPH seeks redress with claims that directly question the contents of the medical certificates or claims that false medical certificates were produced, their freedom is put on hold and they remain confined as they navigate said "dysfunctional" and "backlogged" legal system. Furthermore, while the insertion of "person of unsound mind", "person", or rarely "patient" (Mental Hospital Ordinance, 1930), instead of "lunatic" (Lunatic Asylum Ordinance, 1905), might give the appearance of a colonial mental health system under reform, such an assumption is dismantled when, as per section two of the Mental Hospital Ordinance of 1930, "person of unsound mind" means "idiot" or a person who is afflicted with "mental derangement". The Mental Hospital Ordinance of 1930 asserts that people experiencing distress and utilizing the NPH and mental health services be regarded in this way. Destigmatizing mental health issues is a difficult task when the foundation of the present system is built upon and reinforced by this colonial Ordinance. When patients are viewed with such bigoted disdain and there exists contempt for basic civil liberties, the inhumane NPH conditions that patients, past and present, endure is unsurprising.

The state – via past and present governments – claims that it is seeking to deinstitutionalize mental health care by promising to take a more decentralized approach through primary and community care, yet the situation on the ground remains fragmented and under-resourced ("Dr. Anthony Charges", 2021; "Mental Health Services", 2020; Thompson, 2021). The goal of greater deinstitutionalization in Guyana is yet to be realized, especially given the primacy and institutional centrality of the NPH. When headlines tout state plans for deinstitutionalization – which has yet to be comprehensively actioned – what is largely unmentioned and made invisible in this type of reporting, however, are the oppressive, institutional conditions that inpatients are forced to languish in at the NPH. Over the last few decades, patient deaths and the horrific conditions at the NPH tend to initially trigger a series of promised government action and grand statements of intent for institutional reform. These promises – as historically demonstrated – appear to be predictable, Pavlovian responses of virtue-signalling that ultimately expose themselves as inaction when little or no substantive change is delivered and yet another harmful or fatal incident occurs to spark public outrage and restart the carousel of purported government concern. Proposed changes, however, are informed by the same biomedical psychiatry model, colonial legislation, and carceral institutional structures that created conditions of violence and grievous bodily harm, which originally failed the deceased patients. These promises function to launder a history of state ineptitude and institutional violence; to whitewash, or what I call psy/psych-wash, the tragedies that elicited them – patient murders and deaths for which the state appears to abdicate responsibility. Over time, these proposals often prove themselves to be meaningless or principally serve to maintain the status quo: a state-backed system that is the spawn of colonial biomedicine and the British lunatic asylum architype.

Numerous, aforementioned examples in this chapter illustrate how the state has historically neglected its responsibilities to its citizens and did not meet minimum standards of care in its provision of health services to patients at the NPH. Without sufficient funding and comprehensive policy, legislative, and institutional overhaul, Guyanese experiencing mental distress will continue to experience shortfalls when seeking care; NPH patients will continue to face the heaviest burdens of risk and harm; and medical professionals will continue to encounter untenable working conditions. Patients are made to bear the catastrophic consequences of these inadequacies in a system where internal deficiency and perpetual crisis appear to be constitutive features. They are not merely symptoms or glitches of peculiarity; instead, they are the hardwired and durable mechanisms borne out of colonial psychiatry and maintained by the postcolonial state. The system, as a colonial creation, functions the way it was intended: as a tool of empire and an imperial inheritance that wields socio-cultural power (MacLeod & M. Lewis, 1988). Furthermore, mental health and NPH stigma, poor resource allocation, and operational failures only lend power to each other, ultimately contributing to the compromise and collapse of patient care.

Chapter Four:
Suicide

In February 2020, it was reported that a patient, Simone Broodhogan, died by suicide ("Mental Patient found Hanging", 2020; "Patient Commits Suicide", 2020). Based on reports, Broodhogan "had asked the nurse in charge for some sanitary napkins while she was tending to other patients. But it was said that the woman (Broodhogan) was only dressed in her underwear and was sent to get properly dressed" ("Mental Patient found Hanging", 2020). Broodhogan reportedly left the immediate area, and her lifeless body was later found in a bathroom by another patient ("Mental Patient found Hanging", 2020; "Patient Commits Suicide", 2020). When inpatients die by suicide while receiving care from psychiatric hospitals, these deaths are largely considered preventable and claims are often made against psychiatric hospitals because "courts and juries generally perceive inpatient units as having a greater degree of control over the patient and, thus, a greater responsibility to prevent suicides" (Knoll, 2013, p. 36). In light of the unacceptable NPH conditions that were previously outlined in Chapter Three – particularly around the persistent problem of staffing shortages – it is unclear if these conditions played any role in the circumstances surrounding Broodhogan's suicide. The tragic death of Broodhogan is one of many suicides that occur annually in Guyana, contributing to what is internationally considered a crisis situation in the country ("Desperate Measures", 2014; WHO, 2014). One of the more conspicuous failings that is often linked to the under-resourced mental health care system is Guyana's consistent ranking among nations with the highest rates of suicide in the world, where the country topped the list in 2012 with a suicide rate of 44.2 per 100,000 people (age-standardized, all ages) (WHO, 2014). Additionally, suicide is a criminal offence in Guyana. The criminalization of suicide exacerbates the silence and stigma attached to mental distress; it instils fear in a population that is already deeply distrustful of the police and the criminal justice

system in general (Sutton & Baxter, 2017). In the first section of this short chapter, I explore how Guyana's high suicide rate precipitated public condemnation and calls to action resulting in a greater push toward and propagation of psychiatric discourses and psy-oriented interventions. The second section explores how the criminalization of suicide is regressive and leads to perverse outcomes within the legal system through an examination of personal disclosures by two research participants.

The Propagation of Psy-oriented Interventions

> You know that Guyana for some time now has had the reputation of being the suicide capital of the world, with a rate of suicide per capita higher than any other country. I saw in the news earlier this week that we had slipped from number one to number four, but that is little consolation.
> – Guyana's Ambassador to the UN, Rudolph Michael Ten-Pow (2017)

Suicide is a complex phenomenon; and, from the outset, it must be understood that proclamations such as "suicide capital of the world" – which is uncritically employed by politicians, government officials, and media outlets – does nothing to comprehend, contextualize, or address the profound suffering and significant human and social dimensions that lead to the loss of life on such a comparatively large scale. Guyanese continue to die by suicide, but the ways in which these deaths have been framed and counted on the world's stage is done in a manner to potentially stigmatize and shame survivors, victims of murder-suicides, family members, and the dead. The discourse surrounding suicide tends to be captured through a biomedical lens, with distress predominantly owed to mental illness, which is then frequently cited as the cause (Manning, 2020a, 2020b). To be sure, this framing acknowledges how there is an increased risk of suicide among people diagnosed with mental illnesses such as clinical

depression (Manning, 2020a, 2020b); however, it is too singular and individualistic an explanation that does not capture the full picture, which can be replete with multiple external conditions of causality. Research shows that the reasons for suicide greatly vary across time and place, beyond the purview of the medical model, intersecting with the social, economic, and political realities of one's specific context (Durkheim, 1952; Joiner, 2005; Manning, 2020a, 2020b). Suicide, therefore, can and does occur in the absence of mental illness. Yet when Guyana comes to be known as the "suicide capital of the world" (Rawlins & Bishop, 2018) – acknowledged in 2016 by Guyana's former President, David Granger ("Guyana President Calls", 2016) – the commanding state response was to frame this issue as a mental health crisis through the lens of biomedical psychiatry, where medical professionals were deemed the primary experts (WHO, 2017b) to address what is openly acknowledged as a complex and multifaceted problem that must engage diverse stakeholders (WHO, 2008).

The release of the 2012 suicide statistics was accompanied by increased international scrutiny, which highlighted the shortcomings of the country's underfunded and under-resourced formal mental health care system (Rawlins & Bishop, 2018; "Desperate Measures", 2014; Handy, 2016; F. Mohammed, 2015). Per the WHO-AIMS Report on Mental Health System in Guyana (2008), it was previously known that Guyana – with a population of over 750,000 – had only three psychiatrists, which "translates into 0.5 psychiatrists per 100,000 population (equal to 5 per million) significantly below the world reference average of 4.2 per 100,000 (WHO, 2005)" (p. 6). After the publication of the 2012 suicide statistics, the government responded in ways that mainly served to bolster and shore up psy-oriented interventions (Ministry of Public Health, 2014).

There were moves to implement mental health and suicide prevention strategies, helplines, and to increase human resources by training more professionals within the psy-disciplines (Ministry of Public Health, 2014; Bishop, 2017). In the National Suicide Prevention Plan 2015-2020, one of the stated goals is to "strengthen human resources in the health system to provide care, treatment and support in cases of suicidal behaviour" (Ministry of Public Health, 2014). In 2017, Guyana had six psychiatrists, four psychologists, and an additional complement of four social workers and 52 nurses with some level of psychiatric training ("Mental Health Laws to be Broadened", 2017). In 2021, per *Stabroek News*, the number of psychiatrists has grown to 14 (Bhagirat, 2021). The Ministry of Public Health began conducting trainings based on the WHO's Mental Health Gap Action Programme (mhGAP) in 2017, "which offers a non-specialist programme providing a lower level psychiatric education" (Haynes, 2018). In 2018, 120 doctors were trained (Haynes, 2018); and in 2019, a total of 300 doctors, nurses, social workers and staff engaged in mhGAP trainings (Haynes, 2019), with two dozen nurses receiving further specialized training in psychological trauma (Rooplall, 2019). The Inter-Agency Suicide Prevention Hotline was also launched in 2015 and is administered by the Guyana Police Force ("Police Launch 'Suicide Helpline'", 2015). Per the WHO's 2016 statistics, Guyana still ranked as the country with the highest suicide rate at 30.2 per 100,000 people (age-standardized, all ages) (WHO, 2018a, 2019a). In 2017, figures suggested that Guyana was ranked fourth in the world ("Guyana No Longer Suicide Capital", 2017); and reporting and research published in 2018 and 2020, indicated that Guyana ranked third in the world ("Ahead of Oil Riches", 2020; Rawlins & Bishop, 2018; Shako, 2020), with one source citing a rate of 29.2 per 100,000 people (World Population Review, 2019, as cited in Shako, 2020, p. 2), though this specific statistic appears to be based off of the WHO's 2016 crude suicide rate for Guyana, not the age-

standardized rate (30.2 per 100,000 people) that appears alongside this crude figure (WHO, 2018a). In a 2022 *Lancet* article, C. Shaw et al. reported that in 2019 "Guyana's age standardised suicide rate was estimated as 40.9 per 100,000, the highest rate for the country in nearly two decades and the second highest suicide rate in the world" (p. 2). As articulated by Guyana's Ambassador to the UN, Rudolph Michael Ten-Pow, these high rankings offer "little consolation" (2017). Additionally, Guyana's suicide rate is significantly higher than many of its regional peers (WHO, 2018a). While the socio-politico-economic conditions in every nation are different, some English-speaking Caribbean countries – all of which are former British colonies – have the lowest rates of suicide per capita in the world; Jamaica, Grenada, Bahamas, Antigua and Barbuda, and Barbados rank 179th-183rd respectively out of the 183 countries captured (WHO, 2018a, 2019a).

It can be argued that these initiatives may have slowed deaths by suicide in the years following the 2012 numbers ("Guyana No Longer Suicide Capital", 2017); however, more research is necessary to establish a full and comprehensive picture of these interventions in practice and their outcomes. Participants of this study – like NGO/civil society actor, Daniel – generally questioned the quality and quantity of training programs that emerged following the publication of Guyana's high suicide rate and the follow-up/continuing education being offered thereafter:

> There's a lot of training that's been done in the area of mental health but the question is what kind of training and what kind of follow-up is being done. If you go to the articles you'll see that a lot of training is done. The Ministry of Health did a large training last week. This costs a lot of money. That's such a small budget, and they're using it to rent large hotels and just talk, so the priorities have to be in order. They are not in order. There is serious fear and stress among qualified professionals because people working in this area are not properly qualified.

The WHO's mhGAP, intended to be a universal tool, is built on the assumed supremacy of biomedical psychiatry and is particularly attentive to "treating individual conditions" and enabling "the way for further medicalization of global mental health" (UN Human Rights Code, 2017, p. 5, as cited in Mills & Hilberg, 2019, p. 165). The evidence base for the creation of mhGAP and later the mhGAP-IG (Mental Health Gap Action Programme – Intervention Guide) tended to discount qualitative data, and according to Mills and Hilberg (2019):

> By setting the parameters of what counts as evidence, and not including users and survivors in the early formulation of mhGAP, the makers of mhGAP-IG craft the epistemological parameters of critique for the guidelines, excluding alternative conceptualizations from different worldviews of distress (such as different cultural understandings and/or user/survivor/Mad epistemologies). (pp. 166-167)

They show that mhGAP and mhGAP-IG is only conceivable and actionable because it is based on "expansionary logic… built into diagnostic criteria from its early formulations" which includes "the conceptualisation of mental disorders as universal and the desirability of uniformity in usage globally" (Mills & Hilberg, 2019, p. 170). As a Western-based technology, mhGAP cannot be viewed outside the purview of a shift to "numerical biopolitics" and "colonial political arithmetic" where "essentializing and enumerating human communities became not only concurrent activities but unimaginable without one another" (Appadurai, 1993, p. 333, as cited in Mills & Hilberg, 2019, p. 170). When biomedical psychiatry is privileged and local and Indigenous knowledge and/or user/survivor/Mad epistemologies are excluded or branded "irrational", which was a colonial strategy (Mills & Hilberg, 2019, p. 166), these dismissals echo colonial legacies akin to the "civilizing missions" (L. Smith, 2010, p. 1) of the past. In the Guyanese context, titles such as "suicide capital of the world" – which appeal to "numerical biopolitics" (Appadurai, 1993, p. 333) – potentially serve to pathologize the nation and promote

rescue narratives that position biomedical psychiatry as the only legitimate and viable solution through interventions such as mhGAP.

Other research also cite contextual, social, and cultural limitations as a major challenge to mhGAP (Faregh et al., 2019; White & Sashidharan, 2014), with some calling mhGAP – and, more generally, technologies and ideas associated with global mental health – an "oxymoron" and a form of "medical imperialism" (Summerfield, 2013). Relating to questions of mhGAP's legitimacy and suitability in non-Western contexts, White and Sashidharan (2014) state:

> In our view, the failure of the mhGAP initiatives to recognise the limitations of the biomedical and institutional models of healthcare undermines the validity, relevance and appropriateness of the approach that it advocates. We appreciate that there are inherent risks associated with managing the tensions between the urgency with which services need to be scaled up, and on the other hand ensuring that this is done in an ecologically valid, ethical and sustainable way. The growing connectivity, integration and interdependence between people across the world can create great opportunities for progress. But these networks of connectivity are only as good as the ideas that are shared. We must critically reflect on the merits of biomedical conceptualisations of mental health and weigh these with local perspectives and local resources (including indigenous healing, social support networks, rights-based organisations and family support). (p. 416)

Bhiro Harry, Head of the Department of Psychiatry at Georgetown Public Hospital, noted in a November 2021 talk that while there was increased mental health training among doctors, the mhGAP-IG initiative was of little success (Bhagirat, 2021). In addition to these concerns, there is also the question of whether or not those trained will be paid commensurate with their newly acquired skills. When trainings like mhGAP and other specialized programs are conducted, as mentioned by NPH staff, the government has a responsibility to be abundantly clear in communicating what professional incentives employees/participants should expect, if any, upon successful completion. As a related issue, the high emigration rate of nurses and other tertiary-educated professionals presents a situation of concern that appears to pose long-reaching consequences if not substantively addressed (PAHO, 2011; Matera et al., 2020; Mishra, 2006).

As is the case in addressing mental distress (WHO, 2008), experts acknowledge that suicide prevention requires multi-sectoral and multidisciplinary approaches and interventions (Miller & Coffey, 2021; WHO, 2014, 2018b; Government of Canada, 2016). The practice of biomedical psychiatry and psychiatric institutionalization in Guyana is a colonial import that is imposed without substantive consideration for the indelible legacies of colonial conquest, slavery, and indentureship or for the manifold ways in which the nation's multi-ethnic population conceives of distress. The propagation of biomedical psychiatry in Guyana today, particularly biomedical interventions centred around suicide prevention, fails to acknowledge the country's difficult history and complex socio-politico-economic realities.

The Criminalization of Suicide

Under the Criminal Law Offences Act of Guyana, chapter 8:01 (97), "Everyone who attempts to commit suicide shall be guilty of a misdemeanour and liable to imprisonment for two years" ("Gov't to Amend Law", 2021). In January 2021, Minister of Health Frank Anthony announced that the PPP Government intends to amend the law: "I think the offence carries with it a penalty to be jailed and therefore, we believe and in the modern-day dealing with psychiatry and so forth, that you shouldn't have these types of punitive measures" ("Gov't to Amend Law", 2021). Local NGOs have questioned how serious politicians are in their commitment to increased mental health awareness and suicide prevention given their failure to repeal the law ("Decriminalise Suicide", 2018; Rooplall, 2018). In 2016, the PPP – who were the opposition at the time – proposed a motion "calling for greater measures to address suicide, including decriminalisation" ("Gov't Votes Down", 2016). This motion was voted down by the governing APNU-AFC majority "with its speakers arguing that the manner in which it [the motion] was

framed both politicised and trivialised the problem" ("Gov't Votes Down", 2016). Even as the APNU-AFC acknowledged that the decriminalization of suicide was a necessary step (*Hansard*, 4 August 2016), they failed to repeal and reform the law during their tenure, which only compounds the grim fact that the PPP took no action to decriminalize suicide during their previous 23-year period (1992-2015) in power. These shows of political gridlock and overall government unaccountability continue to place Guyanese at the mercy of this and other archaic laws from which the mental health care system is informed.[47]

While officials emphatically deny that the law is enforced (*Hansard*, 4 August 2016), Guyanese are apt to question and be wary of the law's continued presence on the books ("Decriminalise Suicide", 2018; Thompson, 2020), particularly in a nation where public trust in government, law enforcement, and the criminal justice system is compromised (Sutton & Baxter, 2017). This distrust is due in no small part to structural failures in policing (Sutton & Baxter, 2017) and a history of alleged police bribery, extortion, and brutality; political corruption and impropriety; state torture; and extrajudicial killings (Bahadur, 2015b; "Banglegate, Hubris and Entitlement", 2021; "Corruption in the Guyana Police Force", 2020; "Crime Chief Suspended", 2019; "Gov't Pays Tortured Boy $6.5M", 2013; Haniff, 2019; "Land Corruption", 2020; "Most Serious Human Rights", 2012; "Police Force Confirms", 2019; "Shameless Nepotism", 2015; Thompson, 2019; United States Department of State, 2018; "U.S. Report Highlights", 2019). These factors only serve to amplify fear and cynicism among the general population, especially so when the country's Inter-Agency Suicide Prevention Hotline is run by the Guyana Police

[47] Since the finalization of this chapter in April 2022, there have been new legal developments in Guyana that are of consequence to this work and which must be acknowledged. In July 2022, the government tabled the Suicide Prevention Bill, "which, once passed, will decriminalize attempted suicide and mandate counselling for survivors" ("Suicide Prevention Bill Tabled," 2022). The Bill will need to pass through the parliamentary process before becoming law, which may take several months or longer. Until this Bill becomes law, suicide remains a criminal offence in Guyana. It is my intention to analyze this proposed legislation in future research.

Force ("Police Launch 'Suicide Helpline'", 2015), which in 2014 was considered the "least trusted institution in Guyana and had the lowest trust score of any police force in the Americas" (Sutton & Baxter, 2017, p. 13).

Mustaq, a village imam, and his wife, Sadia, who is a leader among the women in their small Muslim community, are two religious/spiritual helper participants in this study who have been personally affected by these issues. After Sadia's nephew – who was visiting their home at the time – tried to end his life by hanging, they allege that this incident resulted in police extortion under the threat that Mustaq would be held criminally liable after he attempted to help the young man when he came across the body and released the noose. Sadia and Mustaq explain:

> Sadia: I have me nephew. He hang heself right in dis yard hay [here]. He was about 32 years of age… When me husband [Mustaq] come back now [from mosque/masjid], he [nephew] was hanging. Me husband shout fuh me: "Come bring one knife! Come see wha' dis bai do!" So me ah bring knife fuh cut down rope but by de time me reach wid de knife, you know dem draw knot [referencing the knot on the noose] wha' he [nephew] mek, he [Mustaq] just pull de knot [on noose] and there was he [nephew] down to the ground. And we try, we try, we try… We get car to carry he to de hospital and so, Best Hospital and then to Georgetown. They send he wid ambulance, and he was in intensive care at Georgetown Hospital for 11 days. Never regain consciousness. Never regain and then he died. He wasn't to die the day he hang himself… I guh everyday and visit he. De nurses dem gat tube… and tekkin care ah he and everything but he never regain he consciousness and he pass away…
>
> Mustaq: Me get lack [lock] up all fuh dah thing… But me nah supposed fuh cut am [him, nephew] down but ah lucky thing de man [nephew] nah dead right away too. But me nah know, me see de man [nephew] hang up, wha' me guh do [what am I going to do]?
>
> Sadia: If you see somebody hang demself you nah guh play rescue fuh help dem. You leh de police come and loose dem down. You nah trouble dem. Imagine you see a child hanging and you kyan [can't] loose dem down. Law nah look at saving a person life… Dem [police] detain he [Mustaq] fuh almost half of de night or more than half of de night. Threaten he! And den everyday police ah come.
>
> Mustaq: And den meh gah guh back [And then I have to go back to the police station]… And you know dem police dis wha' dem want. Money! Money! Ah money dem want!
>
> Sadia: Look for a raise [money via extortion].

Mustaq: Dem ah frighten you.

Sadia: Dem ah frighten you if you nah geh dem [give them] a lil thing [money]. Dem ah lack [lock] yuh up…

Mustaq: You know de same chap [names specific police officer]. Dah man mussee get ova [must have gotten over] one hundred and something thousand dollah [from me]. Every time yuh gah giam [got to give him, police] money because yuh nah frighten?

Sadia: $10,000 $10,000.

Mustaq: Me nah gat nobody [lawyer, advocate] fuh go [to the police station] wid me.

Mustaq explains that it was only after his "*saro*" (sister-in-law's husband) returned from abroad that this relative, who has a greater understanding of how the law functions, was able to advocate for Mustaq and stop the extortion payments to the police. Mustaq and Sadia's account is one important story that points to the venal and perverse incentives created by such an inhumane law. While it might be true that formal charges related to the criminalization of suicide are not pressed or pursued by the state, the corrupt and criminal latitude that some law enforcement officials may exercise in the name of this law and via threats of extortion is a reality that appears to be unaddressed.

As a consequence of the criminalization of suicide, Guyanese may choose not to report incidents of suicide given the attached stigma; out of fear under the threat of extortion or corrupt police behaviour; and the more serious, though slim, possibility of criminal prosecution under this law ("Decriminalise Suicide", 2018; Thompson, 2020). As well, the under-reporting of suicide is flagged as an issue of concern as it relates to the Guyana Police Force's transparency and accuracy in reporting on suicide statistics more generally ("Releasing Stats", 2015). Despite the inadequacies of the formal mental health care system in Guyana, biomedical psychiatry is viewed as the main approach in addressing the complex issue of suicide. Biomedical psychiatry takes an individualized approach based on a ridged top-down model with unequal doctor-patient

and state-individual power dynamics (Morrison, 2013), which are further complicated by the imposition and haunting of the colonial lunatic asylum model and the criminalization of suicide in the Guyanese context. If it is understood that plural, multi-sectoral, and multidisciplinary methods must be engaged, then biomedical psychiatry alone cannot stand as the primary model from which to source solutions. It is one important approach but its dominance as a place of unassailable authority, whereby other methods are subsumed under its power and gaze, is questionable.

Chapter Five:
"It gat mad people, but she nah mad"[48]: Meaning-Making and Personal Disclosures

In choosing to interview an array of helpers (medical professionals, NGO actors, religious/spiritual practitioners), not only did they share their various understandings of specific terms akin to distress, but they also spoke at length about social perceptions and other associated language and meanings that they encountered through their everyday interactions assisting people experiencing mental distress, the families of those experiencing distress, specialist and non-specialist populations, and the general public. The first section of this chapter captures these varied understandings of mental distress in Guyana, which generally engage the terms madness, mental illness, and disability. Mental distress is predominantly – though not exclusively – understood through the stigmatized language of madness, the most commonly engaged term used by the helpers as this is how distress is colloquially understood by the general population. The psychopathological and biomedical umbrella concept of mental illness is also discussed by the participants, as is the language of disability, though disability is cited to a lesser degree because it is viewed primarily as a physical or sensory impairment. The participants also discussed stigma at length. The stigma attached to mental illness and madness is a common thread that is discussed throughout this chapter, particularly so in the accompanying understandings of madness because of how perceptions of madness appear to be shaped by ineffaceable abjection.

In the second section of this chapter, several participants openly shared personal accounts of how they (n=9) or a family member (n=8) were affected by mental distress. Their stories are gripping and the terms that they use to talk about their mental distress or the mental distress

[48] Priya (Interview), a Hindu priestess practicing Shakti (goddess) worship, talks about her daughter's experience of mental distress and caring for her. This is discussed in the second section of this chapter, "Personal Disclosures: The Impossible Mad Subject".

experienced by a loved one, for whom they provided care, offer a window into the polyvalent ways in which mental distress and madness are personally engaged, disavowed, and treated with ambiguity in Guyana. The stigma of madness in particular makes it impossible for any of the participants to personally identify with and individually claim madness as an identity marker or subjectivity as they relayed their lived experiences of mental distress. Their stories are dynamic and speak to the humanity of those with experiences of mental distress. They tell of diverse stressors, where mental distress is a likely and reasonable response to the hardship of their lives. It is in these accounts that they trouble the fixed scripts of madness and the attached stigma. Importantly, their tellings emphasize how people with experiences of mental distress would like to be treated – with respect, dignity, and compassionate care.

Meaning-Making: Understandings, Stigma, and Distinctions

Mental Illness

When discussing distress through the lens of mental illness, some helpers utilized the biomedical model – from which this term springs – to serve as a basis for their definition, especially so for those who are trained medical professionals, particularly the medical staff working at the NPH. Others, instead, chose to predominantly speak about social perceptions of mental illness through their interactions with the general public. Words such as "psychologically sick", "nervous breakdown", "genetic inheritance", "psychotic symptoms", and "sanity and insanity" were utilized in their narratives, which signal to biomedical understandings of mental distress. For David, a Christian Pastor, mental illness is a "psychological impairment of the human body and the human mind… Someone who is psychologically sick." Lesley – who works in social services and has an autistic child – believes that people with a mental illness are "people who have a nervous breakdown, a nervous mental health issue". Salima, a medical professional

at the NPH, defines it as “between normal and stable and not being stable. You would see some psychotic symptoms. They would hallucinate and all these kinds of things”. Colleen, also a medical staff at the NPH, explains how “it's a thin line between sanity and insanity and as such people should show more concern over mental illness or mental health”. Colleen goes on to say that the general population “don't feel that mental illness is like any other illness, like the diabetic”. Teke, another medical professional at the NPH, mentions how there are various definitions and understandings of mental illness that spring from multiple international public health organizations:

> You have different, different definitions from PAHO, World Health Organization, because the label of, different label of mental problems... I think it’s a crisis to produce lack of productive years for the patients… Detach the individual of their productive life.

Teke’s account, referencing PAHO and the WHO, expands to consider the “productive years for the patients”, alluding to the socio-economic consequences of mental illness at the individual level. In these various understandings, the individual is centred and their behaviour is talked about through the use of medicalized descriptors – terms that were particularly used by medical professionals, but also by the civil society/NGO actors, government officials, and religious/spiritual helpers (to a smaller extent).

Daniel, a civil society/NGO participant, describes how the term mental illness is hastily employed in the absence of any medical expertise and how this is a common practice in media reports, particularly those concerned with violence:

> Well, what you would find is a lot of professionals would say mental illness and you would see in newspapers, almost every newspaper, people talking about the mentally ill… There was a man who attacked a schoolboy and the headline was, “Mentally Ill Man Attacked Schoolboy”, and my question is how did the reporter know this man was mentally ill? He's not a psychiatrist. The person living in the streets was obviously not evaluated by a psychiatrist, and there's no clinical judgment there and so you hear the term mental illness and people don't realize that, that it's a spectrum and that there are different conditions.

Indeed, the Guyanese media privileges the dominant biomedical model but also has a history of labelling people as "mentally ill", without any apparent substantiation or input from doctors, families, or the individuals themselves involved ("Schoolboy Hospitalised after Attack by Mentally Ill Vagrant", 2012; "Mentally-Ill Man Clubbed to Death after Attacking Cop", 2013; "Mentally Ill Escaped Prisoner Shot Dead", 2018; "Robb St. Stores Threatened by Violent, Mentally Ill Vagrant", 2019). For Daniel, this diagnosing from a distance and without expertise – when a psychiatrist does not personally evaluate an individual, but a diagnosis is nevertheless rendered (by a reporter in the case that he cites) – is misguided, especially here and in relation to the media's use of the term "mentally ill". Daniel believes that "clinical judgment" in diagnosing is necessary, and psychiatrists should carry out evaluations. The American Psychiatric Association (2018) also calls for an end to similar practices specifically involving psychiatrists who engage in what it calls "armchair psychiatry" and deems this practice "unacceptable and unethical" to publicly issue "professional medical opinions about individuals that they have not personally evaluated in a professional setting or context". Daniel's response appeals to a biomedical understanding of distress, where illness, diagnosis, and treatment are emphasized, and the medical knowledge and authority of the psychiatrist is central in this process.

Daniel also states what he sees as a problem of knowledge translation of the biomedical model in Guyana:

> You'll find that there are very few people in Guyana who really understand things from the clinical point of view and explain it in an easy enough manner where average Guyanese can understand it. So for example: the five psychiatrists, they know their stuff really well but if you ask them to do a workshop for an NGO they probably wouldn't be able to really connect because they wouldn't be able to explain it at the level that they need to.

He explains that psychiatrists are probably unable to expound on biomedical understandings of mental distress in ways that allow them to "connect" with lay populations. Further, Daniel believes that Guyanese do not have the language to express how they feel:

> In Guyana you just don't have the vocabulary to describe what you're feeling. You might feel something and know that it's not the way that you should be feeling but the vocabulary isn't there to put a name to something.

It is unclear if the "vocabulary" that Daniel mentions is mainly informed by the biomedical model – a "clinical point of view" as he previously puts it. This is, however, not to say that Guyanese do not express their feelings of mental distress through an array of context-specific and meaning-centred language, which may or may not intersect with biomedical understandings of distress.

Most participants were unable to talk about mental illness in the absence of discussing madness. Madness was a circulating proxy in the helpers' discussions of mental illness and broader ideas of biomedical mental health practices, which is why these associations with madness are included in this subsection on the meanings of mental illness. In the previous paragraph, Daniel signals how mental distress is not widely viewed through the biomedical lens by the general population. This is a view that is expressed by the majority of helpers and is captured through a sampling of their responses in what follows. The interviewees underscored the prevalent use of the terms mad and madness. Participants emphasized how these terms are widely utilized in the vernacular to describe mental distress, especially by the lay and non-specialist populations that they encounter every day in their professional capacities. The participants explain that the terms mad and madness, not the biomedical term of mental illness or psychiatric diagnoses/labels, are the predominant expressions used by the general public to

describe their understandings of mental distress. Hafsa, a civil society/NGO helper, describes it this way:

> I don't know that the vast majority of Guyanese would even call it mental health… I think the thing that most people would think of is mad people… Most people think of it as just a negative and once you have it, that's it. It's not something that you can work through… It becomes how you're defined. That becomes *the* [Hafsa's emphasis] way you are defined.

According to Hafsa, the term mad is commonly used, and it becomes *the* all-consuming, pejorative, and defining aspect of one's identity. For Hafsa, madness is indelible. Ponel, a medical doctor, concludes similarly: "Madness. And that's the worst stage of their definition. And that's wrong because when you are called mad then it's okay for society to treat you in any way that they want to." Other participants convey comparable sentiments:

> They'll just say, "You mad" or "You insane." (Nicole, Interview)

> If they see somebody different, "Oh, that's a madman! Or madwoman!"… You see in Guyana, nobody understands. They just look at them and say that person is mad. But we don't know their condition, and in Guyana we don't have proper medical and people to diagnose them to say that this person is autistic or this person has a disability mentally. I don't think we have that here. (Mohini, Interview)

> Dat saying mad is … a term we use. "That person is mad" … But how do we know that he or she is mad? What proof do we have? Because he bruk a glass or he bruk somebody car or do something. (Navindra, Interview)

> "Yuh mad, yuh mad! Bai, you ah madman." And they leave it at that. In our culture we don't engage mad people. We chase them because they mad. (Ralph, Interview)

> You know, mad, madness. It is and how it's understood in Guyana. It's still highly stigmatized. People are fearful but also very suspicious… It's different from a physical ailment that people can recognize and see and know… That's why it's so easily seen as a demon related interference. (Jean, Interview)

Mohini – who works in social services and has an autistic child – privileges the authority of the biomedical model, like Daniel, and she cites Guyana's shortage of "proper medical and proper people to diagnose" while also mentioning the common usage of the terms "madman" and

"madwoman" in addressing "somebody different", or the difference and othering that madness conveys in this context, particularly the public's usage of the term. Kali Mai *Pujari*[49] Navindra, affirms that "mad" is the common parlance. While Daniel and Navindra cite different models that capture mental distress, with Daniel giving credence to the biomedical model and Navindra centring the term mad to discuss distress, they both believe that the public is too quick to label people as mentally ill or mad, given their respective understandings. Similar to Daniel's criticism of the haphazard ways that people are labelled mentally ill without psychiatric assessment, Navindra's line of questioning interrogates the general usage and application of the word mad to describe people whose behavioural expressions may be violent ("Because he bruk a glass or he bruk somebody car or do something"). "Mad", "madness", "madman", "madwoman", and "mad people" are just some of the shared terms mentioned by the participants when they were asked to talk about mental distress, its meanings, and its associations. Stigma, which is raised in several of the above interview excerpts, is a common theme that spans the interviews.

On the question of violence and the public perception that people labelled mentally ill are more likely to be the perpetrators of violence, international research studies – conducted in countries with large populations of people of Caribbean descent – have debunked this idea, which is generally accepted amongst medical practitioners, but not necessarily the public at large, which also appears to be the case in Guyana given the helpers' responses. In its January 2011 issue, the *Harvard Mental Health Letter*, citing several studies on the relationship between mental illness and violence, referenced a 2006 national survey conducted in the United States, which found that 60% of Americans believed that people with a diagnosis of schizophrenia were likely to commit an act of violence against someone else. Research, however, suggests that most

[49] A "*pujari*" is a Hindu priest who, among other duties, performs worship/religious ceremonies known as pujas.

people with mental illness are not violent (*Harvard Mental Health Letter*, 2011). While violent crimes and assaults can be attributed to a subset of people with mental illness, findings here are "inconsistent about how much mental illness contributes to this behaviour and how much substance and alcohol use challenges and other factors do" (*Harvard Mental Health Letter*, 2011). Also, the dissimilar methods used to assess and attribute rates of violence to people diagnosed with mental illness and in control groups may lead to under and over estimations of incidence rates (*Harvard Mental Health Letter*, 2011). Further, the United States Department of Human Health and Services (2017), through its mentalhealth.gov portal, also concludes that the vast majority of people with mental illness are no more prone to being violent than the general population, with only 3% to 5% of violent acts attributable to people living with what it calls "serious mental illness", which include individuals with a psychiatric diagnosis of schizophrenia, bipolar disorder, and major depression. This resource goes on to state that "people with severe mental illnesses are over ten times more likely to be the victims of violent crime than the general population" (United States Department of Human Health and Services, 2017). The picture is deeply nuanced, and some studies have not controlled for compounding variables outside of substance and alcohol use that "contribute to violent behaviour (whether the individual is mentally ill or not), such as poverty, family history, personal adversity or stress, and so on" (*Harvard Mental Health Letter*, 2011). In Canada, there are similar findings from the Canadian Mental Health Association (2011), which contends that there is no established, definitive causal relationship between violence and mental illness, and that media portrayals and reporting heavily influence and contribute to the public's misperceptions about this issue. Public fear that people with diagnosed mental illness may behave violently contributes to and compounds stigma (Canadian Mental Health Association, 2011). While there are no country-based studies in

Guyana looking at the relationship between diagnosed mental illness and violence, these international studies offer insights into various factors that affect how this issue is misperceived and how some of these findings might also be relevant in other contexts, including Guyana.

Wendy, a medical professional at the NPH, explains how her patients at the NPH have been subjected to violence by the public:

> There is a stigma. When it comes to persons with mental health, they [general public] are violent towards them… Recently we had a patient that got away, that absconded from the ward. He wasn't from here [Berbice]. He was from Georgetown, and he went up to the Corentyne area, and the persons there gave him a severe thrashing… When he came back, all of his teeth were broken up. He had bruises all over because he was just walking, maybe looking you know, because he is not from here… Somebody called and said they saw a man that looked like he was severely beaten and the nurses from here along with the ambulance, they went and collect him. When they went they saw that it was a patient from here. So they brought him back, took him over to the hospital. When it comes to persons with mental health, people are very violent towards them. People don't want them around them, and it's a segregation.

Daniel's viewpoint, like Wendy's, aligns with some of the findings from these international studies previously mentioned:

> So a lot of the times in the newspapers when you see the editorials they'll say that we need to provide care to people with mental illness to keep society safe. Even though the stats show that they are more likely to be victims of violence than the general population.

Indeed, and as mentioned previously, some media outlets in Guyana engage in reporting which can work to deepen the stigma around mental illness and madness and breed fear because the complexity of these incidents is captured through sensational headlines and articles that do not substantively engage with the multifaceted issues at play ("Schoolboy Hospitalised after Attack by Mentally Ill Vagrant", 2012; "Mentally-Ill Man Clubbed to Death after Attacking Cop", 2013; "Robb St. Stores Threatened by Violent, Mentally Ill Vagrant", 2019). More research in Guyana is required to analyze stigma and the perception that these populations are more likely to be violent.

Madness

> Yet, still contributing to stigma in the Caribbean are myths and one of the most common examples Dr. Osunbiyi pointed out, is the case where persons equate mental illness with being "mad". "Less than 10 per cent of the work I do as a senior psychologist here is about insanity. Psychology and psychiatry is not about treating 'mad' people, it's about helping others who find themselves challenged, vulnerable or at-risk to find answers or options or solutions to whatever it is they're confronted by," Dr. Osunbiyi corrected. (Hamilton, 2018)

The opening quote in this subsection, taken from a newspaper interview with Balogun Osunbiyi – a senior psychologist at Guyana's Ministry of Public Health – describes how mental illness, per biomedical and psy-oriented understandings of distress, is often captured through the stigmatized language of madness (Hamilton, 2018). When participants spoke about the meanings of the terms mad and madness (often used interchangeably), the general consensus by the participants is that these terms are pejorative and stigmatizing, where people deemed mad are treated "like they are not human" (Sally, Interview). Madness is a term that is almost immediately employed and tied to subjectivities whose behaviours are deemed out of character, irrational, aberrant, chaotic, and aggressive; it is perceived as a complete state of tragedy for those who "trip out" (Ralph, Interview). Coupled with ideas of unmanageable variability, the imputation of madness is also often applied to people who are especially hyper visible in public spaces, particularly people experiencing homelessness and/or substance and alcohol use challenges, with the stigmatized term of "junkie" (Kim, Interview) employed alongside madness.

The helpers reflected on the general population's stigmatized usage and the associations that the words mad and madness harbour. Phrases and words such as "trip out", "mental sick", "head nah good", "unsound mind", "run off", "got jumbie", "yuh get demon on yuh", "yuh ent normal", "something wrang wid you", "somebody do dem something", "crazy", "lunatic",

"outcast", "paagli" (stupid), "junkie", and "stupidy" were among the many terms employed that were considered synonymous with madness and being labelled mad:

> Trip out. You gat a term "mental sick". Once you look a certain way on de road, yuh mad. (Ralph, Interview)

> Well that is what people say. The people are mad, they crazy. They call them lunatic. They call them junkie. (Kim, Interview)

> Mad, paagli. Paagli means kinda stupidy, I don't know if that's so common. And then there's the whole junkie. (Hafsa, Interview)

> Well mad and head nah good… Dem say, "Man, nah worry wid he. He's a madman." (Deonarine, Interview)

> Now other terms they've used would be insane, unsound mind, run off, trip out, got jumbie. (Daniel, Interview)

> You're an outcast! Nobody wants to admit that they're mad because you immediately become an outcast. (Nicole, Interview)

> Guyanese ting. Yuh getting mad! Yuh gone. Yuh getting mad. Yuh crazy. Yuh trippin'. (Indra, Interview)

> Trip out. They will say you are mad or you are crazy. They say you freak out. That's one they use. They say you overboard. You flipped the switch. There are so many terms that they use but these are some of the common ones that I can think of at this point in time. The common one is, "He's a madman. You gone mad." Gone mad. Madman. (David, Interview)

> They say crazy, mad. I grow up hearing those statements about people. (Patrick, Interview)

> "Oh, yuh trip and come back!" Trip out is the next word for mad. (Charmaine, Interview)

> Yuh head ent good! That's how they categorize it. You mad! You should be put away. Take the truck, and pick you up, and throw you to the observation ward [Georgetown Public Hospital] and move you to Berbice [NPH]. They don't see the problem… Put you in the Madhouse. They want to get the problem out of their hands. So that's how they look at it… They are not tolerant. They push it aside. There is no big understanding of mental health. (Lionel, Interview)

The meanings cited by the participants are more varied and nuanced when compared to their explanations of mental illness. Madness is viewed as unreservedly undesirable.

When madness was described, its most abject representation was that of the incoherent and sometimes violent "street dweller" (Samuel, Interview) and people with experiences of precarious housing, homelessness, and extreme poverty. Charmaine, who works in social services, describes this common understanding:

> You're on the street, picking up things and eating, you might be running [chasing] people, you might be walking and talking to yourself. If they see you doing that, well, "Yuh mad!"… There are a lot of people that are mad and on the streets. Nobody is taking care of them. They are just there, lying down on the road, or doing people things on the road. They need to take those people and take care of them. When they are in the madhouse, we say madhouse, when they are there I don't know if they does give them any medication.

Other participants describe similar representations:

> Mad people. Once they see you and you don't really look well dressed, you're walking without shoes, you got on little clothes or no clothes, they just say you're mad. They just put you aside or don't pass you by. It's like you are mad, that's it! (Sally, Interview)

> I have heard this so many times growing up. A woman walking down the street, now I know that it's because she had a nervous breakdown and she is not in her right sense, and you'd say, "Look dah mad woman!" And you'd run like crazy! That was taught to us, to be scared of mad people. "Oh, mad lady comin'! Run! Run!" And we'd run like crazy from anybody that we'd see walking down the street. They are mad, mad people. (Lesley, Interview)

> They got mad people walking around the road with a stick and when you walk he lash you sometimes right in Main Street in Georgetown. So it's the uncertainty of the behavior that they don't understand. (Lionel, Interview)

> That's the general wastebasket category. People who live on the street, who eat out of garbage cans. (Ponel, Interview)

> The people you see on the street are human beings but they may have a mental condition. We treat them like dogs. We chase them. We beat them. We throw water on them… Guyanese people think there is only one way to deal with it. Throw you away. Keep you locked away or leave you to roam the street. (David, Interview)

> A mad person on the street is still treated the same way. Pushed aside. Rejected. People would still give them something, give them food, give them money. But that is just physical sustenance. In terms of the application of a medical intervention, I think we're sorely lacking in that. (Ralph, Interview)

Some participants explain that the high stigma associated with mental illness and madness (depending on the term that they privilege) might be the reason why this representation is common because it is the most observable; madness when attached to homeless bodies is made hyper visible and the convergence seems inevitable where to be homeless is to be mad.

Pastor David describes how the stigma of being labelled mad creates conditions of fear toward the individual being labelled, whereby mad people are equivocated and treated "like a junkie in the street". He states how the indelibility of madness means that "normal expressions" and emotions are inevitably read as madness. David explains:

> The moment you are off a little bit and you are labeled mad. Oh! Anything you say after that, anything you be after that, you're a madman! People won't take you seriously and they treat you that way like a junkie in the street. Ignored, treated as if you are literally a burden to society and so normal expression of anger, normal expression of frustration, normal expression of being lethargic and tired, will now be associated with "You've gone mad!" Family members again, spouses, children, churches, government organizations, don't know how to deal with these things and so it's left untreated only to get worse. This is my experience.

David highlights how the imputation of madness, once levelled, appears inescapable. Ralph, another Christian leader, has a similar understanding and says that he knows a "madman" on the streets who does not fully conform to this narrow representation of madness because he is thought of as a "madman with words", nevertheless he is still "termed mad":

> We have another madman on the road and I like to talk to him because he is a madman with words. He is a graduate. He is a tertiary graduate and when he engage you in a conversation and if you ent up there in terms of your vocabulary, you will look mad. He uses a lot of big words and I use the word ramble cautiously but he can talk on an issue intelligently; politics, history, all of that with all the big words and make sense. I can't keep up with him, but he is mad. He is termed mad.

The all-consuming nature of madness is captured in Ralph's encounter with what he calls "sane mad people", where madness seems to be identity-defining, even as "they catch back themselves" and even with folks who "catch fits", which is commonly understood as a term to describe the experience of seizures and epilepsy:

> Now, I've encountered if there is such a thing, the sane mad people. These people are well dressed. These people have jobs, working, but they exhibit some weird behaviour at certain times. They switch on you suddenly but it's only like for short periods and then they catch back themselves. In one case I knew it was fits, this one guy he used to catch fits.

Ralph also goes on to clarify that he realizes that "there have well-dressed people with mental problems. Somebody might be sitting, engaging you in a normal conversation and they could have mental problems"; however, it is this realization, according to most participants, that is absent from public conceptualizations of madness. Kenroy, a civil society/NGO helper, explains:

> Once a person is referred to as being mad, being referred to as mad means you can't be taken seriously. There is no understanding that you may have periods where you're perfectly normal, as people understand normal.

For Kenroy, any sense of what is "normal" cannot coherently be attributed to bodies labelled mad by the general public. The two, per public perception, are diametrically opposed.

For Kim and Hafsa, both civil society/NGO actors, the "junkie" – like the "street dweller" – is also perceived mad by the public. This may be because of what is seen as the increased prevalence of homeless and precariously housed people who may simultaneously experience substance and alcohol use challenges, which creates conditions whereby madness is assumed and the public "cannot really differentiate those people on the road" (Kim, Interview). Hafsa explains how madness becomes a catchall that is attached to substance and alcohol use challenges, homelessness, and precarious housing:

> Hafsa: The term junkie in the last couple years is also being conflated with, because in town especially, when you see a person who looks like they might be homeless but then

> there is also that they may be homeless slash also a junkie slash also mentally ill. So with those three things, to what extent a person can be any of those, I think it sometimes gets lost and they're seen as just all three.
>
> Savitri Persaud: So they just become collapsed?
>
> Hafsa: Yes, exactly, into the junkie who is mad, who is homeless, who is a drug addict. Yeah, yeah.

Kim agrees and believes that because they "operate in the same way," it is difficult to make distinctions:

> The junkies are those people who use the drugs continuously and they end up on the roads and so forth. Basically, they call them mad people, crazy people, and junkies, but not all those people are suffering from mental illness. Not all of them… In terms of mental health, some people cannot really differentiate those people on the road who really are suffering mental health from who are drug abusers. You really cannot differentiate them on the road just like that because they both operate in the same way.

It is this lack of differentiation, this collapsing of vulnerable and marginalized populations, and the paucity of resources to address these complex needs that contribute to and fuel stigmatized perceptions, which may prevent help-seeking behaviour.

Samuel, who pastors a Christian church that volunteers with underserved communities in Georgetown, completely disavows the term madness when speaking about "street dwellers" because of the stigma associated with the term. Throughout the interview he makes his preference clear: "My word is insanity or differently oriented" (Samuel, Interview). He believes that it is "social issues" that have resulted in people experiencing distress and homelessness (Samuel, Interview). Once on the streets, he believes that there is an increased likelihood for them to use illegal substances. Samuel explains:

> There are people around here. We call them street dwellers. I don't like to use the word, I see you have madness there. I don't like to use that word. I prefer to use the word insane. We don't call these people mad. The people around here, most of them, they have had social issues, probably in the home something happen. Abuse. Incest. Rape. Violence. Not being treated equally in the home. Favouritism in the home. There are so many issues. And those persons have chosen to leave their home and the street becomes their

> home. Being on the streets, most of them have taken to alcohol, marijuana, and hard drugs. Last night, I actually saw one of them smoking cocaine right at the corner of the street.

Samuel's outreach work in his community leads him to place emphasis on the perceived social causes of mental distress, which will be discussed in the next chapter. Other participants like civil society/NGO helper Daniel have heard what he calls "politically correct" phrases to reference madness, such as "something is wrong":

> A lot of people would say especially if they're trying to be politically correct what they would say is 'something is wrong'. I mean I know I've had like four phone calls where the person said, "I have a family member and I think something is wrong. I think that he or she needs to see a mental health professional." So they would say that "something is wrong" with them.

Vishnu, a Ministry of Health official, has heard a similar refrain: "They say that they are mad. Loose screws, 'something is wrong'. People say that a lot: 'Something is wrong with him, that's why he behaves badly.'" Even when madness is expressed in ways that are intended to be "politically correct" (Daniel, Interview) – as a "something" that is "wrong" – this "something" is still viewed as a state of being that cannot easily, if at all, be "righted".

As articulated by the helpers, the attached and all-consuming stigma of madness is viewed as defining; it constructs and scripts people labelled mad as other, as subhuman. Daniel is blunt: "They [mentally distressed people] are somehow seen as less human than others and they are seen as having less human rights." According to some helpers, this stigma is compounded by a general lack of patient confidentiality and privacy that they believe is pervasive in Guyana. Ponel, a medical doctor, states: "The problem is the talk name [gossiping] side of it. If someone is referred to a psychiatrist then people know… People do not like to be known as visiting a psychiatrist… People are afraid." This lack of confidentiality creates conditions whereby people

are hesitant to seek help, due in no small part to the ways in which this help is organized with little respect for patient privacy. Daniel expands:

> There are multiple cases where kids go to a counselor to talk about private issues and the next thing you know the entire village knows about it. Confidentiality is a big, big issue from the top all the way to the bottom. I don't think the Ministry of Health understands how important it is. On Mental Health Day, they had a mental health fair. Basically, they set up a tent where they provided free counselling. The tent has tables and chairs, and you go there and you talk to [names specific doctor and staff] … and it's visible to anybody passing by on the road. They see who is being counselled and you can go and stand nearby and that's their outreach. I think that something like that does a whole lot more harm than good because it gives the impression that any kind of counselling that you receive is because you're a mad person.

Vishnu acknowledges these shortcomings: "Lots of times, stigma is propagated through the way how health services are delivered… Try to break the stigma even from within the health care delivery personnel and other people too, other service providers. I think that's the first challenge." Nicole, a civil society/NGO helper, agrees: "Even having the nurses in the health centre, I'm not certain how beneficial that will be… They see one of you going to that nurse, they think, 'Oh yeah, he, yuh know [referring to a person being labelled mad when seeking medical help].' That stigma is there instead. It's like a magnet." NPH staffer Teke also believes that the stigma attached to madness must be tackled at all levels, especially among health care workers: "They [general public] don't even have a clue why this person needs to see a psychiatrist. Here in Guyana, until now, some of the professionals, the other health workers, they make jokes about psychiatrists: 'Oh, the mad doctor. The mad doctor.'" Madness is perceived as an irrevocable social mark of shame in Guyana, but even as the helpers acknowledge the stigmatized realities in Guyana, they are keen to point out how these perceptions are present in other nations. Teke is clear: "The stigma is there all over the world with psychiatric patients." Violet, another staff at the NPH, sums it up this way:

> Throughout the entire world, mental health is stigmatized... They already been labelled. You're a madman or you're a madwoman. They are not terming it, "Oh, God. This patient got simple depression. She just went to see the doctor." You're a mad person. We can't run away from that throughout the world… All over the world, mental health, I think you find this... I don't know how different it is here [Guyana] than Canada.

Stigma is an issue of global concern (Krendl & Pescosolido, 2020; Lasalvia et al., 2013; Thornicroft et al., 2009). The multiple ways in which stigma is experienced in Guyana requires additional and sustained research, particularly from the perspective of individuals who have or were given psychiatric diagnoses/mental illness labels, people labelled or who self-identify as mad, people with psychosocial/mental disabilities, neurodiverse people, patients, ex-patients, consumers, service users, and psychiatric survivors.

Disability

When the interviewees were asked to discuss disability as it is understood in Guyana, most employed the medical model of disability in their initial explanations as they spoke of how disability is perceived by the general public. Of significance is how they outlined distinctions, emphasizing that most Guyanese understand disability to be "strictly physical" (Lesley, Interview) and "something that you can see" (Daniel, Interview). Others mentioned visual, hearing, and speech impairments as disabilities. Participants explained these distinctions:

> The mental part, they say madness. The physical part, disability… In Guyana, once the brain ent well, yuh crazy, yuh mad. Once the limbs ent well or all the parts ent right, yuh got a disability. (Indra, Interview)

> Speech, hearing, that is disability. Physical. The body. (Samuel, Interview)

> The average person does not think of mental illness, mental disorder, mental impairment as a disability. People don't even realize that there is a category of disabilities called mental disabilities so that's where the conversation is around disabilities in Guyana, physical disabilities. (Lance, Interview)

> Lots of people think that it's only physical. I think the vast majority do. (Sally, Interview)

> Okay, if they can't walk. If they come and they can't walk. (Priya, Interview)

> They're mostly the physical ones, like if you're blind, if you can't talk, you don't have all of your limbs. A physical thing – that people look at you and see you're different than everybody else. (Hafsa, Interview)

> Man can get dem hand cut off, foot cut off. Man can get sick and get paralyzed. Dem kyan [can't] help demself no more. (Navindra, Interview)

> I think that for most Guyanese that it would be a physical impairment and that's because that's what you can actually see. (Dawn, Interview)

> In terms of talking about disability, on a normal face value level, people look for a physical inability, whether it is the limbs or whatever so that would be seen as a disability. So you cannot use your limbs as well or your arms as well. You have a vision issue. That is a standard way. (Jean, Interview)

> The talk of disability is mostly physical. And that is if you're born with something or you meet in an accident, you can become disabled. (Nicole, Interview)

Mental distress, according to the helpers, is usually erased in any substantive understanding and discussion of disability, never mind the ways in which disabling socio-politico-economic relations and contexts can lead to the acquisition of impairment and disability (Erevelles, 2011a), which, in part, signals the social model but also points to the historical legacies and material consequences of Western imperialism and hegemony. This is particularly significant in global South nations – like Guyana – with histories of colonial and neocolonial intervention and violence, neoliberal structural adjustment, and uneven and exploitative capitalist exchanges with the global North (Chouinard, 2018; Erevelles, 2011a; Meekosha & Soldatic, 2011).

Some helpers discussed a social model driven understanding of disability, which is aligned with the UN Convention on the Rights of Persons with Disabilities (CRPD) (2006).[50] Teke states: "I think because of the stigma a lot of people reach the point of being disabled because of the stigma of the society we have in Guyana." For Teke, societal attitudes – particularly the stigma attached to mental illness and madness – are disabling on multiple fronts

[50] Guyana signed the Convention in 2010 and ratified it in 2014 (Chouinard, 2018).

because they also fuel material deprivation. This NPH medical professional goes on to explain how patients have difficulty finding and securing work because they have been labelled mad by their communities: “A very young girl, very highly qualified, her diagnosis is bipolar disorder. She have a scholarship in India. She have a degree in social work and due to the sickness, this girl here in Berbice has been stigmatized and called ‘mad’… She is not able to get work.” This patient was forced to switch careers and worked for a short period of time in another industry before being terminated when her diagnosis was disclosed to her employer without her consent by a member of the public:

> She end up working in a business… She was very happy and one day somebody who knows her when she was in crisis visit… and said, “Oh, you have this mad girl working there! When dis mad girl is sick, nobody can control her. Police have to be called!” And right away they fired her. On the spot. And right now, she is very depressed because she wants to work… If she was working with the government, I am sure she would have to get disability [benefits]. (Teke, Interview)

Not only do stigma and these narrow distinctions have the ability to incite employment discrimination, they may potentially affect the types of benefits and support services people experiencing mental distress are entitled to. Civil society/NGO helper Nicole explains: “Even in terms of the facilities that we provide for people with disabilities, they mostly cater for physical disabilities.” More research is necessary to comprehensively understand these and other socio-economic impacts.

Guyana enacted the Persons with Disabilities Act in 2010. Disability, per the Act (2010), is defined as “a physical or mental impairment caused by the limitations of the body structure or of one or more bodily functions that restrict the ability to perform ordinary day-to-day life activities”. “Body structure” means “anatomical parts of the body such as organs, limbs and their components”, and “body function” means “physiological functions of body systems, including psychological functions” (Persons with Disabilities Act, 2010). Even as the definition of

disability in the Act (2010) recognizes impaired "psychological functions" – with emphasis on the medical model – socio-cultural understandings of disability in Guyana, as outlined by the helpers, do not align with this definition. Patrick, an official at the Ministry of Health, says that while the Act (2010) intended to capture psychological impairments, there are barriers and limitations in the operationalization of this given how disability is generally understood:

> I think the intention is to. That is what I'm saying. I know in the conversation about disability, they are attempting to have it wider than persons who are disabled via [for example] some non-functional limb. They are now discussing that psychological issues contributes also to disability… There is intention… There was a caucus dealing with that matter… where those issues came up as to attempting to widen the net, so to speak, to include people as being disabled persons who have psychological conditions. So it is in the Act but the operationalizing of that has not happened.

Patrick adds: "I know there is a conversation that is saying at the level of technical and professional people that there should be a need to capture people who have mental health conditions as disabled." Colloquially and among the general population, however, this is not the case according to the helpers, which poses significant barriers and may result in adverse outcomes for people experiencing mental distress.

Dawn – a civil society/NGO helper, who has knowledge of the consultation process which led to the drafting of the Persons with Disabilities Act (2010) – believes that when the Act refers to disabilities that are related to "psychological functions", this does not capture mental distress or mental illness. She expounds:

> I think when you see "psychological" in the Disability Act it is not mental illness because mental illness is still seen as mental illness and that will cover the gamut of things like bipolar, schizophrenia, and that kind of stuff. When you talk about the other, it's the intellectual impairments, learning disabilities, children with autism. That's where the differentiation comes. So when we talk about disability and it covers psychological, those are the kind of conditions [referring to intellectual and developmental disabilities]… That's where the differentiation comes. (Dawn, Interview)

While the Persons with Disabilities Act (2010) might intend to capture developmental disabilities – like the ones mentioned by Dawn – other helpers identify how this legislation still fails to wrestle with general understandings of disability, not only among the wider lay population but at the public service and ministerial levels. Three of the social service helpers – Lesley, Mohini, and Charmaine – have autistic children. For them, the Act does not function in ways to recognize developmental disabilities because the socio-cultural distinctions – which mainly recognize physical or sensory impairments – parcel out which impairments are considered disabilities. Their children do not have a physical impairment; thus, their disability is not recognized, and they have been denied social benefits:

> I went to this place by the market, somebody advised me to go there, the Ministry of Human Services. That's when I wasn't working because it was very hard. Somebody told me that people does get help, even with normal children, if they have a certain amount of children. The lady [at the Ministry] asked me what is wrong with my child. I say is autism. She say, "Wha' is dah?"… She said if nothing ent wrong with she physically, she can't get nothing. (Charmaine, Interview)

> When they turned me down it was because he [Lesley's autistic son] did not have a physical disability… When we were with that first school, I had to pay $40,000 per month. My husband could not work, and he was home for nine months. I could not go out and get a job, and he was really ill. So I went in to look to get some help [from the government]. My son was still wearing Pampers at that time and we were in dire need. So I went and asked them. They said my son is not under that Act: "Your son has no physical disability. It's only for physical disability. Disability Act is for physical disability." … I can't get assistance for my son and I don't get assistance for my son. (Lesley, Interview)

Lesley points out how this denial of funding is common, affecting autistic children and their parents: "None of the [autistic] kids... get assistance from the government through that Act. None. I don't know how many must have applied but none of them… The government has never come in and said, 'Okay, we have this Act. Educate your parents. Let them apply.'… All of that money, I don't know where it go."

Furthermore, these distinctions are not only exclusionary but highly stigmatizing, particularly when the behavioural expressions of autistic people are not considered "normal" or "narmal" (Charmaine, Interview) and are viewed through the prism of madness. One common thread in their accounts is how autism and other developmental disabilities come to be associated with and are read as madness, among other deeply pejorative and ableist terms in which disabled communities and disability studies scholars have levelled important criticisms, pointing to the dehumanizing material effects of these words (Erevelles, 2014; "Why the R-Word is the R-Slur", 2020). Lesley describes how other children made associations with "mental issues"; she explains how autism is perceived as being synonymous with madness:

> For me son, they say that he was "retarded"… And this brings up a very sensitive, a very hurtful issue for me. My daughter's school was next to her brother's school. She used to go to the fence and get him snacks during the days that I wasn't there when he was going to the nursery. I would ask her to go and give him something or just check on him… Because of the kids and how they are taught, they used to tell her, "Oh, yuh brotha, they gat fuh send him down to Berbice," which in Berbice means Madhouse. "Leh yuh mudda [mother] carry he to de Berbice Madhouse. She son mad!" And my daughter had no awareness of what is mad and we didn't expose her to those things. We never exposed her to Berbice Madhouse and [words like] "retarded". "Yuh brotha retarded! He suh mad!"… That is how you grow up thinking. If you have those issues, you are mad, mentally ill.

Mohini shares a similar story:

> Sometimes people would look at a child and wonder what's wrong with her and some people if they see you, they would ask: "Oh, she is retarded?" That impact of the word. I don't like hearing the word "retarded". I didn't want to hear that… She is autistic but not saying that word… For the neighbourhood, other children look at her differently and the neighbourhood would think, "Oh, they have a mad daughter!"… For the Guyanese people, it's like you have a mad child. You need to lock her away because she is going to affect other people.

Charmaine, whose daughter is also autistic, is confronted by the same social attitudes:

> Once you're behaving in a certain way that means you're mad. That's the whole thing here. They ent concern with autism or Down's syndrome… Everybody is mad… Like how children with autism does throw a tantrum and bite themselves, they would say, "Yuh mad. Yuh get demon on yuh." So you ent narmal. Something wrang wid you… They would say, "Oh, is dem paagli [stupid] chirrin [children]."

The mothers explained that these attitudes are profoundly hurtful and harmful to the wellbeing of their children. The denial of supports and services for their children are drivers of mental distress. Lesley, Mohini, and Charmaine all pay out of pocket for specialized educational services, therapies, medications, and other necessary supports for their children, which they cite as being expensive, often unavailable, or difficult to access. These accounts show how certain disabilities are not acknowledged as such and how the Act (2010) is not operationalized to address the material realities of all people with disabilities.

The helpers believe that service provisions must improve, and current legislation must be reviewed and revised. They would like to see laws tailored and enacted to address the specific needs of disabled people and to combat the types of discrimination people with a broad range of disabilities encounter.

> We need to review our legislation. Go back and review it. We need to have people who are knowledgeable of mental health, of physical health. And so those are the people we need to get aboard and to write up legislation for those issues. You can't have people who don't know about something to write legislation. We have a great need for services. We haven't even touched a percent of the people that is affected in this country. (Lesley, Interview)

> We need to draft proper legislation to protect the rights of these people… The legislation needs to be expanded to encompass things like protection against at one's workplace… HR people don't know anything about mental illness. We will do a training program with people who are managers and HR so that they will know how to recognize and signal red flag behaviors and appropriately respond. We have to understand that they want to ensure a safe environment for their staff, that we have to respect the rights of people with mental illness. It's going to be kind of tricky because there is no kind of legislation in Guyana about discrimination against individuals with mental illness so we are basically appealing to their sense of what is right. (Daniel, Interview)

> I think that they need to put more specialists, people who know how to deal with these things. They can diagnose that this child has autism. This child has a disability of this kind. (Mohini, Interview)

> We don't have mental legislation at the minute. We are far below to get the human rights really settled in this country… If you see how the patients are abandoned here [NPH], if

> you see how sometimes patients not getting the quality of service they deserve, that is part of human rights. That is human rights. (Teke, Interview)
>
> They need to be doing way more in terms of providing resources and services to people on multiple levels: educationally, socially in terms of health care. Like I said before, all of those things combine to affect somebody's health, mental health and their wellbeing. (Hafsa, Interview)

Education and sensitization campaigns are another crucial element in comprehensively addressing these barriers. The Ministry of Health official, Vishnu, states, "I think education is the key. We have to continue to educate at all levels." Sally, a civil society/NGO helper, observes, "There must be a focus on sensitizing persons and let people understand the whole issue of mental health." Sally emphasizes that people with disabilities must be involved in this process: "We should actually act on it and make sure that people are included in the plans and the policies of our country. They should be included in those plans and policies. Not enough is being done." As stated in Chapter Three, the government has promised to carry out a "review and revision" of the Mental Hospital Ordinance of 1930 ("Special Allocations", 2021). Embarking on this review presents a unique opportunity for the government to not only centre the voices of people with experiences of mental distress and patients at the NPH (including former patients and individuals who are/were service users), but to also engage people with a range of disabilities to comprehensively understand how disability and mental distress are understood by Guyanese and to respond to calls for the implementation of necessary resources and supports.

Personal Disclosures: The Impossible Mad Subject

In this section, the participants disclose how they (n=9) or a family member (n=8) experienced mental distress. Priya, the Hindu Priestess who performs Shakti (goddess) worship,

explains how her daughter experienced a “nervous breakdown”, which she believes was prompted due to the rigour and strain of her daughter’s academic pursuits: “She was going to classes and like she get nervous breakdown… She been ah guh [was going to] computer class… Well, we say she too young and she want study three things one time… Is the brains, because you cannot take it. Too young for the study.” She cites a biomedical understanding when discussing the difficulty of finding appropriate medical care and her frustration with the public hospital system: “Because when you go to the hospital, you gat to deh [be there/wait] from morning til night... Some people cannot find this money to pay for the medicine… You have to wait long. Who gat money, can get [people of financial means will be served]” (Priya, Interview). Priya describes her struggle to care for her daughter:

> Me nah mind she pee up me bed or whatsoever. Me guh look [take care of] she. Is me child. So me pass through that in that stage… It was very hard because it was six ah dem [Priya has six children]. He [husband] ah wuk and me ah hustle fuh sell [at the market]. He gone morning till afternoon and den when me come home me gat to hustle wid she… Was a very tough time fuh me.

Ultimately, her daughter found relief with the help of a private medical doctor who gave her daughter a regimen of “injections” and “tablets” (Priya, Interview). Priya does not classify her daughter’s behaviour through the lens of madness:

> Me guh tell people, honestly me guh tell dem say that me know it gat mad people, but she nah mad. I will tell dem that. It have mad people, but she nah mad. A nervous breakdown, anybody can get it. Just so… And she deh [is] back pon she foot and she gat three children, two girl and one boy. So me nah gat no complaint… Me pass through it and me know and me pass through plenty things suh me can tell people about it.

Priya parcels out madness through her insistence that her daughter was not mad or experiencing madness, even as she concedes that “it gat mad people”. At once, there is the recognition of what madness and mad people look like; however, when applied to her daughter’s case, madness is invalid and entirely rejected. For Priya, her daughter’s “nervous breakdown” is one that

"anybody can get it". Priya believes that her daughter's experience – caused because "dis child pick up dis book" or studied so committedly to the point of severe mental distress – is not specific to her child alone. The information that her daughter is "back pon she foot [back on her feet]" or has regained her health, and that "she married" and "she gat three children" is said as if to imply that the creation of a new nuclear family unit is in keeping with life's milestones – particularly for Indo-Guyanese women living in rural communities – and is beyond the realm of possibility for mad people; therefore, her daughter was not mad ("she nah mad") (Priya, Interview). Madness is perceived as being incapable of regenerating this arrangement of presumed stability, the nuclear family. As understood through the proximity of caring for her child, madness is disavowed by Priya in favour of an explanation that touches on the demanding context of her daughter's scholastic life or the academic pressures that give rise to distress, which – in Priya's view – should not be categorized as madness.

Kim, like Priya, describes how mental distress affected a family member, her cousin. Kim explains that her cousin's distress and trauma were triggered after witnessing the violent death of a close family member in her early teens: "She saw. She froze. And she couldn't say a single thing. She didn't speak for a very, very long time. She just freeze… That story was tight-lipped by the family." Kim mentions how different biomedical treatments were utilized in an attempt to ease distress and her cousin's response to these interventions:

> She had what you call… the shock treatments. She had it three times… It helped but the thing about it, any least thing she gets triggered off easily if she's off the medication. If she's off the medication, she gets really scary and she would talk with herself. From the time you listen to her she would start talking to herself and walking around the house. And she grumbling and you have to check up on her if she had her medication. She's big [an adult] now but since I am a little girl, I know she trouble with um, they call it a nervous breakdown. My paternal grandmother was trouble [affected] with mental health too.

Biomedical interventions (electroconvulsive therapy and medications) provided some relief for Kim's cousin. At some point, the cousin's immediate family sought out supernatural/spiritual interventions as they believed that she was "possessed" (Kim, Interviews). These interventions proved detrimental:

> Her mom [cousin's mother], which is my father's sister, went to get one of the spiritual person or they call them Obeah person… because they feel that she was possessed. Evil. Or that somebody "do she" as Guyanese term, would say, "do she". So the [Obeah] lady was there, I didn't even know she [Obeah practitioner] was going because if I knew she [Obeah practitioner] was going, I would not have go. I went over to see my cousin and I talk with her… And I said, "What's the matter with you? I want you to go with me, you going by me." She [cousin] said, "Okay." And I said, "Let's go and take a bath." She didn't had a bath in three days. I got her to bathe. I give her the bath and then came this [Obeah] lady. She [Obeah practitioner] said, "No, she can't come out of the bathroom." She [Obeah practitioner] has to give her a whole set of bottles, bring a whole set of small bottles, different drugs, and she mixed it in a solution. I don't know what is what, and she had to lit some candles and she said I must come out the bath and leave my cousin there with her. And I don't know what she did but my cousin went berserk. She start screaming down and run out of the bathroom naked skin onto the road. It was kind of shameful for the family… We caught her like about 800 yards away from the home. We got her back. (Kim, Interview)

Kim's cousin "calmed down" shortly after the family was able to bring her back home and administer her medications. Kim was able to assist her cousin to the doctor, and she was prescribed new medications, which helped in bringing her cousin "back to normal". She explains that her cousin's memory of this event is partial, but that her cousin did not consent to the supernatural/spiritual interventions.

> And she asked questions about this Obeah lady. "Where did she [Obeah practitioner] come from? Why did you [family] bring her [Obeah practitioner]?" … So, in her mental state she remembers flashes of things… She [cousin] cuss dem [cousin's family] up. She 'buse [verbally abused] dem up and tell them [cousin's family] that it's her life and they mustn't do anything [like Obeah] and so… When she's back to normal, she does everything. She had a husband. She has children. She has grandchildren. She has a normal life. (Kim, Interview)

Kim's cousin was deeply traumatized by her family's use of supernatural interventions against her will, which seems to have spurred feelings of distrust and additional distress. Like Priya,

Kim implicitly talks about the importance and normalcy pinned to nuclear family life and the generation of a family unit, which her cousin has done as she leads a "normal life".

Other participants shared their individual experiences of mental distress, outlining how their personal wellbeing is affected. Hafsa, when speaking about madness, relayed her "struggle with being mentally well":

> It's such a derogatory connotation [madness] because I would say that I struggle with being mentally well all the time and issues with depression personally, but I wouldn't call myself a mad person. Maybe friends would joke around, but not seriously.

Hafsa utilizes the clinical diagnostic label of "depression" when discussing her experiences, but she is adamant that the term mad does not capture her experience, nor can she identify with it. Madness is a "derogatory" imputation and one that is only tolerable when used in jest ("friends would joke around"). To "seriously" apply the term, to her or to anyone, is to discredit and denigrate. Earlier Hafsa clearly articulated how being mad is a "negative" that "becomes *the* (Hafsa's emphasis) way you are defined" (Hafsa, Interview). She employs the term "depression", which is informed by biomedical understandings, to capture her experience when she is not "mentally well". Madness is too stigmatized to be personally applicable for Hafsa, and labels that spring from the medical model appear more agreeable as she recounts her lived experience.

Winnifred, a Faithist Reverend, also uses the term "depression" to talk about the physical and mental toll of performing spiritual healing:

> Sometime when I finish working, my whole body hurting me. Sometime when I finish working all here swell up [motioning to her body]. Lumps, lumps, lumps because of all the pulling [pulling out/exorcising spirits]. All my veins raise up in my skin. Sometimes my fingers hurting… Sometimes I does get a little depression as I getting older now.

Throughout Winnifred's interview, not only does she use the term "depression", but she also explains how she was possibly perceived as mad when she was a young adult struggling in the navigation of her faith. Before she became a Faithist, Winnifred describes "the kind of illness,

we would say madness" that she experienced in her youth when she initially rejected what would become her calling to the Faithist religion:

> Consciousness came through illness. Not realizing or understanding what is the purpose for my ailment. I had dreams. What you might call visions. They were kind of strange at first because I had no knowledge of what was going on around me... I saw candle lights, bowl lights, religious service being kept like persons wearing white garments, head ties, like a group of people holding religious service. Now I must say that I was brought up in a Christian church… So I had no knowledge really about this way of worship but then as I got these visions and I tell it to my mom, she said it was something from our ancestors. I couldn't understand and I didn't want any part of it. I shall not want any part of that.
>
> And let me tell you, one reason is because at that time I was much younger and very stylish. And that was about the age of 25. I was working in a factory. I did not want my colleagues to know anything about this because I never heard my colleagues speaking about these things but then one day I got ill in the factory. I started to feel like somebody was pulling away my chair from under me while I was on the machine because I was sowing in the factory and I couldn't understand how. They advised me to go home and that's where it all started. I did not understand what is happening around me. I started to say things that probably I did not understand. In my vision I was told I would have to hold a service, a thanksgiving service. Again, I would say I didn't want to be a part of that but because of my illness I had to decide my fate. I did that; that was the first adventure. But after that I said I would go back to my normal way of living but time and time again it increased and I was saying to myself, 'Wow, I have to do more and more of this thing.'
>
> I was getting very, very, very ill. Can't do anything for myself. In other words, my body was broken. And until I did this thanksgiving service, I never felt better. So it was like from one stage to another. Then I started to get another set of visions that I was looking after people, healing people. I saw bushes. I was like boiling bushes. There was an old lady coming to me and showing me how to boil these bushes in my visions. Still I paid no mind. Again, I still didn't want to say anything to anyone because I didn't want to do these things. Going to functions. Going to parties and so. Right in the party place I got ill. And I tell you, the kind of illness, we would say madness. Mad and running out the place. Kicking off my shoe and gone down the road. Speaking out of my head. But then for those who knew what was going on, they understood what I was saying and they advised. I decide to do whatever I was told to do. However it took me some time to do that and during the time I wasn't doing it, a lot of things happen to me…
>
> I passed through so eventually I went into fasting and I started to manifest the kind of work that I'm doing, the healing. It was being done, part of my knowledge and part not. Like I was kind of unconscious at first, doing things that I couldn't give account for after it was finished. Then my mom told me that when she was pregnant with me, she did a religious work for one of my great aunt, she was very ill next to death and she healed her. So while I was growing up they would always say that I am going to be a person who is a spiritual healer and I used to cry a lot for it [chuckles]…

> I started praying towards this with consciousness and said look if this is something by and through the Spirit of God and the power of God, I'm willing to do it. Or if I find that looking after the people they got healed, and so I started to become conscious. Well look, this is something good so I might as well go through with it. I continued to do my healing and it did increase from one thing to the other like persons come to me.

The "illness" that Winnifred explains was probably interpreted as madness by those who witnessed her behaviour, and she uses the terms "illness" and madness interchangeably; however, while Winnifred was possibly perceived as mad, she does not label herself as such and does not personally identify with the term. While the evocation of "illness" can signal a biomedical response, biomedical interventions were not the remedy here, nor were Winnifred's early acts of passive acceptance of the ancestral religion enough. Instead, she believes that the journey to her faith through dedication, committed practice, and the performance of healing predicated the end of personal "illness" and suffering. Relief for Winnifred came through her faith.

Kali Mai Pujari Navindra conveys a similar story. He explains how "he took sick" and sought out healing from doctors and through different religious communities (Navindra, Interview). He says that his parents were an interfaith couple "who jointly support each other" (Navindra, Interview); his mother was a Roman Catholic, and his father was a Hindu. He explains that he was baptized and was once a Christian, and it was during this time that he "took sick and nobody coulda help me" (Navindra, Interview). Navindra sought help from other faiths: "I tried the Christian faith, and I did not get the help that I should get. I went to *maji*[51] and get jaray and so on… I did not get the help." Eventually, it was the maji who advised him to "get back to yuh parents background [roots]" (Navindra, Interview). For Navindra that implied a

[51] "Maji" (Williams, 1991) or "meiji" ("A Comparison of Eid", 2012) refers to Muslim leaders, such as an imam or mullah.

return to ancestral worship; to commit to Hinduism, specifically Kali Mai practices. He describes his sickness and what led to relief:

> I feel like things coming to lick [knock] me down… I getting like ah [I] mad. I eating grass. I doing all sart ah madness… The vibration came to me [spiritual manifestation of Mother Kali or other deities] and started to talk in different language and so on and said, "Listen, yuh ought to do this and yuh have to accept it. If not, you're not going to feel well." And then I surrender myself. I say if I have do it then I shall do it… I was getting pain. I was getting headache. I was getting fever. I was getting lifeless. I've been seeing doctors upon doctors. No help… I accept it. (Navindra, Interview)

Like Winnifred, Navindra experienced physical ailments and mental distress; he found relief through the navigation, arrival, and commitment to his present faith. The "sickness" he describes led him to act "like ah [I] mad" and do "all sart ah madness", but he also does not personally refer to himself as mad when he "took sick". While he behaved *like* he was mad, he did not identify as mad. For Winnifred and Navindra, to act like or to be seen as mad is not necessarily to be mad, but they acknowledge how their behaviour can be read as madness and how the public would perceive them as such. The call to religion, namely ancestral religions, led to relief. Biomedical interventions for both were unsuccessful. Winnifred set aside mainline sects of Christianity in favour of a syncretic form of worship, Faithism, which has its hybrid roots in African folk religions and Christianity. Navindra stopped practicing Catholicism and converted to Hinduism, specifically Kali Mai worship. Both also emphasized how engagement with their ancestral faiths allowed them to intervene and heal others experiencing distress. The role of religious leaders like Priya, Winnifred, Navindra, and others will be discussed in greater detail in Chapter Seven.

Pastor David told me a story about the devastation, anguish, and mental distress he suffered as a consequence of a failed romantic relationship and how it led to suicidal ideation:

> I got involved with a young woman in the village. Everything was progressing well. My mom was single. She was working pretty hard to put us through school. I had now

entered university. This relationship started out really good but like everything else everyone is trying to get to North America and her parents decided that she will leave 'back track' to go to North America… Backtracking is an illegal way of acquiring a United States passport through fraudulent means and they change your name. They change everything about you… While you have to pay about $12,000US at that time to get this passport… They have all the links and they get you over there illegally. Well it happened. I didn't like it because I knew the long-distance relationship thing would not work and after a few months I recognized that the girl whom I was in love with, she was different.

She had married someone… She literally called me and said that was it. The end. I was devastated initially. This is the person that I had made plans with and so at that stage in my life I became very angry, bitter… And so I became very much unstable in my life. At that time I was searching for something. I tried to follow my parents' religion of Hinduism. There was no fulfillment to it. And then she was a Muslim and I began to think of being a Muslim. The dedication, the commitment, the rigid life didn't work for me to the point that I began to follow being a Rasta. I didn't smoke weed or anything like that but ideologically, philosophically wanted meaning to life because I was jostling young life with no father figure, and a community where nobody really comes and help you. My mom is busy working. She was trading from Guyana to Trinidad. She was gone from us. Weeks we have to be and I have to stay there, cook and clean everything, send the kids to school, taking on all the responsibility. It was tough…

As a matter of fact, I attempted suicide… This was just when I got the information. She said to me that she has somebody with whom she is with and our relationship is over and I was at that point in time really, really devastated. I remember the day I got the phone call. I didn't have a phone. We didn't have a phone where I lived. I have to travel all the way to the East Bank to a relative… and call her back because she had called and sent a message. I called her that day in the evening and she said to me straight up, "I don't love you anymore. I have somebody else in my life, and you need to let go of me now." I just dropped the phone, ran out of the house, caught a bus straight home and I remember when I came home everything was just not the same. It was the night maybe seven o'clock at night. Where I lived, there is a huge trench, the koker, at the back and I just threw off my bag and my clothes and I just ran to the koker with the intent of casting myself in the water and not to come up back again.

Life had come to an end for me. I was pretty messed up but when I arrived there I remember something that I've always thought about, and I used to think that I would be different than most of the guys in my neighbourhood. And something struck me… Why do I need to kill myself? She is having a good time. She is married. She is enjoying life. I will live and prove to myself and even to her that I don't need to be devastated. I was weeping, crying. I don't know what happened but I slowly walked back. Came home and I saw my mom and I explained everything to her and she literally hugged me and said, "You will get over this. I will be here for you." And from that point on, I took it one day at a time.

David examines the social and personal conditions of his life during his youth. The abrupt end of this love relationship – compounded by the difficulties of his home life in having to assume a parentified role and manage his household given the death of his father and the labour obligations of his mother, which meant prolonged periods away trading goods in the Caribbean – deeply affected his sense of self and will to live. In David's telling, he does not evoke the terms mad or madness nor does he use psychiatric labels to describe his mental distress at the time. Instead, he outlines how specific social and personal circumstances and stressors led to suicidal ideation.

For David – unlike Winnifred and Navindra – relief did not come through the calling of ancestral religions or as he puts it, his "parents' religion of Hinduism". Solace came through his budding friendship with a young woman who was involved with a local Christian church, his religious curiosities, and eventually through the mutual support and optimism that the church itself inspired:

> She [friend] began to talk to me and invited me to her church. I was reluctant, nevertheless I'd been grappling with stuff in my life and I decide to go one day. She [friend] wasn't there but I saw the fellowship of these young people. They embraced each other. They talked, they laughed, they had fun… I had lost everything that was good in my life at that point in time. I saw a glimmer of hope. I became part of that youth fellowship and more and more I realize that life was getting better… I saw hope. I sought fresh relationships. I saw laughter, joy – something that was missing in my life and it took me out of a place of darkness and sadness and literally bitterness… And that young person [friend] eventually became a very good friend of mine… She became somebody I saw as first a friend then someone I fell in love with… I gave my life to Jesus. I always admired Jesus as philosopher, a teacher… I first came to Jesus at that stage of my life just after this break up… I thought about if I'm going to be somebody in this life and I want to be somebody… And so I came, and they were talking about sin and I recognized how bitter, how miserable I was, and I laid it all to Jesus and He came into my life and changed. From that day on, I followed him. I became a youth leader, a youth pastor. I was called to go to Bible school. I had gotten married. I got married as a Christian. My wife and I went to a Bible college. We studied. Came back as a pastor and I have since been a Christian leader, leading the church and now I'm really enjoying the life I have. (David, Interview)

David's renewed desire to live was birthed out of affirming and compassionate personal relationships within and through the church; in the camaraderie and a life partner who introduced him to the Church and then through his newfound faith, which allowed for greater self-discovery. Positive personal relationships and religion enabled David to transform his suffering; to conceive of his life differently.

When Lesley, Mohini, and Charmaine – social service helpers – discussed their personal experiences with mental distress, they cited the pressures and expectations of mothering in a nation that does not provide the necessary resources to comprehensively care for autistic children. Lesley explains: "The frustration of not getting help is the greatest or hardest thing a parent who has a child with any sort of disability has to face in Guyana. I speak with so many other parents and it's the same thing over and over again." Additionally – and as discussed in the previous section – the stigma, discrimination, and ostracization that their children experienced as a consequence of wider societal attitudes were also cited by the mothers as a driver of distress. Lesley adds: "One time I have a lady say, 'Oh you live at de back deh [there] with that retarded son.' I had so many things that I wanted to say, but my shock that she would say it blankly to my face was the hardest. And I cried the whole way in walking into the street." Mohini describes her experience, after speaking generally about the "stress" and "depression" that people endure:

> With mental health, people go through stress and depression and that's what drives them into this mental state. For me it was an experience, so I understand that point. For me, if I wasn't strong enough or if I didn't get help fast, maybe I would have been at that point that I would've been wandering off the streets and talking by myself, which I did start talking by myself and scream. Sometimes I lash out and scream and yell and shout… So angry that I just want to hit at things.

Charmaine experienced suicidal ideation, triggered by the difficulties created through the lack of support she experienced as the primary caregiver for her disabled daughter. While her husband is also present and financially provides for the family, she is charged with the majority of childcare

and domestic responsibilities, which creates “extra pressure” and adds to her overall worry about the general wellbeing of her daughter:

> I did say to myself that I am so stressed out. I have to watch myself because of the thoughts that does come to my mind sometimes. I am a very conscious person and I say sometimes [self-talking], “You gah watch yuhself!” I like to take on [worry about] things. Things does bother me. You know some people can be in an environment and certain things would not bother them. Not me, it bothers me. And I can't sleep and this kind of way. I used to say that I have a slight mental problem because things would bother me and I can't sleep. They say once your nerves start bothering you, you could trip. I does watch myself. When I find I does be thinking about things too much or getting negative thoughts.
>
> At one time I used to think about doing things to myself… Like just drink something and lie down [alluding to poison or some other noxious substance to end her life by suicide]. I couldn't deal with it. By I don't have any help, because my husband he sees his daughter is normal and certain things that I'm looking out for and be behind her in this way where I can’t be settled. He doesn’t walk around behind her like that you know. So I have this extra pressure on me. Well, it's me, I have to do it. It's all on me. So sometimes when I couldn't handle it, I said it’s best I just drink something and lie down. I tired. Nobody ent helpin’ me. But when I watch at her, I say, “What if I do something to me self, wha’ gon’ happen’ to she?” … And then I does gah say, “I rebuke it in Jesus name!” The devil does be workin’. Da [that] is a period of time da used to happen to me. That is a period of time but that used to happen to me and I gah deal wid it because where I gon’ go? Who I gon’ talk to? (Charmaine, Interview)

Charmaine turns to her Christian faith to renounce the thoughts of taking her life. And while she later emphasizes that she no longer feels this way (“I really improved a lot now”) and beams when she reflects on the joys of raising her daughter (“I am so proud of her”), she also wonders whether she has a “slight mental problem” (Charmaine, Interview). Through her contacts in the social service sector, Charmaine reached out to a friend and expressed interest in speaking with a psychologist, only to realize that the kind of care that she was interested in was only available through private practitioners, which was financially out of reach. She expresses the strain and expectation of having “to be strong and just deal with everything”:

> Wha’ deh [they] does call dem people, a psychologist? She [friend] said she know somebody but you gah pay right away. Wheh [where] I goin’? I can’t pay. I ent gat money fuh pay. Where am I going? I start on my own… Whether you have the strength

> or not, you have to gather it and deal with it… It has days when you get tired and mentally I just shut down. I does gah keep talking to myself, "You have to do it!"
>
> You have to be strong because who else is going to do it for you? You have to, you have to use that word "*have*" to [Charmaine's emphasis]. You kyan [can't] depend on the men to do certain things. Some men like they just don't understand certain things. They just don't understand and it don't have nobody that will come and ask you: "How yuh feelin'?"; "Wha' botherin' you?"; "Yuh need help wid anything?" They [women] just expected to be strong and just deal with everything. You're supposed to be strong and deal with it. That's it! It's your child. You have to deal with it. You ent got nobody in Guyana wha' helpin' you or get no counsellin' session or nothing. Nothing! You just gah deal with it and go with the flow. You even gah talk to yourself. For me, it has a lot of days I used to cry. When I look at her, I used to cry. Naturally cry. I tell yuh, I really improved a lot now because I start to understand certain things. I see now that she can relate to me about certain things, like what do you want? And she say, "Bread or tea." Oh my, you know how good that doin' for me. Before, I gah watch her and say, "Well, she should be hungry now." I have to think for her. So now that I could ask her and I would say, "Toilet?" If she wants to use the toilet, she would go with you. (Charmaine, Interview)

Charmaine's frustration with the cost of counselling and the lack of supports available is one that is voiced by other participants as well. She does not identify with the term mad as she talks through her experiences of mental distress, instead she wonders whether to classify her distress as a "mental problem" through a biomedical lens. She underscores the pressures of the gendered expectations of women in Guyana and the personal health effects and consequence of bearing the responsibility of childcare alongside other domestic duties and paid work outside of the home as a social service helper.

To what extent does any engagement with madness or biomedical understandings of distress provide space for revelation, camouflage, and/or disruption? In relaying these experiences, the participants recognized how their behavioural expressions or those of a family member may be read as madness by the public; however, none of the participants self-identified with madness, even as they utilized the term as a close, yet still removed or distanced, proxy to speak about personal experiences. This is not surprising given the stigma attached to madness

and people labelled mad, as outlined in the previous section and in Chapter Three. The madman of the Guyanese imagination is generally understood as an archetype marked by contempt, fear, and suspicion; an identity that appears impossible to find oneness with, standing in contrast with Western mad movements that reconceptualize and reclaim madness. At the same time, some participants consider the utility of and employ biomedical terms such as "depression" (Hafsa, Interview; Winnifred, Interview) or "mental problem" (Charmaine, Interview) to partly describe their experiences of distress, but to what extent – if any – might Guyanese defer to these terms to protect themselves from the brutality of the meanings of madness and the potentiality of violent material consequences if labelled mad? In choosing, however, to employ madness or mad as a near-synonym for their experiences, the subtext of their stories counter and critique the stigmatized, socio-cultural perceptions of madness and people labelled mad in Guyana. These stories are rich and polyvalent; they express the multiple meanings of distress that cling to, complicate, and challenge mainstream, surficial, and caricatured tropes. Taken together, these narratives allow for the recognition of subtle and constant undercurrents: a call to understand the humanity at the root of mental distress and an insistence that the general and rarely scrutinized perception of madness is the delusion.

As mentioned in the Introduction and Chapter One, this project intended to focus on the way mental distressed is talked about and the wide-ranging practices utilized to foster relief from the perspective of multi-sectoral helpers. This work did not originally set out to capture the narratives of people with experiences of mental distress; people who have or were given psychiatric diagnoses/mental illness labels, people labelled mad or self-identified as mad, people with psychosocial/mental disabilities, neurodiverse people, consumers, service users, and psychiatric survivors. This dissertation ultimately and unintentionally does some of this work

because of the rich, first-hand, and substantive lived experiences of the helpers. Indeed, nine of the helpers spoke from this lived vantage point, and their narratives of mental distress were multidimensional; the stories were subtle, raw, explosive. These stories are, however, no substitute for the intentioned, methodical, and critical call for additional research that must be done to primarily and extensively capture the narratives of the aforementioned groups of people and their experiences of mental distress; however, in sharing the personal stories of these helpers, it is my hope that we may begin and continue conversations that glean perspectives from which to challenge the rigid and hallow scripts of madness, an orthodoxy which serves no one.

Chapter Six:
Explanatory Models: Capturing Perceived Causes of Mental Distress

When Lionel, a medical doctor, says, “It's a multitude of factors that hinges on mental health, not just one thing,” he captures the general understanding of all of the helpers, who cite two or more drivers as they talk through the perceived causes of mental distress in Guyana. Lionel’s sentiment is more fully apprehended when read alongside an insightful commentary, “Debunking the Two Chemical Imbalance Myths, Again”, where psychiatrist and scholar Ronald Pies (2019) argues for the consideration of a “bio-psycho-sociocultural model” of care in order to address the multidimensional causes of distress. In advancing this model, Pies (2019) cites the following:

> The closest thing we have to an “official” position on the etiology of psychiatric disorders is this 1978 statement from the American Psychiatric Association, which was approved by the APA Board of Trustees: “Psychiatric disorders result from the complex interaction of physical, psychological, and social factors and treatment may be directed toward any or all three of these areas.”

In this chapter, the helpers point to a complex, multiplicity of causes that largely align with Lionel’s views and the American Psychiatric Association’s position cited by Pies. Even as the participants outline how mental distress is, in part, considerably attributed to supernatural causes by the general public and the individuals they have professionally encountered and helped, this attribution is circumscribed by the socio-cultural milieu of Guyana, whereby social solutions are sought (e.g., seeking out the care and counsel of religious/spiritual helpers to remedy distress). Like the American Psychiatric Association, the participants of this study acknowledge that the roots of distress are multifaceted and that the remedies to ease distress, as employed by Guyanese, are similarly nuanced and targeted depending on the cited etiology.

The first section of this chapter captures the diverse explanatory models and drivers cited by the helpers. The perceived causes that they attributed to distress were nuanced and traversed

different explanatory models, with helpers citing a multiplicity of drivers. The perceived causes given are grouped under four main categories: biomedical; (inter)personal; socio-economic/structural; and spiritual/supernatural. In addition to their own perceptions, the helpers discuss their interactions with the general public and also point to lay perceptions of etiology, especially when considering spiritual/supernatural causes. Under this category, distress is referenced through socially sanctioned idioms of distress (Nichter, 1981), namely dominant spiritual/supernatural colloquial expressions such as "somebody do dem something" (Sally, Interview) (malevolent religious/spiritual rituals are performed against a targeted recipient to cause harm and mental distress in this context) and, to a lesser extent, the invocation of jumbies via "jumbie deh pon" (Navindra, Interview) or "jumbie gat dem" (demons/spirits are on them or have possessed them). Throughout my discussion of the four main explanatory models, I also discuss specific research resonances stemming from each.

Biomedical

Biology and genetics were cited as a perceived cause of distress, particularly – though not exclusively – among trained medical professionals. Salima, who works at the NPH, says: "It's a hereditary something." NPH staffer, Monty, agrees: "Hereditary… It's a genetic factor." Wendy, also a medical professional at the NPH, says that the genetic connection to mental distress may go "generations back":

> Some of them [patients] failed to look back at generations back. You might have had some great-aunt or uncle, somebody who had a mental illness, but it took a while before it came through and now it may have affected your child but you do not look at it way back then. So now that this happens to your child, you might say it's some possession, "somebody do he something", you know, instead of looking way back down to the generation line.

Another NPH worker, Indra, points to specific cases as she cites biological etiology: “It’s more biological. Just based on the history… Some, we got mother and daughter. We had the mother, the daughter, and the son. Then the mother gone [died], so we have a daughter and the son.” Pastor Samuel believes similarly: “There is a tinge of insanity that runs through the family. With some members of the family, it is more pronounced than some.” Ponel, a medical doctor, was initially adamant on the role of genes in relation to mental distress: “Predisposition, genetic inheritance. Predisposing factor to mental illness is genetic principally, being so disposed, dependent on the amount of stress that one has to endure.” When asked for further clarification on stressors, Ponel’s response offers additional perceived causes: “Everything [chuckles]… The stressors are economic. Societal, political to name a few.” NGO helper Daniel also cites the perceived role that genes play but believes that other factors are also involved: “Genetics has some role to play. It's not the be-all and end-all and I think the environment plays a very important role.” Ponel, whose assessment places significant emphasis on biological causality, goes on to cite differentiated stressors even as genetic predisposition is underscored. It bears repeating, however, that a definitive biological basis or physical cause/marker accounting for mental illness is yet to be identified (Borsboom et al., 2018; Deacon, 2013). Medical professionals in Guyana, as in Western nations and other societies that espouse biomedical psychiatry, render diagnoses based on symptomology as it correlates to the labels in the DSM. Per Teke, a medical staff at the NPH, “We have to do everything clinical through the symptomatology of the patient.”

The helpers cited substance and alcohol use challenges as specific and compounding biomedical issues that lead to mental distress. Their explanations align with generally accepted understandings of addiction and dependence due to substance and alcohol use, which is viewed

as “both a complex brain disorder and a mental illness” (National Institute on Drug Abuse, 2018). NPH worker Colleen mentioned in Chapter Three how specific segments of the patient population at the NPH experienced “drug-induced psychosis”. Colleen expands: “You have drugs, which is a big factor. I think most of the, especially in the male admission ward, most of the patients that are being admitted there, young males, the main issue there is drugs.” Indra concurs, “Now, three quarters of the patients is drug abuse. Substance abuse, the admissions… We're really not getting the chronic schizophrenia, the paranoid patient much, very small amount. All our admissions, especially the males, substance abuse.” Violet, another NPH staff, also finds this pattern to be true: “With the men right now, most of them are substance abusers.” Government official Patrick also cites substance and alcohol use challenges as major contributors: “You have people now who end up in the stream of a person with a mental health condition from abusing and using drugs. Alcohol, you have people also who are abusers of alcohol, who have drifted into having those types of conditions.” Vishnu, another government official at the Ministry of Health, adds that drugs are “easy access and very cheap. It's combined with very limited amount of legal restrictions”. Pastor Samuel, who leads a Christian church in Georgetown, points to the rise of substance and alcohol use challenges as he speaks about their impact as drivers of distress, especially among people experiencing homelessness in the country’s capital city:

> The use of drugs. I think the use of drugs in Guyana have come to such an extent it is destroying the minds of a lot of people by leading them into insanity. It is evident here. Every Saturday morning, we do a feeding program. About 50 to 60 of the street dwellers would come here and all of these individuals, all of them, it’s either marijuana, alcohol, or cocaine.

Sanatanist Pandit Deonarine agrees: “People use cocaine, marijuana and these things and they just flip off. A lot of them walking [on the streets and/or homeless] in Georgetown.” In thinking

through how these challenges are layered, Salima explains: “We have a lot of patients coming in with depression… They turned to drug abuse. These depressive states would lead them to substances.” Among most of the participants who attributed substance and alcohol use challenges to distress, there was a general feeling that these particular issues are on the rise and that increased government action and resources are required to address the needs of this specific population.

Some helpers, without necessarily using the technical language tied to biomedical psychiatry, signalled biology-based causality as they spoke generally about the need to address mental distress through medical interventions. Sadia, the wife of an imam and a women’s leader in her small Muslim community, declares: “Mental illness would need medical treatment… So if a person mentally ill, he will need medication.” Christian Pastor David feels similarly: “Legitimate mental health issues has to be treated with medication and proper diet and proper advice from medical professionals and practitioners.” Many of the participants emphasized these points because, in their experience, mental distress is not usually perceived as an illness in need of medical attention by the general population. For these participants, it is necessary to see mental distress through, in part, a biomedical lens. Recall in Chapter Five, participants cited how distress is largely understood as madness by the lay population, with madness commonly utilized instead of the biomedical terms of mental illness or mental disorder. Civil society/NGO helper Lance speaks to this:

> People don't see this in the way like you got chikungunya and you couldn’t control that you’ve gotten that. People don’t see mental health impairments as a medical condition which some people get… One that requires medical and related types of psychosocial interventions… The first realization that is that people need to understand mental health issues are, first and foremost, medical in nature… People need to realize that people need clinical interventions and care.

Violet and Wendy, both NPH workers, relay similar opinions:

> You have to work around things. Let the family know, try to educate them and tell them… This is sickness, like schizophrenia, where they [patients] have to live on drugs all the time like persons who are hypertensive or diabetes. And you have to bring them to clinic, is the most important thing, and have the medication and have them being checked up by doctor. (Violet, Interview)

> They are not educated about it. They have no clue as to what to look for and what to expect so anything happens, most of them would point to [spirit] possession. People wouldn't take a second thought to, well, oh maybe he needs some help, maybe he has some mental issues or something. (Wendy, Interview)

Patrick used a personal anecdote to illustrate a view that largely corresponds with the attitudes of Lance, Violet, and Wendy – the belief that medical and psychosocial approaches are better suited to respond to mental distress and that sensitization and education about these interventions is necessary. He relays how a family member "started to act up", was "terrorized at night", and unable to sleep after the death of another loved one. He recalls:

> I believed that it was trauma, psychological trauma that she couldn't deal with. She couldn't process… That psychiatric intervention helped. The point is that we could have taken the position that "something happened" to her, some spirit or whatever was on her but again it was knowledge, you understand me… People's trauma can create those psychological conditions and if not treated, it can develop… She is a healthy, strong, vibrant young woman…If you don't have in your family information and you're not educated to these dynamics, you can make other decisions. You can say "Take her to the Obeah man" or the "Mother"[52] or the "Kali Mai Puja man" or somebody. (Patrick, Interview)

Though Patrick points mainly to (inter)personal causality in this example – the individual distress and trauma experienced after the death of a loved one – he flags how psychiatric interventions proved beneficial in this instance, eschewing traditional medicine and healing approaches. Kim, a civil society/NGO helper, on the other hand, was more adamant in her rejection of spiritual interventions as it relates to addressing distress:

> But for me personally, going to that spiritual healer or whatever you want to call it, Obeah lady, whatever, it doesn't make sense. It doesn't make sense! Because if you have a mental health problem, you have to seek the right help medically… Some people believe

[52] The use of the term "Mother" in Patrick's telling references women leaders of Faithism, Spiritualism, and Comfa worship more generally (Gibson, 2001).

> in it but honestly, I don't believe in it. There is nothing that you can say that can convince me otherwise. It's a myth!

For a subset of helpers, mainly medical professionals but also civil society/NGO actors, it was wholly unacceptable to consult religious/spiritual practitioners in matters related to mental distress, even if that distress – from the perspective of the distressed and/or their family – is thought to have been brought on by spirit possession/interference. In the view of these helpers, the roots of distress are not related to supernatural causality, even though their patients or the populations that they work with have cited it. This will be further explored in the subsection on perceived supernatural etiology.

(Inter)personal

The helpers indicated that (inter)personal conflicts were another factor attributed to mental distress. Many spoke generally about its role in producing individual stress and creating adverse, harmful, and violent environments, particularly in the domestic sphere; they cited family conflicts (among marriage partners, in-laws, children), breadwinning responsibilities, abandonment and neglect by family members, and family violence, among other (inter)personal issues discussed. Kali Mai Priest Khemraj says: "Stress you know… Man and wife, money problem, children problem… And men ah tek on [are worrying about] all dis thing and that can mek you mentally disordered." NPH staffer Wendy agrees: "It's basically stress. Some it's marital issues… Some problem with the neighbor or some problem with in-laws and those kinds of things." Patrick, a government official, spoke on how feelings of abandonment play a role: "People feel abandoned by society, by family, by everybody, by God. They're unable to cope… The stress of life, the pressures of life. So, we have to in the [national mental health] strategy have a holistic approach in dealing with the matter." Pastor Samuel, in Chapter Five, mentioned

the social issues ("Abuse. Incest. Rape. Violence.") that affect some of the homeless population in Georgetown when he spoke about the outreach work that he and his church do with this specific group. Charmaine, who works in social services, puts it this way: "Domestic problems. Some people are being abused and when they can't deal with it, they trip."

Neglect and violence against children were cited by several participants as drivers of distress. Civil society/NGO helper Nicole talks about her experience working in Barima-Waini (Region One) with children and young people living in one of Guyana's hinterland communities:

> In Region One, we found that there are mostly single-parent families where the mother is working and the father is in the mines... So, you would find the parents are fighting and they would take it out on the children. Or in the single-parent family where there is more economic pressure. It's a way that parents take out their stress, or even their depression or issues that they are going through. A lot of them reported, and these are reports from children, that they were being verbally abused by their parents, physically abused by their parents, and emotionally abused by their parents.

According to Nicole, much more focus and social outreach work is needed in Guyana's interior communities, which are home to large Indigenous populations, in order to address these issues. Pastor David also relays that children and young people seek his counsel to discuss the problems of their homelife:

> I've had recent cases of persons who are literally ill, children were literally ill. They are stressed out from school and all the work they have to do. And parents, rather than talk with them, yell, quarrel, fret and generally talk them down. I've had to talk with kids who can't handle their parents. Esteem is very low. They feel as if their life has no value and so other than that, parents don't really know how to parent. Families don't know how to care for each other. Culturally, it seems the way to go is to beat the kid down, talk the kid down, literally, verbally demoralize the child and even the spouse and the family member… They get "mouth licking", if you understand what that means. That means there is nothing gentle. There is nothing thoughtful. There is nothing peaceful. It's only fret and quarrel and verbal abuse… And I've had to deal with this over and over again… People's morale, their self-value, their self-esteem is literally hammered down… Rather than talking and looking for the positive reinforcement and affirmation, the next thing we do is say, "You're good for nothing! You're a waste of time! Why don't you leave! You're a dunce!"

Lance, a civil society/NGO actor, also mentions the role of child abuse:

> There's a great deal of child abuse happening. It's both physical and sexual… Most of the times, it happens at the hands of somebody who they [children] trust or are in a trust relationship with, like their parents or guardians or teachers and religious leaders. Very often times, people don't like to talk about that.

Christian Reverend Jean conveys a similar message:

> We have a great level of sexual violence against children… We are not doing anything at any level of the nation in terms of how do we attend to this. It's still hidden. It's still a dark area… In the church, so many young people, most of the teenagers that I have, they are around the ages of 13 to 15. They come to me with issues that they are facing now.

Some of the participants went on to explain how the distress experienced by children, as a consequence of neglect and/or abuse, is widespread in Guyanese society and is often hidden, trivialized, or dismissed, which can serve to further compound suffering and feelings of abandonment. As a systemic issue as well, child abuse and violence will be discussed in the next subsection on socio-economic/structural etiology.

Priya, a Hindu Priestess, talks specifically about how conflicts tied to romantic relationships are at the root of many mental distress cases that she encounters: "Most of the cases is, okay, somebody like the girl and the girl family is not 'greeing [agreeing] and most of de problem does come like that… They come and they have house problems." These "house problems" that Priya references sometimes stem from discord that arises due to romantic relationships, and, in this case, parental/in-law disagreements regarding the chosen partner of adult children. Pastor David and Sanatanist Pandit Deonarine also spoke about how these particular kinds of (inter)personal conflicts trigger distress. In Chapter Seven, they provide specific examples, which are utilized to also demonstrate how religious/spiritual helpers act as interlocutors between distressed people and their kin and kith to resolve (inter)personal struggles. Samuel also encounters conflicts among his parishioners related to their romantic relationships. He talks about how a worshiper, a young woman, became distressed after the breakdown of a

romantic relationship due to infidelity. According to Samuel, she had "gotten very thin. Some people were telling her that she has AIDS. Dismiss her. Speaking all kinds of things about her. The relationship she had before, the people probably use the word 'duh her' [do her]. Put evil spirits on her." Samuel expands:

> When she got to know [about the infidelity], there was a terrible breakdown. Eating was a problem. Working was a problem. Studying was a problem because she is doing a degree at UG [University of Guyana], and she started to thin out. She sought psychiatry treatment at the Public Hospital, and they told her that it's the mind. I agree with them and I said it's a mind thing. While I believe in evil. I don't think that it's evil that is affecting you. And I asked her how she feels about the breaking up. But she started to cry... She is stammering and crying. So it's pent up feelings. So you have to make the distinction of what is evil and what affects the mind and what has caused the mind to be where the mind is at any particular time. You got to make that distinction.

Samuel signals his general belief in two causes of distress here: he believes that the breakdown of this relationship was traumatic and affected the mind; he also suggests that evil may likewise play a role, though not in this case. In distinguishing different etiology, Samuel gestures to different approaches to care. In this passage he explicitly names psychiatry as a useful approach. In other portions of his interview, Samuel says: "By God's intervention, if it is evil, God will stave off the evil and they will live in ease and so on," as he talks about a separate case in which he believes spiritual interference or evil played a role, thus necessitating "God's intervention". In Chapter Seven, religious/spiritual practitioners – like Priya, David, Deonarine, Samuel, and others – outline their process in making distinctions about the causation of mental distress and how they respond depending on perceived etiology.

Ralph, a Christian Pastor, when talking about interpersonal conflicts, emphasizes the role of gender and society's expectations of women as keepers of the domestic space and men as perceived breadwinners, which lead to stressful home environments when these expectations are unmet. He says:

> I believe there are cases where how some men have been socialized, "You women are supposed to be subjected. You are supposed to shut up. You're supposed to give up the sex when it's wanted. You're supposed to keep the house clean. You're supposed to look after the chirren [children]. You're supposed to cook." And also, in that, the man is not earning enough to demand all of that. So the stress factor comes in. (Ralph, Interview)

NPH medical worker Teke also spoke about restrictive gender roles within the family and how this can bring about stress, particularly for young women in Guyana:

> Women on the other hand, some of them marry very young. A way of life, especially if they marry in a family well established or economically stable, and then they have to submit themselves to the husband. This is very frequent here… They have two, three kids and they don't have no other option but to go by what the husband say. They don't have no opportunity… I think that that pressure what the women feel… It draw them to the depression and stress.

Gender-based and intimate partner violence were common themes mentioned by the participants:

> We got some patients that would come with domestic violence that gon' lead them to the depression… For the female, most times it does be domestic problems. Probably with husband, children, family affair, and from there it escalates if it's not treated well or how the patient responds to treatment and they start this abnormal behaviour, withdrawal. Three quarters of the time we get them withdrawn. That's what they start with. Today I ent eatin', tomorrow I ent bathin'. (Indra, Interview)

> Relationship problems... Husbands and wives have issues at home. Some of them turned to suicide. Domestic violence is quite prevalent these days. Most men, even men are being abused, but most women are being abused by men… I've seen many women being abused and some of them look at it as something they just get accustomed to it… Some of them get depressed and suicidal being constantly abused and all of that, eventually coming into the hospital here. It does play a big role. (Salima, Interview)

Participants spoke at length about sexism and misogyny. They believe that these attitudes are prevalent in Guyana and play a role in fuelling domestic and intimate partner violence, which they cite as systemic issues that lead to the onset or worsening of mental distress. These issues will be further discussed in the subsequent section on socio-economic/structural causes of distress.

Socio-economic/Structural

Material deprivation and poverty – which were named as contributing to a lower quality of life – were also cited as major perceived causes attributed to mental distress. Hafsa, a civil society/NGO helper, puts it this way:

> I think poverty is a huge one. Poverty in terms of how it drives stress and just makes people's lives miserable. Quality of life is really bad when you're poor and you have to worry about money for everything... The quality of food you're eating, the amount of sleep, if you're working 12 hours and have to come home and do work, you're not getting enough sleep. It can affect you not just physically but mentally, right?

Other participants commented similarly, noting how economic stressors may lead to the acquisition of mental distress:

> Economics. Economics… There is a Guyanese term is that they are stressed. They are "stressed out" because of their situation. (Kim, Interview)

> Then you're working for a little money and you can't buy enough food. You can't buy enough clothes. You can't pay the rent. You have all the bills. All of those are things that could drive you. (Mohini, Interview)

> You working whole month or whole week and the money what you're working for, soon as you done get pay, it can't even pay your bills. It's stress… You're not getting to relax. It can't maintain you and your family. (Charmaine, Interview)

> A lot of people especially in Guyana have economical problems. Economical problems like financially they are not strong. They may be very poor. They're not having enough or adequate finances. They are unable to deal with matters of like simple sicknesses like seeing a doctor on a regular basis. Like maybe other countries have regular – what they call it – a family doctor, where they visit on a regular basis… This may have resulted in the worsening or escalating of sickness. Make small problems, bigger. (Balram, Interview)

> I think poverty. Statistics on paper are very misleading about the state of development in Guyana. We are experiencing economic growth but there is a great deal of inequality in Guyana, especially income inequalities. We are experiencing economic growth in certain sectors and some bodies are lauding us for economic growth, "Ya! GDP, GNP is up!", but that is in particular sectors and that is not trickling down to anybody… Anybody's average living expenses of just basic utilities is more than the public service salary. There is a dwindling middle class… There is this huge amount of people who don't have and who can't meet their basic needs. They can't pay for utilities. (Lance, Interview)

> Poverty does affect one's grooming and nurturing. If you don't have a stable environment where you grow up, it could affect you. What I mean by stable is, is there enough food coming into the home, balanced diet? Are there amenities in the home for the child to make the child comfortable, at ease, and not only the child, the entire family? … Poverty is still impacting a lot of homes. And it's not only about food and the intake of food. There are so many other things that poverty can affect. When you go to a school and you see that there are other children who have their books and pencils and rulers and probably a tablet, and you don't have anything, it affects you. It affects your mind. You can't perform as them although you might have the ability. These things are restricting. It is a continuing factor. (Samuel, Interview)

The participants place emphasis on the high cost of living in Guyana and the inability for people to adequately provide for themselves and their families, which, as Lance – a civil society/NGO helper – further explains, creates "a great deal of pressure". These pressures and "economical problems", according to Balram (Interview) – a Sanatanist Pandit – multiply and manifest in other ways to "make small problems, bigger", such as minor health concerns, which can balloon into larger complications when Guyanese do not have the money to seek out proper primary care. Pastor Samuel believes children are especially affected by poverty and cites the way in which they may be hindered scholastically when parents cannot afford basic school supplies.

Expanding on economic and structural concerns, participants discuss the high unemployment rate among young people and the shortage of job opportunities available to them. The helpers believe that these difficult economic realities contribute to distress among the general population, but especially so with Guyana's young people:

> There is a high unemployment [rate] among young people... They're not able to find decent paying jobs, or decent employment at all. (Nicole, Interview)

> I think the pressures of life. Like everywhere else, developing places, developing states, need to progress the provision of opportunities. Even though that has improved, people still need to be able to educate themselves and find good jobs. So those are some of the social determinants that are impacting, so housing, access to employment, good wages. (Vishnu, Interview)

> I going to talk a little crude about the reality here [chuckles]. You don't have no kind of infrastructure here in Guyana. People no have the opportunity to find jobs. The young

> people. I think the education here in Guyana is really good because I have a [family member] in high school now and sometimes I cannot cope to help her study because it's high quality and the children really go out of their way to get good grades in the school, and at the end of high school, some of them have 13 subjects, some of them have 14 subjects, and where they can work? They don't have no opportunities. Job opportunities are not here in Guyana for the young people. I think that is one of the points that draw the young people to alcohol and the drugs. You understand? (Teke, Interview)

Salima, who like Teke, is a medical professional working at the NPH also believes that the lack of opportunity and high rate of unemployment among young people causes distress:

> Firstly, we don't even have that much jobs around. You know young people coming out of school, there isn't enough jobs there. Cost of living is expensive of course… It's hard for some young people just coming out of school. It's frustrating. You don't have a job. You need to earn money. Everybody needs to earn money these days because cost of living is expensive. That would eventually lead them to, they would get frustrated and depressed.

One detrimental consequence of few economic opportunities is the resultant "brain drain" that it precipitates among a young, educated labour force, which was previously mentioned in Chapter One.

In the previous section on (inter)personal etiology, the participants also alluded to the structural or systemic nature of violence, particularly against women and children in Guyana. Christian Reverend Jean underscores the normalization of violence in Guyana against these groups:

> The domestic violence is normalized in households. Violence against women, it's normalized. You're immune to this because it's a normal way of relating. It's normal… Older women who have been sexually abused when they were young and never said anything about it and they have stored it in someplace and it's been affecting their lives…. At some stage, even in old age, it's haunting them. But somehow, maybe feeling freer to talk about it to somebody, at least to somebody. I had someone with dementia and when we got down to it, terrible, this person is almost 80 and when she was seven to ten, she was sexually abused by her uncle.

Lance also comments on how widespread this violence is:

> The people that are experiencing abuse are our children growing up. If you're a girl child or a woman, worse yet. You're getting abused because you're a child; you're getting

> abused because you're a woman… It's very, very, very much so socially acceptable to beat a child in the most violent ways as a matter of discipline, and I see that in my own family. Because a three-year-old doesn't want to eat, you think it's okay to pick up a 12-inch wooden ruler and beat a three-year-old to eat breakfast. That is accepted and that is considered discipline. There is physical abuse; there is sexual abuse; and of course, all of that is intertwined because there is also a great deal of emotional abuse... We are very, very much a violent and abused country… The statistics around women, the last statistic that I heard, is that two thirds of Guyanese women has experienced some form of violence or abuse in her lifetime by the time she becomes an adult.

This "normal way of relating" (Jean, Interview) is tied to broader gender roles, where women, according to the participants, are expected to assume a subservient role. Some of the helpers explain:

> And, of course, you got the violence. "You got to be the woman. Put she in she place." You know, a man is a man and you got tuh let her know who is the man in the house so the guys go and drink some rum with their friends and they come home and demonstrate who is the man in the house… That very often ends in beating the kids, beating the wife, breaking up the home. (David, Interview)

> Men are supposed to behave a certain way and do this and that – provide for the family and if you can't provide then there's something wrong with you, and I think that that drives a lot of domestic violence… If you're experiencing physical violence, that's going to affect your psyche as well. (Hafsa, Interview)

> It [domestic violence] is a contributing cause [of distress] because Guyanese men are male chauvinists. We have not been taught different… The woman is not still equal to a man in Guyana. (Lionel, Interview)

In view of these perceptions, I am reminded of a common adage shared by Sanatanist Pandit Deonarine: "Dem gat a saying, 'If yuh husband like yuh, he gon' beat yuh.'" Asked to further explain the expression, Deonarine expands:

> There is a story where umm, where a girl used to get licks [beatings]. Ole story [chuckles]. She used to get licks from she husband, right… One day there had a girl who live at the other house. She [neighbour] married and she say, "Why yuh husband ah beat yuh?" She [abused woman] say, "Wait, you husband doan [don't] beat yuh?" She [neighbour] say, "No." She [abused woman] say, "Well, he nah love yuh because if he love yuh, he guh beat yuh." So when she [neighbour] guh home now, she swell up [angry] wid she husband. He [neighbour's husband] say, "Wha' wrong?" She [neighbour] say, "Yuh nah love me because yuh nah beat me" [chuckles].

While Deonarine may not have intended to make light of domestic violence, his telling certainly speaks to the way in which violence against women becomes trivialized in a sweeping and anecdotal fashion, where abuse is treated as a display of affection instead of a serious criminal offence with damaging personal effects. There are few resources available to women experiencing domestic violence and looking to leave abusive partners, which is partly touched on by NPH medical helper Colleen: "They [some women patients] were abused by their husbands. They ended up in shelters where shelters can't keep you for long… It causes emotional disturbance and as a result you cannot function normally. You end up in a state of depression and once it's a prolonged state, it can… lead one to lose their mind." Colleen – and other participants previously cited – goes on to call on the government to address these complex realities that lead to distress.

The homophobia experienced by members of the LGBTQ community is also perceived as a driver of distress. Lance connects this discrimination with violence experienced by children and the need for counselling resources in Guyana that are tailored to specific populations:

> If you happen to display any signs of being lesbian, gay, bisexual… and so on, that becomes more of a basis for you to be abused, whether you are male or female. You will be physically abused because people believe that they could beat it out of you. That's where the religious element comes in because a huge part of what happens here, which is not spoken about, is that in many religious organizations, people try to perform these ex-gay, "pray the gay away" exorcisms and so on, and it's very, very prominent in the Pentecostal and evangelical churches but they don't do it publicly in front of other people. There are faith-based organizations here… who actually believe that you can pray the gay away, who actually promote that through pastoral counseling prayer and so on… That becomes a point of more vulnerability and abuse. Any young boy or young girl, and they might not even be LGBT, displaying any kind of tendencies which are outside of the gender spectrum and the gender norms, they become more vulnerable for physical abuse by their parents, their family members, and for sexual abuse. If it's a girl, they think that "You just need a good man to straighten you out." If it's a boy, they think that violating you, raping you, will teach you: "Yuh waan [want to] be like a woman? I'll show you."
>
> In the Guyana context, it's more like boys displaying effeminacy or girls displaying a sense of masculinity, which is outside of the norm who are punished by people close to

> them, sometimes family members, sometimes siblings, brothers, sisters, mothers, fathers, guardians… That sexual violence is used as a form of punishment for the "deviation" from the gender norms. It's done privately and away from other family members generally. It's usually targeted against children and adolescents. What I can tell you is that people [LGBTQ community] want psychosocial support. People want counselors and people want people to talk to.

Hafsa agrees and also believes that homophobia curtails the employment and economic opportunities afforded to the LGBTQ population in Guyana:

> There's a lot of bullying on children. From a young age if you are innately different and you manifest that – again with the pressure to conform and the pressure that girls must be like this and boys must be like that, there is no in between or there's no allowing for flexibility – the ones who don't conform get bullied and ostracized and may get beaten up. From a young age, a lot of LGBTQ Guyanese end up dropping out of school. They don't finish school and then that leads to then, now, how do you support yourself. The whole precariousness of work, I mean, unless you can pass as "normal", for the fit within the gender roles, they don't get work. There is so much unemployment here, that the boss, the employer, is going to choose somebody else before they choose you. So that leads to a lot of sex work, people putting themselves in dangerous positions and doing dangerous work in order to get money or putting up with abusive situations because that's how they're going to get money, which, of course, will lead to stress, mental issues, depression, suicidal behaviour… I think that things are getting better slowly. There is more awareness. There is more dialogue, but again, religion and religious conservatism is still very strong.

Both Hafsa and Lance cite the role of conservative religious beliefs in fuelling some of the discrimination experienced by LGBTQ Guyanese. At the same time, Hafsa also mentions how individual faith leaders are supportive of the LGBTQ population, though there is still a lack of institutional and broad-based religious support: "There are individuals, who are leaders, in the Muslim or Hindu or Christian faith who are supportive, but I don't know if the entire church or institution is. We can't say that this branch is or isn't, but you will find individual people." Teke, through their work at the NPH, mentions how many of the LGBTQ patients suffer because of the ostracization that they face in their communities:

> Some of these patients, okay, really have difficulty to come open and live life how they want… I think the Caribbean in general has a very macho attitude towards that. Some of these persons are really submitted to cruelty. They laugh them. They attack them in the

> street. They cannot express themselves how they are because they are scared. They are scared, the reactions from the society.

Monty, like Teke, is a medical helper at the NPH and speaks about the rejection faced by LGBTQ Guyanese when talking about the suicide of a close friend: “It's stifling for them. It's just that they are not free because of rejection... Up to like five months back, one of our peers killed himself because of resentment from family when they found out that he was a bisexual but on the ‘down low’. He could not face it.” Vulnerable groups – particularly women, children, and members of the LGBTQ community – were viewed by the participants as being particularly susceptible to experiencing mental distress and violence in Guyanese society.

Supernatural

> Dr. Harry pointed out that he cannot count the number of cases where a patient is hearing voices or hallucinating and those around him insist on saying that he [patient] has been “cursed” or “somebody do he something” or “is obeah” when in fact these are all symptoms of mental illness. (Conway, 2011)

This subsection opens with a paraphrasis from a *Kaiteur News* interview with Bhiro Harry, Guyana’s Chief Psychiatrist at Georgetown Public Hospital and one of the few and leading specialists in the country. In this interview, Harry acknowledges the dominance of perceived supernatural causality and how frequently he encounters colloquialisms such as “somebody do he something” in his professional practice (Conway, 2011). Indeed, of the four main perceived causes of distress discussed, the helpers in this study placed the most emphasis on supernatural etiology. All 37 participants noted that supernatural causality is viewed as an intelligible landscape among the public, which – regardless of whether or not the participants personally believe in this causal explanation – they must strategically maneuver and negotiate

across in their role as helpers. NPH worker Salima passionately spoke about the frequency in which patients cite supernatural causality:

> We hear that every single day!... It's a very, very common thing… We have several patients in the ward, even most of the patients presently there, the relatives are under the impression that, you know, "somebody Obeah them" or "somebody give them something to eat" and then they start to behave like this. Or "somebody put a demon on them" or something of that sort and that is why they behavin' like that, that they need prayers. They don't seem to understand that it is a mental disorder. So we have a few patients in there whose relatives believe, and who even they believe, the patient. The relatives tells them that, so they believe that. And if you really gyaff [talk, converse] with them, chat with them, and ask them about the whole of what happened, how they become sick, most of them you would hear that "this person give them something to eat" or "this person put a ghost on them" or something and they went to several Obeah men and nothing didn't help. It eventually comes down to the same, they end up being here [at the NPH]. So it's a prevalent thing here, belief here. It's common belief… Probably if we have more awareness about this whole mental health and mental disorders and issues, it would be less people saying it's jumbie and that people "do them" and they're possessed.

Other medical professionals at the NPH (Monty, Colleen, Indra, and Wendy) and in private practice (Ponel) felt similarly about the way in which the public, patients, and patients' families tend to attribute distress to supernatural etiology:

> That is a belief and you can't get that out from people. It's a mindset, whether you are Christian or Hindu or Muslim because they want to believe that you're being possessed. (Monty, Interview)

> Sometimes you would find that some of them would come believing that the patient is not for here because they are of the belief that she is possessed – he or she is possessed, demons or whatever…This patient that had a baby and after having the baby, a couple of days after, she had this condition, puerperal psychosis. It's after you getting the baby and she started to behave strange and de mother [mother of patient] was taking her [daughter/patient] to different people saying that she was possessed and after intervention and persons around see how the girl [daughter/patient] is behaving they say she doesn't look like somebody that is possessed, it's something else. They encourage them to bring her here [NPH] and as a result of bringing her here, she is well. She was admitted. She spent about two weeks. I saw her up to before I would go off on vacation and she is well. The baby is well, and she comes to the clinic and we'd give her the treatment. The mother really understood that she was not demon possessed but instead she was ill … It's common. It's common. It's still very common. (Colleen, Interview)

> Those are superstitious beliefs… It is common… Those things don't be reported until something actually happens… Here what happen, for most of it, if it happens, it's

> undercover. We don't know. We're not aware. We are not aware until somebody die. … Somebody got a church and something going on in there and you're not really aware. Somebody die and then it becomes an issue. (Indra, Interview)

> Some of them would tell you, yeah they are possessed. At least for the girl who would bite the other patients, she was raped by her cousin and she got a child and then the cousin took the child away from her and she would say that he told her directly that he is gonna make her mad. She is holdin' on and believing that he did something to her because when she is sane, she would tell you, "Nurse, whatever craziness I'm doing, it's not me." She believes that he did something to her. (Wendy, Interview)

> There are many people who when suffering a breakdown will assume a different persona. They will speak differently, carry themselves differently, and I have understood that during that phase, they are classified as being possessed. (Ponel, Interview)

Teke, another medical staff at the NPH, explains that families will often come to the facility and ask to perform a religious "work" or "wuk", which is any number of spiritual rituals or ritual duty – some of which are performed to solicit desirable outcomes (in this case, with the intent of alleviating distress) – particularly, but not exclusively, in reference to Comfa (Peretz, 2020, p. xix) and Hindu practices (Rampersad, 2013, p. 60). Teke explains in a short exchange:

> Teke: We have people admitted here in the hospital and the families come and ask permission to do "work" here.
>
> Savitri Persaud: What kind of "work"?
>
> Teke: Work! The largest one is to bring a pastor for praying. Other is to bring things to bathe the patient and give them things to drink and you see that among the religions. You surprise because I know Hinduism, in the Hindu religion… they have the people who believe in Kali, the people who they believe in this kind of work. In the Muslim community also. People are very afraid of Obeah.

Doctor Lionel also speaks about the various faith groups in Guyana and how Guyanese across different religions seek out religious/spiritual helpers to bring about relief:

> What we have with spirits and Guyana, if yuh sick they say go an' see a maji [imam or other Muslim faith leader] or see that type of thing. So that is quite high here. They believe they're possessed by the devil and the only person that can get dem better will be the head of a religious group. Like Catholics would believe in priests. The Hindus, would of course, have their own pandit*s*, and the Muslims have the majis and so. And the

> Africans… they do Comfa and try to get the spirits out and so. If you go in the villages they do it, eh? Especially if the patient is mental.

Most of the medical professionals were of the mind that mental distress must primarily be addressed via biomedical means, while also acknowledging what they see as widespread supernatural beliefs among their patients and the general public.

This is, however, not to say that some medical professionals did not personally believe that distress may be attributed to supernatural causes. NPH staffer Monty is firm in his conviction that there are times when people are not "sick naturally" and where biomedical treatments are inappropriate, instead pointing to supernatural etiology:

> As you may heard the term: "Like dem put yuh suh"… "Somebody do yuh suh." Yuh gat people dat do those things… From the time you look at them, you could see this person is not natural, yeah. There is a glare in their eye, the way they talk and all these kinda things... It do happen. Let's not run away from the fact. Not everybody who might be sick, sick naturally.

Lionel is a Western trained medical doctor who completed his studies in North America. He returned to Guyana to practice medicine in his homeland and believes it was his duty to repatriate given the shortage of skilled professionals. He, like Monty, believes that supernatural forces – in addition to biomedical, (inter)personal, and socio-economic/structural causes – may lead to mental distress. Lionel is resolute as he talks through one particular and compelling experience:

> There is possession you know… Oh, I've seen it! I went to see a lady, and she was there in the bed. And I don't know if you say, was it *The Omen* [referencing the movie], where she stretch out de tongue [stretches out his tongue to demonstrate]? This lady was just like that. Speaking languages, stretching out her tongue [demonstrates again], and I took the Bible and put it on her and she pushed it away. I said, "Jesus!" Eventually they are praying over her and suh and she got better but that was possession… Two or three times I've come across it when I feel it's something doubtful and it's not insanity. This one was not insanity for sure because I've seen the lady after… Six, eight men couldn't hold her down. She was strong as hell. She and her husband divorce now, but that one I couldn't relate to medical conditions… Not with that behaviour! That hyperextension of the tongue and the languages! She was speaking different languages… Now some people

> will say that it is gibberish but it's not gibberish! I know! I'm not the best at languages. I think that was a possession. Even the Bible says they had possession. They have to be… So, even though we are scientists, and scientific-minded, we still have to believe in the Almighty.

While other medical professionals like Wendy disavowed supernatural attribution, she says that this belief exists among staff working at the NPH:

> Even with staff also, you would find some of them saying, "Oh, she is not crazy. She is just demon possessed." They would say demon possessed. You have people working here too who think that some of the persons who come in here, they are not mentally ill, they are just demon possessed.

Teke agrees and has also witnessed the way in which NPH staff attribute distress to supernatural causes:

> Marjory[53] was a schizophrenic, a lady who have about 200 different voice, and Marjory from time to time when she was very psychotic, Marjory isolate herself. She stop communicating and… start to do this [Teke starts to knock on the table mimicking the drumming done by Marjory]. Like drum. She was wid the drum and from time to time she voice was like small kids. Sometimes she talks like a man. And the nurses were terrorized by Marjory [chuckles]. They don't want give Marjory the treatment because they say Marjory was possessed by the devil. It cost me a lot to convince the nurses that Marjory is a schizophrenic, okay? And Marjory needs treatment. Eventually, Marjory get discharged and is with the family too.

Monty's belief in supernatural etiology is a testament to Wendy's and Teke's experiences when they cite how other staff at the NPH believe in the supernatural causality of distress. Ponel, a medical doctor with a private practice, says that it is not uncommon for other medical professionals to tell his patients that their distress is rooted in supernatural causes: "That's part of the conversation: 'Somebody do yuh.' That's the conversation, and they'll be told this by upstanding members of the community, sometimes a nurse."

Civil society/NGO and social service helpers, in addition to the government officials, outline the narratives of supernatural etiology that they have encountered:

[53] The name Marjory is a pseudonym.

> People associate it with some supernatural cause to it… I think it's very common because there is not enough education and awareness about the real causes of mental illness… They don't understand the biological and social underpinnings so whenever you can't explain something then you look to some otherworldly factors. (Hafsa, Interview)

> You see some things you know like bottles on trees and all this sort of stuff [chuckles]… It can be cruel. Some of these evangelicals have a lot to do with this because they promote and prosper around this whole issue of devils, possession. (Kenroy, Interview)

> There is the traditional Guyanese spiritual influences of Obeah man, Obeah woman, Kali Mai Puja, and these sorts of things, but also this notion of spirit possession and demon possession is also coming from the influx of new religious denominations, particularly the evangelical and Pentecostals who believe that certain things are a spirit and demons that you need to pray out. It's completely acceptable to go up in front of a church or a special service and have something prayed out of you. (Lance, Interview)

> If you go back in time, once we can't find an answer – we can't find some scientific basis for something – we put it as either God or de devil responsible because we are unable to understand it. But as society develops, many things that we thought were spiritual things, they are natural things. People who have mental health conditions, there were times when families believed that "something happened", that "somebody do" as they say. (Patrick, Interview)

Generally, most of the civil society/NGO participants do not personally believe that distress can be attributed to supernatural etiology; however, they cite how it is a common public perception that they frequently encounter.

Lesley, Mohini, and Charmaine are social service helpers who work with children with disabilities; these women are also the parents of autistic children. In the previous chapter, they explained how autism is often read as madness in Guyanese society. Here, they express how this interpretation of madness is usually attributed to supernatural causality by the public. Lesley explains, "Definitely, it's superstitious belief… Is that your child is possessed… Your child is possessed or somebody 'do you', meaning they invoke some spirit or evil on to your child." Mohini concurs: "A lot of people would keep saying that, 'I think this child is possessed. I think that somebody did something to this child.'" Charmaine shares a more detailed experience:

> One time a man saw me down there [on the street near the building where she works], just somewhere around here and he said: "All ah dem chirrin [children]... they possess – demon possess. 'Bout autism?! Dem chirrin possess. They get demon pon dem. They need somebody fuh tek off dem demon. Is demon! And den yuh does gat fuh [got to] know wha' dem parents does be doin' when dem does be getting dem chirrin [referencing the birth of children with disabilities]. Some ah dem [parents] musse be doin' [must be doing] bad ting [in reference to perceived occult practices performed by parents, which, per the man who approached Charmaine, may lead to the birth of children with disabilities]." And I'm passing and hear he, "She [Charmaine's daughter] goin'… deh [there] too!" And I just look at he and I keep walking. The next day that I'm coming in and he was right at the front and was like, "I name suh suh suh. You muss come by me [must come to my home]. I gon' geh [give] you a readin'[54] and I gon' tell you is wha' happen' to she [referring to Charmaine's daughter]." I said, "I don't want no reading." I said, "God is in charge, and He knows best." Hear he, "Well, if you waan say suh! All ah y'all ignorant to de fact. Autism?! Is demon they get pon dem."… These kinds of things, same demons, same line they go with it. And, "You must carry dis chile to church." Well, I don't take that in a funny way. Yes, it's good to take children to church. But, "Yuh muss come leh ah [let me] give yuh a reading"? I take that one funny. I don't want no reading. God knows best. God knows why He put her on this earth and why she is that way.

Charmaine finds solace in her particular Christian faith and believes that her child was born the way God intended; therefore, no other spiritual interventions are necessary as she eschews the ones offered by the man on the street, who seems convinced the children with disabilities, autism in particular, are possessed. Charmaine uses her faith to serve her ends as a parent who is, as she tells me, "so proud of her [daughter]".

Mohini, on the other hand, explains that when her daughter first began experiencing seizures, she desperately tried to establish the cause and find relief for her child. In addition to seeking out medical doctors – who were initially unhelpful and dismissive because they were not trained to recognize her child's eventual diagnosis – she sought out religious/spiritual practitioners for assistance at the behest of her close networks:

> Sometimes you get scared, and you follow people [follow people's advice]. You are inexperienced about these things and you listen to people and you go "out" and you find out, being inquisitive and try and ask, but in my mind I am never a believer in those

[54] A "reading" refers to an analysis and interpretation of religious texts, which also often confers practical advice for the recipient(s) receiving the reading and is usually performed in Hinduism (Pillai, 2020).

> things. I never believe in possession, evil, but as parents we all try. So I did. I went "out" to people. Asking, you know. Oh, I went to maji [imam or other Muslim faith leader]. (Mohini, Interview)

Mohini explains that these interventions proved useless and costly:

> He [maji] said "somebody do something" to affect me [when Mohini was pregnant]. It [also] affect the child, and he was putting this thing and showing me that person but I wasn't seeing anything. I am still not a believer, but I went, and he was taking $20,000 from me. When I come out, I tell my husband, "You know what? These things are all bull." Why are you charging so much money? And we were so stupid. We believe that, these people. We believe in this nonsense. Yes, I did, I did it.

Asked if there were other religious/spiritual practitioners that she visited, Mohini replies, "About five or six." She explains:

> That [maji] was the last person that I went to but before, because I wasn't experienced with anything, I went to pandits. They are telling me this. They are giving me dis thing to bathe the child with, a lot of things. A lot of people we went to till I said, no, this is too much. I'm not going to believe. (Mohini, Interview)

Like the mothers in Aho and Minot's (1977) study, Mohini sought a range of care options for her child, inclusive of allopathic and Caribbean traditional medicine and healing approaches. Unlike most of the mothers in the Aho and Minot (1977) study, Mohini favours biomedical interventions and believes that they are best suited to address her daughter's health concerns. When first faced with her child's health crisis, Mohini was agnostic not only about the type of intervention (biomedical, traditional medicine), but also about the specific religious practices (Hindu, Islamic) employed with the hope of achieving relief for her daughter. Deonarine also witnesses this agnosticism as a Sanatanist Pandit: "Not only Indian society, Black people society and all religious society because I can tell you, some devoted Christians does come to me." He goes on to say, "All faith. All belief. All come" (Deonarine, Interview). Priya, who practices Shakti (goddess) worship, shares a similar experience: "All ova de country. Yuh gat from Canada, America, everybody. They just want to know the phone number and they call. All

over… We have Hindu, Christian, Muslim." Priya later describes a referral system and goes on to say, "One tell one body [one person tells another person], the next one tell a next one, so everybody come fuh help." Speaking about the diverse populations that attend his mandir or Hindu house of worship for healing and prayers, Navindra, a Kali Mai Pujari, says: "We accept the Muslim. We accept the Christian. We accept the Hindus, and when you come to the mandir we say do not leave your faith… Do not leave your faith. That is your belief." Pastor David, citing Guyana's diverse ethnic population and array of faiths and spiritualities, theorizes that this created a "fusion" where syncretic practices emerge and participation in numerous forms of religious worship are viewed acceptable among Guyanese:

> The multiplicity of religions, religious faiths, and religious works and religious activities that is happening, you know we have the Comfa drumming, we have the dig dutty[55] for the [Hindu] wedding, we have all of these rituals, all of these religions. Generally, we're all so intertwined with each other that we live with one another and we participate within each other's religious practices and hence that really causes a fusion. So, there is no singularity and that separation from the previous involvement and things is not clear-cut.

David's analysis is complemented by Navindra's account of interfaith worship ceremonies at his mandir:

> This [Kali Mai mandir] is not only a place for Hindus, it's a place for me and you. The country is for me and you. The [Christian] Church is for me and you. This [Kali Mai

[55] The "dig dutty", also known as the *matikor* or *matakor* (Halstead, 2001, p. 318), is a Hindu pre-wedding ritual and ceremony practiced among Indo-Caribbean communities. Reflecting on her ethnographic research and participation in a dig dutty ceremony in Guyana, Narmala Halstead (2001) writes: "For this ritual, a group of women headed by the bride's mother, and with the assistance of the instructing *nowa* (helper), sally from the house at nightfall to perform a ritual at a street corner. This involves the digging of *Dharti Mata*, the earth. Both this formal, ritualistic performance, which includes a ceremony by the pandit at the bride's home and the celebrations which follow, mark it as women's night. Their control over this event continues after the digging of the dutty (earth). It is displayed in a celebratory dance, continuing well into the night, often in suggestive routines (cf. Miller 1994: 197). At the formal level, they are the upholders of traditions and honour. In this specific Guyanese Indian context, this is a concern with guarding against shame, particularly through inappropriate sexual behaviour, which can also extend to Indian notions of respect generally. At the more informal level, these women enact a different ritual which reverses their approach to shame. They show themselves as lovers. They become unfettered by the need to observe propriety and to protect themselves from shame. It is their night. The men cannot have any say in this particular space… In the closed session of suggestive talk and 'wining,' (sexually-explicit dancing) my inclusion was first at an initiation level as the 'target' of such banter and then within the 'inner circle'. Then, I could join in teasing others present, where this private display of women's sexuality and their role as lovers rather than mothers were also part of being Indian" (p. 318).

> mandir] is not a coolie[56] one, or Hindu one as you call it. The place belongs to the nation. Anybody could come. I does gat interfaith service. The pastor would come and they would read their scriptures and get together and sing lil *bhajan*[57] and so on you know. And everybody clapping they hand and enjoying it. I will go to the [Christian] Church… and make a whole set a *parsad*[58] and send it down for dem.

In Mohini's case and given the narratives of these religious/spiritual practitioners, it is easier to comprehend why she sought out diverse methods to alleviate her child's symptoms. In the end, biomedical interventions eventually helped her daughter, but Mohini's initial embrace of a range of spiritual approaches when her child became distressed and experienced seizures is not specific to her, per the interviews of religious/spiritual helpers, and is perceived as a common practice in Guyana.

Moreover, and similar to the sentiments of Wendy and Teke from the NPH, Mohini concedes that the belief that supernatural interference leads to poor health outcomes is one that she encounters at her place of work in social services. She chuckles as she relays an exchange among the staff:

> Was a conversation right in this [place of work] today. It's like, "I can't eat from people because you don't know what they can do to me."… I think that it's common for a lot of people [to believe this] so I told them that I think if you have a good heart you shouldn't believe in such things. Because if you have a good heart, you're pure and good, why do you believe in evil? Because I don't believe that. (Mohini, Interview)

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[56] The meaning of the term "*coolie*" varies. The term is usually regarded as a racially charged slur, which was "the bureaucratic term the British used to describe indentured laborers" who migrated from Asia, usually of East Asian or South Asian extraction (Gandhi, 2013). In Guyana, the term is also used colloquially to describe Indo-Guyanese people. It may be used with contempt but has also been reclaimed by some Indo-Caribbean people (Bahadur, 2013; Outar, 2014; Singh, 2021). Though not identical, one may make connections to the word "*chamar*", which is an inflammatory and racially charged term of abuse directed at Indo-Guyanese. "Chamar" refers to lower-caste or *dalit* people (Bahadur, 2015a). The term "has historically been used as a casteist slur" against Indians and is "akin to calling them uneducated and uncivilized" (Singh, 2021). "Chamar" is also mentioned in debates on the reclamation of the word "coolie" (Singh, 2021).

[57] Per Vatuk (1967), the *bhajan* "in its primary meaning is a devotional song", which is an element of Hindu worship (p. 255).

[58] "*Parsad*", also "*prasad*" or "*parasad*", is both an offering to Hindu deities at worship ceremonies/pujas and a meal served to attendees of the worship ceremony/puja (A. Brown, 2013; O'Callaghan, 1998)

While Lesley, Mohini, and Charmaine believe that the biomedical model is the better and most suited approach capable of addressing the needs of their children and children like theirs, they all acknowledge that supernatural attribution is widespread in Guyana, with one of the mothers (Mohini) having initially sought out Caribbean traditional healing practices.

Sally, a civil society/NGO helper, who has a child with a disability believes that biomedical and supernatural causes may lead to distress. First, she explains that it is commonplace in Guyana for distress to be attributed to supernatural causes as a knee-jerk response:

> Especially with schizophrenia, where people hear voices and that's how they describe it, they say that one is possession. And again, I'm saying it comes down to persons who are not sensitized on this particular situation… We need to stop thinking that everybody that you see is possessed or they need licks [beatings] to get out whatever is in them. (Sally, Interview)

Later, Sally goes on to say that a "professional" perspective – with reference to biomedical or what she goes on to call "health" responses or screenings – must be the first care approach as she also talks through her belief in spirit possession:

> I think that they should take a professional look at it and try to understand what is the real reason for the person being the way they are but go through the process to find out exactly what's wrong rather than saying in your head that the person is possessed. I don't think that they should just take a stand right away and to say that the person is possessed. There must be a process where you test what's actually happening because there is possession. C'mon, there is possession, but the thing is you've got to know exactly between somebody who is just literally possessed, or somebody has a mental health issue.

When asked about how one deciphers between a mental health issue and possession, Sally explains:

> I'm not sure. I'm not so sure. I'm not very clear on making the difference because possession is persons who, should I say, dabble with the devil… [chuckles]... I believe that there is a devil. I believe there is a God. If you do the things that God wants you to do, then you're not trying to do the things that the devil wants you to do, but if you want to get into those people who deal with the spirits and all these kinds of things and so on and so forth… and that issue of it can definitely cause somebody to be possessed. That's

> how I would look at it. If for 40 years you are quite fine, you haven't had no issues or bouts with schizophrenia or anything like that and all of a sudden you start acting weird and that kind of stuff, then people need to start checking to see exactly if… I'm still saying, they need to go through something health wise, health screening, to make sure before you go and say people are possessed. That screening, I think, must be done.

Sally's beliefs – similar to Monty's, Lionel's, some of Wendy's and Teke's colleagues at the NPH, and some of Mohini's co-workers – illustrate how Guyanese working in health care, social services, and civil society/NGO sectors weigh competing rationalities and hold polyvalent understandings on the causes of distress, inclusive of supernatural etiology.

Most religious/spiritual practitioners believed that distress tied to supernatural etiology was a genuine concern, though – and as discussed in previous sections of this chapter and will be further explored in a discussion below on cross-referral practices, in addition to large segments of Chapter Seven – many also emphasized that medical and social causes must simultaneously, if not initially, be investigated. Below are a few responses that are representative of most of the sentiments expressed by the religious/spiritual helpers when distress is attributed to supernatural causality:

> People can call from the realms of evil and somehow bring harm to somebody… I believe that evil can be very dangerous in whatever form. It can create the impact that is intended. (Samuel, Interview)

> Demonic possession – which I believe is a true and real thing because I have had to deal with it – very often the manifestation, that possession, triggers mental and psychological impairments, at least behaviorally… Mentally, they are definitely not stable. They lose their equilibrium. It is as though this possession of this force is causing them to harm themselves, harm others, and to create havoc. Many a times, it causes the person to go into depression. It causes the person either to lash out and become angry. It causes the person to behave in a way that is tormentful to others, and many a times it literally wants them to kill themselves… Because many of the cases – and in my experience close to 100 – I would've dealt with, most of them want to destroy the person. First the thing that possesses them, the thing talks. I've had a conversation with this thing and I know it cannot be this person who is in front of me. This person that is talking to me, whatever is talking to me, responding to me, giving me names, locations, information. The voice, I know it, and because I'm a man of God, I know that this is not the human vessel. This is something alien to this individual. Many a times they come to kill, to destroy the person,

> to destroy the family. The end of it, is to mentally, physiologically, socially destroy a life. So yes, mental health [issues] is one of the result of demonic possession. (David, Interview)
>
> If they are sick or mentally ill because of possession of evil den they would have to get the word of God. (Sadia, Interview)
>
> Spirit does enter into people in different form. People might born and inherit a spirit. Yuh does inherit spirit yuh know… People does walk pon de road and pick up a spirit, and people would send spirit pon you – compel them to come, to kill and to destroy and to make people uncomfortable. (Navindra, Interview)

Mustaq, the village imam, puts it simply: "It gat good, and it gat evil, and people can be possessed by evil spirits." Mustaq also tells me of the prayers and other cleansing rituals that he, majis, and other village imams like him perform to remove bad eye[59], especially among children: "Me know that people come and say that dem chirren [children] get bad eye and we pray with dem an' suh, and blow pon the person [dam karna][60] and geh [give] dem one word [scriptures] from de Quran and so fuh keep 'way [away] spirit because de word ah God is very powerful." Similar to the accounts of the religious/spiritual practitioners in Aho and Minot's (1977) study, along with the numerous studies cited in Chapter One on evil eye/maljo/bad eye/najar beliefs in various societies, Guyanese health belief systems continue to involve the supernatural concept of bad eye in the contemporary moment. Deonarine, on the other hand, tells of a cautionary example, which illustrates how prudence must be exercised especially when small children – who may be unable to fully articulate what they are experiencing – are subjected to spiritual practices and interventions. Deonarine – a Sanatanist Pandit – explains that he witnessed cases involving children where parents are told by other religious leaders in their community that spiritual interference is at play, though medical interventions were ultimately necessary, as the

[59] Refer to footnotes 13 and 14.
[60] Refer to footnote 19.

cause of the children's illnesses was found to be biomedical in nature. He conveys one specific incident:

> I had to tell a lady, "Yuh betta get this chile [child] to a dactah," because she tell me that she took de chile to the church and they say the chile have a spirit. I say, "If this chile die, I gon' tell de police to lock you up because I warn you, right." They had to carry, take the chile to the hospital and because of that, it save the chile life. On the way, the chile get fits [seizures], the feeva [fever] fly ah de chile head [made the child's temperature rise further causing the child to become sicker – in this case causing seizures], but they meet in time at the hospital.

Kim, a civil society/NGO helper, dismisses bad eye:

> The tradition that came down from our ancestors, they believe, you know**,** bad eye, they does call it. That they got to get this onion skin, garlic skin and burn it, and put pepper [to jaray or ouchay][61], me ent know [I don't know], whatever, whatever. And den they gat to put a *tika*[62] pon the child. Black dot keep out bad eye. Black bead fuh wear pon the hand. I did none of those things where my daughter is concerned. None of it. I took her out evening time, come back late, 11 and 12 o'clock at night. If she is sleeping in my hand or the father hand, just so we go. Open the doors and take her in. They say you must back in, go in with your back in[63] and you must… [She trails off exasperated]. Oh my God! She [Kim's daughter] was small, and they say you mustn't carry babies to funerals because dis is goin' to happen to them. Oh, it's just a myth! A myth! People need to move away from those myths because they are negative to society. It doesn't do society good. The more you move away from those things the better you will be. I call dem superstitiousness. Believe in too many stupid things.

Another civil society/NGO agent, Dawn, also details and rejects the bad eye beliefs and what she generally refers to as "superstitious" viewpoints that she has encountered professionally, particularly from parents who seek her assistance for their children:

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[61] Refer to footnote 19.

[62] *Tika* – also *tikka* – refers to *kala tika*, meaning "black dot" or "black spot", which is a round mark placed on a child's forehead or other part of the face usually using eye makeup (*kajal* or eyeliner) to ward off the evil eye or bad eye (Falck, 2019, p. 14; Nesbitt, 2001, p. 155). The use of the kala tika is usually practiced among societies belonging to the Indian subcontinent and its diasporas (Kaya et al., 2009).

[63] In this part of Kim's telling, she speaks of a common superstition among Guyanese. When one enters their home after dark, one should walk in the doorway backwards; or, as Kim explains, "They say you must back in, go in with your back in…" which is said to prevent spirits and jumbies from following one into their home (Chutkhan, 2020; Donato, 2016; Primus, 2014).

> They [parents] would come with the little bracelets[64] that they put on the children's hands. You know I grew up in the city [Georgetown]… and my parents were very Christian… so you know, we did not have contact with a lot of these kinds of superstitious things. So they would come with the little beads around the children's hands, and they would put the thing [referring to *kala tika*] on the children's forehead... They would say they would not accept the child had a medical problem, which needed intervention. It was all some spirits and they would go and have the child "bathed in blue".[65] They would always talk about this. They would never say to you that my child, when she was born, did not cry; she lacked oxygen. That was something that was very foreign to them. It was always "something happened to this child" or "something happened to me" or "somebody has done", you know, "done something to the child", you know give them bad eye. That's the term that you hear. That somebody give them bad eye. It was pretty frequent.

The accounts of Mustaq, Deonarine, Kim, and Dawn communicate the prevalence of bad eye beliefs as they talk through the limits and possibilities of supernatural attribution and the spiritual and medical approaches sought to solicit relief, especially as it relates to children.

When detailing their encounters with the public, some religious/spiritual helpers outlined how people seeking their care primarily assume that distress is caused by supernatural interference, despite their insistence that distress – in specific cases/contexts – is related to biomedical drivers. Winnifred, a Faithist Reverend, explains:

> Well, all the time they use the phrase "somebody do". But I find it, for me, it's an ignorant thing to say all the time, "somebody do". And it's not so. It's not true. Many times, it's medical cases… Sometimes you have to make long speeches before they understand. Sometimes they leave you and go other places, see other people [other practitioners of varying faiths], and eventually they have to turn up back seeing the doctor indeed.

Pastor Ralph emphasizes the need for medical intervention as the main approach when the situation necessitates it, with prayer and spiritual rituals assuming a role – though not the primary method – especially in emergency situations:

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[64] Like kala tika, small bracelets made of black thread or black beads are utilized as a protective measure and placed on a child's wrist to ward off bad eye in Guyana and other societies with similar belief systems (Ali-Chand et al., 2016).

[65] "Bathing in blue" refers to a traditional medicinal bath that gets its colour from the indigo or synthetic ultraviolet agent (such as Reckitt's Blue) added to the water (Vossen et al., 2014). This bath is intended to be a cleansing and protective ritual from bad eye, especially for children (Vossen et al., 2014).

> When it involves [the need for] a medical intervention, we have to be strong enough to do a referral and we have to come to the place where we ascertain quickly whether this thing is possession or this thing is just a mental disability. We pray [for healing] for both, but there has to be the medical connection. Of course, this is my position… Point them towards medical help where it is needed. Pray for them.

Deonarine takes a particularly strong stance and stresses the need for biomedical intervention: "You see generally, generally in the environment that we live, if you are mentally ill, you have to go to the doctor." Earlier in his interview, he explains that most of the cases brought to him with claims of spirit possession are instead caused by biomedical and social drivers, but that "there are a lot of religious fanatics, who tell you about demons" (Deonarine, Interview). In Chapter Seven, the religious/spiritual helpers expand on their belief systems and the ways in which they intervene on multiple levels to relieve distress when distressed individuals and families of the distressed seek their counsel.

It is important to note that religious/spiritual practitioners are not the only segment of participants who refer people to a diversity of approaches. Medical professionals also engage in cross-referral practices, sending their patients to seek what is commonly referred to as "outside" help or "outside doctors". "Outside" tends to mean practices and practitioners who operate separately from the conventional biomedical model and often references Obeah and Kali Mai traditions, which, as mentioned in Chapter One, are historically stigmatized belief and faith systems in Guyana. Lionel believes that distress is caused by a multiplicity of factors, including supernatural drivers, as demonstrated by his firsthand account of witnessing spirit possession. For this physician, even though the biomedical model is the primary approach utilized in his practice to care for distressed people, he also understands that supernatural interventions may be necessary. This is so because he believes that possession events, like the one he witnessed,

necessitate it; or because he believes that medical doctors have lost the confidence of their patients. Lionel explains:

> Some doctors will say it like that [to go "outside"]. I try not to think like that. To be honest with you, I haven't seen too many here but some illnesses can be mind over body, eh? And mind over body illnesses, if you don't have the confidence in them [patient] and you tell them to go to a maji [imam or other Muslim faith leader], that alone would cure them. So, when you say "go outside", you don't have the confidence of the patient.

For Lionel, the placebo effect may be at work when people are referred to, consult, and find relief when they "go outside". NPH worker Monty, who believes in the supernatural etiology of distress, outlines how some medical doctors refer "out":

> Some [medical doctors] who would know from the time they look at this patient based upon their evaluation, then they would say that this is not for here [doctor's office/hospital/medical clinic]; you have to take them "out". They [patient's family] would understand what the doctor means: "This is not for us [medical doctors]. This is not our case. You have to take him or her 'out'."

Asked to clarify exactly what is meant by "out", Monty says: "Either to your witch doctor, or your priest, or your pastor, or your whatever." Teke, another medical professional at the NPH, also mentions what is considered the common practice of utilizing "outside" help: "You have to go to the bush doctor or you have to ask for help 'outside', 'outside' help. When the patient tell you… 'I went for outside help', they talk about these kind of work." Religious/spiritual helpers, too, shared stories of people being referred to them by medical doctors. Kali Mai Priest Navindra recounts an experience where a medical doctor ordered a patient's family to consult an "outside doctor":

> Boy from West Bank was ill, and the medical doctor told the family to go and see an "outside doctor"… Dat mean people like me and suh… So they [boy's family] came and after I finish reading[66] [interpreting from religious text] and tell them what happened, the mudda [mother] say discharge de boy [from the hospital] and they bring him to the temple… I guh an' do de wuk an' thing [I performed the ritual duty]. And when I done do de wuk, de bai feel good.

[66] Refer to footnote 54.

Khemraj, another Kali Mai Pujari, had similar experiences. He explains the advice of "going outside": "When it's an 'outside' sick, it's like 'somebody do you something', right, or 'something happen' [spiritually]. So, the advice now is that you have to go to the Mother [Kali], and there again is your belief. You can't do something and nah believe." These narratives show how referral practices operate in multidirectional ways, simultaneously demonstrating how some Guyanese embrace plural approaches.

"Somebody do dem something"

"Somebody do dem something", found in several aforementioned accounts, is the single-most common refrain mentioned by the participants when distress is perceived through a supernatural etiological lens. As a socially sanctioned idiom of distress (Nichter, 1981), "somebody do dem something", is an adaptive, context-specific, and culturally centred conceptualization that is attuned to Guyanese realities, worldviews, and, as Reverend Jean says, "a phenomena to explain hurting, people in pain"; it is an expression which prompts the recognition of woundedness and suffering and is a colloquial tool utilized by Guyanese to make sense of the phantasmagoria of their lived experiences. Below is a representative sample of participant accounts detailing the multifaceted use of this idiom:

> Most of dem persons say, "Somebody do dem." Or they say, "Somebody Obeah dem." Well, they have done some evil thing to them and cause dem to be sick… Persons all over the place, yuh hear dem say sometimes that "somebody do them". It's a common something in Guyana. (Violet, Interview)
>
> People have come with this inclination that it is "somebody who did something" to cause them to run off and what have you. (Samuel, Interview)
>
> Yuh guh say like dis person "Obeah you" or he "duh you". (Mustaq, Interview)
>
> In the first, people are in denial [of a medical issue], and when people are in denial, these things [supernatural attribution] come up. The person is probably born with a disability or acquired a disability during life. And if they acquire it, most people will say, "Oh, somebody do dem something", especially if they are in the country [rural, village] areas.

> You may not hear it so much in the town [Georgetown], but in the country areas you might hear that a lot because of their upbringing whether it's the African upbringing or the Indian upbringing. When things happen to them, it's because "somebody do them something" that cause them to become whatever. That's a regular fear. Sometimes they say it and they believe it and they don't look for ways in which they can support the person… They leave it as it is. (Sally, Interview)
>
> In terms of somebody "doing evil" to you, that's a reality. It has happened… That is common. The problem we have in our culture is that as soon as you exhibit those things [mental distress], the first thing they say is that "somebody do you". There are, sadly, churches that play on that characteristic of our market. In Guyana, this thing is a "do yuh"… We have "somebody do yuh man, somebody tek yuh man", "somebody been to de Obeah man fuh yuh wife"… I remember hearing an advertisement a couple months ago, "Come to our service. Come let's pray for you. If yuh think yuh gat bad eye or 'somebody do yuh', come and walk through the fire of the Lord and be delivered." Man, duh ent [that is not] me thing but if you see people from the East Coast that full up that place! This is the independent church. Sadly, enough you have people who play on that characteristic of the market. If I call a service to pray fuh people who get bad eye and "somebody do yuh", this place gon' be full to the max. I slip down and fall three times, like "somebody do meh" [chuckles]. That is just a reality, and it's part of our culture from way back. (Ralph, Interview)
>
> I think it's ["somebody do dem something"] fairly common. I think that one person in their entire lifetime would have heard it or have probably said it themselves. We're a very cultural society. We still hold on to our religious beliefs. I've heard family members say it all the time. (Nicole, Interview)
>
> It's a culture Guyanese grow up with, with that Obeah thing or whatever you wanna call it… "Meh head hurtin' me, somebody do me" [chuckles]. I find it very amusing. (Kim, Interview)

Like Kim, some religious leaders expressed skepticism about the belief of "somebody do dem something", mentioning that it is too frequently adopted as an explanation for the unknown. Kali Mai Priest Navindra frowns on its common usage: "That is what's killing people. You know, that is one of the things people must take out of their mind: 'somebody do meh something'. Dem nah even guh see dactah yet." Faithist Reverend Winnifred explains that – as a typical response – the belief of "somebody do dem something" is often assumed mistakenly and is used to malign Faithists (and Spiritualists) like her:

> Everybody say that "somebody do you something", "somebody do somebody something". Every day "somebody do somebody something". "Eh, eh! Somebody do she something!" Many times, I have to stop the foolish talk… Some people say you is a spiritual leader, how you not agreeing with that? How you can agree with something that is not so? For me, I think that it really messed our religion [Faithism] up because people kinda do a lot of foolish thing and involve us in a lot of things that it's now attached to [Faithism]. Especially the one like doing evil things to people. That is not supposed to be a part of us at all. We is supposed to be saving the people instead of hurting the people and this attachment is there with our religion that we are the ones that hurt a lot of people. They [general public] don't want the chirren [children] come around you. They [general public] don't want walk to your yard, pass yuh place because you gonna "do them something". But I would tell you the plain truth because I don't have that kinda problem here… But it happens a lot. But it do happen, people don't want people to go into Spiritual people yard.

For Winnifred, Navindra, and other religious/spiritual helpers, "somebody do dem something" – while it may be a valid concern – is usually too hasty a response, which fails to consider other causes of distress and leads to the stigmatization of particular faiths and religious practices.

NPH staffer Teke recalls how often this socially sanctioned idiom surfaces in a clinical setting: "Thousands of patients come in here [NPH] and thousands of patients say it [referencing 'somebody do dem something']." Teke goes on to relay a story about a patient:

> We have a patient here. Thank God she is stable. She is a bipolar. Her husband is disabled, and they have good education, good education background. And the mother of the girl really believe that since she get up in life [elevated her social positioning, status usually via increased job opportunities, income, possessions, property holdings], her husband is a sailor and have very good salary and they bought a parcel [of land] and they have a pharmacy and very nice house, the mother really believe [referring to the belief that "somebody do" her daughter]. Coincidentally, is when the daughter started showing symptoms of bipolar, and the mother is convinced "somebody do" to her daughter because of jealousy. They [family] tell you. They [family] come in here and tell you and they believe in that ["somebody do dem something"] and even if they take medication, they go and open book [for a reading, interpretation of religious text] with the pandit and the pandit say, "Yes, I see this thing and you have to do work, but you have to continue taking your medication."

Teke's example illustrates how distressed people and their families simultaneously seek out medical and spiritual interventions – how some Guyanese do not subscribe to either/or models;

but, instead, seek relief from multiple sources, especially when they believe that distress is, partially or entirely, attributed to supernatural causes.

Patrick, a government official, explains how the idiom of "somebody do dem something" is referenced among Guyana's two dominant ethnic groups, Indo- and Afro-Guyanese:

> "Somebody do someone", "somebody work", put some spell on you, basically some evil spell via Obeah or whatever, or through the Kali Mai Puja. So, whether in the Indian community or the African community, you had people think that somebody can "duh yuh" because you wrong somebody. They go to the Kali Mai man and you know, they have your name and reading... The same thing in the African community.

When asked to what extent these beliefs are held by Guyanese, Patrick responds:

> I believe they exist very much in society. Society is more sophisticated. These matters are more private matters now… but I suspect that Guyanese people in large measure across the spectrum of ethnic strands, still believe.

Hafsa, a civil society/NGO actor, explains the expansive ways in which "somebody do dem something" is taken up and the pervasiveness of this belief across class, age, and race:

> From what I have heard, that idea that "somebody did you something", I think that more common than possession but maybe the two go together, that somebody send a spirit to possess you. I'm a big skeptic. I don't believe in any of these things. When I hear people saying that they are sick or that something is not going right in their life, their business is floundering or their relationship is having problems or that something is going wrong and they can't quite point to why or maybe there are too many factors, and they can't pull out what they think is causing it, if they've had a negative interaction with somebody, that becomes what they blame it on. Or maybe, sometimes they go and talk to somebody, an Obeah man or Obeah lady or somebody who is known to do such work, and that's what they are told, that "somebody did you something" and this is what you must do to remedy it. I have heard that from several people, people who are esteemed in their communities who I've heard this from… I've heard this from Amerindian people, in the interior, on the coast. It's pretty prevalent. And heard it from young people as well as older people. And, like I said, it surprises me because I'm skeptical but so many other people seem to believe it and sometimes, I think maybe there is more to this than I'm giving it.

Nichter (1981), in coining the concept "idiom of distress", exposes the varied ways in which people from non-Western societies express and manifest distress – through specific terms, sayings, and acts or performances. For Nichter, idioms of distress are not a "museum exotica

separated from their contexts of origin", nor are they to be held captive by the DSM-IV's (2000) categorization of "culture-bound syndromes", which only serves to reify this idea (Kaiser & L. Weaver, 2019, pp. 589-599). Idioms of distress emphasize the ever-shifting realities of local contexts and people who live in these societies. "Somebody do dem something" is not a fixed expression of distress; it is sensitive to dynamic, Guyanese-specific worldviews and experiences, which should prompt helpers to "explore how people experience distress" so that they may, in turn, "examine how they [distressed people] talk about it and act around it" (Kaiser & L. Weaver, 2019, pp. 589-599). At the beginning of Hafsa's explanation, she makes a point of citing her skepticism, which she also reiterates nearing the end of her account; however, there also appears to be some ambivalence and ambiguity in her voice as she talks through how common this belief is among Guyanese from all walks of life. Hafsa wonders if there is "more" to these beliefs than she allows herself to believe, which is a polyvalent refrain that other helpers also expressed. Jean, a Christian Reverend, captures the inexactness of the struggle to make sense of the world:

> As I said, we are people who come from different places with different kinds of philosophy of life and religion. Still people have some kind, some level – not total – of understanding of themselves in relation to this whole universe and all of the forces of life around them. People are always trying to make some sense of it.

Perhaps "somebody do dem something" allows for people to engage in a kind of sense-making of their realities and their struggles. The idiom of "somebody do dem something", as an expression or manifestation of distress, is an emphatic request for assistance that is intelligible to Guyanese and recognized as a pain point; it is an expression that allows for the ventilation of a range of feelings and emotions, bearing an implicit desire to comprehend and alleviate suffering.

Based on the accounts of the helpers as they outlined their professional and personal experiences in this and the previous chapter, it appears that Guyanese, in aggregate, do not

subscribe exclusively to any single explanatory model or approach to care in managing mental distress, even though the biomedical model is the privileged and formalized site of care. Indeed, even as the biomedical model is not as widely embraced and is less emphasized by the lay population according to the participants, it remains an important avenue of care where relief may be derived. Though perceived supernatural causes are emphasized, and the help of religious and spiritual leaders is frequently sought – as will also be further explored in Chapter Seven – these specific explanations do not capture the full picture of perceived causality. To be sure, interpersonal and socio-economic/structural causes are also given great weight as well. Wrap-around and diverse approaches to address and ease distress are underscored. Based on the accounts of the helpers, Guyanese are exploratory in finding and utilizing a range of methods to relieve distress, and they appear to be apprehensive to ultimatums and either/or approaches in care, opting for a diversity of choices instead.

Chapter Seven:
The Role of Religious/Spiritual Practitioners

This chapter is attentive to the specific role of religious/spiritual practitioners and their modalities in addressing mental distress. Helpers across occupational categories including those belonging to the medical professions and social service and civil society/NGO spheres pointed to the immense social purchase and appeal of religious/spiritual helpers. For better or worse, they explained how people experiencing mental distress and/or the families of those experiencing distress often seek out religious/spiritual intervention initially, whereby religious/spiritual practitioners may be the sole point of care or may be utilized as one of many points in an individual's care pathway as they utilize multiple approaches and access other resources. This is especially common when Guyanese understand distress through the prevalent spiritual/supernatural explanatory model. The first section of this chapter outlines these narratives, specifically the way in which helpers across the other occupational categories identify how religious/spiritual practitioners assume the role of first responder.

The second section narrows its focus to the specific accounts of the religious/spiritual helpers and how they talk through their methods of assessing and intervening to provide care – detailing their approaches to ensure that people seeking their counsel "come back good" (Deonarine, Interview). The previous chapter made clear that all of the religious/spiritual practitioners believed that mental distress is caused by a multiplicity of factors, some of which intersect. Correspondingly, and as will be demonstrated in the first and second sections of this chapter, their approaches to healing and restoration also differed depending on their assessment of causality. Through powerful storytelling – sometimes in dramatic form in the ways that they physically acted out and expressively recounted detailed examples of care, ritual, and healing – the religious/spiritual helpers revealed their process for differentiating causality; how they

listened, intervened, and worked to restore the wellbeing of the individuals who sought their help. This chapter demonstrates how religious/spiritual practitioners are interlocutors of care; they are bridges between mentally distressed people and (1) medical/social service professionals; (2) the supernaturally interfered body and the spirit world; and (3) kin and kith. They are powerful mediators who intervene on multiple levels with an expressed desire to generate holistic healing.

This is not to say that religious/spiritual practitioners in Guyana respond dramatically different from religious/spiritual practitioners elsewhere. Numerous studies show how, in other parts of the world, they intervene in similar ways (Hays & Aranda, 2016; Igbinomwanhia et al., 2013; Leavey et al., 2007; Turner et al., 2019; A. Weaver et al., 1996). This section intends to show how religious/spiritual helpers in Guyana provide care – detailing their methods and practices – because they are widely considered by the majority of participants to be first responders. To be clear, this chapter is not meant to argue that the counselling provided by religious/spiritual practitioners in Guyana is superior or profoundly peculiar from similar practices in other societies. I am provoked to investigate how Guyanese religious/spiritual practitioners do their work because they are so frequently sought out to provide care. This phenomenon is understudied in Guyana. The nuance of how this proceeds in the Guyanese context, specifically in relation to questions of mental distress and madness, is not extensively documented.

Importantly, the third section of this chapter is attentive to the hazards of paternalistic, siloed, and fixed models and practices of care – whether they act alone or together. To be sure, and as shown in previous chapters and will be further explained in this chapter, all of the religious/spiritual helpers spoke authoritatively about their curative abilities when they believed

that care and healing were within their power. Nevertheless, they also emphasized their referrals to and/or collaborations with other agents of care (doctors, social service professionals/NGO actors, families) who employ different (i.e., doctors dispensing psychopharmaceuticals) or similar approaches (i.e., social service professionals/NGO actors utilizing lay/peer counselling or clinical psychoanalytic therapy, an in-depth form of talk therapy), when they were not able to fully provide all elements of care they deemed necessary to ensure therapeutic outcomes. In this way, the religious/spiritual helpers expressed that they understood their limitations when they made referrals.

Even so, the best of intentions – driven by the desire to bring about healing – can be nullified if approaches to care are filtered through existing, morphing, and interlocking systems of oppression (e.g., sexism, racism, saneism) (Combahee River Collective, 1983), which is displayed in some of the attitudes expressed by a few participants, serving to complicate and reveal polyvalent and problematic narratives of intervention. Even joint collaboration between different categories of helpers – employing various methods of care (i.e., biomedical psychiatry and traditional medicine) – with a common mission of alleviating suffering and mental distress, can lead to questionable approaches. An example of this will be discussed in section three of this chapter through an analysis of the psychodynamic therapy sessions conducted on an Indo-Guyanese girl named Drupatie by Psychiatrist Enrique Araneta, in cooperation with Kali Mai Pujari Jamsie Naidoo, at the NPH in Berbice (then known as the Mental Hospital) during the 1960s (Singer et al., 1980).

Religious and spiritual interventions and other practices that come to constitute Caribbean traditional medicine and healing approaches should not be romanticised. The deaths of Sangeeta Persaud, Todah Richards, and the alleged violence that mark these cases outlined in

Chapter Two and other incidents like them are haunting reminders of this. Conversely, these approaches must not be discounted either because they can serve as beneficial elements of care in relieving mental distress (Koenig, 2009a, 2009b; McKenzie et al, 2011; P. Sutherland et al., 2014). This chapter concludes with a provocation by asking what it might mean to decenter and to provincialize (Chakrabarty, 2000) biomedical psychiatry's dominant and pervasive role in the treatment of mental distress in Guyana. Biomedical psychiatry is considered the original site and method of treatment though other, centuries-old approaches also persist and provide degrees of utility. In view of Guyanese understandings of mental distress as discussed in previous chapters and in consideration with the first and second sections of this chapter – which are attentive to the role of religious/spiritual practitioners as first responders and their approaches and practices that intend to allay mental distress – it appears that biopsychosocial-spiritual (Sulmasy, 2002) understandings of health and wellness are an important aspect of the human condition as understood in Guyana. As important as the biopsychosocial model (Engel, 1977, 1980; Ghaemi, 2009), the spiritual element is emphasized by participants; whereby, religion, spirituality, and traditional medicine and healing practices are inherent and constitutive of holistic and integrative understandings of health and wellbeing in the treatment of mental distress in Guyana.

Religious/Spiritual Practitioners as First Responders

When distress is, in part or in significant measure, understood through the prism of supernatural etiology, religious/spiritual practitioners tend to become first responders. This is especially amplified in a country where mental illness and madness is highly stigmatized (Lacey et al., 2016; World Health Organization, 2008) and patient confidentiality appears to be compromised surrounding these specific issues, per participant accounts from this research as

outlined in Chapter Five; the vast majority of the population (73.6%) live in rural village communities (Goede, 2014), away from the inadequate, formalized mental health care system where resources are particularly centralized at the Georgetown Public Hospital and the NPH in Berbice; there is distrust of the public health care system, the government, and other bodies of the state, such as law enforcement and the criminal justice system (Oosman, 2019; "Activists Protest GPHC Cancer Deaths", 2019; "Social Activists Call for Greater Transparency", 2019; Sutton & Baxter, 2017); and there are high economic barriers to access private health care through a fee-for-service model (Gafar, 2005; "The Deaths of Two Children Should be a Wake-Up Call", 2019). As mentioned previously, Guyana's public health care system is also positioned poorly in global rankings, is underfunded, and its infrastructure is deteriorating (Fullman et al., 2018; Walker, 2017; Goede, 2014; Misir, 2015). Pastor David clearly and succinctly captures most of these aforementioned barriers to care:

> Because economically, it's expensive to treat people in Guyana. One session with a psychiatrist, who wants to pay that? Who wants to take your child to the Georgetown Hospital because this child is acting funny for them to say, "Okay, we're going to keep them overnight in the Madhouse," and everybody gon' know you child is a mad or you spouse is a mad person? Very often involves getting the police involved. Who wants to bring the police to the community? … They come and dash you in a van and take you. Who wants that?... These are some of the stigmas and difficulties of treating and handling mental issues. The first thing they do is quietly go to the church. Quietly say we are taking you to the church and go their way in private and do what they gat tuh do.

While all of these factors contribute to the ways in which religious leaders come to act as first responders, it must be emphasized that when distress is attributed to supernatural etiology, biomedical methods of alleviation are usually adjudged incompatible or unfit in the provision of treatment and finding relief.

For the medical helpers, it is common for their patients to first seek the counsel of religious/spiritual practitioners and the use of Caribbean traditional medicine and healing

approaches before biomedical interventions. Lionel, a medical doctor, says: “I think they do it first [visiting religious/spiritual practitioners for care] before they come to us [doctors]… Majority would do that.” Another physician, Ponel, states: “People go to church.” Sati, an aide at a physician’s office, explains: “They don't see it as a medical condition at first. They think that they need other help and so they probably go to church or the pandit or maji or whatever. I think that happens to most people... We had two known cases in recent times. Persons or relatives took them [patients] to church before we saw them [patients] here.” Staff at the NPH explain how most patients seek religious/spiritual helpers first before psychiatric interventions:

> They [religious/spiritual practitioners] are normally the first responders most of the time because relatives would say we took him [patient] to church and pastor pray for him… But other persons would take them [patients] to Spiritualists. They [general public] call them Spiritualists. They [Spiritualists] give them things to bathe with, things to eat, and those sorts of things to remove whatever sorts of spirits they think they have on them. (Wendy, Interview)

> Sometimes they [patients] say that they went to this pandit and pandit tell dem. They went to the maji and the maji tek off dis thing. They went hay [here] and some man do some work and get off part of it, and the last place they comin’ now is at the mental hospital, the National Psychiatric Hospital. But then you have to give people their way. We cannot tell them no. Everybody has their belief. And you know, belief kills, belief cures. Give them their way. They went. Respect their view but let us look at our aspect now of treating with them and how we will deal with that issue… Religion is something you don’t play with. They have their belief, and you can’t take that away from him… You have to respect persons’ religion… But as I tell you, still you cannot stop the persons from going to their maji, pandits, their pastor. They would still do it. Persons sometimes tell you what they think you want to hear. Then they go back and do what they want to do. We still can't stop that, like any other human being. (Violet, Interview)

> They would go to different people. They call them the Obeah man and whatever, people who tell dem, I think they would tell dem what they want to hear that “somebody do dem”, and they would go to church and churches, and tell them that they need prayers and that they are demon possessed. They would go different places. (Colleen, Interview)

> Most of them would probably turn to church and these things instead of coming [to the NPH]. If they do have a mental issue or illness, they wouldn't really want to come here to the Hospital. They prefer probably to go to the church and talk about it. It depends on the situation. They’d probably get some counselling there and all, and some church would deal with it differently as if it’s possessive behaviour… Sometimes if it's a new patient,

> even an old patient, what they [family] would do, they would take the patient. They [family] personally believe that it's something possessive with the patient and they [family] would take the patient to several, these Obeah men or people who do these things, several of them, they would take the patients to, and after a long time, they would see no help, they bring them right here [NPH]. (Salima, Interview)

> "Somebody put evil on you", so the first thing we do is we take you for deliverance to see what our imam, or our pandit, or our priest or whatever can do for you. And when the situation gets out of hand, they have to bring them to the mental hospital. Or you have to go to the bottom house doctors [similar to "outside doctors"], back to the witch doctors dem. So there is three choice: either the physicians which is the psychiatrists, either to the witch doctor, or to your pastor or priest or de pandit. (Monty, Interview)

In addition to citing how religious/spiritual practitioners act as first responders, some of the medical helpers emphasize how Guyanese seek out care from those representing different faiths and how they also utilize biomedical interventions, but usually as a secondary option if they primarily attribute their distress to supernatural causes.

Balram, a Sanatanist Pandit, explains why some Hindus seek out pandits first and why there appears to be reliance on religious interventions:

> Those persons have confidence in the pandits more because they would come to you firstly and they will make sure their astrological inclination and beliefs are in the best way; it safe that their planets are well, the influence of the planet is good in their lives, and then they can turn to the doctor. We [pandits] will tell them that "Oh, this is a medical problem. You need to seek doctor's advice and their professional medicine."

According to Balram, conducting these readings requires consulting a host of Vedic astrological indicators, which allow pandits to "see if there are particular instances where the person is being affected, we will say the person is suffering the negative influence of the planet, which is a *grah*[67] we call it". Per Balram, some Hindus view their wellbeing holistically and want to ensure

[67] *Grah* or *graha* generally "symbolizes house which is denoted by planets in a person's ***kundli***" (Yadav, 2021, p. xiii). Kundli refers to the "natal chart in Hindu horoscopes" and "encompasses the twelve houses and details of an individual's planetary positions in those houses" (Yadav, 2021, p. xiv). Grah, with its origins in the Rigveda, also means to grasp, seize, and to take hold or possession of (Yadav, 2021, p. xiv). In Guyana, grah has negative connotations and tends to mean the "pain caused by the influence of the planetary deities… of Hindu astrology", which is viewed as a "source of affliction accepted with equal gravity by Shakti practitioners and Sanatan Dharm pandits" (Strange, 2021, p. 144). As a source of affliction, grah may translate to ill-health, untimely death, job loss, and other misfortunes, including mental distress.

that their cosmic and astrological chart is in alignment before seeking medical care. Once astrological balance and favour is established – sometimes through the performance of ritual duties or "work"/"wuk", as mentioned previously (Rampersad, 2013, p. 60) – people are more assured of the possibility or need for medical intervention.

For civil society helper Nicole, there is a perception that some religious leaders – in contrast to others – embrace the position of personal counsellor more readily, which serves to catalyze the role of religious/spiritual practitioners of specific faiths as first responders. Nicole believes that Christians and Christian clergy see personal counselling with the goal of alleviating distress more favourably; therefore, it may be viewed acceptable to initially seek out Christian clergy to address diverse personal troubles that lead to the acquisition of mental distress (e.g., financial, interpersonal, familial stressors). Nicole explains:

> Counseling in the Christian faith is more of a normal or a regular something that you do and more accepted. It's okay for you to go and talk to your pastor about something. It's okay to go and confess and talk to your pastor freely. I'm a Hindu, and I've not noticed that in the temples. The pandits… the most counseling that they would do in terms of religious aspect is if somebody needs a religious service done [work/wuk]. But in terms of counseling to say, "Oh, I think I mad, pandit" … Unless they're going to say, "Do you think 'somebody do me', 'somebody do meh', and that's why I'm mad?" But we [Hindus] don't have that kind of counseling.

While Nicole claims that Christian leaders appear more receptive to the role of counsellor to address the nuanced causes of distress, she simultaneously admits that it is customary to see a pandit for reasons related to spiritual interference, even though – in her opinion and through her experience as a Hindu – people may not seek the counsel of pandits for other life stressors. Additional research is necessary to comprehensively explore this perception and the role of religious/spiritual practitioners across faiths as first responders in Guyana more generally.

The immense role of religious/spiritual helpers, especially when distress is attributed to supernatural causality, is also emphasized by another NGO/civil society participant, Daniel. He

describes one case where a young man was first taken by his family to see several religious leaders before medical professionals:

> Some members of the family did not believe that this person had a mental disorder, and they took him to see various religious leaders to be healed and after it didn't work and after about four to five years, they came around to accepting the fact that it was a mental health issue. The individual accepted it from the beginning, but the family didn't. (Daniel, Interview)

Daniel describes another case of a young woman whose family initially sought the care of religious/spiritual practitioners when she became distressed, only opting for biomedical interventions after exhausting available spiritual approaches:

> There are some people who according to their religious leaders, especially if they don't understand that it's a mental health issue, they both think that it's spiritual possession and we've seen that in a lot of cases… I know a young girl personally. Apparently, she has schizophrenia and she started hallucinating and the family members thought that she was demon possessed. Took her to the pastor; he prayed over her. This was a pastor at a Christian church. Nothing happened. So they took her home. They took her to another pastor and no improvement. They took her to a Hindu pandit. Nothing. So then at some point somebody probably told them that there may be a medical explanation for it… I think it was a relative that was living in the [United] States who told them to go to the Georgetown Hospital. So the family took this girl to the Georgetown Hospital and she was diagnosed… So everybody in the village knew that this girl was mad, and she's on medication and it is helping her to get better. She is still on medication… She gets a lot of support from the Church. That's a big, big factor. Getting the support from people, even if they don't understand what mental illness is, at least understand that there's some clinical medical reason for a person behaving the way that they're behaving and it's not just acting out for no reason whatsoever.

As pointed out by Daniel, biomedical options were more effective, but the support rendered by religious leaders can be a crucial element of care as well. Recall from the previous chapter, he does not privilege the supernatural explanatory model of distress. Instead, Daniel believes that religious/spiritual practitioners must acknowledge the parameters of their interventions: "Religious leaders have a very important role to play. They are a group of people that ordinary Guyanese turn to in times of distress… It's important that they be properly educated on the limits

of things that they can do to help, and we need for them to make referrals when they cannot address the situation."

Daniel's sentiments on the crucial role of religious/spiritual practitioners and on the limitations of their interventions are also emphasized by others. Among medical professionals, civil society/NGO agents, and social service actors, many believe that the role of religious/spiritual helpers should only be limited to referring people experiencing distress to biomedical pathways and psychosocial supports, though some believe that pastoral or clerical counselling is an important element of care.

> Religious leaders should know their limitations. Guide, advise, but if you can't help, send for professional help… They should know when they have a psychological advantage or when the advantage cease, send to the doctor. Religion is good. If you're respected and you talk and listen and you see positive vibes, not a problem, but if you feel you're not getting at it, you must know the limitations. Nah true? (Lionel, Interview)

> Religious leaders have an important role to play. They have to assist with the awareness. When they have their sermon on a Sunday or so in this way, they also have to bring in the issues to the congregation, the social issues. There has to be collaborators. (Kim, Interview)

> I think that their [religious/spiritual practitioners] role should say to go to the doctor. Because mental health is so particular, you really need that specialist. And not for somebody to pronounce on something. I think they should say go to the doctor. (Nicole, Interview)

> The churches need to educate too… Yes, they believe that there is evil spirits but not every behavior is demonic behaviours. Stay away from giving a diagnosis that they have demonic possession, and not be so quick to judge that this person is demonic. (Lesley, Interview)

> To be adequately informed to begin with and to not diagnose because remember they are caught up with evil and sin predominantly and this is how they are trained, so their role should be only a conduit, an ability to recognize that there is need for special help and to conduct that person towards the help they need. (Ponel, Interview)

> I think we should work together as a team, because they does their counselling and so on, but then they don't refer the patient here, right? They does their counselling, and they deal basically with God and say that God gon' heal it and everything gon' be okay and so on. They don't look at the medical part that maybe the patients can come [to the NPH],

along with the help of God and treatment and get some more help. But that don't really happen. If they [religious/spiritual practitioners] take over the patient, the patient start going to church or going to mandir or whatever for healing, it stays there and that can basically be that the family don't want it out [don't want others to know]. They go very easy [quietly and/or privately] because there is stigma. (Indra, Interview)

I think the role of religious leaders should be limited or restricted to identifying the problems and then referring people to professional services and professional help where they do exist. I don't think religious leaders should try to become psychiatrists, psychotherapists or anything of the sort. There also needs to be training and sensitization to religious leaders for them to recognize that their role is limited… There needs to be a lot more work with faith-based communities on gender issues, issues of gender justice. More on the prevention aspect to show how good doctrines and so on that they promulgate and put forward, often around gender issues, the role of women, eye-for-an-eye mentality, beating children, on homosexuality, how they are driving some of these issues. I think we need to work with religious leaders more on the preventive aspect of things. I think there's a small minority of religious leaders who understand these issues and they need to be supported more into broadening those networks. (Lance, Interview)

Sometimes I hear people beating up on religion, and I make the point always, I don't beat up on religion because I believe. With all this deficiency, it is serving a useful purpose… For me, religion is a useful tool for mankind. Like it or not, I have seen it help people. Of course, they have a part to play but they believe that it is their faith. I don't take that away from anyone… So, I forever say, with all the deficiencies of religious organizations, there are many, don't take people's faith away from them. You will have a worse place to live in… He [religious/spiritual practitioner] is trained to dispense the Spirit of the Lord. He is trained to believe that God can deliver miracles. That is in his psyche. It's not easy a lesson to have him say, "Listen, my God will not be able to deliver or work a miracle." So, it calls for our relationship and education whereby I don't see any difficulty with the two of them [medicine and religion] working together. That is where we have to get… Too many religious people continue to rely on the faith alone. If you're a Bible student, the Bible says that which is natural comes first and then that which is spiritual. So, the prophets recognize that there are natural things that we have to do and spiritual is not a substitute. That is where we walk over the line, when we're attempting to use spiritual intervention as a substitute. Spiritual intervention is supposed to be complimentary because after they finish stitching me up, I must continue to believe that I will get well. I can't just continue to believe that I gon' get well and I still got a cut that needs 23 stitches, so you have to have the natural and the spiritual working in conjunction. (Patrick, Interview)

They [religious/spiritual helpers] need to refer, but I don't know if some of them refer and the people don't come. Remember that the people going there pay large sums of money, and I'm not the one to say whether or not that faith leaders don't say, well, come to the Hospital… When we're doing education, we always try to involve the faith-based leaders from various denominations, but it's left if they want to come, you cannot force them to come. But once you're doing education, they are always involved, but it's left to

> them. If they don't want to come, Savitri, we cannot bring them… Sometimes we use the temple to educate. Sometimes we use the church to educate. Put aside this clinic, sometimes you go out and do medical outreach. You involve the pandit, the priest, the maji, and you get large attendance, and you get to do the groundwork in the church. Sometimes you have a good influential church leader and there is where he could get a hold of the flock of audience and you know, you bring them in. (Violet, Interview)

> They [religious/spiritual practitioners] should talk to them [distressed people], like you know, just talk to them on a one-on-one. Give some advice. They should pray with. I mean, some persons do say prayers to help. Of course, prayers to help. If they [religious/spiritual helpers] pray with them [distressed people] and get them involved in sessions where they would discuss their issues and see what advice they can give to them and all of that…. If they're [religious/spiritual practitioners] counseling or talking with a [distressed] person, they see that something is wrong with them, they should probably refer them for some medical treatment if that is necessary. What they [religious/spiritual practitioners] should do is making sure, you know, it's being done because sometimes they [religious/spiritual helpers] might tell a person to go seek some medical attention and because they [distressed person] are afraid or ashamed or the stigma, they [distressed person] wouldn't come. (Salima, Interview)

Most helpers cite the frontline status of religious/spiritual practitioners and all believe that religious leaders have a role to play (mainly one of medical referral) primarily because of the outsized influence of religion in Guyana. The role that religious/spiritual practitioners should play according to the other helpers, however, is circumscribed in size and scope depending on the meaning and etiology of distress that the helpers privilege, with most medical professionals, civil society/NGO agents, and social service actors predominantly preferring biomedical and psychosocial interventions.

This is not to say that religious/spiritual practitioners do not make referrals to helpers in other fields. On the contrary, and as shown in the previous chapter and will be demonstrated more fully in the next section, they readily make referrals to medical, civil society/NGO, and social service helpers when they deem it necessary; however, when they adjudge that supernatural interference is the cause of mental distress, they respond by utilizing a range of Caribbean traditional medicine and healing approaches. Jean, a Christian Reverend, keenly

understands the difference that religious support makes, even though she cites that the role of religious/spiritual helpers can sometimes be "detrimental": "They are the ones who are the frontliners, who people go to first. And this can be very detrimental. I've seen it being very detrimental." Jean describes how some religious/spiritual helpers may target and play on the vulnerabilities of distressed people seeking their counsel, but she also explains that religion remains an integral part of Guyanese life:

> Let me say this as a religious leader, there are some religious leaders who pray and then there are some religious leaders who p r e y [Jean spells out the word prey] off of people's vulnerabilities. This is a huge one because it is an unknown [understanding and addressing mental distress more generally]. Not only that no one wants to talk about it. That's one factor, but people don't know how to deal with and address it [mental distress]. That's why it becomes demon possessed. If you see something and you can't quite label it, it's not high blood pressure, it's not a cut, so it's unknown and it's fearful and it's labeled demon possession very, very easily. The moment that more people start to talk about it, it becomes more and more demon possessed. You need the pastor, or the maji, or the pandit, or whoever who becomes the authority on this and who has all of that power to deliver – you know what is the power to deliver someone?! It is tremendous! I think that there is a grave danger here where, on the one hand, we don't have resources in the society. It's not recognized. We don't know what's going on. There needs to be so much work in terms of people understanding what's happening… not just consciousness but education… So who will have the authority in this? That's why the religious leaders in a big way are the authority and many of them p r e y [Jean spells out the word prey again] off of people's situation. A religious leader cannot say… "I can't do this." … You are supposed to be a mediator between God and this person and therefore if you cannot show and demonstrate that, it's a big deal… People come to church, one, with hope; a lot of strength; but also, with a lot of vulnerability. They come to find relief in some ways. To find something else apart from what they know about… I do believe that the religious institutions here are of tremendous influence in this society on every aspect of life.

Other religious/spiritual helpers expressed similar narratives, especially as it relates to the financial exploitation of distressed people:

> There is this gospel or healing for money. People are led to believe that they can pay their way into blessings; they can pay their way into instant healing… You cannot pay your way into these things. (David, Interview)

> Dem [some religious/spiritual helpers] ah do this thing [spiritual interventions] fuh moneymaking… Dem does use people to get money. (Khemraj, Interview)

> They [some religious/spiritual practitioners] just look fuh see where de money gon' pass. [chuckles]… They [some religious/spiritual helpers] wouldn't be willing to help anybody. Lewwe [let us] say somebody come through that door now and they sick. They [ill person] would have to wait and give them [some religious/spiritual practitioners] money right before they [some religious/spiritual helpers] heal them [ill person]. C'mon, you know what I mean? Dah kyan [that cannot] be de manifestation of de Holy Spirit at all! Yuh see? You gat tuh [got to] look at [take care of] the patient because God must provide. He [God] call you to the realms and provide the stuff to look after the people. And when you look at dem [take care of ill people], well, some people would give [money] and some don't give [money]. Wha' you gon' do? Would you not heal them? You gat tuh heal dem! I can't allow them to dead. You can't allow them to die. (Winnifred, Interview)

Medical professionals like Lionel believe that these attitudes, such as preying on a distressed person's vulnerabilities, are also accurate: "And some of them fleece them you know. Cost them [distressed people] a lot of money sometimes. You have to pay a lot to get rid of it [spirit/supernatural entity]." NPH staffer Teke expresses that religious/spiritual practitioners have great potential to be changemakers in Guyana if they reject the influence of money: "The religious leader, if they really believe in their faith, they could do a lot of change in the population, but they have to be honest. They have to be honest with themselves, and not use religion as an opportunity to make money. You can see that in all the religions." There have been reported instances where migrants from India purporting to be pandits "allegedly scammed several Guyanese into believing they possessed mystical powers capable of solving problems" as they "raked in millions of dollars" only to vanish shortly thereafter (Gildarie & Andrews, 2010). Suspicions about the financial motivations of religious/spiritual practitioners are not uncommon in Guyanese society. Williams (1991), notes:

> Even among Sanatan Dharma Hindus, Brahmins who are practicing pandits are suspected of exploiting religion for economic gain. The expression 'pandits are bandits'… summed up their belief that most pandits are greedy opportunists who falsely claim a Brahmin identity and assume the duties of pandit in order to fleece their fellow Hindus. (p. 227)

It is essential to weigh these narratives, which are critical of religious/spiritual practitioners, even as this category of helpers are generally thought to play a vital role in Guyanese society by all of the participants in this study. Based on their experience, Reverend Jean and other religious/spiritual helpers also hold the opinion that religion is an integral component of care when people experiencing distress deem it so:

> I also have people who were getting help from a psychiatrist, but they still come to me to talk. They want to pray because they feel a sense of feeling well, a personalized connection, and I think there's a spiritual dimension in all of this that cannot be negated… That feeling of a greater force that's involved in your own sense of being, who is able to carry you through what you are facing.

Jean emphasizes a mixed-methods approach here, psychiatric intervention and prayer. For David, a Christian Pastor, who also emphasizes multiple approaches in alleviating distress, the government must invest in its religious/spiritual first responders by providing comprehensive trainings that broaden perspectives of these specific helpers about biomedical and psychosocial interventions and by funding social support programs that run through religious organizations, thereby fostering a wrap-around and wide-ranging approach to care:

> We are first responders but ill-equipped. That's the fact. I am first to say that. So if your first responders are ill-equipped, what are they going to do? Abuse! Misuse! Mishandle! And hence the negativity you see in the papers. We're doing our best. Much more could be in the papers had it not been for the churches and the pastors like me who are trying. If the church pulls out from this and the church doesn't do its part, chaos in the society… So, I'm saying, we are first responders. We really need help. I need help. I need the government to set up education facilities, places where they can train us… We don't turn people away. The church don't turn people away… We are accepting of them but in accepting them we don't know what else to do and that is sad.

Like David, Jean underscores the need for a multi-sectoral approach, inclusive of checks and balances on religious/spiritual interventions:

> I think religious leaders should, one, have some ways of equipping themselves [mental health training], screening, but also be made accountable. It [religious/spiritual interventions] shouldn't be happening in hiding. A lot of this happened in hiding where people don't tell about the consequences. So more community-based as with NGOs… We

> should be able to expand the scope of how we address this... There are so many stories that I have about people who have put their child in a kennel. Again because of not understanding and feeding them like that and treating them like that. And then we treat animals terribly; we shouldn't but that's how it is. So because they are fearful, because they believe that some kind of evil spirit is there. The only way that you can dispel these myths is really through education. This can only be effective if it's done at levels of community organization and through faith-based communities.

The religious/spiritual helpers in this study are under no misapprehension; they understand the negative perceptions that persist about them and what they do, which circulate widely in Guyanese society. They speak openly about "fleecing" and the ways in which abuses occur; and they are clear about the need for diverse approaches to care, including spiritual interventions when deemed necessary. The next section of this chapter specifically delves into their modalities and how they specifically assess distress and care for distressed people who seek their assistance.

Emphatic Listeners, Providers, and Interlocutors of Care

As mentioned in the methodology section of Chapter One, the voices of my participants are crucial in this dissertation; and, in many ways, they are the dissertation. Documenting their realities, at times through long excerpts of animated and penetrating storytelling, is necessary if we are to better understand their approaches – especially given their role as first responders – and the practices that Guyanese seek out. In these interviews, the religious/spiritual helpers cited how empathic listening was important in establishing a rapport with and understanding of the lifeworlds of the mentally distressed people who sought their help. They discussed how, through active and responsive listening – where prayer was sometimes secondary – they forged bonds of mutual trust, cooperation, and understanding with individuals in distress, which enabled them to differentiate the causality of distress, provide individualized and family counselling, and recommend supports/other avenues of care. In this section, and through their detailed accounts of

assessing and responding to people experiencing distress, I argue that an integral aspect of their care practice is their ability to also act as interlocutors and facilitators.

Listening and Counselling: Differentiating Causality through Talk

The religious/spiritual helpers capture the power of being heard and the bonds created through telling, listening, and counselling. It is first through listening, whereby prayer is sometimes ancillary, that they are able to distinguish causality of distress. David – with great gusto, his voice booming through his tiny office – describes his process of listening and counselling:

> Come and talk with me first before we pray. Let's talk. I'm hoping that can be one of the outcomes and sensitize people more to that. Before you pray, before you begin to shout down, and lay hands and all of that, let's engage, let's engage! … You know I have not had to do exorcism or pray and call together the church for prayer because in the counselling people begin to weep and cry and shed all of this burden and all of that and then I pray a prayer with them.

Throughout the interview, Pastor David emphasizes the need for counselling:

> Counselling for me has become one of my greatest demands as a pastor… I want to meet with them and hear what they have to talk. Somewhere, I help, because the little I can do, I want to do. But my first response is not to pray. My first response is to talk. And then I pray. It helps me to pray better too.

For David, talk and counselling are central to his role as a religious and community leader of an underserved Afro-Guyanese neighbourhood. Exorcism is rarely his response because it is through talk that he deciphers why people are anguished and distressed, which he concludes are usually "burdens" or what he later describes as "difficult lives, poor nutrition, stressful family life" which cause "people to take on [worry]". He describes one memorable example of pastoral counselling where a woman was experiencing "depression, anger, anxiety" after the loss of her child:

> Two Christmases ago… I'm a sanguine personality and so I'm always happy around people and so I went to the bank. And I'm humming you know, "It's a holly, jolly

> Christmas," and this young woman who is tending, this bank teller who is tending… looks at me and said, "What are you singing about?" And I said, "It's Christmas, and I'm happy." And she said, "Well, good for you!"
>
> I recognize that she was really depressed and troubled and I said, "What's wrong? Can you talk?" She said, "A year ago, I buried my child and I don't want life. I don't want to serve you… but I have to be here so leh me deal with you and done with you."
>
> I recognized right away that she is so troubled. I took a risk and… I wrote my number on a piece of paper and said to her, "There is my number, please give me a call." She called me and I set up a meeting. I said come talk with me. She came. She had been going through depression, anger, anxiety. Life was spinning out of control. She was suicidal. She had family problems. She was beginning to become a recluse now and she didn't want nothing to do with life. And I believe she would have taken her life.
>
> From that engagement, two years ago, she meets with me every month. Every single month for the last two years now, she meets with me for one-hour sessions to talk. She has moved her life to a place where she is a businesswoman now. She serves in the church. She's about to get married… but that mental issue, that condition of losing her child with whom she loved so much and no one was there to help her to go through that… She found in this pastor a man willing to bring her to sit down and listen to her and talk with her and encourage her. She is mentally able to tackle all the issues of life now.

David, in welcoming this woman to meet with him and talk, created a space for her to mourn and to recover from the loss and grief of losing a child. He continues to hold space for her in meeting and talking with her once a month, and it is in providing a trusted ear that he believes she is able to "tackle all the issues of life" (David, Interview).

Pastor Samuel, who also listens first and then prays, describes his process, especially in trying to arrive at the heart of an individual's problem.

> You listen to what they are saying. You got to listen to what they are saying, look at their general demeanour and so on, and other aspects of the whole thing, and then you make a distinction because when people come to me to offer prayers ... and they start to talk about demons, I say don't pray right away because you might be praying for the wrong thing. Investigate, probe, ask questions. See where the person is. It is not necessarily any evil spirit affecting them, right. There might be so many other issues, relational problems, social problems, problems in the home, problems at the workplace, and so on.

Samuel does outreach work with marginalized communities affected by homelessness and substance and alcohol use issues in Georgetown. He understands that there are multiple causes of

mental distress, many of which do not involve spiritual interference. For Samuel, it is important to distinguish the root of distress, which happens through listening and counselling. He relays an experience of trying to provide care for a young woman in his church who "started to act abnormally":

> She came out of training college. She started to teach at school… Some people from the Pentecostal Church went to the home. They thought that she was demon possessed. They did all kinds of prayers to exercise the supposed demons in her. Our pastor, together with me, we didn't feel so. So we went to the home, we sat with her in privacy, and we tried to probe her [ask questions]… Then she told us her story. She was in training college for two years, and she had an ongoing relationship, not an intimate relationship. Towards the end of the training, the boy said we will have to part ways… It affected her. It affected her. So I would make the distinction there to say that it was not demon possession or evil spirits. She had an issue that she was dealing with. It affected the mind.

Samuel emphasizes that his approach to listening as a mainline church pastor must include deep inquiry: "We try to ask questions. We try to probe. We try to investigate and then we make a decision." In this particular case, it is through questioning that he was able to ascertain that this was not an instance of "demon possession or evil spirits" (Samuel, Interview). Samuel names another Christian denomination, the Pentecostal Church, and in some ways implicates their approach: "We are not dismissing or discarding evil or spirits right, but that's how they look at it to some extent, Pentecostalism." For Samuel, supernatural interference is not deemed the immediate cause of distress: "The mainline churches, like a Lutheran, Baptist, Anglican, Roman Catholic, we look at those aspects of things in a more, I use the word again, rational way." As a mainline church leader, Samuel was not alone in this sentiment; other religious/spiritual helpers (Deonarine, David, and Winnifred) also expressed how more charismatic Christian denominations more readily associate distress with supernatural causality:

> Right at the back of me there is a Christian church and you find that the pastor gat dem vomiting in bucket and tell dem the spirit is coming out… When he start preach, he gon' push dem and dem gon' fall and somebody gon' catch them and dem gon' say dem feel good, all these kinds of things, right. (Deonarine, Interview)

> The second case [referring to the death of Sangeeta Persaud], I'm aware of this one… Very, very sad … This was a Pentecostal church. We are not like that… This denomination, we're not like that. (David, Interview)

> And you have it happening in the churches too, sis! People professing to be workers of righteousness and they are workers of evil. Anyhow through their works you will know them. (Winnifred, Interview)

Ralph – who ministers a church belonging to a subdivision of the Pentecostal denomination – also emphasizes the need for careful listening and counselling, speaking back to the notion that charismatic Christian denominations are quicker to point to spirit possession as he discusses his process:

> I have a talk. They come to my office or they come to the church. In other words, I don't take their word for it. They may feel it's possession. I have to ascertain if it is. Or if it is something else… When they come, I listen to what they tell me. I take cognizance of what they tell me but I have to ascertain for myself and I ask the, for want of a better term, I ask the subject questions to ascertain again how they are behaving, who they are, if they are thinking clearly, if they can answer basic questions and that sorta thing. You take them through a process. It's not that the family comes and says this person is possessed and immediately I start praying. No, no, no! I have to find out for myself.

In Ralph's church, talking allows him to establish or rule out different drivers of distress. He strongly emphasizes how he must determine causality for himself and how he tries to prevent his judgement from being swayed by the opinions of others, like the family of the distressed person seeking his guidance. In many ways, his approach ("ask the subject questions") is similar to Samuel's (Ralph, Interview).

For Hindu (Deonarine and Navindra) and Muslim (Mustaq) helpers, counselling also involves behavioural prescriptions or explicit guidance and direction on "how fuh live" (Mustaq, Interview), "conduct yuh all self" (Mustaq, Interview), and how to "do the right thing" (Deonarine, Interview), especially in cases where discord appears to be rooted in familial relationships:

> I am a kind of counsellor… Because I'm a priest, you find people coming to me for counselling... I make up a family that had been separated for a couple of months, a young bai and girl. I make them up, ah talk to dem and this is about a couple of days now. They only came back yesterday and tell me that everything going fine, which I hope will continue. (Deonarine, Interview)

> Dem nah get none guidance…You need gat people to counsel dem. Bring dem closer to God… Talk to people. Bring dem closer to God. (Mustaq, Interview)

> Now you gat a man and he and he wife gat a problem. I put dem to sit down. Got two chair hay [here]. If the bai gat he mudda and father too I bring dem and put dem deh fuh sit down. Dat two chair deh fuh dem. Now you got to start the story from the bottom [from the beginning], right? And you finding out what tek place between these two young people. She guh give she side, and he guh give he side. Parents ah listen. I is the judge. Listen to both party, you can tell who right from who wrong. (Navindra, Interview)

Advice on "how to behave" (Deonarine, Interview), as we are told by Deonarine and Navindra, was especially helpful in easing distress and mending spousal relationships. The guidance given here, while it might seem benign and neatly reconciled in the retelling of "I make up a family that had been separated for a couple of months... They only came back yesterday and tell me that everything going fine…" (Deonarine, Interview), is deeply gendered. As will be demonstrated in the third section of this chapter, the advice given by religious/spiritual practitioners is also a product of their environments, some of which are entrenched in and reinforced by multiple systems of oppression (e.g., sexism, racism).

In these various tellings of how listening and counselling played an intrinsic role in alleviating mental distress, an important takeaway is how the religious/spiritual helpers continued to expose their particular understandings of causality; how supernatural etiology was not necessarily the default assumption. They expressed how emphatic listening and counselling has the potential to break silences as it creates and holds space for people experiencing mental distress to give voice to their concerns. According their accounts, these spaces foster conditions of healing in allowing people to feel like their suffering is acknowledged.

Interlocutors with Medical Professionals and Social Service Actors: Deciphering and Acknowledging the Parameters of Spiritual Care

> If it's a physical matter, if it's a real genuine sickness, no demon will be exorcised. That is an exorcism in futility. (David, Interview)

This subsection accounts for religious/spiritual helpers' process of deciphering biomedical, (inter)personal, and socio-economic/structural causality and their care responses, which often entailed referral to medical and social service supports. Some religious/spiritual practitioners talked at length about how the divine provided clarity, beckoning them to refer distressed people to other helpers. In this way, they recognized their domains of authority and also understood their limits in providing care. Priya, the Hindu Priestess who performs Shakti (goddess) worship, describes how "dem", referencing spiritual guidance from Mother Kali and/or other Hindu deities, lead her to make medical referrals:

> Dem [Mother Kali and/or other Hindu deities] gon' tell yuh. If you have nervous breakdown, dem gon' tell you. De mother dem gon' tell you. So dem gon' tell you go to de dactah, tek yuh treatment and den come back… Advise people to go to the doctor and then come back. When you check dem out and dem don't have things like that [spirits], tell them go to de dactah... You don't have complaint for de Mudda dem look yuh [look after/care for]… You have to go to the hospital and get treatment… You understand?

Priya, throughout our conversation, was unwavering as she talked about referring people to the doctor, particularly when it was divinely established that "you don't have complaint for de Mudda dem". Priya and the Kali Mai participants in this study physically manifest "de Mudda dem", with their bodies serving as vessels for the divine. It is through spiritual manifestation that she and others are able to decipher which methods of treatment are necessary. For Priya, it was crystal clear: "You gat dactah complaint? You gat to go to de dactah!"

Pujari Navindra describes a similar process of manifesting Mother Kali, whose powers act like a divine compass in allowing him to know which spiritual, medical, and/or social interventions are necessary for recovery:

> Right away, I'll call up the entry [Mother Kali and/or other Hindu deities]. And they will take the child before the entry to get jaray and so on. And while de Mudda guh jaray them, it guh tell dem well if a spirit hol'[hold] on pon dem. If it's natural sickness, well alright, bring am fuh jaray two morning but carry am back ah de dactah. So we wuk along wid de dactah. If yuh come here and we done treat you too, we done tek out yuh evil spirit and so on, yuh does get weak. We does send yuh back to de dactah. Go now and the dactah would find yuh complaint."

In this instance, Navindra describes how dual interventions (spiritual and allopathic) are necessary. He believes that an exorcism or other form of expulsion ritual is needed to "tek out yuh evil spirit", but once interventions are made to bring about healing in the spiritual realm, the individual is referred to the doctor because medical care is necessary to bring about physical, bodily recovery because "yuh does get weak" (Navindra, Interview).

Others, like Faithist Reverend Winnifred, describe how prayer helps her establish if and to what extent her intervention is necessary:

> Well, as soon as I go into prayers, this will become clear like somebody's talking to me: "This is not your case. This fuh de doctor." Or even though it's for the doctor, you can help by doing x, y, z. Because even if it's not a spirit thing, it can be a case where herbs can use and the person can feel better.

Winnifred, like Priya and Navindra, believes in divine instruction and that religious/spiritual practitioners have a collaborative role to play with medical professionals. Her knowledge of traditional medicinal herbs also allows her to recommend plant-based or ethnobotanical treatments as well. Winnifred talks through one case where she insists that the "patient", a baby, be taken to the doctor. In this example, a worried parent – who believes that their child was the victim of an old higue – brings his baby to Winnifred for her "to look" [to look after, to care for]:

> I find babies come to you and the parents will say somebody do dem something, like a ole higue suck de chile and when you check on de baby, the baby got a heavy cold pressing the stomach down. [The parents will say,] "You know. Dis chile blowing up… Like somebody suck dis baby." When you check de chile, de chile gat cold... About a month ago, I was right at the church here and a boy run wid dis chile and the chile stretch out. [Winnifred enacts how the child was stiff and appeared to be unconscious]. As soon as they reach me, I smell the odour of the drugs and the rankness of some egg and

> something they use on de chile. So I said, "Hold de child, just hold de chile! I want to talk to you."… And the Spirit of the Lord say take this child to the doctor now. I said take this child now to the doctor because dis chile is gonna die right here so take them now! And I saw his face fell [disappointment in parent's face] you know like I don't want to look [to look after, to care for] the baby… Anyhow, they took the advice and went right away wid the child. A few days after he come back and tell me the child was hospitalized. It was pneumonia. (Winnifred, Interview)

While Winnifred does not identify this case as an experience of providing care for mentally distressed people, she cites this case as a proxy – as a way of announcing that she knows when to make medical referrals. Indeed, she views these situations as matters of life and death and referral is, therefore, an essential component of her care practice. In this above passage, the use of eggs in ritual is mentioned. Some African ancestral spiritualities/religions in the Caribbean, including rituals in the Comfa religion, use eggs as a way to "exorcize the spirit", where eggs are a conduit to draw out evil (Gibson, 2001, pp. 185, 46). Doctors Lionel also mentioned witnessing the use of eggs in Comfa rituals to treat people labelled mad: "I remember a small boy in Berbice, mad as hell from the next street. Dem people used to buss [burst] egg on he and all kinda talks goin' around. It's called Comfa." Lionel's understanding of Comfa rituals appears rudimentary and surficial, nevertheless, it reaffirms the use of specific objects (i.e., eggs) in practices intended to be curative. Winnifred, however, held firm in her belief that the child in this case required medical care; therefore, the use of eggs was unnecessary given that the child was not spiritually ill.

Khemraj, one of the Kali Mai Priests, also receives divine guidance, which is sometimes communicated through "de book" in order to decipher whether or not medical care is needed: "Me ah consult book and if de book says so and I can do this to help you, I will. If not, me guh say go ah dactah." The book that he refers to here is the *Hanuman Jyotish*, which is a specific

text of Hindu or Vedic astrology (Dreyer, 1997) that allows him to ascertain best practices of addressing specific life problems:

> Well, we does use books… We does use a book named *Hanuman Jyotish*… So you get a system… Well, in this circle right here now, you have a headline, a heading, and you would look under that and you make them go around [encircle] their hand, three times like this [demonstrates how to encircle specific sections]. Well, this book now is like question and answer. (Khemraj, Interview)

When the book reveals that medical intervention is necessary, Khemraj reaffirms: "I'm not a medical doctor to prescribe any medicine and so."

Sanatanist Pandit Deonarine (Interview), on the other hand, says that sometimes he can immediately tell, without prayer or spiritual guidance, that medical care is required:

> A man came… and brought his daughter to me saying is spirit. The girl was smiling with me when she come in, you know, nice girl... I tell them about a doctor [instructs them to visit a specific psychiatrist]… And they took her there and he [psychiatrist] talk to her and she come back, and she is alright.

In this case, Deonarine's recommendation is specific. Not only does he think that it is necessary that the girl visits a doctor, he recommends that the family seek out a specific medical specialist, with referral to a particular psychiatrist. His knowledge of the formal mental health system – particularly the biomedical institutional sectors mentioned in Chapter Three – and of the key actors in Guyanese mental health care are made known here and throughout his interview. This knowledge is also echoed by Navindra: "It gat dactah. It gat specialist in all thing."

Acting as interlocutors with the social service sector, in addition to the medical community, is also a significant aspect of the care practices of religious/spiritual helpers. For Samuel, who talked at great length in Chapter Six about the socio-structural causes of mental distress, this means that his church has "to work on social issues, work along with organizations and institutions". He explains how he participated in a prison fellowship program intended to "make interventions with prisoners… and their families", especially when incarcerated people

were about to be released (Samuel, Interview). Through this initiative, Samuel did extensive work with prisoners where "something", usually adverse social conditions and environments, "trigger off the mind". With familial support, community assistance, and clergy mentorship, the program creates pathways for success for incarcerated and formerly incarcerated people as it helps them re-establish their lives and networks outside of the prison.

Ralph, like Samuel, believes that the church and the community must work side-by-side as he describes his role: "I am not just called to pastor a church; I am called to pastor a community". In bringing together social service actors, he oversaw the construction of a skills training centre that facilitates employment opportunities and community development in his area. Of the work undertaken at the centre:

> We are involved in also training, skills training… It takes people who are, the only certificate they have is their birth certificate and… it is what the social organizations term "vulnerable peoples" and we introduce them to skills training... Presently we graduated a batch… 50 something of them in videography and video editing and sewing and cookery. And we also do IT. (Ralph, Interview)

Ralph often directs the people he counsels, his parishioners, and the community-at-large to the centre. Similar to Samuel, Ralph works with people, particularly youths from his community, who have been involved with the criminal justice system:

> I am not just concentrating on church members. I am involved in a lot of application endorsements, character references you know. I've stood in the court on behalf of juveniles to agree to counsel them so they could not have to do the jail time you know. I'm involved with [names specific joint clergy and law enforcement initiative]. That is where the police force is using us as community leaders… Is a group of pastors that work in conjunction with the police force… The baseline for that is instead of jailing these petty first-time youth offenders, they basically hand them over to the pastors for the pastors to counsel and mentor them.

Ralph has witnessed how this centre and the social service actors who teach specific skillsets there and his involvement with the joint clergy and law enforcement initiative have given community members purpose and provided social and economic opportunities, especially in

underserved working class areas like his where there are higher rates of unemployment, poverty, and homelessness.

In this subsection, the accounts of the religious/spiritual helpers illustrate how they serve as bridges to medical care and social service supports for mentally distressed people and their communities at large. They made specific referrals to medical doctors and created links to the social service sector to alleviate socio-economic/structural stressors, which they cited as one of the main causes of mental distress in Chapter Six. In these accounts, the religious/spiritual helpers understood the possibilities and limitations of their care. They also accepted that spiritual mediation alone does not encompass holistic care, which required the intervention of other helpers. Their narratives indicate that multi-sectorial approaches and collaborations – inclusive of medical, social, and religious/spiritual interventions – are considered vital in the provision of care.

Interlocutors with the Supernaturally Interfered Body and the Spirit World: Exorcism and Healing

In the previous chapter, supernatural causality is one commonly cited explanation among the religious/spiritual practitioners as a cause of mental distress and madness. When supernatural causality is cited, these religious/spiritual helpers performed exorcisms and other forms of expulsion rituals that involved specific and sacred ceremonial practices – including but not limited to prayers, blessings, the use of herbal medicines and oils, offerings, and meditations. Some methods cut across different religions (i.e., capturing spirits in bottles and the use of herbal medicines – also known as bush medicine – as cited by Hindu and Faithist helpers), while other practices were specific to certain faiths (i.e., reciting particular verses from the Quran intended to cast out spirits). Beating out the spirits or supernatural entities by way of physical strikes to the body was disavowed by all of the religious/spiritual practitioners; however, many acknowledged

that “dis spirit beating and suh” (Navindra, Interview) is common and is a part of the repertoire of practices utilized in Guyana when mentally distressed people and people labelled mad seek out care from helpers of various faiths. In these accounts, the religious/spiritual practitioners are intermediaries between mentally distressed people, the supernaturally interfered body, and the spirit world. They are adamant that none of their religious/spiritual practices involve physical beatings or strikes to the body; however, some cited the use of physical restraints and holds. The following accounts of exorcism and other forms of expulsion rituals are detailed and piercing; they give voice to one subset of Guyanese etiological understandings of mental distress and madness and some practices intended to foster relief.

Reverend Winnifred, a Faithist, recalls her encounter exorcising “animal spirits” that took hold of a young woman’s body. Winnifred explains that the “patient” was “working in an office… and she just run out like that and run down the street like mad and start performing like that”. Winnifred is adamant that the “animal spirits on this child” were sent, that “somebody just did that to her”. Winnifred recounts her experience:

> One time I went to Linden to look [care for] a patient… I spent 13 days in Linden anyhow. Leave to spend one day… Can’t bring the patient… She doan [doesn’t] wan put on clothes… I say well I’ll come… I didn’t walk with change of clothes really. When I get there, oh my God!... She was in a room. They [young woman’s family] got it all case up [covered, enclosed], you know. Nail up, strap up because she would break up and jump through the window and run out.
>
> So she is in this room. Lock up… I say open up. Let me see her. When they opened the door, the girl sit down like this. [Winnifred re-enacts the woman’s sitting position]. You know like how monkeys sit? Her head between her legs. She has on nothing at all. Naked. Young girl. And they open the room, the room smell like animal feces. You can’t tell which animal but is a set of animal feces in the room, but the room is literally clean. Nothing is in the room just the girl alone because they can’t put a bed. They can’t put a mattress. In half an hour they say she strip [rip, tear] it up fine fine fine fine [into small pieces] whatever they put there, clothes everything… But when I go, lemme tell you now, soon as I open the door, I saw like a whole zoo in there. That’s what my eyes saw spiritually. And as soon as I make like this. [Winnifred stands up and demonstrates how she motions to enter the room]. They [animal spirits] make so, whoop! [The animal

> spirits move off]. Disappear. I say, "Oh gosh, this room full ah animals!" They [young woman's family] say, "You see them?" Well, I didn't answer anybody. I tell dem bring her out. Cover her up with a blanket and bring her out.
>
> She said to me: "Oh God! You come to beat me now! Ow, don't beat me!" I said, "No, baby. I didn't come to beat you. I come to help you."… They bring her out and she trembling and then she crying. And one of her sisters say, "Dah is how she does behave! Dah is how she does behave! She going on like if she ent doin' [is not doing] nothing when she see people come. Dah is how she behavin'!"

Winnifred explained that the spirits "move away" because "the spirits know they bringing somebody to look her". While one sister believes that the young woman is only acting "normal" to garner sympathies from strangers who have come at their behest to "beat out the spirit", Winnifred sees this differently. When this young woman was previously beaten, Winnifred believes that the spirits left her body before the beating only to return once the violence ended: "When the beating finish and they [person or people hired by the family to perform exorcisms via physical beating] gone, the spirit come back so is only de beating she [distressed woman] know about." This, according to Winnifred, accounts for the young woman's "normal" behaviour when she is visited by strangers; the animal spirits sense Winnifred's presence and – believing that their host will be beaten again – have temporarily left the young woman's body.

Winnifred describes some of the violence that the young woman sustained in previous exorcisms performed by others. She also talks about her dedication to healing:

> So when I took her, I said come and put her head on my lap [Winnifred gestures to how she caressed the woman's head as it lay on her lap]. When I pull the blanket they throw over her… The whole back had brands on it… They [the wounds] start to dry up and she was fair [in complexion] so you seeing the black marks. I said wha' happen to dis girl when I realized that somebody had to beat her like this. They say that they carry her to some man and the man beat out the spirit. I said well they beat out the spirit and she still sick? I say you know if these wounds were fresh I de make the police lock up all ah y'all! How I get so vex! I say y'all gon' sit down and watch somebody beat dis girl so till she bleed, 'cause she had to bleed?! They say well is the spirit they try fuh beat out. I say oh my god, which spirit staying to tek the licks [beatings]?! I say y'all mo' mad more dan she! Because which spirit guh stay and tek all de lash?! (Winnifred, Interview)

Winnifred renounces physical violence. In her mind, and as will be explicitly reiterated by Priya, Navindra, Sadia, David, and Ralph, beatings have no place in healing rituals. Winnifred explains that she sought out the Lord to provide instruction on "how to start dealing with this case". She describes how she placed the young woman's care and wellbeing above her own:

> So when she see me now she say that I will beat her… I say, "I am not beating you." I say, "Lord, just show me how to do it." I started to get the inspiration now of how to start dealing with this case. Now I forget about my clothes. I forget everything. Forget I don't have clothes. I forget I come fuh one day. I can't move… I say well, if I get couple underwears and ting and some jersey or something I gon' be good for whatever time. I had to work with her in the night when the place was quiet. When the place is quiet, they [animal spirits] will come around. So you gat tuh set fuh catch dem. (Winnifred, Interview)

Below Winnifred describes her process to "catch" and "draw the spirits". She also speaks too of the physical effects on her body as a consequence of "pulling" or exorcising spirits:

> Well what we do, we use certain oils, and meditation. And the spirit [Holy Spirit]… I rub her up [anointing the body with oils] and I encourage them [animal spirits] to come. And I use clove and water, clove and water to pull. Sometimes you have to use spirit, like strong drink [alcohol]. It all depends on the kind of spirit, you have to put strong drink. Sometimes you have to take the strong drink yourself. Sometimes you gat tuh pull da spirit through yuh own body fuh catch it. Sometime when I finish working, my whole body hurting me. Sometime when I finish working all here swell up. [Motions to her arms and legs]. Lumps, lumps, lumps. The pulling. All my veins raise up in my skin. Sometimes my fingers hurting… You get a piece of string, cotton string, new cotton string. You cut the cloth in pieces and you tie… You pull them on the cloves and you catch them…
>
> You put them [animal spirits] in a bottle… You dispatch them… You throw them in the sea… So I pulling the spirits from this girl. I couldn't do it one day because of her weakness… But everyday, I work. She becomes calmer. Calmer. When I finish, I do the medicine, the bush medicine to cleanse the inside because now these spirits when you pull it from the body, they leave a kind of musk… You gotta clean the body. Now she wasn't getting a menstruation period for months, for six months. So within that time, it came and it was like black like coals… The first come down [menstruation] was so black… Before I left, she started to feel better. She come normal. She didn't want to bathe and these things. She allow you to bathe her. She get up in the morning and bathe herself. We were so amazed. And she said to me I must take her away with me. She's not staying. So before left, I had to get away from there [chuckles]. But she is living in the [United] States right now. She got married. Got children… It was in the year, that case, that was '92. (Winnifred, Interview)

Winnifred's encounter, her compelling account of exorcism and healing practices, is a part of the rich history of Afro-Guyanese women traditional healers and herbalists, most notably Mama Fiffee. Mama Fiffee was a prolific traditional healer and bush medicine woman known for her knowledge and expert application of herbs and plants (French, 2017). Like Mama Fiffee, Winnifred believes that bush medicine is a central component of holistic care. In the above example, Winnifred negotiates the spiritual realm, but she also physically cares for the young woman by bathing her and using "bush medicine to cleanse the inside".

The land and the body are connected for Hindu Priestess Priya. Bathing the body – a common purification ritual in Kali Mai worship (Case, 2001) – is necessary to remove spirits, even if the spirits might reside on the land (i.e., "Dutch people" [Priya, Interview], "Dutch jumbies" [Jean, Interview]):

> Sometimes they come, they have things on the land and they have to bathe… Well dem say that it does have Dutch people on the land. But dem does say is masta [master], yuh understand? White people in days back… So dem does come and I does go and look after the places fuh dem and dem does be okay. Some of dem does have to bathe for three days, so you bathe them. You call up de Mudda and Mudda gon' come up… on the body and do what they [Mother Kali and/or other deities] have to do. Sometime if they have evil thing on the body, de Mudda or whosoever gon' come and catch it and take it out from dem. (Priya, Interview)

Priya underscores how Dutch phantoms, the first colonizers of the land, continue to inspire angst, terror, and haunting in the country. The Dutch colonial presence in Guyana is described as "cruel" and "sadistic", where permissive laws lent themselves to the atrocious treatment of the enslaved (Swan, 1957, p. 38, as cited in Rauf, 1974, p. 22). Priya believes that Dutch spirits create oppressive living conditions and must be removed from the body and the land, establishing that the two are connected, while also signalling to the violence of colonialism and the indelible ways in which this legacy manifests and lingers in the present moment.

Pastor David also talks through his encounters with people who have made "deals" with supernatural entities, including Dutch phantoms:

> People can make deals, I think – based on my experience with people talking with me, counseling families – people can make deals with these dark forces: the Obeahman, the witch doctor, the land masta. I don't know if you've ever heard these terms, the land master, the Dutch man. That's the Dutch spirit. They can make deals with these demons to feed them; take care of them; keep a place in their yard for them in exchange for their children to do well in life; in exchange for their business to do well; in exchange for good health. Making deals with these forces eventually turns out to be very much a problem.

Another Christian leader, Jean, cites colonialism's haunting legacy through expressions of ghostly persistence, especially so given how "people are still seeing Dutch jumbies". She emphasizes the need for Guyana to reckon with its history:

> As a nation, one as a whole… we really need all to be washed [chuckles]. Because, I mean, we haven't been healed from our history, whether it's, you know, the history of how did we begin as a people with genocide, the genocide after Christopher Columbus came killing all of the Indians, the Indigenous Indians, and then slavery, and that was massive. Where was the healing from all of that? We are carrying that still. I think that there is a deep psychology in our history that we have not been talking about and dealing with and that's why people are still seeing Dutch jumbies. I mean, people are seeing these jumbies all over the place... And they are drinking rum and speaking Dutch and so. (Jean, Interview)

Jean signals to the effects borne out of neglecting the history of genocide and slavery, or what Alexander (2005) names as colonization's production of "fragmentation and dismemberment at both the material and psychic levels" (p. 281). Jean, like Priya, signals the need to be cleansed ("washed") in order to elicit renewal, with "washing" being a common Christian invocation to gesture the same via ablution rituals such as baptism (Jensen, 2012). Jean's sentiments ("Where was the healing from all of that? We are carrying that still."), speak to the need for a rasanblaj – a recognition and assembly of collective pain and suffering with the goal of reckoning, reconstitution, and restoration (Alexander & Ulysse 2015; Ulysse, 2015). In some respects, Jean speaks to the "deep yearning for wholeness" (Alexander, 2005, p. 281) that postcolonial nations

experience as they continue to grapple with the wounds of colonization that so profoundly influence the socio-politico-economic systems of Guyana, none more apparent than the influence and inheritance of colonial psychiatry at the NPH.

Teke, a medical professional at the NPH, also echoes the haunting effects of the Dutch in Guyana's colonial history and how their role manifests in the present, particularly the impact on other NPH staff and the general psyche of Guyanese. This ghostly presence – born of the inhumane material conditions under Dutch colonialism – serves as a warning and representation of death:

> Remember many years ago, Guyana was a Dutch colony too… Some of the staff of here [NPH], they told me in the night that they were very afraid to be here at the back, close to the kitchen because a man, a White soldier, a Dutch soldier used to ride a horse and have big chains and you can hear the noise all over the compound. Going to Corentyne, going to Skeldon, you have a part called Unity Village. They say in the turn [referencing a stretch of road that curves], they have a lot of accident in that turn. A lot of people die there. People say that at the time the people get in the accident in the night, is a White lady, is a Dutch lady appear and ask the driver and try to stop the car. The driver gets confused and end up in accident. And that is part of the culture of Guyana. (Teke, Interview)

Priya, Jean, and Teke's perceptions of Dutchman jumbies – conceived predominantly as a source of terror – is a common sentiment and way of understanding this phenomenon historically and in present-day Guyana (Deonandan, 1999; Mello, 2016; Monar, 1987; Williams, 1991; Paravisini-Gebert, 2017).

Priya, like Winnifred, explains how she exorcises "the evil thing on the body"; and how to "catch it [the spirit] and take it out from dem" and place it in a bottle:

> You gon' start fuh raise it [the spirit] up now. Yuh raise it up. Yuh does get dem and catch it. And when you catch it deh now, yuh put it in a bottle and they [recipient of exorcism] calm down… Sometimes they [the spirit] bite you. Yuh hand, when you grabble them, dem bite you. You fight them and get it. You doan leggo [don't let go] when you hold it, nah mind dem bite you.

Like Winnifred, Priya describes how spirits can resist and be violent; how they "bite you" when they are being drawn out. Her insistence that her methods are non-violent enlivened her tone. Priya determinedly declared, "You don't hit nobody!" It was as though she believed that I missed or misunderstood her point and practices; that my perception of her work as a village healer was muddied by the case studies of Singh, Persaud, and Richards, which catalyzed this study. In the interest of transparency, I disclosed the relevance of these case studies to Priya and to all interview participants because it is these cases that enabled me to arrive at the research questions posed in this dissertation. I understand that my disclosure – and the severity of alleged violence against Singh, Persaud, and Richards – may have directly or indirectly caused my participants to self-censor the range of interventions that they practice in their encounters with people experiencing mental distress out of fear that their approaches may be interpreted as causing harm. This is one limitation of this dissertation. Further research with all relevant stakeholders, particularly work that purposefully engages the voices of distressed people who have experienced these interventions in Guyana, is of the utmost importance if we are to capture the complete picture of these practices from all vantage points.

Priya goes on to cite a specific example of possession experienced by a village woman: "One night one girl come. About six fat, fat person… can't control dis lil girl and she fine [skinny, slim]. Is about one o'clock in the night. Dis girl heist up a whole minibus with the evil things wha' she gat pon she." Priya explains that after the exorcism – similar to the intervention of drawing out spirits and placing them into bottles – the young woman began to confide in her, relaying her marital problems:

> Den she come in. Meh husband go out and bring she in and she come in and she sit down. Well, she talk she whole problem… She problem was she husband. And after that she go and she drink [consumed alcohol]. De husband have somebody [a lover]… and they [husband's lover] send this thing [spirit] pon she and she start to behave bad. When she

> overcome it and you get it [spirit] out now, den she start tell yuh she whole history of the problem.

In this example there is interplay between what appear to be two causes of distress. One cause appears to be interpersonal, springing from the husband's infidelity. The second appears to be supernatural ("they [husband's lover] send this thing [spirit] pon she"). In exorcising the spirit sent by the husband's lover, Priya has also created a bond of trust with the woman, who was then willing to share her "whole history of the problem", detailing the husband's infidelity and marital conflicts. Priya counsels the young woman, talks her through the distress, and encourages her to come back and talk again. Priya affirms that her healing practices are favourable because "dem does come back", where repeated, future visits signal to Priya that her practices are effective. In both examples provided by Winnifred and Priya, they were attentive to the needs and vulnerabilities of the young women in their care. Winnifred and Priya felt deeply obligated to provide care because they adjudged that the required treatments were within the domain of their expertise; further, they thought that they were competent to provide the necessary care. Both healers established therapeutic rapports with the young women, who they believe were responsive and positively affected by the care received.

In the following example, Kali Mai Pujari Navindra details his ability to remove "the evil spirit" from an Indo-Guyanese man:

> A big strong coolie bai, they handcuff he you know. Police all deh deh [were there]. I lef' and I go. His mudda say, "Oh God! You can't go in! De bai guh kill yuh!" I say, "Man, kill me." I guh an' rap [knocked] ah de door… He say, "Alright, let him come in." I go in. I gyaff [talk] wid the bai and suh. I jaray de bai all and de bai nah even tell me nothing [did not argue or resist]. And dem had to bring am [him] ah de church. You know fuh bring am hay [here] dem had fuh handcuff he and bring police wid he fuh me look after am … When de Mudda come [Mother Kali manifesting through Navindra], she guh say, well, alright, do this, do that, drink this medicine… She might give yuh two lime fuh peel… She might remove the evil spirit from you… She will say, well listen, if dis bai been ah see dactah, when we finish looking after am, carry back he [to the doctor]. The doctor might see [the sickness] because the spirit does block the sickness. You can't see

> it and things like that. And that bai feel well. Up to today, up to the other day, he come from Canada right and he always does bring a sari for Mudda dem [for the sculptures of the deities at the temple]. He does bring one lil change (money, offerings) fuh de church. He does bring one lil change fuh me too right. And he good, good as gold.

While Navindra plays no part to physically "bring am [the man] ah de church", we are told that the man was allegedly handcuffed, physically restrained, and forcibly brought by police to the temple against his will. These accusations of coercive approaches by the police in the treatment of mentally distressed people are normalized and are a part of a wider "historic and present-day participation in violent and corrupt activities" levelled against the Guyana Police Force (Thompson, 2019). Navindra, like Winnifred, utilizes specific traditional medicines ("Drink this medicine"), which are botanical in nature. Navindra uses limes, which are also utilized in Comfa practices, as a protecting agent: "Lime is to keep away evil spirit. Yuh gat tuh protect the area where yuh performin' yuh work." In line with Winnifred and Priya, Navindra believes that spirits "nah get no lash", and rejects violence in his practice:

> I hear about dis spirit beating and suh. Dem nah suppose to beat nobody! Not supposed to beat you. You ought to take care of the individual. Not to beat them and then beat them and kill them too? What kind of religion is that? You know, that is brutality. I am saying that people should get charged! Fuh murdah! You don't beat people no matter wha' deh pon dem.

Similar to Winnifred, Navindra believes that it is the human body that is the recipient of the "lash", not the spirit that has possessed that body; therefore, no spirit will be exorcised since "the spirit is not getting any hit". Flesh is the only receiver of the "brutality" (Navindra, Interview).

David explains how careful he must be in his approach when possessed people "are fighting" and pose a risk of harming themselves or others. He disavows making a public spectacle of exorcism among general churchgoers. Instead, he says that possessed and supernaturally interfered people must be brought "away to the private" where "all family members are there":

> I remember this one guy in this possession… He literally knelt to this young lady's ear and was screaming into her ear at the top of his voice. Loud, loud, loud! I'm not too sure how the human ear can handle that right there. And I said to him, "Sir, stop it! Move away! You do not know what damage you are doing to somebody!" … Remember they are fighting, their hands and their wrists and their body… I've had to be so careful. That is why I pray I don't have to do a lot of this. I'd rather talk and we can share, and if it's a genuine case then I'll arrange it if its something manifesting itself right away. And if people just in church like that and started to manifest, we have to deal with it. I bring it away to the private. I don't do it in front of people. We bring it to this room and invite only those who need to be there including family members because I'm not going to lock the door on family. All family members are there… Talking, taking time to deal with this. So sensitivity to the matter is very, very much so important. (David, Interview)

It is unclear how people are actually brought "away to the private", and whether or not physical restraints or holds are performed against the recipient's will in order to do so, or if distressed people consent to these rituals in the first place, regardless of family presence. For David, he believes that the family's presence is a mechanism of accountability. Also, he signals that the dignity of the possessed person is respected when these matters are dealt with in a separate, private space. David's sentiments about physical beatings are similar to Navindra's and Winnifred's: "Even if somebody is possessed, that's not the way [physical beatings] to treat them because legitimately speaking a demon will leave the body and a person will remain and have to function again in society." Three religious/spiritual helpers across three different religions – Winnifred (Faithism), Navindra (Hinduism, Kali Mai worship), and David (Christianity) – provide similar rationalizations that steer clear of strikes to the body. For these helpers, it is the human body, not the "demon" (David, Interview) or malevolent spiritual entity, that is ultimately the recipient of beatings; therefore, such acts are cruel, counterintuitive, and do not facilitate healing.

When asked to explain what happens once spirit possession is determined as the cause of distress, Pastor Ralph explains matter-of-factly:

> We cast out the demon. Simply. That is done through prayer in the name of Jesus. We cast out that demon. Sometimes it's quick. Sometimes it takes a longer period…Dealing with somebody that is demon possessed in the church that I pastor and most other churches that I know don't involve no beating, you know, and that sort of thing. The most you'll have is restraint. There is some cases where you have to restrain, where you have to involve maybe two physically strong men from the church or so to help you with that you know. But most times it is very subdued because we pray in the name of Jesus to deal with these issues like when we had the attack on the school over here couple years ago [referencing an instance of spirit possession among girls at a local school].

Ralph goes on to detail the "attack on the school" mentioned. In most of the overall examples provided, the religious/spiritual practitioners cite women and girls as the recipients of their interventions, even as they emphasize that Guyanese across genders seek out their assistance. Ralph describes the case of a "demon attack" among schoolgirls and how he intervened:

> Well, I was over in church here and I just got a call that there was a demonic attack on at the school… We encountered some strange activity with young ladies jumping on the desk and growling and behaving weird and same thing, writhing and crawling on the ground, and their eyes enflamed you know… It's like hysterical mixed with violence. You know like somebody is planning to kill you if you come around them. That sorta look… It's a school with what, about 200 children, and this was going on with just about 5 or 6 kids… All young women interestingly, no males.
>
> Later on I found out, can't remember the date, it started out with one girl and like, you know, it just catch [spread]. We went over there to deal with those. We started praying, but then we had a struggle. We had a struggle because the media got wind of it. Oh my gosh. So we had to battle this situation plus trying to regulate the media because the media is looking for a story. They are not looking for any facts. So I don't even really talk to the media on these issues, but they were around with the camera and asking questions. Well, I ent answering any questions. And then we realize, hey, we got to get these people away from here. So we literally grab all of them [the schoolgirls] and bring them over here to the church… And that's where we prayed for them. We spent about an hour and a half with them right and we rebuked those demonic attacks and they left here sane and in their right minds. And to date, we have no report of any relapse you know. But that day was chaos.

The language of hysteria ("hysterical") is one charge that has been used historically to describe women as irrational and infantile subjects (Tasca et al., 2012). The implication of misogynist and saneist language and scripts will be further discussed in the third section of this chapter, which analyzes the psychodynamic therapy sessions conducted on a fourteen-year-old girl named

Drupatie in the 1960s. Ralph explains how prayer "rebuked those demon attacks" and was the primary intervention; prayer was enough to make the girls "sane and in their right mind". Of his general approach in addressing demon possession, he mentions that restraint, not strikes to the body, is "the most you'll have" (Ralph, Interview).

Ralph signals that restraint was used in this incident: "We grab all of them [the girls] and bring them over here to the church." Among the religious/spiritual helpers who mention or allude to physical restraint, there seems to be a general undercurrent that physical restraints and holds are the preferred method to gain control and that restraint is perceived as non-violent. It must be emphasized that the use of physical restraint and holds, however, can be as harmful as strikes to the body and may lead to death.

As an imam, Mustaq has a specific name for the spirits that possess people, *jinns*, which are mentioned in the Quran:

> It [jinn] guh talk like you. It guh act everything wha' you want. It guh know what you want 'cause it deh wid yuh [is with you]. So, yes, we believe that spirit that possess people ah wan [one] wicked jinn, right. And dem very powerful so yuh does gat tuh get people wha' know, wha' study… It gat some people ah train fuh handle, expel this spirit.

Mustaq generally describes how jinns are identified:

> Dis spirit guh talk… Yuh guh to de imam, the imam say, "Who sen' yuh?"… Like yuh call dis person name. Dada [name of person] sen' yuh. And it could be true because people gat certain power over dis spirit can call dem up and tell dem fuh do wrong thing. We know all dah. We believe in all dah.

Sadia, Mustaq's wife, who is a leader among the women of their small Muslim community, expands:

> In our book [Quran], it have words to read. Okay, leh we say I am possessed by an evil, it have words to read to get this evil within me to speak. So you now will be speaking to me in person but not me in soul. It's the spirit wha' you would be speaking to… So you as the religious leader who has the idea would be able to know if it's indeed spirit or this person is medically ill. You would know that from your studies.

> The Quran itself tells you about the words that would cure these things. So like I said, if I am possessed by an evil and you're the person who knows about it, you would know how to get this evil to talk.

Mustaq and Sadia describe how a trained imam will intervene and communicate with the jinn in order to better understand the kind of supernatural force involved in bodily possession. Through discourse and inquiry with the jinn, the imam will establish which particular verses in the Quran must be recited to exorcise the spirit. While these verses in this example are specific to the exorcism of jinns among Muslims, the recitation of appropriate scripture from other religious texts (i.e., Bible, Bhagavad Gita, Torah) in order to spiritually intervene and exorcise spirits is common in other faiths (i.e., Christianity, Hinduism, Judaism) (Hunt, 2009, p. 5-6) and was also referenced by Christian and Hindu practitioners.

In all of these various tellings in this subsection, we see how the religious/spiritual helpers act as interlocutors between mentally distressed people, the supernaturally interfered body, and the spirit world. They act as brokers who, through diverse healing methods and practices, are entrusted to handle delicate situations in divine realms. Based on some of their narratives, they act like warriors engaged in a spiritual "battle" (Ralph, Interview) for the mind, body, soul, and physical lands (as with the case of Dutchman jumbies), especially in the ways they describe their struggle to exorcise spirits. It bears repeating – particularly due to the vociferous condemnation of the practice – that beatings are spurned by the religious helpers in this study, even as strikes to the body are commonly referenced and acknowledged as being part of the wider landscape of interventions employed by others in Guyana. Sadia's denunciation of beatings captures this sentiment:

> Me nah believe in tying dem [spiritually interfered or possessed people] and beating dem… When dem [other religious/spiritual practitioners] beat dem [spiritually interfered or possessed people] fuh tek out dis jumbie, dem nah tek blame say [they are not blamed or held responsible]: "We kill dem."... "Ah de jumbie me been ah beat fuh kill."… But if

me beat yuh, beat yuh, beat yuh, and you dead, ah who kill yuh? Nah me kill yuh?

As mentioned previously, additional and sustained research is required. This work must necessarily centre the perspectives of distressed people in Guyana who have experienced exorcisms and/or have utilized the range of other traditional medicine and healing approaches – whether done in the name of religion and spirituality or not – in order to fully contextualize and comprehensively understand the diverse landscape of these interventions.

Interlocutors with Kin and Kith: Repairing Relationships

Some of our earliest understandings of our subjectivity – of who we are (not), see ourselves as, and where we belong – spring from our interactions and relational bonds with primary socializers (parents, guardians, and other kin and kith) (Mead, 1934; Parsons, 1949). When people experience mental distress, fractures within these foundational relationships may be at the root of or contribute to experiences of distress in addition to other triggers (Alm et al., 2020; Landstedt et al., 2015; Weich et al., 2009). The two examples of care and healing described below by Deonarine and Jean represent the strategic and interlocutory relationship that this category of helpers and religion more broadly play in restoring relationships between distressed people and their kin and kith.

Sanatanist Pandit Deonarine describes a case where the in-laws of a young Indo-Guyanese woman sought his help because they believed that their daughter-in-law was "hol' [hold]" by a "jumbie or a spirit, some Dutchman". He recalls how he renounced violence and advocated for the young woman by appealing to the language of possession in order to speak with her one-on-one:

> Majority of possession, right, of evil possession of people, I won't able to say one hundred percent, right, but I can able to tell you, right, majority of evil possession is through problems [domestic/(inter)personal problems]… Like for example, I gon' give you example… They [in-laws] say, "Pandit, this jumbie or a spirit, some Dutchman hol'

> [hold] this girl." I say leh [let] me go an' see. When I go, dis girl start to behave bad, right? She kicking up and fighting and like she gettin' extra strength and so you know... And de same thing they [in-laws] mentioned you know… Putting one an' two lash and so I say, "Stop it." I say, "Stop it right away."... I say, "Everybody come out dis house. This is a serious case. I gat to deal with this because the jumbie gon' kill somebody." (Deonarine, Interview)

It is through personal counselling and the creation of a trusting rapport that he is able to arrive at the source of the young woman's distress. Deonarine describes how her suffering was prompted by the breakdown of her relationship with her parents because they disapproved of her marriage:

> When dem come out de house, I put she fuh siddown [sit down]. I say, "Listen to me carefully. There is a problem with you." I say, "Doan [do not] behave stupid because I gon' tell dem people and you gon' get problem, right, but I gon' help you now. There is a problem with you, and tell me your problem and we gon' sart [sort] it out right here." She say she get away ah dis house couple a week wid dis bai and she parents dem doan want see she no mo'. Meh say, "You go an' offer some prayer and get sleep." Meh say, "Lie down an' guh sleep."

Deonarine's tone is, at times, read as authoritative and paternalistic ("Listen to me carefully. There is a problem with you"… "Doan [do not] behave stupid because I gon' tell dem people and you gon' get problem"), even as he simultaneously attempts to be of assistance ("…but I gon' help you now") and circumvents the violence that the young woman's in-laws were encouraging or that she might have encountered at the hands of another religious/spiritual practitioner ("And de same thing they [in-laws] mentioned you know… Putting one an' two lash and so I say, 'Stop it.'").

As a pandit in a rural Indo-Guyanese village, Deonarine is keenly aware of the power dynamics at play within Indian families. The role of Indian daughters in a traditional household is one of duty and obedience; where, in marriage, parental choice of spouse is respected, even though shifts to notions of romantic love and individual choice have grown more common (P. Mohammed, 2002). When they choose to defy the wishes of their parents; in this case, to marry someone without parental blessings, familial bonds may fracture as a consequence. While he

believes that the cause of the young woman's distress is directly related to the collapse of the parent-child relationship, he uses the language of possession and invokes jumbies ("terrible family spirit") to make appeals to the young woman's in-laws, to persuade them to ask the woman's parents to visit her and resolve their differences:

> Me say the only way dis girl can get help is if ayuh [all of you] [referring to the in-laws] sen' fuh de parents and ayuh tell dem dis girl gon' lose she life if dem nah come and talk to dis girl because it's a terrible family spirit. Just to do that. They [woman's parents] came and everything alright. (Deonarine, Interview)

Deonarine wore an Anansi[68] grin as he recounted different elements of this story. So influential is his position in this rural community that he – through the strategic use of jumbies, which he fashions as a "terrible family spirit" – played a central role in family reconciliation. I sat in awe of this multifaceted narrative recounted by a venerated village pandit. I still wonder if a medical or social service professional would have been able to negotiate the nuances of this social situation and experience of mental distress, particularly given the invocation and belief of spiritual interference or possession by the in-laws. Deonarine skilfully played the role of a reconciliatory and compassionate trickster. He confidentially counselled this young Indo-Guyanese woman, establishing a therapeutic rapport to ascertain the cause of her distress. Unbeknown to the in-laws, he disavowed their suggestion of spirit possession. Through these practices, Deonarine acknowledges the significant grief and trauma of parental ostracization. He authoritatively advocates for this young Indo-Guyanese woman in his assertive calls for family reunification, which, given her new and junior position in her in-laws' household, seemed untenable for her to personally request. At different stages of his telling, Deonarine's care

[68] Per Asante (2014), Anansi – also Anance, Aunt Nancy, Anancy, Hapanzi, Nanzi – is the name of an "Akan character who has become famous throughout Africa, the countries in the Caribbean region, and beyond because of his insight, intelligence, and wisdom". Anansi is a trickster spider and protagonist in folktales intended to impart "moral, ethical, political, or social values based on his ability to lead a person to the truth through example, puzzles, and the least-expected turns and twists of fate" (Asante, 2014).

practice can be read as patriarchal and imposing, while also deeply attentive to the needs of the young woman and conscientious in how he tactically apprehended and capably responded to scripted and ethnically gendered (Williams, 1996a) understandings of distress and madness through the resonances and strategic appeal to spiritual interference and possession, even as he privately believed that supernatural causality was irrelevant and played no role in this particular case.

Christian Reverend Jean relayed a story about the power of the church and religious fellowship more generally, which she believes gives people the confidence to self-advocate and mend familial relationships. Jean recounts how she required assistance to care for an ill family member. She interviewed and decided to hire a woman named Rose[69]. During the interview, Rose emphasized that she must be granted one week's leave to attend a women's camp at her church, otherwise she would be unable to assume the position. Jean granted the request but remained curious about the significance of the retreat. Rose clarified that difficult life circumstances brought her to the church. According to Jean, the women's camp held space for Rose, allowing for "peer support" and "catharsis":

> She came for the job and then she said that there is something that she doesn't negotiate on. It's in the women's camp at her church, one-week camp. And no matter what happens she does this. She is burdened with a lot, you know. I quite admire her. She gets up from one in the morning and she makes pastries and she sells them wholesale to someone who takes them into the interior. Then she has to prepare her whole household. Then she comes to work [for Jean]... She has a good relationship with her husband but it wasn't always that way when at one time he was being unfaithful to her and there were a lot of problems in the relationship… She couldn't talk about it… Many women feel that if they talk about that, that is a judgment on themselves.
>
> And then she went to this camp and they were having a night of prayer. So they all gather around. They do Bible studies. Bible studies means that you read, not only a literal or literary approach to reading and interpreting, but you are also making applications for life around you… They were praying and crying… That's when she felt the movement of the Spirit in a powerful way in her life… A lot of women were talking about their pains in

[69] The name Rose is a pseudonym.

> relation to their partners, their husbands… And she is not the type to talk at all. She never told people about what she was experiencing at home. But she said something in her moved… She could feel it physically and she was squealing like an animal. There she hollered and she couldn't recognize her own voice and she was peeing herself, you know. And then the sisters, you know, they helped her, clean her up, took her to bed. Stayed, prayed, and held her hand and all of that… And she said she's never felt so good the next day!
>
> It's amazing! It's really amazing, you know! And sisters were, are walking with her every day. And so, it's about how women were sharing their stories of pain, peer support, in a very powerful way and how that was, you know, a place of catharsis. Therapy bringing some kind of healing and she believed that there is a force greater than everything else, greater than what she is struggling with, greater than her pain, greater than what she is experiencing with her husband, that is in charge. That gives her hope. That gives her hope that something new and better is possible down the road.

Rose had a transcendental experience. Some will read Jean's description and might label Rose's behaviour as an expression of madness, but as Jean tells us, it was during that moment of "catharsis" – of "squealing like an animal" where Rose "hollered… and couldn't recognize her own voice" and "was peeing herself" – that she felt the power of a "force…greater than her pain", an experience bridged through the Christian women's retreat. It was in fellowship that Rose allowed herself to be vulnerable, to realize that her suffering was shared, and to know that she was not alone as she processed her pain. The "peer support" that Rose experienced with other Christian women allowed for the expression of suppressed hardship and enabled her to be filled with the "[Holy] Spirit" (Jean, Interview). For Jean, it is in fellowship and through collective prayers that people, like Rose, "feel a great sense of relief, support, and it brings hope to them"; it is, in many ways, a therapeutic experience.

Winnifred also speaks to how manifestations can be divinely sent from God, whereby the subject is manifesting the Holy Spirit, not malevolent entities:

> Sometimes when they [family members] feel the [distressed] person is manifesting evil, the person is not evil. Is a manifestation of the Holy Spirit. You gat tuh correct dem and tell dem no, you see. Many times cases like that come. The person is not, "nobody do"

> the person, the person has just a manifestation of the Holy Spirit and they are not having an opportunity to put it out.

Rose's experience appears to align with Winnifred's understanding of "a manifestation of the Holy Spirit" where, based on people's life circumstances, "they are not having an opportunity to put it out". The Christian women's camp held space for Rose to have that manifestation, that "opportunity" (Winnifred, Interview). As also mentioned by Priya and Navindra, they manifest the "Mudda [Mother Kali]" and other deities in order to perform healing. It is through these deities of benevolence and healing that Priya and Navindra's bodies are used as vessels to achieve curative outcomes. Not all spiritual manifestations, therefore, perform the work of "evil" (Winnifred, Interview), nor should that be the implicit assumption.

For Rose, the women's retreat and the bonds of Christian fellowship forged there gave her the self-assuredness to make demands on her marriage, and to ultimately advocate for her wellbeing as a valued, equal partner in her union. It also gave her the confidence to demand specific conditions in the terms of her employment contract with Jean. While Jean, as a religious leader, played no direct role in facilitating Rose's experience, she relayed this story to illustrate the power of faith and Christian peer support to deliver people from distress, restore relationships, and inspire self-confidence. The communion of Christian women and the solidarities produced in that space through Rose's filling with the Holy Spirit mediated and produced betterment across different areas of Rose's life.

In this section of the chapter, the numerous stories shared by the religious/spiritual helpers across diverse faiths speak to their roles as interlocutors of care between mentally distressed people and the different actors and dimensions that affect their lives. These stories also reveal how experiences of mental distress and encounters with distressed people, told through the lens of religious/spiritual first responders, are complex. In view of this, it must be

emphasized that the lives of Radika Singh, Sangeeta Persaud, and Todah Richards matter. They count; the ways they lived and the brutal circumstances surrounding their deaths – particularly in the cases of Persaud and Richards, where it is alleged that religious intervention played a role – must be remembered and reckoned with. The cases of alleged violence and death shared in Chapter Two are part of this history of religious intervention in the treatment of mentally distressed people and people labelled mad. Violence is one part of this complex landscape, which is marked by polyvalence and ambiguity as much as it is punctured by narratives of harm. These interviews intended to go beyond the headlines of "jumbie hold am" (Child Dies after Frenzied Attempt to 'Beat out Spirits'", 2010) or "ritualistic beating" ("Nurse held for Murder", 2014). They demonstrate that spiritual support through the involvement of religious/spiritual helpers can – in some instances, not all – be a beneficial component in care, and profoundly so if the needs of the care recipients are centred and their rights and wellbeing made paramount in the provision of that care.

The Limits of Religious/Spiritual and Psychiatric Interventions in Care

Any approach to care in Guyana, even ones with the best of intentions, may be filtered through a web of interlocking oppressions informed by colonialism, sexism, racism, and saneism. Equally destructive are the tropes that spring from these systems, the gendered and racially coded representations and understandings of madness, which are discussed in this section. I begin this section with an analysis of the psychodynamic therapy sessions conducted on a fourteen-year-old girl named Drupatie at the NPH in Berbice – then known as the Mental Hospital (Singer et al., 1980). These sessions occurred in the 1960s, during the nation's anticolonial movement for independence. As mentioned previously, the NPH – throughout its

history and in the contemporary moment – is colloquially referenced as the "Berbice Madhouse". The racist and sexist stereotypes birthed during the colonial period produced haunting gendered and racially coded understandings of mental distress and madness that were felt in the push for independence. These stereotypical attitudes continue to be reproduced in the contemporary moment when we analyze accounts by some religious/spiritual helpers with regard to Indo-Guyanese women in particular, which will be explored in the second subsection.

Mad Indian Girl? Femininity, "Compulsive Promiscuity", and Psychodynamic Therapy

> The coolie woman is respectful to her husband, and a negro woman will knock him down. A [coolie] woman waits upon him at the table, and a negress sits down with him. They are totally different people; they do not intermix. That is, of course, one of our great safeties in the colony when there has been any rioting.[70]

As briefly discussed in Chapter Two, colonialism in Guyana mediated interracial conflict and constructed racialized distinctions and stereotypes between the bodies of Indo- and Afro-Guyanese people (Rodney, 1981). The opening quotation in this section is excerpted from 1898 British Parliamentary Papers describing colonial interpretations of the social relations between Indian and African women in Guyana. To take this quote at face value is to believe that Indian and African women are each other's foil; that the inherent nature of the women belonging to the colony's two largest ethnic groups is diametrically opposed and irreconcilably different; that these differences are also reflected in the characteristics of their respective male counterparts; and that these distinctions alone create the necessary conditions to breed racialized animosity and violence between these two groups, which, by happenstance, and not deliberate colonial intervention, is to the benefit and security of the colonizer and the colonial security state. Instead,

[70] See British Parliamentary Papers. 1898, L (C. 8656), Royal Commission, Appendix C, Vol. I, evidence of M.J.E. Tinne, 4 January 1897, q. 1082.

when this excerpt is read through a transnational feminist lens, it lays bare the racist, colonist-mediated perceptions of Indo- and Afro-Guyanese women (Trotz, 2004; 2018); perceptions that were constructed to serve colonial divide and conquer tactics. In this short but revealing passage, British imperialists wield immense discursive and material power by authoring and disseminating ahistorical representations of Indo- and Afro-Guyanese women (Trotz, 2003; 2004). As a consequence, these farcical and paint-by-numbers depictions come to influence the lives of women labelled mad, mentally ill, and/or possessed. In particular, and with reference to these racist and sexist tropes, normalcy and sanity for the Indo-Guyanese woman is defined in opposition to the Afro-Guyanese woman and through the realm of domesticity and familial duty. Indeed, hegemonic representations of Indo-Caribbean womanhood are rife with characterizations of subservience and fragility, among other typecast descriptions (promiscuous, "morally loose") "despite the established record of stridency and agency among Indian women in negotiating their gender, sexual and wage-earning status during indenture and the post-indenture period" (P. Mohammed, 2012, p. 2). When Indian women deviate from these racialized and gendered stereotypes – forms of ethnic gendering (Williams, 1996a) – the imputation of madness can be levelled to silence them, and violence is sometimes wielded as a disciplining mechanism. In this way, nuanced accounts of the full and textured experiences of Indo- and Afro-Guyanese women are stifled. The convivial entanglements and multi-ethnic solidarities (Bahadur, 2013; 2018) forged between them to resist colonial conditions are stolen from these women in an attempt to silence mutuality and relationality and to suppress histories of camaraderie and solidarity.

From 1963-1966, revered Indian Kali Mai Pujari Jamsie Naidoo, worked in collaboration with Anthropologist Philip Singer and Psychiatrist Enrique Araneta at the Mental Hospital (Singer et al., 1980). Naidoo, in collaboration with Araneta, counseled Indo-Guyanese people

who requested the guidance of a Hindu faith healer as a component of their care. Philip Singer conducted anthropological observations of the psychodynamic therapy sessions carried out by Araneta and Naidoo. Together – reflecting on their involvement and experience of treating, counseling, and observing patients at the Mental Hospital – Singer, Araneta, and Naidoo (1980) coauthored the essay, "Learning of Psychodynamics, History, and Diagnosis Management Therapy by a Kali Cult Indigenous Healer in Guiana." It must be noted that this novel collaboration proved beneficial and achieved therapeutic outcomes for some patients at the Mental Hospital; however, and as will be detailed here, it can be argued that the consequences of colonist-mediated racialized and gendered tropes in Guyana permeated the Mental Hospital and were felt in (un)expected ways, particularly in one instance outlined in their 1980 essay.

In this case study, the authors describe the "compulsive promiscuity" and "compulsive neurosis" of a fourteen-year-old girl known only as Drupatie, whose family "begged" the psychiatrist to admit her because she "brought shame to the family" after she "would run away from home and live with one man after another until she was located and brought back to the family" (Singer et al., 1980, p. 169). Drupatie is described as being "physically well developed for her fourteen years" (Singer et al., 1980, p. 169), alluding to her perceived nubility despite her age. Her mother explains that before the child's menarche, Drupatie was "submissive and obedient" (Singer et al., 1980, p. 169). Since then, according to her parents, she became "rebellious" despite imposed restrictions and warnings about "doing 'what black girls do'" – which we are told means "being flirtatious and going out with boys to dances as Negro girls like to do" (Singer et al., 1980, pp. 169-170). We are told that when Drupatie first meets with the psychiatrist, his interview with "the patient [Drupatie] was most unproductive" as "all she would do is cry and remain mute" (Singer et al., 1980, p. 169). Hospital staff concede that the restrictive

parenting style of Drupatie's family might have led to some of her behaviours: "It was suggested that if they [parents] could show her more trust and discuss with her the consequences of her behaviour, it would enable her to make up her own mind about what would be a more beneficial course of action for herself and she would be less likely to be 'mannish'" (Singer et al., pp. 169-170).

The value judgments that are placed on her actions and expressions appear to be overwhelmingly couched in ethnically gendered (Williams, 1996a) stereotypes and narratives of Indian respectability (Mehta, 2004). Her behaviours, as an Indian girl, are deemed pathological and, therefore, require correction. Drupatie's behaviours are labelled "mannish"; the authors read "mannish" to mean "wild" (Singer et al., 1980, p. 169), but "mannish", as the term suggests, can also be read as characteristics that are typically associated with men and masculinity – behaviours and performances which are considered unfeminine or unbecoming of an Indo-Guyanese girl like Drupatie. Given this account, it appears that the same "mannish" activities, however, may be constructed as inherently characteristic of Afro-Guyanese girls' behaviours. Per the essay, it appears that Drupatie's Afro-Guyanese female-gendered peers are simply "doing 'what black girls do'" or following scripts of expected masculine behaviour that have been attached to Black women's bodies; therefore, it appears that no corrective measures are necessary for these girls in the same way that the "mannish" behaviours of boys and men do not appear abnormal or in need of reform. In the case study of Drupatie, Afro-Guyanese girls are cited in a most caricatured and contemptuous way. This alludes to what Shona Jackson (2014) – through her reference of the trailblazing work and legacy of Guyanese historian Elsa Goveia (1965) – describes as the anti-Blackness and racial subjugation that "became foundational for the societies that ultimately emerged from colonialism" in the Caribbean; Guyana is not excluded

from this larger anti-Black colonial-ideological framework that operates in the region. When drawing from the work of Goveia and S. Jackson, I am reminded of the killing of Todah Richards, outlined in Chapter Two; and how Richards, who was labelled mentally ill in news reports, was allegedly restrained and ritualistically beaten in order to control what appeared to be written about as an unruly body ("Ritualistic Beating of 20-Year-Old", 2014), similar to "wild" as an imputation on the body of Drupatie (Singer et al., 1980, p. 169). Richard's case is a reminder of how the mutually constitutive and reinforcing systems of saneism, racism, and sexism take root, in part or entirely, through colonialism. All of this also speaks to the contingent and subjective understandings attached to psychiatric diagnoses and labels. In this case study, pathology and diagnostic labels ("compulsive promiscuity" and "compulsive neurosis") appear to be subjectively coded through ahistorical representations of the archetypal Indo- and Afro-Guyanese woman, enduring constructions of the colonial imagination.

Drupatie is brought back to the Mental Hospital by her family two weeks later; her parents cite the same complaints (Singer et al., 1980, p. 170). During this second visit, she is deemed "uncommunicative" (Singer et al., 1980, p. 170). Drupatie is committed to the Mental Hospital for two weeks as "it was decided that admission was worth a trial" (Singer et al., 1980, p. 170). Drupatie does not appear to consent to hospitalization, and we are told that during this period, she "cried continually, begging to return to her parents" (Singer et al., 1980, p. 170). What are the rights of a child when hospitalization is framed as being "worth a trial"? The current Mental Hospital Ordinance of 1930 has no provisions to address this. According to the authors, Drupatie later held that "she did not know why she behaved as she did, that she was sorry because she knew it [her behaviour] was not to her benefit" (Singer et al., 1980, p. 170). Her parent's insistence that Drupatie be committed seems to be tied to the honour of her family,

which appears to be at stake here ("This girl was brough be her parents, who begged the psychiatrist to admit the girl because she brought shame to the family" [Singer et al., 1980, p. 169]). Per her parent's attitudes, they seem to think that the walls of the asylum can correct her behaviour and protect the honour they have attached to her body until the assumed danger and "shame" that mark her non-normative and wayward sexuality is contained. It is through these myths of respectability that are tied to honour and shame that Drupatie's behaviour is read as constituting a moral failing that is judged too great and incorrigible a burden for her Indo-Guyanese parents to shoulder and regulate alone. Power is enacted through the publicly funded Mental Hospital, which appears to assume the role of a social engineering apparatus and a disciplining arm of the state. In this case, one apparent aim of the asylum is to break behaviours deemed transgressive, indoctrinate and ensure conformity to ethnically gendered scripts, and ultimately restore the narrative of familial honour – however unstable and untenable – that is so often tied to the bodies of Guyanese women and girls.

After Araneta's unsuccessful counselling interventions, Naidoo – a revered Indo-Guyanese Kali Mai leader – is later consulted. The pujari "placed his thumb upon the girl's [Drupatie's] forehead, and looked steadily into her eyes" (Singer et al., 1980, p. 170). Drupatie signals her non-consent when she "looked away, cried, and ran back into the ward" (Singer et al., 1980, p. 170). Naidoo renders his own diagnosis. Drupatie was "possessed" by "bad spirits due to a spell cast upon her by a black boy" since she "always ran away with Negro boys" (Singer et al., 1980, p. 170). No other specifics related to Drupatie's "possession" are outlined (Singer et al., 1980). It was arranged for Drupatie to be discharged in order for her to receive "a series of treatments" from Naidoo over the course of seven weeks (Singer et al., 1980, p. 170). Specific details of these religious "treatments" are not made clear. She is later prescribed Mellaril, also

known generically as thioridazine, a first-generation anti-psychotic drug that was widely given to people diagnosed with schizophrenia (Kelly et al., 1963). As early as 1963, which was around the period that Drupatie was admitted (between 1963-1966) and prescribed thioridazine, tests showed that the use of this drug can cause severe cardiac disorders, including cardiac failure (Kelly et al., 1963). The drug was withdrawn from the global market in 2005 (Purhonen et al., 2012). With the use of anti-psychotic medication and consultations with Naidoo, Drupatie's family reported that she was "behaving good" and regularly participated in Kali temple rituals (Singer et al., 1980, p. 170). "Good" behaviour may be read to mean "submissive and obedient", which is how her parents described her before she started acting in ways that were "mannish" and "brought shame to the family" (Singer et al., 1980, pp. 169-170). After seven months of outpatient treatment from both the Mental Hospital and through the counsel of Naidoo, the authors tell us that Drupatie was set to marry a man of her parent's choosing "according to accepted Hindu custom" (Singer et al., 1980, p. 170).

Like Indian women during the period of indentureship, Drupatie is steered into the sphere of domesticity and towards haunting reproductions of Indian family life (Mohapatra, 1995). Here we see how racialized and gendered tropes – historically mediated by colonial encounters – are reproduced through the "total institution" of the asylum (Goffman, 1961). These tropes come to adversely impact the life of Drupatie when her performance of femininity and Indianness do not submit to the ethnically gendered expectations that her parents, and by extension the community (through the language of "shame"), have reified and internalized behind their cultural banners. Drupatie is made to bear the moralistic expectations of Indo-Caribbean girlhood, where respectability politics are centred on her sexuality and also come to symbolize the hazards of creolization (Hosein, 2012), especially given the emphasis placed on her relationships with Afro-

Guyanese boys. In this context, creolization is seen as a direct threat to notions of endogamous Indian family life – never mind her desires to explore romantic or platonic relationships with Afro-Guyanese youths.

There is no record or account told from Drupatie's perspective of the aforementioned events; we know Drupatie through the gaze of Singer, Araneta, and Naidoo. For this Indian girl in the early 1960s, to be "mannish" was, in part, to be labelled neurotic; moreover, was to be "possessed" by "bad spirits", which have been sent and take their instruction from "a black boy" (Singer et al., 1980, pp. 169-170). During this period of Guyanese history, in the 1960s, the country experienced an outbreak of violence and civil disturbances that were fuelled by racialized animosities (Wismar Report, 1965). The ethnic hostilities and false, racialized dichotomies created and enforced by colonial powers endured and, as product of the climate in Guyana at the time, may have influenced the way state institutions functioned, such as the Mental Hospital. Honour narratives and notions of "shame" and respectability drew racialized boundary lines on Drupatie's body. It also appears that her cure was, in part, one of domesticity – marriage to a partner of her parent's choosing and at the cost of her earlier desires. This is a consequence of an archaic colonial protocol intended to castigate and control Indian's women's sexuality and create a "moral order of family" (Mohapatra, 1995, p. 228) – to drive them into the domestic sphere under the subordination of the Indian man – and to ultimately dictate the lives of these women.

As emphasized previously, the role of religious and traditional medicine and healing interventions, especially at the request of mentally distressed people and also in combination with biomedical approaches, can be a crucial and beneficial aspect of treatment (Jilek & Draguns, 2008; Moodley et al., 2008; Sussman, 2008; Thachil & Bhugra, 2009; Wintrob, 2009,

as cited in McKenzie et al., 2011). The inclusion of such approaches is necessary in the equitable treatment and care of Caribbean people experiencing mental distress (Chaze et al., 2015; McKenzie et al., 2011; Mitchell, 2011; P. Sutherland et al., 2014). Research studies show that religious beliefs and practices can be powerful coping behaviours that impart purpose and hope in an individual's life during periods of distress (Koenig, 2009a, 2009b). Other studies, however, have also demonstrated that religion in mental health care may "reinforce neurotic tendencies, enhance fears or guilt, and restrict life rather than enhance it" (Koenig, 2009b, p. 289). In their study, "Exploring the relationship between stigma and help-seeking for mental illness in African-descended faith communities in the UK", which engaged Caribbean participants, Mantovani et al. (2017) illustrate how mental distress and illness, particularly within Christian groups, is conceived as a "moral failing", where "mental illness was regarded as a phenomenon experienced by those who failed to conform to societal norms" (p. 376). This idea of a "moral failing" is also relevant in Drupatie's case. There exists the moral expectation that Indian girls should be "submissive and obedient"; they should, in submitting to the will of their parents, engage in endogamous friendships and romantic relationships. Failure to adhere to these established scripts carries the risk of pathologization. As with Drupatie, it appears that her failed performance of Indo-Guyanese femininity and non-compliance with codes of moral respectability led to her medicalization and to the psychiatric diagnostic labels of "compulsive promiscuity" and "compulsive neurosis".

Furthermore, how did the diagnosis of "possession" affect Drupatie's perceptions of and relationships with Afro-Guyanese people? Echoing Koenig (2009b), how did the use of religious intervention in treatment, in this particular case, possibly create or augment fears of the other and impose unnecessary restrictions on Drupatie's life? Answers to these questions are speculative.

Singer et al. (1980) tell a tidily resolved story of a reformed "mannish" Indo-Guyanese girl child whose honour is restored and who is made marriageable by the joint psychiatric and religious interventions commenced at the Mental Hospital. When we, however, step into this story with a transnational feminist and mad and critical disability studies grounding, as we have done here, the disciplining apparatus of the state via the asylum is deciphered and laid bare. Like the 1898 British Parliamentary Papers that paint the colonial version of the social relations between Indo- and Afro-Guyanese women, the story of Drupatie tells us more about some of the stifling social conditions of 1960s Guyana than it does about the subject it intends to depict. It is only upon closer inspection that we are able to expose and recognize a suppressed narrative, Drupatie's, which prompts me to ask: whose interest does this serve? Drupatie's account of her actions and desires is not given voice. Ethnically gendered codes of behaviour and morality are powerful control mechanisms, and, in this case, these ideas appear to wield immense influence. This case does beg the question: were there other Drupaties? Were there other Indo-Guyanese (or Afro- or differently racialized Guyanese) women and girls who were pathologized or labelled mad because they refused to carry those heavy cultural and gendered banners, those burdens of representation? This will be discussed in the next subsection.

This dissertation, in its own way, strives to be a project of reckoning and reclamation – a rasanblaj. It is in this spirit that I question what recovery and reclamation might look like for Drupatie. Gaiutra Bahadur's *Coolie Woman* (2013) traces the history and journey of her great-grandmother, Sujaria, from Bihar, India to the sugar estates of colonial Guyana, where she worked as an indentured labourer. In her endeavour to detail the life of Sujaria, Bahadur's substantive archival research offers glimpses into of the lives of other Indo-Caribbean women under the indenture system. *Coolie Woman* belongs to a growing collection of work on Indo-

Caribbean womanhood that holds the archive and historical inaccuracies to account – that challenges and stares down narrow depictions in order to tell multifaceted and complex life stories (P. Mohammed, 2002; Mehta, 2004; Kanhai, 2011; Hosein & Outar, 2016). The work and legacy of questioning and dissent must continue if we are to arrive at better stories (Georgis, 2006); if we are to also engage in a project of recovery, where our reading and analytical practices dismantle the patriarchal gaze; and if we are to recognize that the unsung are speaking and choose to listen to those better stories instead.

Who *is* Drupatie? Surely the charge of "compulsive promiscuity" and how this imputation appeared to hinge on ethnically gendered perceptions of Indo-Caribbean femininity does not entirely capture or begin to express her full humanity. I ask this question because Drupatie's narrative and version of events sits at the crux of this particular case if we are to comprehensively understand it, yet she does not speak. The voices of others – her parents and her treatment team – seem all consuming if we refuse to challenge their gaze. As well, I ask this question in the present tense because of the real possibility that Drupatie might be alive. These psychodynamic therapy sessions occurred between 1963 and 1966, and we are told that she was 14 when she was admitted to the Mental Hospital, although there is no mention of the specific year that she was admitted. If Drupatie were alive, she would be in her early to mid-70s. What is her story? Does she live in Guyana? What was her profession? As a youngster, what were her experiences with Afro-Guyanese youth? How would she describe her experience in the Mental Hospital? Did she end up marrying? Does she have children? Grandchildren? What is her favourite colour? What songs does she like to listen to? Does she dance? These questions, ranging in tone from serious to ones manifested out of joy – the ones that do not occupy the record of admittance to the Mental Hospital or her patient file – fill me with hope when I

consider the possibility that Drupatie might be alive and, maybe (just maybe), might want to tell her story on her own terms.

Gendered and Racially Coded Reproductions in the Contemporary Moment

Poststructuralists tell us that language only offers us a negotiated glimpse of experience and reality; that narrations are always segmented, messy, and interwoven with contradictions (Britzman, 2000). All of the various accounts by the participants in this study are complex and interleaved by the incongruities of life, and, at times, some narratives reveal gendered and racially coded reproductions and attitudes. In one story recounted by a religious/spiritual practitioner, I am immediately reminded of Drupatie. This telling is about a young Indo-Guyanese girl who took her life by suicide after her parents disapproved of her union with an Afro-Guyanese partner:

> People mistaken lust fuh love. Yuh eva hear… de story where the girl commit suicide…She had liked a Negro and de father say, "I'd rather bury you than you marry a Black man. I don't want you to marry a Black man." Dah is his view. And she couldn't ah tek it… De father don't want that in his family. They are East Indian people… It's a kinda race problem … Sometimes a Indian girl like a Black bai and you find they get excited over the lust and because of the parents, the girl guh drink poison. Sometimes the family feel that this boy is not suited for the girl and they try to keep she away. She drink poison and he drink poison like Romeo and Juliet style.

It is important to note that this participant is, in part, relaying how the father and the family of the deceased girl felt about her relationship; however, in prefacing this story ("people mistaken lust fuh love"), there is an assumption that these specific interracial unions generate feelings that are grounded in lust, not necessarily romantic love ("Sometimes a Indian girl like a Black bai and you find they get excited over the lust"). Further in the interview, they mention: "Most of these young girls [Indo-Guyanese] when they go to the Christian church, dah is de biggest

mistake because most ah dem marry Black man, the *kapar*[71] race." Based on the usage (also see footnote 71), "kapar" is considered a racist, anti-Black, and pejorative colloquial term. In discussing the religious choices of Indo-Guyanese women, there is an assumption that their decision to follow the Christian faith is a "mistake", in part, because it may lead to interracial unions between Indo-Guyanese women and Afro-Guyanese men, which appear to represent a breach of moral regulation. There seems to be an expectation here that Indo-Guyanese women *ought* to practice endogamy, whereby any prospective partner *ought* to be an Indo-Guyanese man. At the heart of these prescriptions and proscriptions is an apparent base conviction that desire *ought* to be governable, adhering to stereotypes and scripts of Indo-Guyanese femininity or possibly run the risk of death and suicidality per the initial telling of the girl who took her life when her family disapproved of her Afro-Guyanese partner. Like the case of Drupatie, it is implied that these specific interracial unions are viewed as unacceptable and pose moral hazards. Even as these views are expressed, this participant is also of the mind that the racial animosities in Guyana created "a sick" that debilitates the nation: "You find that all over the world, you find that people look at race and this is a sick in this country because the race issue." They acknowledged the negative outcomes of racism, particularly in Guyana, yet their cognitive dissonance does not seem to be apparent to them. It is not clear if they view their personal beliefs as also contributing to the "sick in this country" given "the race issue" that they so aptly

[71] The usage of "*kapar*", possibly "*khapar*", "*kaphar*" or "*kaphaar*", signals that it is a racist and derogatory colloquial epithet directed against Afro-Guyanese. When researching this term, I was unable to locate any scholarly or research sources that cite its usage or potential alternative spellings. I did, however, encounter the word in a short work of fiction in the *Guyana Journal* (Rupnarain, n.d.); and in the online comments section from two *Guyana Chronicle* articles, in which anonymous newspaper readers disparagingly utilized the term in their posted comments (Mohabir, 2019; "Muslim Scholar to go on Trial", 2019). When consulted, Guyanese elders from my networks also agreed that it is a discriminatory and anti-Black expression utilized as a slur to denigrate Afro-Guyanese. I have not encountered any discourse on the reclamation of this word.

underscore, and which has historically contributed to racialized violence and the destabilisation of the nation.

Reflecting on the role that women have "to play in married life" – the wifely scripts – another religious/spiritual helper shares their perspective:

> In this life, women has a very strong role to play in married life. And the role that she had to play, she has to look at the background of mother Sita, how she [Sita] saw Ram in that aspect. Fourteen years she [Sita] went to exile with all the pains and everything. People try to destroy her [Sita] honour and so on, but she still stood up as a wife to Ram. She [Sita] never look at nobody [was not unfaithful to Ram]. In a home, man has a tends [tendency] to do what they want. Wife gat to understand that nah all time de man ah right, but you gat a duty to perform as a wife, to serve and to serve with your heart. It tends to tell you as a wife, if you're determined in your service, loyal, and truthful to that man, you can able to change him, but if you started to bark, harass him, he gonna harass you more. It tends to say too, man ah wrong and dem ah strong. Dem want live with outside people [multiple partners, infidelity]. Dem want to all sort ah thing. Now what cause this? … When dem come home, the man might gah he two drink and he gon' start talk and right away de passion fly [he becomes enraged] and he start beat she. Beat she mercifully too.

This participant goes on to say that when women experience domestic violence, they have every right to file complaints and bring charges against their partners. When couples seek their counsel in navigating domestic violence issues, they explain:

> Me nah geh [give] none a dem right. You gat some wrong, and you gat some wrong. Ayuh [all of you] married, and if ayuh want upliftment in ayuh life, ayuh gah stop this thing. I say man, if you ah drink and thing, why yuh come and beat up the lady fuh? You know dah wrong. If yuh mek yuh pickney [children], you mek yuh daughtah, you think when she grow up yuh guh like anybody fuh beat she up and suh? Study back the thing and don't do it man. I say, if you harass yuh husband, you must stop. Even though he ah do lil wrong, you mek sure you cook yuh food, put am pon de table. Service, service, you wuk is to service him. Do as much as you can.

These normative understandings of Indo-Guyanese femininity, with specific reference to Sita in the Hindu epic Ramayana, underscore how these ethnically gendered tropes of the dutiful and subservient Indian wife are enduring in the present. If a woman's behaviour ("bark", "harass him") falls short of this normative expectation to "serve", then her husband may "harass" her

more. This participant disavows violence; however, Indo-Guyanese women are, as implied, expected to tolerate possible harassment and "lil wrong" in the name of wifely "service": "Even though he ah do lil wrong, you mek sure you cook yuh food, put am pon de table. Service, service, you wuk is to service him." These two narratives, marked by prejudiced attitudes, illustrate how ethnically gendered stereotypes and wifely scripts are alive, but I also wonder how prevalent they are among the wider population. To that end, if and to what extent is madness read onto the bodies of Indo-Caribbean women and girls whose behaviours contravene these ethnically gendered tropes in the contemporary moment? The cases of Radika Singh and Sangeeta Persaud, as detailed in Chapter Two, offer some clues, but there must be wider and sustained studies to comprehensively address this issue.

On this question, Reverend Jean offers some insight in recounting how an acquaintance described the behaviours of their "good" and "bad" Indo-Guyanese daughters-in-law:

> Men have more flexibility in terms of behaviour but women are more constrained in relation to their behaviour or else they'll see it as abnormal behaviour. Someone was telling me about how she has such a good daughter-in-law and I said, "Oh! How so?" She was saying she has a bad one and a good one. The good one, she said, she don't go nowhere. She wake up. She cook for her son [acquaintance's son] and then goes to work and then she goes to sleep and then she wakes up and then she eats and then she sleeps and then she cooks again.
>
> And then I said, "My God!" I'm waiting to hear the next story. The bad one, she's all over the place. She's always going out. She's wearing fancy clothes, makeup and stuff, and she's going out and she's not always cooking on time and that is seen as abnormal, close to, I'm waiting to hear… very close to demon possession too [chuckles] because ya know "de girl wile [wild]". Wild means that you're already outside of the range, right? And people are quick to move to demon possession if they can't explain something or if they want to be at peace with it. At least you're able to put a label on it. Don't matter you don't know what the label is [chuckles].

When I think about Jean's account of "good" and "bad" daughters-in-law – especially with the "bad" daughter-in-law described as "wild" by her mother-in-law – I am again reminded of Drupatie. There was no space for Drupatie to exist in the ways that she wanted to; no room to

create and share friendships and love relationships with Afro-Guyanese youths, unless she was afflicted with "compulsive promiscuity" or "possessed". The "good" and "bad" daughters-in-law are trapped in a similar dichotomy. Some clergy, like Jean and David, recognize that these bigoted representations and attitudes are to be rejected and dismantled. As he discusses how he counsels Indo-Guyanese women who are fearful of their families and for their lives because they are partnered with Afro-Guyanese men, Pastor David explains:

> It's something we're dealing with where you dare not bring home somebody of another race… I've had to counsel many of our young females, Indians, who are having a relationship with a young African male and so scared. Beaten by their parents. Beaten, sent away, locked in their room. Literally put to shame and were told they would be killed. They literally will kill them rather than bring shame and disgrace to the family. So those social concerns of racism, all are impacting on the mental health of people, of young people in our nation.

In David's account, he establishes how systems of oppression, like racism and sexism, combine to serve as drivers of mental distress and how they also function to create disabling environments. Saneism operates in a similar way and is especially apparent in the account of "good" and "bad" daughters-in-law. Violence ("beaten, sent away, locked in their room… told they would be killed") is still a consequence when the myth of familial honour ("bring shame and disgrace to the family") is threatened (David, Interview), as with the case of Drupatie. The progressive attitudes of Jean and David reflect a changing society where oppressive scripts and interlocking systems are scrutinized, denounced, and slowly undone through everyday forms of resistance.

Holistic Care and Healing

There is an increasing push towards discourses of "world mental health" (Jakubec, 2009) or "global mental health" (V. Patel et al., 2008, 2011), even as these discourses are not

universally accepted. This is, in no small part, because biomedical psychiatry does not capture all worldviews or interpretations of mental distress and madness. In *Provincializing Europe*, Chakrabarty (2000) underscored the limits of Western thought by refuting and exploding the idea that modernity, as historically understood, is a consequence of European Enlightenment. Biomedical psychiatry – as a proselytizing and universalizing approach, which was historically delivered to Guyana as a consequence of colonial violence and conquest – is but a single model of care. Despite its prevalence and perceived role as the default approach to care, biomedical psychiatry is an individual ethnomedical system (Gaines & Hahn, 1982, 1985). What might it mean to provincialize biomedical psychiatry; to think of it as one important approach in a toolkit of approaches, whereby – and at the request of the person receiving care – it may be incorporated to complement different, culturally specific and localized approaches to health and wellbeing? A formalized and Guyanese-specific holistic model of care, informed by a biopsychosocial-spiritual (Sulmasy, 2002) approach that is person-centred and grounded in the self-determined priorities of the individual, whereby other methods (e.g., socio-economic solutions and religious and spiritual interventions) may also be welcomed in order to alleviate distress, is worth careful and thorough exploration in light of the ways in which Guyanese engage diverse methods of care historically and in the contemporary moment.

In many ways, the religious/spiritual practitioners speak to the need for a holistic system of care that is inclusive of, but not dominated by any one approach, including religion and spirituality:

> We ought to be working for restoration, remedying, reconnecting these people with their families and the community… We cannot close our hands, close our eyes, or close our hearts to these people. The church is there for them. (Samuel, Interview)

> I say that in all seriousness in terms of a factor that we have to deal with. I think a lack of recognition of our totality of who we are, you know, that we are not only physical,

> physiological… We have emotions. We are also spiritual beings and let me say that from a spiritual perspective that we are spiritual beings in terms of a deeper connection and rootedness in our sense of being, our sense of self… In a nutshell that is a very fundamental issue that we have to deal with as people in Guyana. (Jean, Interview)
>
> So all in all, I know yes, that the dactah gat they wuk. The scientist gat they wuk. Everybody gat a wuk to perform. Everybody gat they duty to perform. Someway or the other, we all can put hands together to give a helping hand to help those who… is unfortunate. (Navindra, Interview)
>
> When we gat God close to us… dis heart become soft. As somebody come to yuh, we guh wan help dem… Look upon the community and help dem. (Mustaq, Interview)

Jean goes on to sum up these expressions of care, where wholeness and health are interconnected and privileged: "For people's lives, I keep saying that you can't compartmentalize this part here and this part. It doesn't work well. People are integrally whole persons… I think community approaches are very, very important." The biopsychosocial model (Engel, 1977, 1980; Ghaemi, 2009) can be expanded to include a spiritual element of care because, and as laid out in this and in previous chapters, Guyanese-specific understandings of mental distress and madness appear to necessitate it, especially given the dominant narrative of "somebody do dem something" and the role of religious/spiritual practitioners as first responders. As mentioned in Chapter One, the government also recognizes the significant function of these traditional methods in the lives of Guyanese, per the WHO (2019b); however, even as authorities acknowledge "the important role played by traditional and complementary medicine", "there is no national policy or regulatory system for traditional and complementary medicine in Guyana" (p. 94). This absence presents an opportunity for the government to develop policies, laws, and regulations in consultation with relevant stakeholders, which will rigorously assess the role of traditional/complementary medicine and healing approaches in order to source best practices, ensuring that help-seeking individuals are presented with safe, effective, and culturally responsive care options for their self-determination.

Conclusion:
Changing the "Dem" to "We": "Somebody do *we* something"

This dissertation apprehends the multiple meanings of mental distress and the diverse practices enacted to generate relief in Guyana by attending to the nuances of Guyanese belief systems, experiences of distress, and care practices, which embrace plurality and refuse either/or models of care. In doing so, these findings present crucial implications for theory, research, policy, and practice aimed at addressing and reducing mental distress experienced by Guyanese and fostering comprehensive, responsive, and accountable public health systems. Some of this research suggests that it is important to meet people where they are in their health journey and to make safe and accessible, for their determination, a range of integrative care options that have the potential to ease distress, inclusive of biomedical and psy-disciplinary methods, socio-economic interventions, and traditional medicine and healing practices – a Guyanese-specific biopsychosocial-spiritual model. This may lead to the creation of new, braided, and health-giving approaches that push beyond the limits of these existing paradigms.

Over the last 300 pages, it is my sincere hope that readers came away with a broadened understanding of these particular and incredibly dynamic aspects of Guyanese life. When I began drafting this dissertation, I was perplexed about how to introduce Caribbean health belief systems, traditional medicine, and healing practices. I commenced with Aho and Minott's (1977) study at the beginning of the theoretical section in Chapter One because evil eye/maljo/bad eye/najar beliefs, while not universally held, serve as a relational point of entry that explicated a phenomenon that is intelligible to a great number of societies, spanning diverse geographies and different historical contexts and periods. This work strives to be relational and reflexive; to, as Gorman (2016) puts it, "reveal the social relations of disability [and madness and mental distress, as is the case with this dissertation] beyond the immediate narrative that the subject

evokes; one which can attend to both the social organisation of disablement and the situated knowledges of and resistance to these social relations" (p. 251). The multifaceted and deeply nuanced stories offered by the participants are about relationalities and the power of social relations in crafting collective and creative solutions to make "life pon de dam"[72] a little more liveable. In countless ways, these narratives are also a homage to the resourcefulness, resiliency, and will to flourish of Guyanese people in a place where the completion of small tasks require greased connections and herculean ways and means. Most germanely, the accounts of the participants serve to demystify and expound some phenomena which are valued and reviled, but, nevertheless, are practiced by Guyanese and other Caribbean populations. These beliefs and practices necessitate candid, engaged, and accountable discourse, which must be sustained.

What I have come away with is that an unceasing, interrogative analysis must confront any belief system and set of practices that claim to alleviate or cure mental distress. None of the interventions outlined in this dissertation is a universal solution or panacea in addressing mental distress. None is a sovereign remedy. Each has potential benefits and drawbacks; the possibilities and limitations of these approaches must be comprehensively and continuously explored, and each claim met with a healthy dose of intellectual curiosity and critical engagement. As evidenced by this research, Caribbean traditional medicine and healing practices are one important, and often maligned, part in a larger matrix of how mental distress is understood and the approaches to care that are then sought. Some of these approaches are considered "outsiders", but what might it mean to bring these "outside doctors" and their "outside" knowledge and approaches *in*, especially so because Guyanese appear to seek them out during

[72] "Life pon de dam" is a colloquialism made popular by Guyanese journalist Gordon Moseley (Craig, 2013). The saying references the range of difficult socio-politico-economic conditions faced by the general population in Guyana (Archer, 2014), but also more specifically alludes to the poverty of squatter communities in Georgetown (Craig, 2013). "Is Guyana we deh" is another colloquialism that is similar in meaning (Archer, 2014).

experiences of distress? How might that change the landscape of mental health care in Guyana? As relayed by the helpers, Caribbean traditional medicine and healing approaches are part and parcel of the landscape of interventions utilized by distressed people seeking care. Creating policies that recognize and regulate traditional and complementary medicine in the interest of consumers of these services and practices is a crucial step towards harm reduction. In its own small way, this research intends to continue the conversation in a push for the creation of a national policy to recognize traditional medicine and healing approaches in Guyana (WHO, 2019b), which has largely been ignored; and to honestly reckon with the possibilities and limitations of these approaches because they are facts of Guyanese life. Guyanese continue to seek out and practice these approaches to their benefit and, as some case studies in Chapter Two reveal, to their detriment. The historical denigration, banning, denial, and ostracization of these methods only serves to drive them underground; to create and uphold conditions that may lead to violence; to silence any beneficial outcomes; and to hide harms when they occur. There is no one approach to address mental distress, only approaches. The interventions intended to alleviate distress should be nimble, with the ability to change and modulate in response to the various and shifting needs of people that require and seek them out.

It is also crucial to engage and sustain research in this area in places with large Caribbean diasporas, such as Canada, the United States, and the United Kingdom. In Ontario, the incidence rate of psychotic disorders among the general population is 55.6 per 100,000 persons; however, when disaggregated to account for place/region of origin and among first-generation immigrants of Caribbean origin, this number is almost 60% greater, recorded at a staggering 94.4 per 100,000 persons (Anderson et al., 2015). When put in conversation with similar international research conducted in other high-income countries with large populations of Caribbean people,

parallel trends emerge. A review of 18 studies carried out in the United Kingdom (UK) – which analyzed the incidence rate of psychotic disorders among African-Caribbean migrants and the baseline population from 1960 to 2013 – found considerably higher incidence rates in the Caribbean groups over the 63-year period of published research (Tortelli et al., 2015). In the United States (US), African Caribbean-born men had increased risks of psychotic disorders; and second- and third-generation people of Caribbean descent had statistically significant elevated rates of mental health disorders (J. Jackson et al., 2007). Studies conducted on the incidence rate of psychotic disorders in the Caribbean countries of Jamaica (Hickling & Rodgers-Johnson, 1995), Trinidad (Bhugra et al., 1996), Barbados (Mahy et al., 1999), and Suriname (Selten et al., 2005) found that the populations living in those Caribbean nations have much lower incidence rates than the aforementioned findings in Caribbean populations living in those high-income countries. These incidence rates in the four Caribbean nations align with global rates (20-30 per 100,000 persons); however, a troubling picture emerges when placed alongside the incidence rate of psychotic disorders among first-generation people of Caribbean origin living in Ontario (94.4 per 100,000 persons) as this statistic is around 300% greater than the incidence rates in those four Caribbean countries and most of the world, with related exceptions found in the Caribbean populations living in the UK and US.

What is it about the Caribbean diasporic experience in North America and Europe that is detrimental to one's mental health – particularly in Ontario, which is home to a growing population of over 350,000 people of Caribbean origin (Statistics Canada, 2007)? There is a lack of qualitative data in Ontario that substantively investigates the nuanced mental health narratives of people of Caribbean origin. As in the Guyanese context, the development of equitable mental health services cannot happen without a knowledge base that is founded on rigorous inquiry of

the ways in which people of Caribbean origin living in Ontario make meaning of mental distress within their socio-politico-economic contexts. In Guyana and in Ontario, research on mental distress must make central the understanding of Caribbean people as they articulate, locate, and understand themselves.

How can Guyanese, as Hickling (2020) so poignantly put it, "own our madness" (p. 28)? I propose that one way of beginning to do so is by reorienting the dem [them] in "somebody do dem something" and asking questions about what these findings mean for us or "we", per Guyanese Creolese, in order to foster better public health responses – to centre "somebody do *we* something" in order to apprehend relationalities so that we may arrive at integrative, heterogenous, responsive, and efficacious approaches to care. "Somebody do we something" inspirits a rasanblaj (Alexander and Ulysse, 2015): a call to recollect, reassemble, and gather together to reckon with and transform what ails us. The monsters in this dissertation are not the jumbies of lore or any number of other-worldly spirits and phantasms, nor are they represented by the stigmatized presence of the "Obeah man" (Colleen, Interview), "Obeah lady" (Hafsa, Interview), or the "Kali Mai Puja man" (Patrick, Interview) and their perceived abilities to "do" or "duh" and unleash harm. Instead, the monsters here are punishing socio-politico-economic conditions and negative social determinants of health: the oppressive colonial legacy, its inheritances and hauntings; historical and continued state inaction in addressing mental distress; and the pervasive social stigma of madness – all of which breed silence and unfavourable health outcomes. The monsters, more generally, are man-made harms. "Somebody do we something" is an invitation to conceive of the necessary work to be done as a collective, relational effort and one that necessarily implicates all stakeholders – *abedese* [us] or *all ah we* [all of us] – in finding shared solutions and best practices. In the spirit of rasanblaj, bringing the "outside" *in*, and

cultivating conditions for change, I conclude with this generative and requisite teaching from Andaiye (2018): "I'm not saying this to be pessimistic. I'm saying it to say that we all know that if we want to change people we have to start from where they are."[73]

[73] See the University of Guyana's Institute of Gender Studies' short profile on Aunty Andaiye: https://genderstudies.uog.edu.gy/andaiye/
Also see footnote 30.

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