ARE YOU LOOKING AT MY MADNESS? EXAMINING CANADIAN-CARIBBEAN YOUTH'S INTERGENERATIONAL STORIES OF MENTAL HEALTH

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ABSTRACT

This study investigated resources used by Canadian-Caribbean youth to define and respond to mental health and mental illness; as well, the study examined the effects that culture, history and intergenerational knowledge have in the mental health definitions of the participants. The study used *Narrative Inquiry* as the methodological approach to investigate the stories of 12 young people between 18-25 years old who are grandchildren of Caribbean women who migrated to Canada under the West Indian Domestic Workers' Scheme. This generation of participants was important to focus on because it allowed the researcher to collaborate or dispute the well-documented notions of strength associated with the former domestic workers. The study examined the interconnection between notions of strength and mental health in the experiences of these young people; as well, it looked at the tools that these young people use to negotiate mental health and mental health care.

Data from the study indicates that there are multiple factors that shape the definition and experiences of mental health among youth of Caribbean heritage. Participants' narratives indicate that the language used to talk about and address mental health or madness draws from the history of indentured labour, slavery, colonialism and the West Indian Domestic Workers' Scheme. Similarly, participants' narratives show that this history has been passed on from one generation to another. Some narratives highlight what it means to demonstrate strength and to rely on the migration survival story and prayer in order to deal with mental health issues. Other narratives show how Black masculine identities are simultaneously reinforced while being redesigned through the use of the mad gaze. These narratives contribute to a wider discussion surrounding mental health and mental healthcare in Canada.

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When I was a teenager, I spent most of my free time buried in books, searching for the right storybook that told a story similar to my mom's. I knew one day I would eventually write my own. Mom, without your stories, there is no telling what kind of experiences I would narrate… If I had the choice, I would still want to write yours. I love how our stories continue to shape together as one. I have deep regards for all of our mad stories. These writings are dedicated to you.

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CHAPTER ONE: INTRODUCTION

PURPOSE OF RESEARCH

This qualitative research uses stories to examine how madness, mental health and mental illness[1] are recognized and encountered among English-speaking Caribbean youth living in Toronto. The study draws on the experiences of participants and their connections in the Caribbean and Canada. The study investigated how Canadian-Caribbean people define and understand mental health and the sources of their understanding. To frame the study, I begin with a personal account that is based on my mom, which illustrates how experiences of mental health are complicated and how dominant clinical practices are used to either legitimize and therefore treat, or negate and therefore ignore mental health experiences.

> *This is a story of a little girl who never left the house. It is important to understand the significance of the house because this little girl loves this house. This one time, she didn't leave the house for 10 years! You see, she is really scared of the outside world. The outside world is really mean to a little girl. Some people from the outside world use words like "crazy," "obsessive," "mad" and even "dysfunctional" to describe her. She is not sure why the outside world is so awful, but for her, it is safer to stay inside. If she stays inside, no one notices that she looks, speaks and behaves differently. No one will "poke" her, "gaze" at her or "tell secrets" about her. This little girl has a secret that most would never understand. She likes to clean and spends days upon days cleaning. Cleaning relaxes her. Cleaning allows her to bury all of her troubles. Sometimes, no matter how careful she is, her troubles rise to the surface. Sometimes her troubles are difficult to bury…*
>
> *One day, this little girl was forced to leave her house. You see, she was taking a shower and fell, breaking two of her ribs. She was taking a shower that went on for almost 10 hours. The shower was really long and she got really tired and decided to take a little nap. I know it is silly to think that such a thing was possible. You see, she had a very long day of cleaning before her shower, and just needed to take a little nap and decided to do so standing up. Why didn't she sit in the tub you ask? Well that's because the tub was dirty, of course. After all, the little girl was taking a shower for 10 hours before her little nap. The little girl was rushed to the hospital and she was really scared. She*

[1] Definitions of "mental health" and its relationship to "illness" are very messy, overall. These definitions are further complicated by race, spirituality, cultural beliefs and one's social location. The terms "mental health" and "madness" are used interchangeably throughout this document however, the term 'madness' is often used by participants to provoke emotions and judgements made by individuals to refer to others within a Caribbean context.

thought the strangers dressed in blue were nice, but she didn't understand their confusion when she tried to explain why she was so tired. The little girl was even more scared of the men dressed in white. The little girl was tired and was really sorry that she took a little nap in the shower. She just really wanted to go home but the men in white kept her there all night long. They asked her questions and did not care for her response. She thought her troubles "in her head" were "contained." She had spent days and days cleaning them all away. The little girl cried and cried and cried for three days long. She finally got to go home when she agreed to take her little magic pills that made her less scared. She promised to never leave the house again. The little girl was safe now. This concludes the story of a little girl who never left the house.[2]

The story illustrates three points: first, it shows how complex one's experiences are with mental health, mental illness, madness and care; second, it demonstrates legitimized dichotomies of power between experts and subjects/patients; and, lastly, it informs how fear and stigma of mental illness are strongly connected to identity and difference, ultimately structuring one's access to care.

In presenting the above story I have chosen to use the voice of a little girl because, in general – and more so in the Caribbean, girls are brought up to be docile and are spoken at without being listened to. Christian concepts of power relations between parent and child are important to note because they are the basis of how children are treated in many Caribbean households. Old biblical teachings that are ingrained in Caribbean child-rearing practices include: *the child should be seen and not heard; and, spare the rod and spoil the child.* In addition to these biblical teachings are remnants of practices from slavery, and especially, the use of physical violence to enforce obedience. Payne (1989) notes that corporal punishment of children is more likely to be supported in Caribbean societies and is rooted in "experiences of slavery, fear of the afterlife/supernatural, high anxiety and pressure towards developing obedience towards adults" (as cited in Babcock, n.d.; p. 3900). Therefore, my use of the voice of a little girl is an attempt to break away from this

[2] I wrote the story originally for a course paper: Winter 2014, (De) Colonizing Research Methodologies EDUC 5225, York University. The story is reflective of true events based on my mother's interactions at Canada's Mental Health Hospital (CAMH) and Mount Sinai Hospital, both located in Toronto, Ontario, in the winter of 2014.

Christian, slavery-informed and gendered patterns. Many of these patterns are noted in my mother's childhood; consequently, up until now, she carries them in her body and her practices.

The symbol of the child in my study reflects more than just gender and family relations; rather, it also represents experiences of race, power and migration. Adults silence the child's voice in similar ways as they silence their own traumatic histories. Valerie Walkerdine, Aina Olsvold and Monica Rudberg's (2013) argue that Caribbean people are part of a "sociohistorical process" (p. 278) that work to frame their serial migration patterns, their family structures and how they relate to one another. Walkerdine et al., (2013) explain that sociohistorical patterns or large historical trauma such as slavery, for instance, "attaches itself to the subject through processes of intergenerational transmission known as the small histories, or micro-experiences of the everyday, experienced bodily, [and] unconsciously" (p. 281). The macro and micro histories that Caribbean peoples experience are further suppressed through the process of migration out of the Caribbean region. Ahmed (2010) critiques the subliminal meanings of multicultural where people are compelled to "embrace the common culture" of the nation (p. 138). She says that there is an assumption by the dominant society that happiness is only achieved when one embraces the new nation's culture and sadness or depression is experienced if someone refuses "to let go" of their former cultural ties or "cultural objects", after migration. Ahmed argues that the wanting to remained closely connected to "back home" is interpreted by the dominant nation to be "a form of pathology" (p. 139). In otherwords, the endorsement of culture only matters if it is suited to the dominant nation. Similar to Ahmed, Paul Gilroy (1991) in *There aren't no blacks in the Union Jack: the cultural politics of race and nation*, writes that racialized people are often pathologized and represented as aliens if their culture is seen to be incompatible or threatening to the conceptions of whiteness. Both Ahmed's and Gilroy's works help point to a deeper source of mental health

that cannot just be cured with a prescription of *little magic pills*. The story that frames and inspires this project undertaking is given a deeper context throughout this document.

BACKGROUND: SELF-LOCATION

As a Canadian-Canadian woman, who has experienced the mental healthcare system through my mother's ongoing relationship with care, I deem it imperative to write from a point of self-reflection and hence have located myself within this study. Navigating between the Canadian mental healthcare system and struggling to make sense of my mother's mental health issues that are informed by Caribbean-cultural teachings, has been an extremely frustrating process. The ethnic and cultural background of the Caribbean and specifically Guyana is significantly important and relevant to the conceptions of my own interpretations of madness. I have shared some of this work with my mother and she concurs with the narrative that frames her as a central character because it states the intricacies of how I have been able to negotiate, understand, cope and work through her revolving relationship with care. In this study, I also delve into some aspects of Caribbean history and personal narratives of upbringing in attempts to unpack how my perceptions on mental health motivated me to pursue this research.

The Caribbean's colonial history is constructed out of forced and voluntary migration, which, as I will show later, worked to shape my mother's cultural and ethnic identity. Forced or involuntary migration refers to "groups of people who have been made to be a part of the society permanently against their will" (Ogbu et al., 1998, p.165). These groups include those who have been conquered, colonized or enslaved. In the case of the Caribbean, the Europeans conquered most of the Indigenous people (also known as the Amerindians), who were predominantly the Kalinago and Taínos. The European colonizers in the Caribbean included the Spanish, Dutch, French and the British. These colonizers later brought Africans as enslaved labourers to work on

the plantations. Africans arrived all across the Caribbean from the beginning of the 16th century up until the late 19th century (Benitez-Rojo, 1998).

Voluntary migrants, on the other hand, are people who are willing to move to another country with the expectation of better opportunity; therefore, they are often motivated by economic reasons (Ogbu et al., 1998). Poor Europeans were the first wave of people who migrated to the Caribbean as indentured labourers. This wave of migrants were largely coercered as punishment for minor crimes committed in Spain. Poor Europeans arrived in the Caribbean as indentured labour following the period of Amerindian slavery, and this process of European indentureship lasted for about 150 years (Hernandez-Ramdwar, 2016; Williams, 1964). African slavery followed European indentureship in 1662 and continued until abolishment in 1834 (Williams, 1964). African slavery aided in augmenting Europeans' socioeconomic status. After the abolishment of African slavery, the second era of migration was claimed to be voluntary under the system known as indentureship that was introduced from 1838-1917 in British Caribbean colonies (also includes the Dutch speaking country of Suriname and the Spanish speaking island of Cuba). The second wave of migration was expected to meet labour demands of the plantation societies in the Caribbean after the abolishment of African slavery (Benitez-Rojo 1998; Hernandez-Ramdwar, 2016; Williams, 1964). Although, Chinese and Indians migrated under better conditions than those experienced by their African counterparts, the living and working environments were no better than those of the enslaved African slaves (Dabydeen, 1996; Lai, 1997). It is important to note that other groups migrated as indentured servants during this period as well, which included the Irish, Portuguese and even some Africans. However, in the case of Indian servants or Indentured labours, many people were bribed, tricked, or kidnapped, and sold into an indentured system, often by other

Indians. Various patterns of migration as a result of imperialism in the Caribbean helped to shape the cultural norms and identities of the people in that region.

The process of migration—whether voluntary or involuntary—creolized[3] many of the region's practices and customs and blended various groups of people together. This is referred to as the creolization characteristics, derived out of the need for survival, resistance and healing, moulding many of the region's contemporary national identities. Though, there is no unified Caribbean identity, there are regional similarities due to the socio-political and economic construction of the Caribbean (Allahar, 1993) and these similarities are especially central to this project in examining the constructions of madness. Furthermore, the shared markers of madness across the Caribbean are partly rooted in how people were treated on the plantations; these treatments generated forms of resistance, such as suicide, destruction of the plantation owner's property, and running away from the plantations. The colonizing plantation owners termed these acts as forms of madness (Mannix, 1962; Williams, 1964).

The importance and relevance of Guyana's and my own family's history was brought back to me through an informal chat I had with my first cousin.[4] He casually asked about my mother and I jokingly responded, "Clothes are an optional lifestyle choice for her these days." I secretly thought to myself that wearing no clothing was certainly "mad behaviour" and I found myself slightly ashamed for revealing my hidden secrets to extended family. As the words slipped through my lips, the reel of tape in my head began spinning, uncovering the abnormalities of my life story.

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[3] Creolization is the blending of various cultural traditions, religions, languages and way of life. Creolization in the Caribbean context is complex as Smith (1965) qualifies that creolization in St. Vincent, for example, cannot be equated within the same context as creolization in Guyana. This includes various forms of dance, music, food, dress, language and other elements of Caribbean life. Benitez-Rojo (1998) on the other hand claims that creolization is not static nor a process but a discontinuous series of reoccurrences. Creolization is a product of the plantation, he says that "threw out billions and billions of cultural fragments" (p. 54) therefore, creolization is a product rooted in power that stems from the plantation system.

[4] Conversation dated: November 24th 2015.

I always knew that my mother was not a “mad woman”[5] since she never rummaged through public garbage cans or talked to herself as mad people in the Caribbean are known to do.

Growing up, I was told my mom was depressed but I also noticed that she had a number of strange behaviors that I could never explain to any doctor who worked within a Canadian medical setting. I remember spending a number of years being told by family members that if my sister and I prayed for my mother’s recovery, she would be healed; so, we prayed, religiously. It never worked. As teenagers, my sister and I lacked the tools to cope with my mother’s complicated mental state. Family members distanced themselves from us due to the stigma and denial that surrounded “madness”. Our Canadian understanding of how to better manage our mother’s mental state was deficient as well. I can recall that there were a number of occasions that I just wanted to run away from the situation. I spent many years longing for my mother to change and I hoped that she would eventually give up on spending all of her energy cleaning away her troubles and sins and eventually desire a “normal” life.

In the above-mentioned conversation, my cousin asked me a simple question: “Karen what exactly is her normal?” The question of normality lingered with me as my cousin continued to talk and explained that both my mother and her late brother (my cousin’s father) experienced a life of great physical and verbal abuse from their own father. My mother is second generation Guyanese, and her father was first generation, born of indentured and formerly enslaved parentage. My cousin explained his own memories of our grandfather ‘uncle Ketchah’, whom he described as abusive, which led me to ask if concepts of abuse can also be contextualized in the framework of emotional health and its relationship to madness.

[5] A person who suffers from mental health issues is often referred as a mad person. I unpack this term in relations to madness further along in this document.

Historically, for Indians in India, madness is a loaded term that predates voluntary migration/indentureship. The fear of madness increased among this group during the process of migration to the Caribbean. For instance, within the spiritual realm, many Indians prayed that the Kala Pani (Black Waters) would not curse them with madness or prevent reincarnation (Dabydeen, 1996). Many Indian indentured laborers who were recruited or "lured by local recruiter referred to as an "arkatis," were promised great fortune if they voyaged to the Caribbean" (Samaroo, 2000, p. 34). The Caribbean looked like the biblical "promised land" in which the hardships that many Indian peasants experienced in India would be erased. Similar to many other Indians who migrated to then British Guiana (present day Guyana), my great-grandfather was also sold on the false promises. It is unknown how he arrived in Guyana and if he migrated with more than one family member, such as brothers or sisters. My great grandfather met my great grandmother after his migration to Guyana and they eventually shared a life together.

I was told that my great grandmother was of British and Indian heritage but there is also little evidence of this since my great grandmother passed when my grandmother was a little girl. I was told recently that my great grandmother walked into a river and never emerged out. At the time my grandmother was 8-years-old and was playing not too far from the river. My great grandmother's story is not a secret; it was just never told. I do not think my maternal grandmother's grandchildren asked for her mother's story because the past always seemed so distant and old. I learned about my mother's maternal grandmother's story when my mother's mental health further deteriorated in 2015. My mother's paternal grandmother's story was a story often told by my grandmother and seemed comical. She died when my mother was a little girl and she was known for running away from home. Often this great-grandmother could be found washing her feet for

hours by the river. Her concept of time was lost and the only thing that seemed to matter was the abundance of water.

My memories of the past are also layered with messages of Guyana's evolving political landscape. My mother was born ten years before Guyana's independence and she can barely remember the hardship of pre-independence; however, she has clear memories of the many tribulations of post-independence Guyana. She vividly remembers that many staple foods such as rice and flour were banned; religious practices outside of Christianity were heavily regulated, and there were many efforts of making a then creolized society "proper" in order to mirror British ideals. My mother also grew up in a day and age where the access to simple healthcare was denied unless you were part of the upper class. After migrating to Canada she spent years praying not to be sent back to Guyana, which included "pretending to be normal" and "pretending to be a good citizen". So, I guess now that she is in her 60's and neglects the confines of clothing, even underwear, who am I to deny her?

Why and how does this history matter in my own experience? Growing up in Guyana I was also surrounded by language such as "mad," "yuh run off" (someone who has gone crazy), "yuh head en gud" (there is something mentally wrong with a person), "yuh studie dem book too much" (someone who is over educated), "somebodi doo yuh" (someone has cast a spell on you). All of these phrases are rooted in a space where emotional illhealth and illness are deemed as reflections of spiritually evil, or are negatively associated with obeah (or spiritual possession). Obeah is "a secretive medicine art that involves a range of religious practices, activities, and beliefs designed to help persons in distress deal with response to tragedy, battle psychological and physical illness, protect themselves against human abuse, and fight for survival" (Murrell, 2013, p. 65). Obeah is a tradition that originated in West Africa, which mixes physical and emotional healing practices that

are based on various spiritual traditions, and herbal medicines of different ethnic groups (Case, 2001; Murrell, 2013). Historically, "obeah provided the oppressed alternative avenues through which they could procure medical treatment and access their African powers for psychological reinforcement to survive the wretchedness of plantation life" (Murrell, 2013, p. 67). That is, obeah was commonly sought out by Indentured Indians, Africans, poor Whites and the middle-class, who used it to battle unwanted attention, physical and psychological illness, fight for survival and protect themselves from outside harm. In contemporary Caribbean societies, obeah is "practiced in traditional religious and cultures, in remote and improvised communities where alternative medicines are a last lifeline, as well as in upscale or middle-class society" (Ibid p. 66). Obeah is strongly believed in the Caribbean to be a practice belonging to the ancestors, which is evident in folklore and "in Caribbean people's consciousness as a protective medicine that can be used for a variety of human needs" (Murrell, 2013: 76.). Murrell argues that Obeah in the Caribbean is a creolized practice that combines spiritual elements from both Indian and African ancestries. This creole practice's has roots, is oral, and often observed in secret.

Obeah is intertwined in my personal understandings of mental health and comes from countless stories told about my family's spiritual past and Christian regulations of the body. In addition to my informal Caribbean teaching to mental health and healing practices, I now have Canadian references regarding mental health and illness based on interactions with my mother's care. I grew up with many more stories on my father's side that are similar to those from mother's side of the family, all of which structure part of what I know about madness, mental health and illness. My mother's health and the tensions related to her access to care are connected to her own historical narrative in which obeah was central. My great-grandfather (my mother's maternal grand-father whom my mother never knew) was known in his village as the "healer" or "the obeah

man." He spoke a mixture of creole (Guyanese dialect) and Hindi. Many of those in the village who did not have access to, or who did not want to access, foreign medicine[6] looked to my great-grandfather's healing power to cure their ailments. It was said that those in his village trusted and feared my great-grandfather's many gifts; to some, he was someone who was a health provider/obeah healer but to others, he simply possessed mysterious qualities that were his innate gifts. Thus, my grandfather had an ambiguous reputation, with some looking up to him as a healer and others negatively viewing him as possessing rare powers and access to the ancestral world from which it is believed, obeah draws its power.

My granny, his daughter, was fearful of her father's practices because she was convinced that his Hindu gods and religious practices were sinful, based on her Christian biblical teachings. Obeah was primitive, devil worship, superstitious and conflicted against Christian ideals. My granny's unwillingness to the practice was also grounded in the notion that obeah was outlawed historically (since the 1700s), under a law known as the Vagrancy Act. Obeah remains an unlawful practice today in most Caribbean states, including Guyana (Murrell, 2013).[7] It was common for obeah men and women to operate covertly. She also believed that her father's spiritual practices were still powerful and could direct negative or positive things to happen to others. My granny wanted to disconnect herself as much as she could from her father's teachings. On the eve of her arranged marriage, at the age of 14, my granny ran away from her village into the city, escaping both the proposed marriage and her father's spiritual practices that she was expected to inherit. She eventually found work beyond the sugar plantations and worked her way into a secure middle-

[6] This was either medicine prescribed by the British medics or American missionaries.
[7] "In 1973, [Guyanese President] Forbes Burnham's socialist government abrogated obeah laws in Guyana, with a proviso that was not to be used for 'capital gains'" (Murrell, 2014, p. 70; Paton, 2009).

class status, building a life with my grandfather (which was a "love" marriage)[8], whom she met in the city. Her children had access to education, an opportunity she herself deeply desired, but never had. Although my granny seemed to escape inheriting her father's healing practices, which were referred to by Christians as an "evil spiritual past", her unwillingness to sanction these practices seemed to have haunted her forever. It is also unclear, based on these stories of that time, how my great-grandfather treated mental health. I see this history as potent to how mental health was addressed in my family, which included a denial of my mother's conditions – perhaps because it was seen as a generational curse brought about by my grandmother abandoning her spiritual inheritance from her father. Either way, my mother's stories are partially the reason she's received limited support from her family and community.

There was little room for a person like my mother to reveal her illness upon settling in Canada. Having migrated from Guyana in 1980 as a young woman in her mid-twenties meant that my mother had to present a front of being "healthy" and worthy of settling in Canada. In the process of her migration she lugged her imagined Guyanese cultural ideologies in her suitcase as part of her essentials (Anderson, 2006; Hall, 1997) and these suitcase contents eventually manipulated the navigation of her new life in Canada. Her Guyanese culture, history, values and other unspoken norms sheltered her from a Canadian culture that seemed cold, insensitive, uninviting and intolerant of differences (Fleras, 2004). More importantly, her perceived ideas of strength, endurance, spirituality and thinking of Canada as a "better" place than Guyana also comforted her during the weak moments of longing for "back home." My mother's former teachings about madness and her ability to hide her own insecurities of her mental state once in

[8] According to Hernandez-Ramdwar (2016), the dynamics of marriage in the Indo-Caribbean communities have shifted overtime. The shift from previously arranged marriages to now interracial and "love" marriages is primarily due to the economic independence of Indo-Caribbean women.

Canada, are important in unraveling the meanings of madness that the story that opens this Introduction attempts to illuminate.

My mother's story that I use to situate this project frames her ongoing experiences with the mental healthcare system and depicts my own accounts of what mental healthcare means. Through this story and my family's history, I am acknowledging that there are significant flaws in the Canadian healthcare system. My mother's fear of the mental healthcare system is heightened by experiences of cultural differences and by what mental health and illness means in a Caribbean context, which differs from, but sometimes intersects with, the Canadian context. These differences and intersections are visible in practice, as the mainstream mental healthcare system fails to treat the whole person, concentrating on illness as only in the mind and or body (Sutherland et al., 2013).

For instance, my mother believes that she has no voice in the current circle of care and that her treatment is only focused on the use of medication as a solution. As a Caribbean immigrant to Canada, my mother's experiences of mental illness and care are not an isolated case, but they are ongoing well-documented examples of the treatment women of color experience when accessing care (Flores-Ortiz, 1998; Heron et al., 2001). She is an example of how the western medical model only looks at mental health and mental illness with a particular set of ideals that continue to dominate and regulate mental health theory and practices (Burr et al., 1998). It is through the existence of my family stories that I have deliberately asked myself the question, what are other Canadian-Caribbean peoples' stories about mental health and care? In other words, are other Canadian-Caribbean young people sharing similar experiences to mine? How might these stories inform and disrupt colonial narratives about wellbeing and belonging?

This study has uncovered that the language of madness is deeply embedded in both colonial and contemporary discourses of mental health and illness (Kanani, 2011). For this project, I use a postcolonial lens as a method for examining stories and experiences with madness and to analyze how these stories are linked to a colonial history. I also use a Mad Studies framework to illustrate the tensions between the language used in Canadian-Caribbean homes and those of first or second generation Canadian. Using both a postcolonial framework alongside a Mad Studies lens enrichens the meaning of my data and broadens the perspective in examining the various challenges to mental health and mental illness such as access to care, informal networks to treatment and the increased awareness of mental health issues within Caribbean and Canadian communities and institutions. Similar to postcolonial studies, Mad Studies goes beyond identity politics, rather examining how the system of psychiatry is oppressive and deeply intertwined with the racist and sexist violence that racialized people experience throughout their lives (Diamond, 2013). Thus, this project accounts for how "racialization, gender, class, disability and/or ability, sexuality and other processes shape and define madness" (Diamond, 2013, p. 71).

RESEARCH QUESTIONS

Mental health does not live in isolation

This dissertation investigated the following questions: **(1)** How do young adults of Caribbean heritage, living in Canada, define and experience mental health? **(2)** How does Caribbean culture and history, shape the way Caribbean young people and their families living in Canada, give meaning to and address mental health and mental "illness"? **(3)** To what extent do Canadian-Caribbean young adults learn definitions of mental health from family/Caribbean communities and does this learning influence the way they negotiate their overall health and wellbeing in a Canadian space? **(4)** What points of convergence and divergence exist between hegemonic Canadian definitions of mental health and how mental health is defined by Caribbean peoples? **(5)** What

factors influence how Canadian-Caribbean young people think about mental health in regard to people of their heritage?

OVERVIEW OF CHAPTERS

Chapter Two provides literature that grounds this dissertation. In this chapter, I demonstrate why history and culture are important lenses through which to examine mental health and illness. I also scan mental health literature that has been developed in Canada to include culturally relevant frameworks designed to address population diversity. Finally, this chapter illustrates the deep history of madness in North America and Europe as it relates to the Caribbean as a former colonial project. Chapter Three outlines the theoretical approach used to analyze participant narratives and overall data. Post coloniality, Critical Race Theory and Cultural Studies lenses help to give meaning to how my Canadian-Caribbean participants interpret mental health and ill mental health. Chapter Four delineates the methodological approach used for the project. In this chapter, I provide my rationale for using narrative inquiry as a method for my data collection. Participants' profiles are also offered at the end of the chapter.

Chapters five, six and seven present my findings. Chapter five discusses how young adults of Caribbean heritage living in Canada define and experience mental health. This chapter uses the stories of four participants—Storm, Sway, Gabrielle, and Cecilia—to illustrate how Caribbean culture and history shape the way Caribbean young people and their families living in Canada give meaning to and address mental health and mental illness. Chapter Six tackles the ways in which masculinity is wrapped into the notion of sanity, addictions and depression/or sadness. The chapter explores the stories of Zordon, Gambit, Cyclops, Havok and Rogue[9]. Chapter, Seven, presents

[9] I have deliberately given my participants pseudonym names that reflected positive characters from the Marvel's 1963 comic book, X-men. I saw my participants as superheroes who had exceptional adept to acknowledge the significance of mental health that their unique stories reflected. Please refer to p. 64 for more details.

personal experiences and impact of madness of three participants. Two participants, Dust and Surge are living with ill mental health and one participant, Phoenix is caring for a loved one who is considered to be mentally ill, which is common among Caribbean families. However, stigma and shame often cloaks these stories as non-existent. This chapter brings the other participants' stories to a full circle in emphasising the urgency of focusing on mental health care within the Canadian-Caribbean communities; as well, it introduces the dangers of denial, isolation and "moving forward" with ill mental health. Put differently, the chapter primarily highlights how ill mental health impacts families and communities. Chapter Eight concludes this project. The final pages of this document end with an Anansi story – half fiction and half non-fictional tale. The story demonstrates how the denial of mental health and the fear of madness can affect families deeply. This chapter discusses possibilities of future work both within and outside of Caribbean communities.

CHAPTER TWO: LITERATURE REVIEW

Mental health is viewed and treated very differently in the Caribbean than it is in Canada. Based on my own experiences, the term "depression" is acceptable and freely used among Caribbean peoples and in their communities. Depression is a condition that provokes minor emotions since the depressed person should be able to "get over it" in a short period of time. Depression is not something that Caribbean people necessarily believe warrants medical attention but is rather something that can be treated in a number of local ways such as through prayer or herbal remedies (James et al., 2012; Schreiber et al., 2000).

Several other mental health issues in the Caribbean are often associated with hallucination, spirit possession, or one's lack of devotion to a higher power and may be treated using traditional healing methods (Hernandez-Ramdwar, 2016; James et al., 2012). The language used to describe the many conditions associated with mental health issues is also important. For instance, the term "depression" itself is used to simplify more complicated issues that might be associated with mental illness. Phrases such as "yuh run off' (The person is not acting in a very sane way- you run off your head)," "yuh head en too gud" (your head is not good), "dem en too right" (That person is not too right), "sick in de head" or "he/she tripping" are a few phrases used to describe someone who is either considered to be mad or just simply mentally unstable. The way language is used is important, since it is linked to the construction and negotiation of one's identity (Dlamini, 1998).

In the following section, I critique some of the ways that language is used to define and respond to mental health issues within the Caribbean context. Defining the various meanings of mental health is vital in setting the tone for this research, given that mental health is conceptualized differently where mental health and illness are used interchangeably in Western medical spaces and not necessarily under the same circumstances in Caribbean communities. Thus, this section is

also dedicated to surveying literature from the English speaking Caribbean in providing a scope of the various meanings of madness and show how people with mental health issues are labelled and treated, through, for example, traditional medicine.

FROM PRISONS TO PILLS:

The history of madness

The causation of madness has been a mystery for many cultures. In Western culture, the evolution of madness is not fixed. Historically in Europe, if one was reckoned to be mad, it meant they were possessed or cursed by God. Madness moved from being studied in association to Christian philosophies to now being more scientific based, situating madness as chemical imbalances in one's brain (Foucault, 1977; Scull, 1979). Thus, the construction of madness is socially bounded, reflective of society's various belief systems. Western ideologies of madness, examine the mind as being dislocated from the body and spirit (Fernando, 2002). When compared to cultures located outside of the western bio-medical paradigm, which view madness as being intertwined with the mind, body and spirit, western definitions of madness are often in conflict to other cultures (Fernando, 2002). Therefore, the social constructs of Western-European views are too important to ignore, since these perceptions continue to shape the understandings of madness and the delivery of care within other cultures (Fernando, 2002; Mills, 2000; Mills, 2014).

Michel Foucault (1977), an important thinker in the field of madness both in Europe and postcolonial societies today is known for his work *Madness and Civilization*, an important book that pushed against normative views of madness in Europe, during the eighteenth and nineteenth century. Foucault examines the interlocking social structures of power and the construction of knowledge, relating to the study of the mind and body. I also draw from Andrew Scull's (1979) work *Museums of Madness*, as an expansion of Foucault's writings. Scull's work is influential in examining the tie of social capital to the treatment of madness. In addition, James A. Mills' (2000)

book *Madness Cannabis and Colonialism,* is useful in discussing the role of the asylum in British India and how knowledge was produced in relation to the colonial subject. Finally, Suman Fernando's (2002) study *Mental Health, Race and Culture,* ties this section of history together, because his work is a deliberate insertion of race, culture, and spirituality into the discipline of madness.

Foucault's work, starts with the Renaissance period (1300-1600) and moves to the age of fear and confinement during the eighteenth and nineteenth century. According to Foucault, Europeans at one point in time, believed that mad people were best kept in secret, out of the public's view and regulated under Christian practices. Foucault illustrated that large institutional asylums were Europeans' way of constructing order; thus, institutions were considered appropriate authoritative models, ensuring that the mentally ill were not disrupting the symmetry of society. During the time of Foucault's reflections, the insane were considered to be anyone who committed petty crimes; caused family upheavals; disagreed with the law; presented as dangerous; vagrants; or those who showed signs of mental abnormality (Foucault, 1977). Foucault's writings demonstrated a societal shift from the beginning of the Renaissance period to the middle of the 1600s, where madness moved from the dishonouring/shaming of family, to later a "condition that provoked laughter and the insulting pity of the spectators" (p. 69). For instance, Foucault wrote extensively about the linkage of madness to comical scrutiny, in his analysis of *King Lear* - a parody of social deviance. Foucault noted that the ideologies of madness shifted once more during the eighteenth century, where it was later linked to the lack of virtue. Thus, if a person was categorized as unstable, it permitted them to be treated with forcible control, when necessary. He wrote that madness was seen to have "…borrowed its face from the mask of the beast. Those chained to cells were no longer [people] whose minds wondered, but beasts preyed upon by a

natural frenzy" (1977, p. 72). Foucault's writings demonstrate that the treatment of madness is a revolving reflection of society's perceptions.

As the sophistication of science advanced in medicine, more people were subjected to brutal experiments in order to locate the causes of madness (Foucault, 1977; Mills, 2000). The over-diagnoses of madness also allowed for the overcrowding of asylums and more aggressive assertion of power over the mad body— thus, the chaining, whipping and other forms of inhumane treatments were vindicated (Foucault, 1977). Foucault said, the "Madwomen were found with feet, hands, and face torn by [rat] bites which were often dangerous…only the most violent of the insane were held in dungeons, the calmer ones were crammed into wards of varying size" (p. 71), exposed to innumerable accounts of abuse and testing. Foucault's writings demonstrate how definitions of madness were a replication of society's discontent for abnormality. Madmen were seen as "psychologically deviant" and "incapable of reasoning" (159). According to Foucault (1977), "…the cure for madness was not so much to care for the soul or the entire individual…[instead] The madman's body was regarded as the visible and solid presence of his disease" (p. 159). Foucault's book *Madness and Civilization*, underpins the central component of power in both the description and treatment of Western psychiatry. Although Foucault's descriptions of madness in relations to power and discipline are worthnoty, his accounts fails to address the details of women's experiences with madness, which were further regulated by systems of patariachy.

Jane Usser (2011) book *The Madness of Women*, provides extensive accounts of women's historical and contemporary experiences regarding psychiatric care. Her research draws particular focus to women's experiences both in the United Kingdom and Australia. Her book provides a timeline of women's mad experiences that dates back to the Middle Ages, where women were often hospitalized for any issue that were related to her sexual or reproductive body. Women who

were hospitalized, often remained in isolation until their families considered them as healthy. According to Usser, women were prescribed treatments which included "injections of ice water into the rectum; placement of ice in the vagina; leeching of the labia and cervix; removal of ovaries to calm raging hormones; enforced weight gain to keep the ovaries from slipping and causing discomfort; electrical charges applied to the uterus; hot water injections in the vagina; and clitoral cauterisation" (p.67). Women who exhibited more serious and hysterical symptoms such as "falling into a trance, strange body pains or paralysis,... were considered to be possessed by evil spirits..." or witches and sentenced to death by burning (p. 66). Although men were also subjected to ill treatments if diagnosed with a mental illness, often times, women were most likely to be removed and hospitalized at the accomodation of men.

As Usser moves through the timeline to the Victorian era, it is obvious that power played a central role for women's hospitalization. She says that women were admitted to a mental institution for simply having a disagreement with their husband. Other reasons also included "not being feminine enough; or for failing in their role as a wife and mother" (p. 68). Usser provides numerous cases to support her research. For instance, she says that "Susannah E. was committed three times between 1869 and 1870 for attempting to leave her husband, and Helen C. was committed following a complaint of marital ill treatment, including being called a `bloody whore' and being ordered out of her home, after asking her husband for a drink of water..." (p. 69). Usser builds a strong case of the expectation of women during this era – to be compliant and respectful. Deviating from such expectations, even in the slightest of ways, a woman could be ostracized from society. These former writings are significant because history demonstrates how easy it was for a women to be deemed mad. Today, women out number men in their access to psychiatric care

(Usser, 2011) and as Mills (2000) describes later on, that power is also central in the examination of racialized people and madness.

Turning to Andrew Scull (1979), in his work *Museums of Madness: the social organization of insanity in nineteenth-century England*, echoes Foucault's observations of madness. Scull agreed with Foucault's historical accounts of the ill-treatment of the insane. However, Scull goes further and links this treatment with the economy; that is, for Scull, the heavy regulation of the body in Europe, was more in support of a healthy economic workforce: "The advent of a mature 'capitalistic market economy' resulted in a segregated response to madness, leading to the building of large asylums in Britain; and similar movements occurred all over Europe and North America" (p.16). Scull further argues that with the rise of the industrial era, the production of capital became the primary focus, consequently, any person diagnosed with deformities, could potentially disrupt a strong, active labour-force, thus, resulting in the person's institutionalization. Scull's arguments are notable, since the discourse of madness and a healthy economic-force continues to thread into more contemporary literature. I tease out the research surrounding health, mental health and the economy, in my examination of Mental Health and Culture in Canada, later on in this document.

In a more recent publication, *Language, Madness and Desire*, Foucault (2015) problematized the relationship between the production of knowledge and the perception of madness. In his interview with Jean Doat, Foucault states, "The tragic expression of madness…is without equal in a culture…because culture has always taken to keep madness at a distance…" (2015, p. 11). He emphasized, "the history of exclusion [in regards to madness] lasted for nearly a century and a half which was rarely questioned. The accounts that are recorded justify reasons for internment" (p.14). In this interview Foucault stated that knowledge is constantly being produced and reproduced but from positions of power, with deliberate intentions of silencing disenfranchised

groups from accessing that power. Again, Foucault's work reiterates the fundamentals in examining the role of power as it intersects with madness and civilization. Although, Foucault's perspective is well respected and validated in attending to the historical accounts of psychiatry, there is little recognition granted to the role of race in the intersectionality to madness.

David Austin (2013), problematizes the little acknowledgement afforded to race and racism in Foucault's writings. In Austin's book *The Fear of the Black Nation,* he argues that the history of slavery and the central link between colonialism, race and power in Europe is worthy of recognition. Austin states, "power is facilitated and exercised through the production of truth and is designed to maintain power, order, and authority, to make laws, and to produce wealth" (2013, p. 48). And although Austin's book does not focus on the history of madness, he does draw attention to the construct of popular narratives, that can silence racialized people's experiences overall. For example, he argues that "Foucault's omissions are a potent reminder of how social movements influence ideas and how those ideas in turn influence social movements…and negated in ways that are connected to prevailing fears and narratives of power" (p.48). The absence of race in Foucault's work erases the experiences with psychiatry for non-Europeans. Thus, the White clinical gaze is a source of power that positions Black and brown people as inferior, primitive and pathologic. Regardless of the absence of race in Foucault's work, his writings serve useful for this study since it provides a historical collection of how madness was deemed overtime. Foucault's accounts offer a lens to understand the disciplinary nature of mental institutions in Europe during the eighteenth and nineteenth century, which is useful for my own work.

Building on the construction of the White clinical gaze, I am drawing on James H. Mills' (2000) book *Madness, Cannabis and Colonialism*. This book discusses the history of asylums in British India and the varying impacts that influence current practices today. Mills' work is

reflective of Foucault's writings of mental health, punishment and power. However, Mills extends the argument of a European's reproduction of power, with the duplication of British asylums in the Indian colony. Mills argues that the creation of asylums was attached to the colonial project, of which the primary objective was the production of "strong and ordered bodies…the Indian inmate's body had been colonized and it was to be disciplined by the British medical officers through enforced cleanliness, feeding, sleeping and a range of other painful interventions" (2000, p. 112). Thus, asylums "functioned to drill and produce bodies that could prove useful in a colonizing asylums" (p.112).

The asylums were constructed as institutional boot-camps, with the premise of reforming the individual. These mental institutions, forcefully regulated the Indian body for the production of a more manageable Indian workforce. Mills (2000) says "…the British hoped to train in the asylum workers [as being] able to motivate themselves to be productive and efficient… the ultimate aim was a self-disciplined Indian" (p. 120). Mills detailed how, even though the asylum was not conducive to the Indian people, it was duplicated throughout the British colonies. The legacy of colonialism is deeply ingrained in the former colonized minds (Fanon, 1967) and partially because pain and shame were used as constant disciplining tactics. Like Fanon (1967), Mills argues that the asylums dwelled on the infliction of pain and persistence of shaming; both were used as methods to confront the unwanted behaviors of Indian patients. According to Mills medical documents produced in the colonies were works of imaginations. They fashioned the colonizer's belief of the colonized and perpetuated one-dimensional truths, written as history. He argues that "…these imaginations survived in documentary form is a reflection of the power relations of the period, as the British had the power to watch and to write about the Indians admitted to the colonial institutions" (p. 178). These former writings that Mills presented in his book provide

significant insight in analysing historical accounts of power and what was deemed mad. It also provides a grounding for the development of language and knowledge when examining mental health and the Caribbean body.

Finally, Suman Fernando's (2002) book *Mental Health, Race and Culture* examines the role of race and culture in mental health and madness and documents ways that race and racism have always been a central feature of psychiatric thinking and continues to saturate current psychiatric theories and practices. Fernando argues that dismissing race and racism from any analysis of psychiatric theory and practice, assume that everyone is equal when in fact it is the opposite. He states, "psychiatry did not develop in isolation from its social environment; social and political norms of European society in the nineteenth century strongly influenced the subject from its very beginnings" (2002, p. 71; Castel, 1985). In addition, Fernando argues that "…while psychiatry was attempting to become 'scientific', racism, too, took on a 'pseudo-scientific' guise in the nineteenth century" (p.71). Fernando's work presented a number of examples of how race and racism are historically ingrained into psychiatry and psychology.

Fernando (2002) uses Carl Jung to consciously address how little attention was allotted to race and culture. According to Fernando, Jung, one of the few psychoanalysts in the mid-nineteenth century to confront race and culture in his work, still reiterated many racist ideologies that Western practices held of Black people as primitive and pathological. For example, Jung approved of White and Black people living in segregated communities, claiming "white people were adversely affected psychologically by living in close proximity to blacks" (2002, p. 76). Thus, race and culture interconnects with the previous production of knowledge of madness. Former claims of mental health and madness continue to inform how the practice perceives Black and Brown people and how treatment is determined and delivered.

The history that I have detailed is important because it provides a starting point for understanding the current mad movement that calls for empowerment of the client; the Caribbean's history and treatment of madness; and the absence of race in the examination of culture and mental health care in Canada. All of these components work together in creating the framework for my study of how Canadian-Caribbean youth understand mental health.

CARIBBEAN DEFINITIONS OF MADNESS:

De mad-man/being mad

There is significance in recognizing various Caribbean definitions of madness because: 1) madness is historically bounded in a context of race and power (Fernando, 2010; Gramaglia, 2008; Keating, 2007); (2) madness can imply mental feedom from political ideologies or current social circumstances (Hickling & Hutchinson, 2011; Kirmayer, 2007; Naipaul, 1959; Sutherland, 2013); and/or (3) madness can be interpreted as identifying a person as worthless or deviant (Arthur et al., 2010; Josephs, 2013). Suman Fernando (2012) argues that the more we know of how people of different parts of the world account for mental health and methods of healing, the better prepared we will be in serving the needs of various communities.

Madness and treatment in the Caribbean are discussed in non-orthodox spaces such as a neighbourhood bar, known as the rumshop, around a person's kitchen table, and in music lyrics and other forms of popular cultural and spiritual spaces. Similarly, the "mad-person" in the Caribbean region is not merely a symbol of mental illness, but also a functional and essential figure. In Caribbean creative art and literature, the mad-person is interpreted as capable of outer body experiences and can communicate with the unknown or the supernatural.

Madness can be linked to the aforementioned spirituality and obeah, colonialism, and Caribbean nationalism, which are all pieces that construct the mad-person and madness as distinctly unique in the Caribbean context. Madness and mad figures consist of competing views:

on one hand, the use of madness as a language in Caribbean popular culture, can be seen as a vehicle to covertly discuss social occurrences that are unique to Caribbean peoples and their societies; and on the other hand, however, the use of madness, exposes the ways in which the colonial legacy persists in the region. In the latter, the term also provides derogatory representations of the mentally ill. As a result, exploring expressions about madness and language in the Caribbean is a useful way of deconstructing how the term is complexly used and how it has multiple regional associations.

V.S. Naipaul (1959), a Trinidadian literary author, used the depiction of the mad-person as a popular post-colonial figure in his writings. Naipaul's novel *Miguel Street*, represents one of many works of literature that invite readers to explore the value of the mad-person. His mad character is written as caught between two worlds: the colonial Christian space and the other that is starving for a new self-governing identity. The story is told through a young boy's lens, who sites the mad-person as multidimensional – he is a part of God's plan; a productive member of society; a valuable symbol of imperialism; and a visionary (Naipaul, 1959). In the novel, the mad character is intentionally given a voice and demands respect, which is a refreshing redefinition of madness that differs from previous colonial meanings. Naipaul attempts to decolonize madness in his literary works suggesting that madness [and the mad-person] is rooted in a colonial past, while also representing change for peoples' future, through the "ability to communicate with God" (p.42). Naipaul's writings are significant because his interpretations of madness are an expression of self and his insertion of the unknown is weaved into the region's uncertainty of a future that attempts to shed its colonial past. The mad-person in Naipaul's work, symbolizes the link between the past and the present, where they must "go mad" in order for change to take place[10]. Naipaul's

[10] Avery Gordon (1997) argues that there is validity to exploring the unknown of social life and explains that the "confrontation [of the unknown] produces a fundamental change in the way we know and make knowledge, in our

interpretations of madness and its representation of nationhood within a Caribbean context is extremely valuable to this area of research.

Hickling & Hutchinson (2011) argue that the representation of madness and the mad-person in contemporary popular culture represents a "solution/salvation to the pressure of everyday life" (p. 17). For instance, the Vincentian (Caribbean) artist Skinny Fabulous' popular 2015 song, "Going Off", uses madness in similar ways as demonstrated in V.S. Naipaul's writings:

> *Its mad people time!*
> *De say we have ah mental disorder.*
> *Too much abnormal behaviour.*
> *Just leave we alone with we syndrome…*
> *we head gone when we tripping off.*
> *Behaving like we going off…." ("Going off", Skinny Fabulous, 2015).*

The word mad, and Skinny's use of madness in music and carnival, is a way to deconstruct the term outside of its clinical meanings. Hickling & Hutchinson state that often, there are cultural messages hidden in the lyrics of popular songs known as "Caribbean social resistance" (p. 18). They suggest that madness in genres such as soca for instance, is not as meaningless as it may be assumed to be by those who are outside of Caribbean culture; instead, the use of "madness is a response to life's stresses…it symbolizes coping behaviours in contemporary Caribbean societies both at home and abroad" (p.22).

Hickling & Hutchinson further suggest that Caribbean music "legitimizes the use of madness as a strategy of social defiance to combat the forces of oppression" (p. 10). Music is a rich reflection of public opinion, since it can serve as a vehicle for tackling trending social and political issues on a different platform. For instance, popular Trinidadian calypsonian, David Rudder teases out a person's state of being mad in his 1986 song "Madness". He claims that the

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mode of production" (p. 7). I am drawing on Gordon's notion of social life and the unknown, to exemplify how Naipaul's Caribbean character acts as a revolutionary social figure, attempting to reinstate power into Trinidad's chaotic state.

true state of madness can be attained through calypso[11] music and the energy generated in a fête[12] during carnival time. His assertion is unconventional, singing:

That kind ah head couldn't come from weed
This is not a fête in here, this is madness
This is not the kind of jam where yuh stand like ah shupidy[13], begging for mercy
This is not a fête in here, this is madness
... everybody mad....

For Rudder, the alternate state of madness cited in a fête (a legal space) is far greater than that which can be achieved by smoking marijuana (an illegal substance). In other words, madness is an alternate reality that can be simulated by calypso music. Hickling and Hutchinson's work helps to situate Caribbean popular cultural singers, Rudder and Skinny and their use of madness. I am building on Hickling & Hutchinson's analysis for my own research, hoping to unravel the linkages between "Caribbean social resistance" and the language that Canadian-Caribbean young people use to discuss madness and mental health.

Kelly Baker Josephs' (2013) book *Disturbers of the Peace: Representations of Madness in Anglophone Caribbean Literature* illustrates how historical notions of madness are interwoven into Caribbean culture. Josephs argues that the terms "madness", "mad", and "crazy" are uniquely different in the Caribbean region, where "it can be both derogatory and desirable" (p. 10); thus, "mad" was not necessarily used in a clinical context only, and also became an adjective to describe a person or situation or casual incidents. Some of these descriptions may be positive – describing someone who, for example, successfully and brazenly did or said something that others would not dare do; yet, other descriptions negatively label a person. Similar to Hickling & Hutchinson's

[11] "Calypso a satirical Song and lyrical rhyme commenting on any subject, usually composed for, but not limited to the Carnival season. Calypso grew out of African storytelling tradition and does not require much instrumentation to enhance its appeal" (Crichlow, 2004).
[12] Fête, the French term for party
[13] Stupid

discussion of madness as social defiance, Josephs makes some interesting correlations in her work between the use of madness and language, which is an angle I explore throughout my project. Many of my participants spoke about madness as a derogatory term compared to the use of mental health, which most claimed to be more widely accepted in Canadian spaces. Participants for this study felt that the terms mad and madness are outdated. Many argued that Caribbean people gravitated towards the use of mad or madness because they lacked adequate mental health education. I deconstruct the use of these terms further in Chapters Four, Five and Six. I argue that there is significance to how we use language and the use of language is rooted in a history that is relaxant to our contemporary experiences.

The derogatory use of madness in the Caribbean is rooted in the plantations where language was constructed out of power to maintain control over African people. The notion of "playing mad" was a form of resistance that former enslaved Africans exercised to contest the inhumane conditions they were living in (Bush, 1987; Hickling et al., 2011). Patsy Sutherland (2013) argues that former enslaved Africans were labelled as "mad" or diagnosed with drapetomania[14] for running away from the plantation, disobeying the enslaver or committing violent acts in order to escape the brutal and dehumanizing conditions of slavery – thus, "they were seen as uncontainable by slave owners… [and] from the colonizer perspective one had to be mentally ill to contemplate escaping the conditions of slavery and indentureship" (p. 23). Sutherland asserts that the term "mad" is socially and politically constructed out of the context of slavery and imperialism; thus, madness and traditional treatment (herbal or spiritual) are all interlocked with colonial power that declares those who were enslaved and /or colonized as

[14] Drapetomania was coined by American physician Cartwright as a disease of the mind that caused slaves to run away from the plantation. In response to this diagnosis Cartwrights (1851) went further and identified a preventative measure called "whipping the devil out of them" (cited in Sutherland, 2013 p. 708).

inferior, abnormal and uncivilized (Sutherland, 2013). Thus, establishing colonizer superiority "in all aspects of culture, history, religion, political and social systems, justified the extreme imposition on the colonized as people in need of intervention" (2013, p. 21). Sutherland echoes Tony Morrison (1990) when she states the importance of examining the ways in which:

> …specific themes, fears, forms of consciousness, and class relationships are embedded into the use of [dominant] idiom: how the dialogue of Black characters is construed as an alien, estranging dialect made deliberately unintelligible…how it serves as a marker and vehicle for illegal sexuality, fear of madness, expulsion, self-loathing (p. 52).

Indian indentured labourers suffered similar patterns of race and body regulation at the hands of European colonizers, as their African counterparts. In British Guiana for example, Letizia Gramaglia (2008) writes about the 1842 Lunatic Asylum (or the Berbice Asylum) established to treat the "insane". According to Gramaglia, by 1869, the Lunatic Asylum was averaging a daily admittance of a hundred patients, primarily African-Guianese and by 1880 the Lunatic Asylum's population changed to reflect British Guiana's new plantation labour population, Indian Indentured workers because, by this time, Indian Indentureship had been introduced following the abolition of African slavery. In a nutshell, Gramaglia argues that there is the "possible connections between the refusal to work on the plantations, and the labelling of their [Indians] behaviours as dangerous and insane" … [The Lunatic Asylum became a] "site of moral reform, where the insane could be brought back to his senses and transformed into obedient and productive subjects" (2008, p. 4). Gramaglia's documentation of history is valuable for my research because it fills a gap in the information about Indo-Caribbean people and their early connections to madness (Dabydeen, 1996; Mohammed, 1995), plus it demonstrates the ways in which plantation owners used madness as a way to forcefully control their enslaved and indentured populations, regardless of ethnicity.

These colonial labels of madness on Black and Brown bodies continue to impact how Caribbean people comprehend and respond to mental health. Arthur et al. (2010), claims that

people in Jamaica for instance, often use the term "mad" to mean someone who is unkempt, unruly, "incapable of carrying coherent conversations …(or) seen as potentially violent" (p.265). Thus, madness and the labelling of mad-people are not only rooted in slavery and imperialism as a way to uphold power and privilege but are also used to re-negotiate perspectives on mental illness. Therefore, my research is interested in unraveling how the varying aspects of these labels are maintained in the stories of those who are indirectly connected to the Caribbean through their heritage.

MY ASSERTION OF MADNESS IN THIS RESEARCH

I prefer the term "madness" for a very simple reason: it links back to a language that is rooted to my Caribbean upbringings. Growing up in Guyana, I was aware of the complexity of the term "madness": it was associated with the unknown, the unexplainable and more importantly, the untreatable. Although this term is often used in extremely derogatory ways, there are instances where it was used playfully and imaginatively. To me, it remains a term that is very Caribbean- "she/he behaving mad" or "don't play mad", and it brings back memories of phrases that children often flung around in schoolyards.

When I was growing up, mad people sometimes played in the streets or they sorted through rubbish cans looking for food. Mad-people (as they are commonly referred to in Guyana) became subjects for childhood "tantalizing"[15] but in many cases they were left alone, invisible to most. Where I lived, those whose family could pay for them to go to the Berbice madhouse (Berbice asylum or psychiatric hospital) were not treated any better than if they were left to wander the streets; nevertheless, the madhouse helped to keep dysfunctional family members hidden away. As a child, I imagined the madhouse as a place where acts of exorcism of ghosts took place; it was

[15] Tantalizing is a term often used in Guyana to mean to tease.

a scary dark space. The imagined ghosts that layered my mad stories, were not my invention; rather though I do not remember exactly, I suspect that I was told these stories at some point when I was little. And now based on my research, I know that the Berbice madhouse has an intense history dating back to 1842 and was the first institution created in the British Caribbean to treat mental illness. Consequently, the use of stories to explain real life events is significant to note, because, as Avery Gordon (1997) points out a "ghost is not simply a dead or a missing person, but a social figure, and investigating it can lead to that dense site where history and subjectivity make social life" (p.10). She further states that the "haunted draws us affectively, sometimes against our will and always a bit magically, into the structure of feeling of a reality we come to experience, not as cold knowledge, but as a transformative recognition" (p.8). Similarly, Jill Matus (1998) argues that there are strong connections between African stories and ghost tales: "Blacks could reconcile African beliefs about the supernatural with their experiences as slaves" (p. 114). Accordingly, the ghost story asserts the reality of the past, and functions as a concept of re-memory (Matus, 1998).

Childhood teachings are important in theorizing how madness was spoken about, understood and treated over time (Dlamini, 2006). Former teachings also invoke the haunting or a metaphor for the past that keeps resurfacing if not addressed (Gordon, 1997). More importantly, stories of the past are not meant to "reveal a literal truth, but an emotional truth which demands to be listened to, and accounted for in our political theories" (Kennedy, 2010, p. 108). Melancholia is the haunting or the refusal of letting go of the past and also allows a space for the lost past to remain alive (Britzman, 1998; Kennedy, 2010). For Lisa Farley (2014), the melancholia can be the place where the past engages with the present. She argues that "melancholia manifests [as] the knots left behind by devastating histories of social violence and loss" (p. 121). Thus, childhood

stories, either told or untold, help to frame my own cultural theories of madness, which I now appreciate as complicated and therefore worthy of addressing further through this project.

THE MAD MOVEMENT

I am grounding my use of madness even further in the more recent mad positive movement (Church et al., 2013; LeFrancois, et al., 2013) that first took place in Britain and now Canada, which is focused on a deliberate taking back of a language that has been oppressed (Poole et al., 2013; Reid, 2008). Mad studies is a growing body of work that acknowledges and validates peoples' experiences as being authentic to oneself. At the same time, mad studies:

> … rejects clinical labels that pathologize and degrade; challenging the reductionistic assumption and effects of the medical model; locating psychiatry and its human subjects within wider historical, institutional model and cultural contexts; and advancing the position that mental health research, writing, and advocacy are primarily about opposing oppression and promoting human justice (LeFrancois, et al., 2013: 10).

Mad is a term of what both Poole and Ward (2013) refer to as a reclaiming of language by those who have been pathologized or psychiatrized as "mentally ill" (p.10). I am situating my work within mad studies for numerous reasons: 1) it acknowledges diverse histories; 2) it is grounded in an inclusive approach where people's lived experiences are storied at the forefront; 3) mad studies is interdisciplinary and advocates for the recognition of the intersectionality of race, class, sexuality, culture and so forth; 4) it challenges the binary constructions of "normal" and "disordered" (Liegghio, 2013); and, 5) it constructs madness as political (Church, 2013). The pitfalls of this body of work, however, few studies respond to how the Canadian immigration population is diagnosed and treated for mental illness (Meerai et al., 2017). Do scholars of the mad movement acknowledge different notions and experiences of madness? And although mad studies is attempting to move away from the bio-psychiatry[16] of treatment (Liegghio, 2013), the literature

[16] By this is meant the medicalization of madness is a treatment (Liegghio, 2013).

that anchors mad studies provides little evidence of how spirituality and herbal medicine are recognized within the field. Cultural markers and alternative treatment are important areas for my research because it is closely tied to representation of madness within the Caribbean context. My project is attempting to highlight these missing areas of the field of mad studies.

Part of my own work is focused on the reclaiming of language. I believe that reclaiming the language around madness opens up the possibility to recognize one's history, begin conversations that are about culturally-informed claims to madness, and unpacks how cultural markers shape one's lived experiences with mental care and education. Kelly Baker Josephs (2013) argues that it is necessary to deconstruct how the historical use of madness is embedded in language that is tied to the colonial project that positions colonial subjects as inferior. This use of language, she explains, differs in a Caribbean context. Similar to Church (2013) and Josephs, my use of madness and mad throughout this document is an attempt to decolonize madness itself within a Canadian-Caribbean context.

MENTAL HEALTH AND CULTURE IN CANADA

Cultural Competency

Efforts to diversify therapeutic practices do exist within clinical literature. Cultural competency is a framework that dominates mental healthcare in Toronto, primarily social and settlement services aimed at immigrant populations (Keating, 2007; Kirmayer, 2012; Shahidi, 2011). Toronto is extremely diverse, yet, many areas in the wider social structures, including healthcare, face challenges in addressing the city's diversity. In using the cultural competency framework in order to understand how mental health is organized, I want to examine how cultures are defined and utilized as well as unpack the various meanings of cultural competency in mental health. This examination is important because there exists what has been termed the "healthy immigrant effect" in regards to mental health (Berthelot et al., 2002; McKenzie, n.d.). The healthy immigrant effect

refers to the foreign-born health advantages that immigrants have over Canadian born citizens. There is a wealth of scholarship, which demonstrates that racialized- immigrants, particularly those migrating from Asian, African and Caribbean countries are generally healthier than the average Canadian native-born. This body of literature also illustrate that recent immigrants' experience a decline in health, both mental and physical after the process of migration and settlement in Canada (See, for example, Beiser, 2005; Flenon et al., 2015; Guisso et al., 2001).

Cultural competency acknowledges the role of culture in mental health among diverse populations (Kirmayer, 2012). According to *The Ontario Federation of Community Mental Health and Addiction Programs,* cultural competency places diversity as a core component of all levels of the mental health and addiction system, including in the delivery of service (Yoo, n.d.). Under this cultural approach emerged recognition of recent immigrant health needs as well (Yoo, n.d). Cultural competency aims at moving beyond cultural sensitivity to acknowledging various social determinants of health, which include experiences of racism, social exclusion, gender, socio-economic status, affordable housing and education (Chaufan et al., 2009; Danish et al., 2007; Raphael, 2004; Shahidi, 2011).

The cultural competency model is useful because it embraces alternative views of mental health; however, the framework is also limited because it offers a very simplistic view of culture, which is then used as a basis for developing mental health care and treatment (Pike et al., 2013). Similar to Ryan Pike and Kimberley White (2013), and based on my own ongoing experiences with mental healthcare in Toronto, however, I assert that this framework nonetheless dismisses how race and culture are multidimensional; therefore, it prescribes a one-size fit all or a "culturally-blind" (Flearas, 2004) solution to treatment. Ironically, in cultural competency, despite the focus on the role of culture in one's mental health progression, the solutions/treatments to mental illness

do not differ from those offered by the biomedical model, which focuses primarily on health and wellbeing (Church et al., 2013). Health and wellbeing supports the ideology of the body being free of physical and mental diseases (Pike et al., 2013). According to the World Health Organization (WHO) (1948) health is defined "as a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity" (p. 3). Wellbeing goes beyond, the "state of physical health to include many different contexts such as emotional stability, clear thinking, the ability to love, create, embrace change, exercise intuition and experience a continuing sense of spirituality" (Harvey, 2013, p.3). Both the definitions of health and wellbeing include interrelated concepts, social constructs and are always evolving (Harvey, 2013; Dlamini, 2006).

Pike and White critique the promotion of health and wellbeing through the analysis of culture, in their article "The Making and Marketing of Mental Health Literacy in Canada". This article presumes that culture itself consists of a set concepts that can be used to measure, diagnose and manage mental health issues. Pike and White offer a critique by arguing that the promotion of health and wellbeing firstly, dismiss the experiences of the mentally ill; and secondly, is easier in gaining political and social support. Pike and White interrogate terms such as health and wellbeing to demonstrate how language is a powerful tool used to alienate the mentally ill. Pike and White further argue, cultural competency makes assertions that "mental health can be restored…if the illness is effectively reigned in, decoded and worked upon by professionals" (p. 240). Thus, I assert that by emphasizing the need for mental health providers to be "cultural competent" in addressing mental health, cultural competency fails to recognize and use as part of the health treatment, histories of racial minorities, the violence of colonialism within the practice of psychiatry, and the psychological scars impacted by the colonial legacy (Fernando, 2002; Foucault, 1977).

Similar to the cultural competency framework, multicultural counselling shares comparable objectives of Canada's diverse population (Arthur et al., 2001; Pedersen, 1995; Ridley, 1995; Weinrach et al., 1996). The primary focus of multicultural counselling is to provide a guideline for those working within a psychiatric capacity or recent settlement organizations, in efforts of eliminating oppression (Arthur et al., 1996; Sue et al., 1998). Multicultural counselling consciously advocates for counselling practices to move beyond culture and acknowledge the clients' family history and values, socio-economic status, sexual orientation, age and geographic location, since these markers impact the access of counselling and or surrounding services (Arthur et al., 1996; Pedersen, 1995). I reiterate that the multicultural counselling paradigm remains anchored as culturally-centred, thus, positioning diversity in Canada as not only recent but problematic. Such a paradigm operates blindly to Canada's own diverse histories and racist policies that continue to disenfranchise groups of people from equitable access to resources. Thus, former dynamics of power and the role of the psychiatrist or counsellor (Foucault, 1977) remains at the forefront, objectifying "non-dominant groups" (Arthur et al., 1995, p. 9) as always foreign and citing their issues at a micro-level.

Furthermore, Augie Fleras (2004) argues that "in racializing culture as a marker of invidious distinction, the mainstream no longer defines itself as racially superior but as culturally appropriate" and that cultural competence is a way of celebrating diversity without having to take "differences seriously" (p. 431). Cultural competency and cultural difference are supported under a false consciousness (Fleras, 2004), where culture is tolerated and managed by a larger governing body. Sara Ahmed (2010) argues that the state embraces cultural differences that dissolve easily into national ideals, thus, purposefully dismissing "histories of racism" and "ensuring civility" (p. 143). She states that "diversity also becomes a way of remembering the Empire….and not to

remember the violence of the colonial rule" (p. 131). The cultural competency model, therefore, does not authentically appreciate the legacy of colonialism, even though it claims to be conscious of interlocking differences (race, class, gender and so on) that define structures of power. Consequently, the cultural competency model looks at culture as homogenous.

Building on Fleras' and Ahmed's arguments, I argue that culturally appropriate services evade every day lived experiences or what Philomena Essed (1991) terms everyday racism. Cultural competency assumes culture to be static and does not leave room to examine how mental health issues are understood differently even within similar cultures. Allahar (2010) argues that Caribbean identities are not fixed or bounded by what is assumed to be "a Caribbean culture" but are complicated by "histories of colonialism, slavery, indentureship, capitalism, imperialism and today globalization" (p. 55). Thus, Caribbean culture is far from homogenous. Recognizing that there are stark cultural differences even within a seemingly unified Caribbean culture is vital when deliberating over the planning and delivery of cultural mental health practices (Allahar, 2010; Fernando, 2002).

Esping-Andersen (1999) suggests that there is a need to move beyond the role of culture to considering issues of economic power and privilege when examining mental health disparities. He states that due to the supply and demand of the capital market, the people who are often marginalized from economic earning power are visible minorities, Aboriginal people and visible minority immigrants. These groups are most often forced into employment contracts that do not offer a sufficient living wage, thus impeding their mental health. Esping-Anderson's argument does not include minority immigrants who are unable to secure contract work and, therefore, are forced to become a part of the informal economy, which may include engaging in illegal activities that further hinder their overall health. Esping-Anderson's argument fails to highlight how

interlocking societal structures work to trap people into the cycle of poverty. Social assistant programs, for instances, rarely work to empower people; thus, they do not provide avenues for social and economic advancements. Despite these shortcomings, however, Esping-Anderson's overarching argument that emphasises how socio-economic status is closely linked to severe health issues, addictions and the compromising of one's state of wellbeing is extremely meaningful.

Similar to Esping-Anderson (1999), Massaquoi (2007) and Keating (2007), discuss the importance of addressing mental health through tools that go beyond culture and to utilize those that tackle barriers that hinder resistance to socio-economic marginalization. Keating (2007) states that the emphasis on culture situates issues of mental health at a micro-level, stressing that people within these communities are the problem and not the structures of power that have created segregated societies. Consequently, examining mental health through the lens of culture without accounting for the stratification of oppressed groups not only stigmatizes these groups and communities but also fails to offer equitable care needed to improve their overall health.

WAKING THE ANCESTORS AND RECOUNTING THE STORIES OF THE PAST

"Storytelling is soul medicine" (Richard Van Camp, 2015).

As previously stated in this chapter, storytelling is an important part of Caribbean culture; as such, I want to trace intergenerational mental health stories and their effects among Canadian-Caribbean people. Stories passed along generations are potent in revealing how historical trauma can still be experienced in the body one or two generations after it has been physically experienced (Gordon, 1997; Walkerdine et al., 2013). Valerie Walkerdine, Aina Olsvold and Monica Rudberg (2013) present significant connections between historical trauma in Caribbean families and its impact on Caribbean people generations later. They suggest that "descendants of slavery carry an unspoken and perhaps unspeakable knowledge in their bodies" (p. 292). They call for additional research in the area of historical trauma and the link to everyday experiences in present day Caribbean

families. Walkerdine et al. argue that the supressed information of past trauma continues to be "transmitted in the everyday practices of gender and sexuality" (p. 292). The transference of trauma also impacts how Caribbean people build trust within families and communities. Walkerdine et al. are not alone in their claim of historical trauma diffusing to everyday experiences. Jill Matus (1998) argues that the trauma of slavery is seen to live in the present both by those who have experienced it directly and generations to follow. She states, "Narrative texture is a buildup of memories that disrupts linear time and blur the boundaries between past and present experiences" (p. 111). Matus draws on Toni Morisson's novel *Beloved* (1987) to develop her argument in saying that the "past of slavery is experienced daily as if it were happening again…." in the present (p. 111). Farley (2014) argues that history becomes a space of "incomplete interpretations" and a "transactional claim [that neither] begins or ends" (p. 70). Instead she argues that history can be a space for learning where we not only learn about others through their stories but we begin to see ourselves reflective in the process of retelling (Farley, 2014; Simon, 2005).
The retelling of hidden stories is further highlighted in the Canadian-Caribbean novel *Soucouyant* (2007). In the novel *Soucouyant* (2007), author David Chariandy, describes the story of one interracial family's migration whose experiences are further complicated by the mother's madness. The youngest son and the main character of the novel, describes his mother's premature suffering with dementia in her early 40s. Her condition changed their family dynamics, placing both a social and financial strain on his father.

The main character is a pre-teen when his mother was diagnosed and their interactions with the medical system seemed inadequate in supporting the family's changing needs. He writes "my parents never felt satisfied with how the medical specialists were articulating Mother's new being [her diagnosis with dementia]. I too never felt satisfied after recovering the pamphlet from the

trash" (p. 40). He goes further to explain, "I couldn't use this [the medical information described on the pamphlet]. I couldn't go further. I put the pamphlet back and joined Mother in the living room, determined to see her my own way" (p. 41). Chariandy's novel is one of the few novels that examines not only the deterioration of one's mental health but the collapse of one's family when caring for a person who is captive by their own mental impairments. The main character's tear-jerking story illustrates how many stories of both 'back-home,' in this case Trinidad, and the new home, Canada, are kept in the dark and the only way these stories emerge to the surface is when his mother is consumed by her melancholic state. Her stories are inconsistent where the main character is forced to process his own history based on his mother's experiences.

This project builds further on Walkerdine's et al. theory of transmission of knowledge, where "historical events are experienced and transmitted in [both] large historical narratives and as small stories that get enacted in relationships" (p.273). My data reflects that the transmission of knowledge from one generation to another is often done in fragments or in silence. I found the silence around participants' former histories to be insightful when examining how they dealt with contemporary understandings of mental health and treatment.

The intensity of research on intergenerational stories is not solely settled around the narratives of slavery but are also grounded in a rich body of work of Canadian Indigenous stories about the many impacts of colonialism. Peter Menzies (2010) investigated intergenerational trauma and issues of homelessness among Aboriginal peoples and found that while there is significant research published around residential schools and intergenerational suffering among families, there was very little focus awarded to homelessness and mental health. Brenda Macdougall (2015) argues that the failing health of Aboriginal peoples in Canada is directly linked to policies that forced assimilation stating, "grandparents raising grandchildren- a practice

intended to provide children with teachers and an opportunity to learn their place in this world – is described [by the state] as a fatal character flaw of parents who are too lazy or disinterested to take responsibility for their own families" (p. 196). She goes further to argue that the [former] practices "...of family life made us healthy and whole" (p. 196). Intergenerational stories are significant because they provide insight into how young Aboriginal peoples come to know who they are today.

Intergenerational trauma has also been associated with the survivors of the Holocaust, returning Vietnam veterans and Cambodian refugees (Danieli, 2007; Sherwood, 2015). The suffering experienced by these groups is said to have a trickling effect on families and generations afterwards (Sherwood, 2015). Since then, research surrounding intergenerational trauma has expanded with both African and Indigenous writers placing weight on past sufferings that are impacting younger generations (Adam, 2015; hooks, 2005; Macdugall, 2015; Morrison, 1994; Sutherland et al., 2013; Richmond; 2015). What is significant to me with this area of research, is exploring exactly how intergenerational trauma shapes the everyday experiences of Caribbean people. Are these past experiences identified in how they understand issues around mental health? I believe that locating my study within a framework that accounts for intergenerational trauma, uncovers some of the "how" and "why" Canadian-Caribbean people understand mental health and madness (Macdougall, 2015; Merriam, 2009; Walkerdine et al., 2013).

WEST INDIAN DOMESTIC WORKERS' SCHEME

I further anchored my research sample with participants who are either the child or the grandchild of a Caribbean woman, who migrated to Canada under the West Indian Domestic Workers' Scheme during 1955 to 1967 (Henry, 1968; James, 2009). The West Indian Domestic Workers' Scheme was an "agreement between the governments of Canada, Barbados, and Jamaica

to send English-speaking Caribbean women to Canada to address a shortage of domestic workers there" (Lawson, 2013, p. 139) and later expanded to include other countries like Guyana, Trinidad, St. Lucia, and Grenada (Henry, 1968). Under this scheme, Caribbean women between the ages of eighteen to forty years of age were recruited by Canadian working families to work as childcare workers, cooks, cleaning women, and so forth (Arat-Koc, 2001). Caribbean women primarily migrated to Montreal and Toronto, fulfilling the demand of cheap labour (Bobb-Smith, 2003; Calliste, 1991; Silvera, 1989).

In addition to systematic discrimination, there is intense documentation about how women who migrated under the Domestic Workers' Scheme used notions of strength to cope with harsh conditions that they endured upon arrival in Canada, which included various levels of abuse (physical, verbal, sexual) at the hands of their employers, (Bobb-Smith, 2003; Arat-Koc, 2001; Calliste, 2001; Henry, 1968; Lawson, 2013; Orlando, 2003; Schreiber et al., 2000). The deliberate Canadian political process that either delayed reunification of families, or forced Caribbean women to reject their families altogether, strained Caribbean families on the whole (Orlando, 2003). Erica Lawson (2013) argues that "…The specificity of the requirements, and the particular erasure of children and intimate partners, produced Black domestic workers as women not expected to have children or to deny them emotional involvement and physical presence in their lives of their children" (p. 143). Agnes Calliste (2001) also writes that Caribbean women who left children in the Caribbean struggled with guilt for being "bad mothers" that eventually impacted the family when these women reunited with their children (p. 408). Lawson further argues that as a result of the criteria of West Indian Domestic Workers' Scheme policy, a vast majority of women still engage in "transnational mothering today" (p. 143). As stated by Valeria Walkerdine et al., (2013), the process of transnational mothering as Lawson refers to it, adds another layer to the

socio-historical experiences of Caribbean people and their families. Frances Henry (1968) argues that there is a denial of the experiences among many women who worked as a domestic, which can be seen as both resilience and shame. Based on the stories expressed, experiences of resilience and shame still linger generations later. Therefore, narratives recorded by the children of Caribbean migrants, can deepen the literature of Caribbean women emigration experiences in Canada (Hernandez-Ramdwar, 2013).

Stories written about Caribbean women's migration experiences of being domestic care workers, illustrated fear of authority or admitting to "breaking down." Caribbean women's migration stories revealed that they used their Caribbean discourses of emancipation and of struggle for independency and national identity in mapping their experiences in Canada (Calliste, 1991). The stories and former experiences of Caribbean women motivated me to investigate if there was intergenerational narrative preserved. The stories collected demonstrated interesting patterns of strength, sacrifice, the use of family support and holding everything together in difficult circumstances.

CHAPTER THREE: THEORETICAL FRAMEWORK

This research uses three theories: postcolonial theory; cultural studies; and, critical race theory (CRT).

(A) POSTCOLONIAL THEORY

Postcolonial theory examines how the political project of colonialism extends to the construction of contemporary societies. It is a vehicle used to unravel how previously colonized societies continue to be interlocked and interdependent on the former colonizers (Henry et al., 2010). Henry and Tator (2010) argue that the field of postcolonial studies is important in examining "the interaction between European nations and the societies they colonized in the last few centuries. The field of postcolonial studies deals with the "impact of colonization or postcolonial history, economy, science, culture, the cultural production of colonized societies" (p.47). Robert Young (2003) states that postcolonial theory examines the relationship of power "between people and their culture, as well as the relations between ideas and practice" (p.7). The postcolonial approach is useful because it will provide context to a colonial history, which continues to be intertwined in Caribbean youth's psyche and various mental health discourses in the Caribbean and in Canada today.

Postcolonial theory first emerged in the 1950s as a tool that examined how race has been tied to nation building. Aimé Césaire (1950) wrote in his book *Discours sur le colonialism* that the imperial conquest had scarred African peoples and impacted their identities; therefore, there was a need for a different African identity outside of the European construction, which situated the African as "the barbaric Negro" (Césaire et al., 2000, p. 32). Later in the 1960s, Frantz Fanon (1959) drew correlations between the constructions of "the Negro," the psyche and medicine and how this construct is intertwined with the colonial project. Fanon stated that "the influences of

white privilege have revealed how alternative methods have become marginalized …[and] much of what dominant society perceives as legitimate knowledge is generated by a small, homogenous group of people" (1959, p. 79). Fanon stressed that the dynamics of power between the medical experts and patients cannot be dismissed because experts are trained through a Eurocentric lens, thus determining the meanings of right and wrong, normal and abnormal behaviours, while preserving capital power. Both Césaire's and Fanon's work are central to how the history of Caribbean people and their perspectives of mental health can be discussed.

More contemporary postcolonial scholars will also layer the standpoint of the cultural inheritance of imperialism and its effect on mental health. Edward Said (1994), in his work *Orientalism*, defined the construction of power through his comparison of the 'Other' as the 'Orient' and the 'Oxident' (p. 3). Said stated that:

> …the Orient is not only adjacent to Europe, it is also the place of Europe's greatest, richest and oldest colonies, the source of its civilization and languages, its cultural contestant and one of its deepest and most recurring images of the Other. The Orient has helped to define Europe [or the West] as a favouring and dominant image, idea, personality and experience" (1994, p. 1).

Homi Bhabha (2004) suggests that postcolonial cultures may be "contingent to modernity, discontinuous or in contention with it, resistance to oppressive; but they also deploy the cultural hybridity of their borderline conditions to 'translate' and therefore re-ascribe the social imaginary…" (p. 9). Said's and Bhabha's writings are significant in the examination of identity among postcolonial subjects because they illustrate how "othering" and "fluidity" are important elements in identity construction, ultimately shaping post-colonial people's understanding of who they are. The constructions of postcolonial subject's identity cannot be divorced from a history of binary opposites that historically positioned them as inferior to the colonizers.

Bhabha's *The Location of Culture* (1994) is valuable in positioning my own work when examining Canadian-Caribbean youth identities. For Bhabha, the interrogation of a person's identity goes beyond the “discursive and disciplinary place from which one questions identity… [rather it is] strategically and institutionally posed” (1994, p. 47). Thus, the "other" is "continually positioned in the space between a range of contradictory places that coexists" (p.48). In my study, I have looked at the contradictions in how madness is defined within the context of the Caribbean and in Canada and in the interplay between these contradictions and lived experiences. Colonialism and psychiatry are interwoven, messy, violence and race-based; further, there is resistance that can be found within this messy interconnection. A postcolonial framework is, therefore, a necessary tool that will be used to explore the relationship of madness to domination and resistance during and after colonialism has ended (Mills, 2014; Van Zyl, 1998).

(B) CRITICAL RACE THEORY & CULTURAL THEORY

I have intentionally adopted Critical Race Theory (CRT) and Cultural Theory because they offer an analysis of race and culture from a structural level while giving voice to the individuals (Dei, 1996; James, 2010; Morris, 2001; Savas, 2013).

Critical Race Theory

Critical Race Theory (CRT) emerged during the 1950s in the United Kingdom in challenging Marxist ideologies. The central argument of those who supported CRT was that race and class are interconnected, which was absent from the popular Marxist framework (Henry et al., 2010; Savas, 2013). CRT helps examine racism and its impact on economic earning power among racialized groups (Henry et al., 2009). In the 1970s, CRT gained popularity in the United States as both a theory and a movement that accounted for how racism served as a rationale for labor exploitation (Bolaria, 1988). Similar to the United States, Canadian scholars found CRT to be a significant

analytical reference for examining how Canadian immigration policies use multiculturalism as a mask of a white hegemonic belief system (Satzewich, 2015). Satzewich (2015) argues that racism is justified through the exploitation of certain groups of peoples' labor, claiming, "Power is attributed to the maintenance of the status quo" (p. 115). CRT is useful since it lends clarity in the examination of how systems are structured based on a history that grants power and privilege to a selected few.

CRT is beneficial in "validating the narrative of people of color" (Savas, 2014, p. 511) and drawing on their histories and lived experiences (Dei, 1996; Benjamin et al., 2010); as well, it pays particular attention to racialized peoples' social interaction with their families and communities (Henry et al., 2009; Savas, 2014). CRT will ground my research project, providing a dynamic view to how my participants' everyday experiences are linked to history, culture and community.

Cultural Theory

Similar to the postcolonial framework described above, a cultural studies approach is useful since it "encourages a critical examination of dominant culture and an effective resistance to its hegemonic control" (Henry et al., 2009, p. 42). Stuart Hall (1997) states that representation is an important component in cultural studies because "representation connects meaning and language to culture… [Thus] representation is an essential part of the process by which meaning is produced and exchange between members of a culture" (p. 15). In addition, Hall states:

> …the construction of identities moves beyond the process of representing not only 'who we are' or 'where we came from' but also how we are represented and how we might represent ourselves; [emerging] within specific modalities of power and thus becomes the product of marking differences and exclusion" (1996: 4).

For my study, representations of mental health and madness within Caribbean communities are crucial components that fall into wider cultural discourses; therefore, my interests in examining

the forms of language associated with mental health among Canadian-Caribbean youth, is saturated within a culture that is specific to the Caribbean.

In addition to Caribbean representations of madness and mental health, Canadian cultural representations of mental illness are important to unpack because they are inherently rooted in colonial processes, which, in turn, still inform public policies including those that govern the treatment of the mentally ill. Gramsci (1983) refers to a cultural hegemony and leadership of the west, which to me is central to unpack when examining Caribbean-Canadians' definitions and experiences of mental health.

CHAPTER FOUR: METHODOLOGY

POWER OF NARRATIVE AS A METHODOLOGY

Narratives have, overtime, influenced my interpretations of mental health in various ways. I was in my third year of my undergraduate degree at York University, when I took a course titled *Black Literature and Cultures in Canada* with Dr. Andrea Davis. One of the required readings in this course was a novel entitled *The Heart Does Not Bend* by Makeda Silvera (2002). Based on the author's accounts as a Canadian-Caribbean person, the novel interrogated issues of shaming, economic struggles, family secrets and diaspora politics among Caribbean families. Silvera's experiences of being raised by her grandmother who suffered from depression and alcohol addiction in Jamaica, after her mother migrated and settled in Canada, were all too familiar to my family migration history. The use of storytelling, which allowed for a presentation of personal accounts such as illustrations of her grandmother's struggle with addiction and depression were engaging because these stories are silenced or ignored within the community or denied among family members. Jackson and Naidoo (2012) argue that Caribbean women endorse addictive behaviours as a way to disengage from their realities. They further argue that Caribbean women may not admit to their addictions for fear of hostility from their family or community members. This novel, therefore, ignited my curiosity around Caribbean peoples' experiences of migration and settlement in Canada and introduced me to the narrative as a tool that I will later embrace as meaningful for the study of these experiences.

Silvera's story also illustrated how mental health goes unquestioned, especially by the child, and how Caribbean women can mirror the stereotype of being "strong and in control" (Drever et al., 2015). The story demonstrates the politics of living in "in-between" spaces (Hall, 2001, p. 27) like Canada and the Caribbean. It demonstrates how Caribbean women living in

Canada feel that they cannot show and admit to notions of weakness and loneliness due to socio-economic issues and other problems that they face post migration (Schreiber et al., 2000). It was by reliving a story through the child's eyes in Silvera's novel that I was further motivated to examine how the experiences of Caribbean women, in turn, shape their Canadian-born children. For instance, I questioned if former Caribbean teachings and hardships experienced in Canada play a role in young Canadian-Caribbean views on mental health.

I use Silvera's novel to draw connections where first and second generation Canadian-Caribbean young adults share similar narratives as a part of their lives. Ogbu and Simons (1998) found in their study, "Voluntary and involuntary minorities", that immigrant groups are guided by "community forces," (p. 161) which are "products of sociocultural adaptation located within the minority community" (p. 157). These sociocultural adaptations as Ogbu refers to them, are constructed out of response to one's history, culture and language. Ogbu's analysis is important to draw correlations to my own work, because it explores the emotional responses and perceptions attached to the told/untold stories of mental health in Canadian-Caribbean families and communities, which are similar to my interests and investigation. Stories are a culturally appropriate way of expressing truths about an issue; therefore, they became important tools for my own research.

Smith (2010) argues that stories have the power to raise consciousness and can create meaningful ways that allow people to understand their own experiences. Clandinin and Connelly (2000) state that life itself is "enacted in storied moments of time and space, and are reflected upon and understood in terms of narrative unities and discontinuities" (p.17). In addition, Grisham (2006) suggests that stories are valuable in examining complex issues as they help build trust, demonstrate empathy and provide inspiration. Thus, I gathered stories of young adults who identify

as Canadian-Caribbean "in order to document their own meanings of and experiences with" (Merriam et al., 2002, p. 286) madness and how they understood treatment. Implementing stories as a research method granted voice to the occurrence and privileged both the experiences of my participants and my own as an inquirer, thus, creating a space for reflection and valorizing a new layer of knowledge (Chilisa, 2011).

THE MEANING OF NARRATING AND STORYTELLING

There are some writers who see narrative inquiry as a tool for researchers to build relationships between themselves and the researched community. This happens when researchers take stories of their participants and use them to analyze people's apprehension and interactions with one another. Clandinin and Connelly (2000) define narrative inquiry as "collaboration between research and participants, overtime, in a place or series of places, and in social interaction with milieus"; it enables the researcher to enter into a matrix where he/she is in the "midst of telling, reliving and retelling, the stories of the experiences that make-up people's lives, both individual and social" (p. 20). Thus, narrative inquiry is about stories lived and told; in other words, it is one way to analyse how people make sense of their own experiences and interactions that they have in the world (Merriam, 2009).

Furthermore, Chase (2003) says that there is relevance to having participants narrate their stories because they are an "integral part of human experiences that should not be ignored" (p. 274). In addition, Clandinin and Connelly (2000) both state that the narrative is important as it provides a way to "think in a more detailed and informative way about the general construct of continuity in individual's lives" (p. 3). Thus, narratives are natural ways of revealing current and traditional health practices, myths and truths of coming to know information and can be a culturally appropriate tool for educating (Haigh et al., 2011).

Other scholars state that narrative inquiry is about the way that researchers work with others to make meaning of the world and pass along important cultural knowledge and histories. Some scholars see narrative inquiry and storytelling as two separate ways of data collection. For instance, Haigh and Hardy (2011) argue that the term 'story' is used as a synonym for 'narrative' by some authors, when in fact there are differences. They suggest that the narrative can be defined as "predominantly factual whereas stories are reflective, creative and value laden, usually revealing something important about the human condition" (p. 409). Likewise, Robert Atkinson (1998) says that stories allow a person to choose the stories that they want to tell. It is "told completely and honestly as possible, and [is directed by] what the teller wants others to know of the story, [which] is usually as a result of a guided interview by another" (p. 8). For the purpose of this study, I use both terms: stories and narrative inquiry (or narratives) interchangeably, to uncover the myths and emotional truths of mad stories that are told among people of Caribbean heritage, which both the narrative and story grants (King, 2013). I favor both the narrative and storytelling based on my own experiences. To me, a person who narrates an event is the same as a person who tells a story. Storytelling then, encompasses the act of narrating, which penetrated through the stories told by my participants.

Storytelling or the narrative are important epistemologies that grant privilege to unwritten knowledge. Bagele Chilisa (2012) argues, "most postcolonial indigenous thought systems have not been documented and are not available in the written literature" (p. 211), which is also a reality of Caribbean cultures because they derive from many oral traditions of the region. Part of those traditions of oral storytelling are layered with the imaginary, metaphors, proverbs, and songs as a way to pass on wisdom (Brathwaite, 2005). For instances, Africans who arrived all across the Caribbean region, mostly from West Africa, used Anansi stories, to educate. Anansi stories are

filled with morals and imagination, hence the reason why I opted to use both narratives and stories interchangeably as tools for data collection. In a nutshell, "storytelling is culturally appropriate in representing the "diversities of truth" (Bishop, 1996, p. 24). Stories "give meaning to experiences" (Flores-Ortiz, 2003, p. 354) and also "hold knowledge while simultaneously signifying relationships…of the rational world" (Kovach, 2009, p. 94). Therefore, capturing the stories of my participants helped to document how Caribbean families build knowledge in both spoken and unspoken ways. That is, there are aspects of any culture that are unspoken but are recognized as 'our way of doing things.' This unspoken knowledge is formed out of symbolic interactions within the context of language, culture and family. I found that narrative inquiry as a methodological tool enabled me to build relationships with my participants and captured how Caribbean people come to learn about madness. As Connor (2006) says, personal narratives are an authentic and can be political form of self-representations that hold power to promote change. This would be a significant contribution to the necessary changes regarding Canadian-Caribbean youths' relationship to mental health.

LIMITATIONS TO NARRATIVE INQUIRY

Narrative inquiry has limitations, as any other qualitative methodological approach. Since narrative inquiry depends on the willingness of the interviewees to share stories (Glassner et al., 2004), consequently these stories become an interactive process, constructed to explain and justify the narrator's own life experiences (Trahar, 2009). For instance, my research project raised questions around migration both to Canada and the Caribbean. Participants used stories of their grandparents and parents' migration to Canada in establishing their own life experiences as Canadians. In doing so, the migration stories to the Caribbean were omitted or given less validity. This could be for a number of reasons – either the migration process to the Caribbean was a story

that was static and linked to a past narrative; migration stories to the Caribbean were unrelated to the participants own experiences; and/or these stories are disjointed between generations. Either way, migration to Canada becomes a common narrative that all participants easily shared. Trahar (2009) argues that “the researcher is seduced into the belief that in order to re-present faithfully another’s story, the story needs to be simply reproduced” (p. 8). As a researcher, the data collected is based on the stories that the participants reveal of themselves.

Second, stories are manifested out of larger globalized and homogenize systems (Trahar, 2009). Subsequently, peoples’ experiences are entangled with sociopolitical factors as well. The process of migration to Canada is recounted by most minority migrant communities, explaining social phenomenons, such as discrimination, injustice and the struggle for betterment. Based on my research, I argue that migration stories are intertwined into the accounts of day-to-day experiences that are sometimes stressful and may lead to experiences of depression or anxiety. Thus, these stories are important to include when examining the meanings of mental healthcare and mental illness.

Finally, narrative inquiry is based on the selective nature of memory. Trahar (2009) offers a critique of narrative inquiry, arguing that “Research participants will often find a way to tell the stories they want to tell rather than, or perhaps as well as, those they think the listener wants to hear” (p. 6). Selected stories are passed on from one generation and they become the most visible truths of one’s history. Clandinin and Huber (2015) argue that the telling of stories is not an untethered process. How people tell their stories and what their stories tell is shaped by "cultural conventions and language usage...that are part of one's culture” (p. 694). In other words, the "audience shapes autobiographical narrative inquiry. Who the characters are in people's stories,

the plotlines people choose to tell and the audiences to whom they tell, all influence autobiographical narrative inquiry" (p. 7).

INSIDER-OUTSIDER PERSPECTIVE

Conducting this study, I was cognisant of the dual roles that I played as an insider versus outside - researcher. In many ways, based on my own lived experiences, I possess pre-existing knowledge and values about the cultural community that I researched. For outsiders of the Canadian-Caribbean community, I am culturally positioned as an "insider" within the research conducted for this project (Narayan, 1997; Pike, 1954; Westoby, 2008). Although it may seem that I have access to a different kind of information being an insider to this community, the experiences shared by my participants are different from my own (Gilbert, 1994). Meaning, I may share similar cultural references as my participants, but our relationship to mental health and care differ based on our race, social location, gender, age, ethnicity, education, sexuality, and so forth.

Insider-research is said to have its original roots in anthropology and sociology, however, these roots are spreading across other disciplines (Greene, 2014; Goodenough, 1970; Harris, 1976). Greene (2014) argues that there is an increase in researchers wanting to study their own ethnic communities adding voice to their experiences that may otherwise be absent from what is considered to be mainstream research. Bonner and Tolhurst (2002) point out three main advantages to being an insider: (1) having a greater understanding of the culture being studied; (2) not altering the flow of social interaction; and, (3) having an established intimacy between the researcher and participants. More importantly, Bonner and Tolhurst argue that being an insider helps the researcher to gain access to the researched community and allows for the establishment of a rapport with their subjects (p. 9). Merriam et al., (2001) suggest that an insider-researcher has the "ability to ask meaningful questions and read non-verbal cues" (p. 411) that can further contribute to the

collection of information. Anthropologist Kirin Narayan (1997) advocates that as an insider, the researcher has the benefit of focusing their attention on the quality of relations they build with their subjects, thus, enriching the course of the work produced. He says that part of the process to conducting fieldwork is "getting to know a range of people and listening closely to what they say" (p. 32). Therefore, it is irrelevant if the researcher has prior ties to the community they are entering as researchers, since "the intense and sustained engagements of fieldwork will inevitably transmute these relationships" (Narayan, 1997, p. 32).

On the one hand, my prior knowledge helped to build a richer data collection, opened conversations and prompted the interviews in different ways (England, 1994) that might not have happened without acknowledging my past interaction with mental health and the mental care system. The exchange of reflections around mental health and the significance of people sharing their stories with me is an important piece to acknowledge. Glassner and Miller (2004) says that being able to gain access to peoples' experiences can present powerful illustrations to "how they experience their social worlds" (p. 126). Granted, the power divide between myself and some of my participants were straightforward, as a result of our former teacher/student relationship. Even though participation in the study was completely voluntary, there was no expunging the dynamics of power, even among adults. The negotiation of power is consistently ongoing in research (Merriam et al., 2001), regardless if the researcher is defined with the status of an insider or outsider. Sharing narratives as a method collapses the barriers that power is constructed within (Schnee, 2009) and in this case I was able to do so as an insider to this project. Some feminists recommend the deliberate use of personal disclosure, as a strategy for putting people at ease around sensitive topics (Barbour et al., 1999). In addition, Farquhar (1981) argues maintaining the position as an insider in research, can be useful especially when the topic is taboo in the community. Ganga

and Scott (2006) point out that one of the advantage to having an insider status is that the researcher is able to understand “the spoken and unspoken language of the interview” (p. 6). Thus, the richness of my data emerged as a result to my position as an inside-researcher, granting the opportunity to negotiate cultural norms and ideologies that were crucial for recruiting and engaging with participants.

On the other hand, there are risks to being an inside-researcher. Merriam et al., (2001) argue that being too close to the culture can create biases, influencing the study’s design and possibly the outcomes. Anselm Strauss (1987) warns researchers that the position as an insider can run the risk of having too much information that may not correspond with participant narratives. Furthermore, DeLyser (2001) states that being too familiar with the researched community can lead to the loss of the researcher’s objectivity. Although as a researcher, I am aware of my own biases, there is no guarantee that if I were an outsider researching the community I would not hold biases as well. Greene (2014) advocates that someone outside of the social group also develops preconceived notions of the people in the community of study. These biases can skew the study sample. Being an outsider to a social group may not offer the lens to ask the right questions or the researcher may receive misleading responses due to the lack of trust (Glassner et al., 2004). Thus, “interviewees respond to us based on who we are in their lives, as well as the social categories to which we belong, such as age, gender, class and race…” (p. 127).

As a researcher, I contend that being able to share my own lived experiences with my participants helped to build trust and unraveled a more in-depth understanding among Canadian youth of Caribbean heritage. DeLyser validates experiencing research as an insider based on her own work that “For insider researchers, interviewees are often..., people with whom the researcher continue relationships. They read the published results - and see how they are represented” (p.

446). It is an important role to be able to represent peoples' stories in the form of research and maintaining ties with the community holds the researcher accountable for the work gathered and produced—not generating "hit and run" fieldwork (Narayan, 1997, p. 30). I am conscious of the importance of building on research that pays tribute to the data collected.

SELECTION OF PARTICIPANTS

This research targeted young people between the ages of 18-25 because this age group is overrepresented in the demographic of the mentally ill in Canada (Government of Canada, 2006). My research sample included those who have been diagnosed as having mental illness themselves and/or those who lived with family members who were diagnosed with mental illness. Young people who have lived with family members diagnosed with mental illness are important to include because there is a growing recognition that family members, either immediate or extended, who are diagnosed with a mental health problem, impact other members of the family. Statistics Canada (2013) reported that in 2012 almost 38% of the Canadian population reported to have a family member who had a mental health problem and needed support of other family members. A further, 1/3 reported that their daily livelihood was impacted due to the care provided to family members. If this is the case for the entire Canadian population, it is unavoidable to ask what these statistics look like for the Canadian-Caribbean community.

Furthermore, a report released by The Canadian Alliance of Student Associations (2014) claimed that "almost 70% of Canadian adults living with mental illness reported to have developed symptoms before the age of 18" (p. 8). This same report suggested, "Canadians aged 18-24 are most likely to suffer from mood disorders, substance abuse, and are more likely to commit suicide" (p. 8). In this same age range, young people are either attempting to attend post-secondary schools or enter into the workforce in a full-time capacity. The Canadian Alliance of Student Associations

report is significant as it identifies the reasons for a focus on mental health initiatives for young people in post-secondary institutions across Canada.

In addition to my Caribbean mental health stories that background this study, the focus on Canadian-Caribbean youth between the ages of 18-25 is because this group is rapidly growing in Canada, with an 11% increase compared to the overall population of just 4% growth from1996 to 2001. More recently, Statistics Canada (2019), reported in 2018, that "roughly 5.3 million Canadians aged 12 and older needed some help with their mental health, including for their use of alcohol or drugs". The current mental health trends indicate that signs of mental illness are appearing among a younger demographic, and there is a rise in mental health cases among young Canadians. The national Canadian data helps to inform my own research sample suggesting that there is a need to address mental health concerns among Canadian-Caribbean youth.

DATA COLLECTION METHODS

The recruitment of participants was an easier process than previously anticipated. The process of sharing stories seemed therapeutic to most in my sample. For many of the participants, it was an opportunity to share their stories from a Canadian-Caribbean perspective contributing to knowledge that is more reflective of their own lived experiences (Dlamini, 2015). These participants' lived experiences include being a part of immigrant households where the home country culture and traditions are pivotal in raising the subsequent generation. As a result, the three participants in this chapter had the ability to share stories that reflected both their views as being children of Caribbean nationals/Caribbean descendants and being first generation Canadian. The production of more diverse views is especially vital in spaces where Canadian-Caribbean voices are traditionally excluded as both producers and consumers of mental health research. More specifically, where mental health literacy, policy and access to services continue to be socially

bounded within the domination of power. Nevertheless, the willingness of such a dynamic group of people to participate in a study examining mental health and its cultural perceptions, floored me. Although I anticipated that conversations around mental health, madness or any other descriptive markers associated with mental illness would be considered private and shameful, my sample proved otherwise. The participants were more than willing to deconstruct their stories to find deeper understandings of their own experiences with mental health.

I conducted twelve semi-structured interviews with young Canadian adults from the Greater Toronto Area, who identify as being of Caribbean heritage and who were between the ages of 18-25. I have deliberately given my participants pseudonyms that reflect positive characters from the Marvel's 1963 comic book, *X-men*. I saw my participants as superheroes who had exceptional to acknowledge to the significance of mental health, which their unique stories reflected. I opted for *X-men* characters due to this comic's imitation of the civil rights movement. According to Paul Branscum and Manoj Sharma (2009) the 1960s comics was the first of its kind to address issues of racial discrimination. They explained that X-men "are a group of mutants, born with special abilities" that gave them super-human traits that differed from their regular human counterparts (p. 432). The uniqueness made the mutants different in appearance, thus exposing them to harsh experiences of discrimination. Branscum and Sharma argue that the mutants' professor and leader, Charles Xavier, is an archetype of Martin Luther King Jr., "who strived for peaceful coexistence between humans and mutants, while their villain, Magneto represents an archetype of Malcom X, who believed mutants should fight for freedom using force" (p. 432). Even though both Xavier and Magneto were on the same side of the cause, they had very different approachs towards the attainment of justice. Magneto did not believe that true equality could be achieved among humans and mutants through peaceful protest and education. The

comic's antagonist, Magneto's aggressive struggle against bigotry was based on his own experiences in confinement, which he feared mutants were at risk for genocide.

I am actively using the comic book's characters because I believe it is an excellent visual tool that can provoke critical reflection of ongoing social issues. Farra Yasin (2010) advocates in her research "Comic strip writing and the construction of identity" that comics are not just written to "reproduce old canons in the more child-friendly format [rather] comics are retelling of stories to reflect the context in which they are written" (p. 15). Although, research points out that comic books carry very little weight in academia due to its portrayal of people "as caricatures of actions who behave childishly" (Heer & Worchester, 2004, p. 44), other research supports that all comic characters are a product of their own adverse childhoods, who are resilient, and as adults embody empowerment (Fradkin, Weschenfelder & Yunes, 2015; Fradkin, 2016; Wilson, 2005, Yasin, 2010). Each of the comic's characters (both hero and villain) wanted to conceal their mutant abilities, and or felt ostracized from their fellow humans' normative behaviours. My participants all showed signs of wanting to blend in or shielding their experiences with mental health away from the public's eyes. These young superheroes, who all brilliantly informed this study, subtly acknowledged that their experiences are important inclusions to the Canadian public discussions of mental health and mental illness. Thus, each participant's name is tied to each of the character's aptitude.

Noting the details

Each participant was either enrolled in a full-time program at the college/university level or was a recent graduate. Table 1. found on page seventy-eight of this document, presents a summary of the participants involved in this study. My interviewees consisted of eight women and four men who were either diagnosed as having mental illness themselves and/or who lived with family members

who were diagnosed with mental illness. Each interview resulted in about an hour and half to two hours' conversation. We exchanged stories about how we thought madness was understood in a Canadian context, compared to an imagined Caribbean space, which gave insight into how Canadian-Caribbean people access mental healthcare in Canada.

My questions centered around memories of madness. All participants consented to having the interviews tape recorded. I began each interview by asking participants to narrate their very first memory of hearing/learning about madness in their families. The first memory revealed how participants were told of the existence of madness. I paid keen attention to the presence of religion and/or spirituality in these families. Semi-structured interviews allows for the expressions of each other's experiences and can create room to acknowledge stories around madness, treatment and the connections to spirituality. This form of communication between myself as a researcher and the participants will enrich our relations as the listener and the teller of each others' stories, while culturally locating our experiences (Dlamini, 2006).

PROCESS & DATA ANALYSIS

Each interview was digitally recorded and transcribed verbatim. The average interview was about ninety minutes. All of the participants decided on the meeting place for our discussions. I met most of my participants in coffee shops. Rouge and HSeavok, who are siblings, invited me into their home on separate occasions for each interview. Gabrielle and Surge both opted for our discussions to take place over dinner. I met them at restaurants of their choice. During the transcription process, grammar, especially the use of creole or patwa, remained true, allowing the participants' stories to speak for themselves (Wolcott, 1994). The data was organised and coded based on the frequency of re-occurring words or phrases used by the participants. Themes were cross-checked and charted according to the five main questions used to frame this study. Some of the data that emerged out

of the participants' interviews overlapped. The overlapping is useful because "a text may involve multiple meanings and their identification requires researcher's efforts in the process of analysis" (Jones et al., 2016; p. 101). The transcripts were carefully reviewed for a list of meaningful ideas and phrases as it related to the questions that the study originally set out to address. I borrowed Jones's et al. (2016) concept of "participant persepective code" that they described as a useful technique which is often used to indentify "the participant's postitive, negative, or indifference comments about a particular experience" (p. 103). Stories gathered using narrative inquiry can be rich with information and often difficult to code. I found Jones et al., "Participant perspective coding" useful in looking for the "abstractions in participants' accounts" (p. 103). It was one way to move the "raw data" to the analysis stage (Jones et al., 2016; p. 103). Narrative inquiry allowed room for my participants to stop and reflect on their various experiences towards madness or mental illness. I found similarities in the various reflections that expressed how my participants come to understand mental health and wellbeing as well.

During interview and coding stages, I kept a writing journal that recorded what I was thinking and feeling at the time of the interview. My own reflectivity formed my research notes and worked towards mapping the analytical process. Jones et al. (2016) argues that maintaining research notes during the process of data coding helps to identify an audit trail. At the time, I thought my journaling was an important way to detangle my ideas and facilitate with the writing process. The collection of narratives lived in my head for a long time, especially when I began to layer bits and pieces of their mental health accounts. Journaling what I was thinking and feeling seemed logical at the time. Seeing my own thoughts on paper, allowed me to puzzle through my larger questions that were originally designed for this project. Thus, the note-taking was extrememly important to my own development as a reseracher, since it "provide[s] researchers

with an opportunity to remember, question, and make meaning of data" (p.105). Research notes "also allow the researchers to remain faithful to participants' perspective…" (Jones et al., 2016, p.105). Most of my notes are included in my master coding spreadsheet that was created for the purpose of this study.

MEET THE PARTICIPANTS

All of the participants identified with the project due to their relationship with mental health, either personally or through family members. I originally met four of the study's participants as I pursued my doctoral studies. Later, I informed them of my desire to collect data on madness and I invited them to participate in the study. I recruited other participants through the snowballing technique – where the other eight participants were referred to this study either through friends and family or previously interviewed participants. Qualitative researchers Rowland Atkinson and John Flint (2001), defines the process of snowballing as "a technique for finding research subjects. [Where] One subject gives the researcher the name of another subject, who in turn provides the name of a third, and so on" (p.2; as cited in Vogt, 1999). Snowball sampling is a purposeful chain referral (Mack et al., 2005) that offers the access to some of the social networks of identified respondents, thus, providing the researcher with an additional set of potential contacts (Atkinson and Flint, 2001; as cited in Thomson, 1997). In the case of this study, snowball sampling was an advantageous method in reaching participants who would have otherwise been reluctant to discuss their experiences with ill mental health. Heyman and Tyrer (2016), identify snowball sampling as a strategy that is "often used when it is anticipated that individuals may be reluctant to be identified ..." (p. 58). I appreciate the pitfalls to this technique, since it limits the diversity of the sample (Mack et al., 2005). Nevertheless, snowballing was a helpful recruitment strategy.

Participants' Profiles:

I met my first participant, *Zordon* in 2013 through a colleague, who later became my student. Zordon enrolled into one of my courses and later that year participated in a ten-day global exchange internship that the college funded and supported. We remained in contact since, and when I told him about my doctoral study, he was excited to be a part of it. It was nice to meet with him as a graduate and reflect on his journey from when we first met. By the time of our meeting, we had so many different conversations beyond school that we had formed a genuine friendship.

Zordon is second generation, Canadian born, who was twenty-four at the time of our meeting. He earned a college diploma the year before our interview and was living in Etobicoke, Ontario. Both of Zordon's parents emigrated to Canada in the late 60s from Trinidad and Tobago. His mother passed during childbirth, resulting in him living with his maternal aunt. His father left the family shortly after the passing of his mother and has been since remarried with two additional children.

Zordon identifies as a Black-Canadian, heterosexual male of Caribbean heritage. He has been living on his own from the age of seventeen and grew up in a heavily urban Caribbean community. He considers himself a local rapper who uses his love for music to connect to other youth like himself. Zordon's relationship with mental health is through his aunt's experiences with depression, which remains medically untreated. He admitted to moments of depression due to the various abuse he experienced growing up, which was sometimes inflicted by his older brother. Zordon not only carries the guilt of his mother's passing but his older brother blames him for her death as well. He admitted to accessing counselling as a way to work through his childhood trauma. He felt comfortable to share these experiences; also, it was the first time that he was able to share his experiences with someone whom he felt understood the meanings of his stories without

having to use words to explain what he meant. He reminded me why I was so invested in the meaning of the work as well.

Cyclop

My second participant Cyclop, was referred by a family member and identifies as second generation Canadian. Cyclop was twenty-four at the time of the study and had recently graduated at the time of our meeting. Cyclop lives in Toronto, with both of his parents. His father migrated to Canada in the 1960s and his mother later followed. Both of his parents identify as Guyanese nationals. Although Canadian, Cyclop lived in Guyana for ten years with his mother and siblings due to their family businesses. His second-hand relationship with mental health is through his mother, who experienced severe episodes of anxiety, immediately after settling in Canada. Before his mother's diagnosis of anxiety, she visited a few doctors with unexplained stomach and chest pains. Cyclop gave accounts of the importance of finding other ways to cope with mental health issues. For his mother, she found medication debilitating and preferred her weekly church sermons as a method to treat her anxious feelings. Cyclop links ill mental health and addictions as a growing problem in his community, which is often ignored. His interview highlights the many struggles that his community faces when battling ongoing issues of mental health and mental illness.

Storm & Sway

Storm and her sister Sway were both referred to me by a previous participant. They were eager to share their experiences that they felt were unique to their Caribbean heritage. Storm is second generation Canadian and at the time of the study was a university student living in Kingston, Ontario. Their maternal grandmother migrated to Canada from Trinidad as a domestic care worker either in the late 60s or early 70s. Their maternal grandfather followed in the mid-80s. Both of their parents migrated to Canada when they were approximately 5 and 6 years old and the

youngest of their siblings. Their mother has experiences of social anxiety and brief periods of depression that started after her divorce from Storm and Sway's father. Storm also experienced moments of anxiety, which started in high school (at the time of their grandmother's passing and parents' divorce). Storm explained in her interview that the occurrences of anxiety continued to interfere with her schooling in more pronounced ways once she started university. At the time, she was in her 3rd year and found ways to cope with her anxiety. She contributed her new coping skills to her school, Queen's University. Storm's sister, Sway, is also a second generation Canadian, who was 19-years-old and lived in Scarborough, Ontario, at the time of the study. She was a very vibrant young woman who was about to start her post-secondary education at the University of Toronto. Sway's accounts of mental health for this study were based on her direct interactions with her mother and sister. Her second-hand accounts influenced her educational choices and potential career goals. These sisters' paternal aunt suffers from schizophrenia, which ostracizes her from the rest of the family.

Rouge & Havok

I met Rouge and her brother through a family member and, like Storm and her sister, they were both eager to share their experiences. When we met, Rouge had just celebrated her 21st birthday and was a recent university graduate. She was second generation Canadian earned her degree from York University and aspired for a career in law. At the time of the interview she was living with both of her parents in East York, Ontario. Her father migrated to Canada in the 1960s and her mother migrated in the late 90s, both from Guyana. Rouge and her siblings spent most of her formative years between Canada and Guyana, due to their family business. Rouge understands ill mental health to have two distinctions — the first as a chemical imbalance and the second as more 'milder' issues, which includes depression, anxiety and so forth. Her interpretations of

mental health influence her interactions with her younger brother, Havok. Rouge's mother also experienced short periods of anxiety and believed that the church helped to settle her anxious feelings.

Havok was 19 years-old at the time of the study. He had just started studies at the University of Toronto. He considered his new post-secondary studies more challenging compared to his high school studies. Havok's knowledge of mental health and madness comes from his own experiences. He developed anxiety when he was in grade 11, after he was robbed on his way home from school one evening. The tragic incident altered many aspects of his day-to-day activities. He felt that he was reliving the incident over and over in his head, especially during high stress periods of the school year. Havok's frustrations with his condition escalated when he found both his school counselling and family support system unhelpful. He felt that he was constantly bombarded with language that suggested he was easily rattled, which pushed him to deal with his anxious feelings in isolation. Havok's experiences are addressed further in chapter five of this study.

Gambit

Gambit was a former student of mine, who took a course at Ryerson during his undergraduate studies. This young man is a second generation Canadian, who was 23-years-old and lived with both of his parents outside of Toronto, at the time of the interview. When we met, Gambit gushed over some of the ways he anticipated his career would launch. The inspiring business entrepreneur's paternal grandparents migrated to Canada from St. Kitts in the late 50s early 60s. His maternal grandparents migrated from Jamaica also during the 60s. His maternal grandmother was diagnosed with dementia and passed away a few weeks before our interview. He claims to have little connection to the Caribbean and took a Caribbean history course to gain a stronger understanding of how his parents are influenced by their Caribbean culture.

Gambit's interview was shorter than the other participants. Where the average interview was about ninety minutes in length, Gambit's interview was about forty-five minutes. Gambit was a bit more reserved in our discussion, so it was a bit more difficult to get the conversation going. While short, Gambit's keen interest working in the Canadian-Black community, strengthens his beliefs that there is a gap in mental health education in his community. Gambit was the only participant who could not account for family-specific incidents that were mental health related. Yet, Gambit's story highlights how mad people were characters in many tales that were once told to him as childhood behavioural teachings. These teachings were aligned with his older brothers' taunts because Gambit said he was too soft as a child. The themes of masculinity and the relationship to mental health are discussed in depth in Chapter five.

Phoenix was referred by a family member. She identifies as first generation Canadian born and was 22-years-old. At the time our interview, Phoenix had just obtained her undergraduate degree from the University of Toronto and was about to start a Master's degree in the field of Social Work. She is an only child and lived with her parents in Scarborough, Ontario. Both her grandmothers migrated from Guyana during the 60s and 70s. Her maternal grandfather passed away before she was born and her paternal grandfather lives in Florida, United States. Her maternal grandfather committed suicide in the family's home when her mother was in her early 20s. Her maternal grandmother is diagnosed as bipolar and believes that she is related to the Queen of England (first cousins). Her grandmother requires 24-hour supervision, which puts a strain on extended family members. There is a deeper history of severe mental health issues on Phoenix's maternal side, starting with her great-grandmother (who lived in Guyana) and experienced hallucinations for a significant part of her life. This interview process was particularly important

for Phoenix because she felt that it gave her a space to share how her mother wrestles with emotions of guilt, anger and fear.

Cecilia

I met Cecilia when she was a volunteer student who was a part of an international placement I was leading in Jamaica. I remember meeting this eager student from Ryerson University who was excited to be engaging with students in an international classroom. Cecilia, in particular, stood out to me. She had a yearning to learn more about the Caribbean and its history, that helps to shape her own identity. Cecilia was a 22-year-old female at the time of the interview. She identifies as a second generation Indo-Canadian female and Christian, who was born to Trinidadian and Guyanese parents. Cecilia was a recent University graduate and a Teacher's College Candidate when we sat down for our interview. She is the youngest of three sisters.

This young woman was very vocal and admitted to having very little connections to both her Trinidadian and Guyanese roots. Now that she was older, she was attempting to learn more about her parents' histories and staying connected to culture through food and music. Although Cecilia identified as Indo-Caribbean, she saw her connections primarily linked to India and Christianity as her guiding axil. Her grandfather traced her family's first migration from India to Guyana and felt rooted in India as well. Her father was a pastor. Her paternal grandmother migrated from Guyana in the early 70s and her paternal grandmother migrated from Trinidad in the late 60s. Cecilia's paternal grandmother and aunt were both medically diagnosed with bipolar disorder. Her grandmother's battle with ill mental health was only revealed to Cecilia a few days before our interview. Her paternal grandfather is a recovering alcoholic.

Gabrielle

I met Gabrielle when I was facilitating a group of students in Jamaica. Gabrielle was the coordinator for the organization on the ground in Jamaica and our main contact person. When we met, she was a student at Humber College and transitioning to the Social Work program at York University. Our interview took place two years after our initial introduction, by which time she was pursuing a Masters at Cave Hill, UWI, Barbados. Gabrielle is a second generation Canadian and was 22-years-old at the time of the interview. Gabrielle identifies as a Black, Christian female, of lower-middle socio-economic status, university graduate student. Her maternal grandmother migrated to Canada in the early 60s from Jamaica and her paternal grandparents migrated from Dominica. This young woman spoke at great lengths about personal struggles of depression. Her history of ill mental health starts with early memories of her mother's on-going battle with depression that stretched for extended periods of time. However, depression, or other mental health issues are not addressed openly in her household, especially by her father and her maternal grandmother. In Chapter Five, I examine and develop this notion of silence and how cultural perceptions were preserved through migration and transferred from one generation to another, influencing modes of mental healthcare practices.

Surge

Finally, Surge was referred to me by a friend. This young woman identifies as a 24-year-old, third generation Canadian, who holds both a Bachelors and Masters degree. Her mother was born in Toronto and is of African heritage. Her maternal grandparents migrated to Canada from Africa in the late 50s. Her entrepreneurial maternal grandparents owned businesses in a primarily dominated Caribbean community, in Toronto. Her paternal grandfather migrated to Canada from Trinidad in the mid-60s and later sponsored her father in the 80s. Surge's experiences with ill

mental health started with her mother, who sought medical treatment when Surge was in Junior High. In high school, Surge had two suicide attempts, which were brushed over by her family. Her father has a history of excessive use of drugs and alcohol. This very articulate young woman described her family relationship as a process, where communication is not always central.

TABLE 1.

Name, Age, Gender	Education	Location	Cultural Background	Migration	Citizenship
ZORDON 24 Male	College Graduate	Etobicoke, Ontario	Trinidadian heritage & identifies as Black-Canadian Religious Identity: Rastafarianism	Both parents migrated to Canada, late 60's early 70's	2nd gen Canadian (born in Canada to immigrant parents)
CYCLOP 24 Male	University Graduate	North York, Ontario	Guyanese heritage 1st generation post-secondary graduate Religious Identity: Muslim	Father was the first to migrate to Canada.	2nd gen born Canadian (born in Canada to immigrant parents)
STORM 21 Female	University Student	Kingston, Ontario	Trinidadian heritage, identifies as Canadian Religious Identity: Christian	Grandmother migrated 60s/ 70s. Grandfather migrated mid-80s.	2nd gen born Canadian (born in Canada to immigrant parents)
SWAY 19 Female	University Student	Scarborough, Ontario	Storm's younger sister Religious Identity: Christian	See Storm's profile for details	2nd gen born Canadian (born in Canada to immigrant parents)
ROUGE 20 Female	University Graduate	North York, Ontario	Guyanese heritage 1st generation post-secondary graduate Religious Identity: Christian	Father was the first to migrate to Canada in the 60s	2nd gen born Canadian (born in Canada to immigrant parents)
GAMBIT 23 Male	University Graduate	Petersburg, Ontario	St. Kitts/Jamaican heritage Black-Christian-Canadian	Both parents' mothers migrated to Canada around the 50s/60s.	2nd gen born Canadian (born in Canada to immigrant parents)

Name, Age, Gender	Education	Location	Cultural Background	Migration	Citizenship
HAVOK 19 Male	University Student	North York, Ontario	Guyanese heritage Religious Identity: None	Father was the first to migrate in the 60s	2nd gen born Canadian (born in Canada to immigrant parents)
PHOENIX 22 Female	University Graduate. Grad student	Scarborough, Ontario	Guyanese heritage 2nd generation post-secondary graduate Religious Identity: Non-practicing Muslim	Both parents from Guyana	2nd gen born Canadian (born in Canada to immigrant parents)
CECILIA 22 Female	University graduate Teacher's candidate.	Scarborough, Ontario	Guyanese-Trinidadian heritage 1st generation post-secondary graduate. Religious Identity: Christian	Her maternal grandparents migrated from Trinidad in the late 60s	2nd gen born Canadian (born in Canada to immigrant parents)
GABRIELLE 22 Female	University Graduate. Grad Student	Scarborough, Ontario	Jamaican & Dominican heritage. She identifies as Black-Christian of lower-middle socio-economic status.	Her grandmother migrated in the 60s.	2nd gen born Canadian (born in Canada to immigrant parents)
SURGE 24 Female	University Graduate- BA & Masters of Social Work	Scarborough, Ontario	African/Trinidadian heritage 2nd generation to access higher education. Her mother has a degree. Religious Identity: Muslim/other	Her mother, African heritage & father of Trinidadian heritage- migrated in the early 60s	3rd generation Canadian. Her mother was born in Canada
**DUST N/A Male	University Graduate – BA Sociology	N/A	Guyanese and Surinamese heritage.	Please refer to Chapter Seven	2nd gen born Canadian

CHAPTER FIVE: SHARING SECRETS

WHAT CAN MIGRATION STORIES TELL US ABOUT MENTAL HEALTH AND TREATMENT?

This chapter highlights a discussion of four out of twelve participants' stories: Gabrielle, Storm Sway and Cecilia. I have chosen to emphasize Gabrielle, Storm, Sway and Cecilia for this chapter because their stories provoke a more in-depth dialogue about mental health, gender and migration. Migration stories are significant because they provide a means of exploring the plethora of ways that family and cultural practices travel with individuals during the process of migration and continue to shape future generations as migration stories get transferred from one generation to another. The stories of these four participants also help expose what is accepted or rejected as a mental illness and what remains cloaked or guarded as family secrets.

This chapter discusses the two worlds that participants endure—their family and the Canadian society. The discussion uncovers the complexity of the use of Caribbean tradition and culture to define mental health. Within this tradition are notions of strength used by migrants to survive the hardships of the Promised Land, Canada. Participants' data show how various meanings of strength are interlocked with religious and cultural values as key markers of identity, which further complicates definitions and experiences of mental health. Then, the chapter examines how the participants endeavour to navigate their two worlds – the world of home and that of post-secondary education, where Queen's University in Kingston, Ontario is used as backdrop institution in the discussion. Finally, the chapter ends with the examination of traditional knowledge and medicine in relation to ill mental health. Together, these stories explain how Canadian-Caribbean people's mental health was and continues to be impacted by the process of migration to and settlement in Canada.

MIGRATION- THE NOT SO DISTANT HISTORY

(a) Language dichotomies, power and mental health

When asked to narrate similarities and differences between Caribbean ideas of madness and Canadian practices of ill mental health, participants revealed that they knew very little about their family histories to form a comparison, especially when it relates to mental health. The first participant, Gabrielle described her own personal journey with mental health and how her access to care is filtered through her family's interactions. Gabrielle's maternal grandmother was the main focal point in her stories; as such, she described her grandmother as a strong pillar of her mother's family. Her grandmother was the first to migrate to Canada from Jamaica during the 60s, leaving her family behind, including her own children. When probed if Gabrielle thought the treatment of madness travelled from the Caribbean to Canada, Gabrielle responded:

> I really don't know how my grandmother migrated, she doesn't talk about it. She won't say. But I know she worked for Colgate for a while. Then my mom came here [to Canada] for high school, and then my aunts… At some point, we [my aunts, grandmother and my parents] all lived in the same building. The entire family. You have one family filled with single women and we're all literally all together for every minute of the day…It's crazy when you think about it… Maybe it's because my grandmother is just so damn Jamaican, you can't escape it….

The Jamaican matriarch mediates how personal affairs are handled in Gabrielle's household. Her grandmother's experiences, even though undisclosed, subtly informs a number of mental health practices in Gabrielle's home. To be Caribbean and uphold 'Jamaican attitudes' like Gabrielle's grandmother upholds, are modified and passed to Gabrielle's parents and influence reactions to mental health and wellbeing.

Accordingly, Gabrielle focused on the language/words to explain the differences between her Caribbean household's talk about mental health as compared to that of her Canadian peers. The harsh language and dismissive non-verbal cues used to describe mental illness in her home made it difficult for her to express the pain that she experienced during her earlier undergraduate

years when she felt depressed and sometimes these feelings were so severe that she contemplated taking her own life. She describes her father's attitudes towards her miserable feelings as unhelpful. She says:

> I got on the subway one day and it was dark. I felt miserable and I just started feeling suicidal... [my dad's response was] "Oh, just calm down." That was his approach. 'Just calm down,' like it's okay, just relax, don't stress yourself out. That's the best he could tell me when it comes down to it.

At times, her father assumed that her emotional health could be sorted out with gifts:

> … with my father, it [ill mental health] would be a complete no. I don't know, I think that they [her father and grandmother] feel that depression is something you could shake off. Yeah, just brush it off and you'll be fine. He kept offering material stuff, that wasn't really helpful at the time… it was like he was off put. He kept saying, "What? You wanna kill yourself? What is this?" Like he could not understand how I could do this. "My own daughter wants to kill herself." He was ready to buy me the moon and the stars let me tell you.

I got the impression that her father assumed that the treatment towards Gabrielle's mental wellbeing was a simple issue that could be settled through a simple exchange of material goods. His words to her indicated disbelief that his daughter contemplated taking her own life. As the researcher listening to Gabrielle's story, I felt that I needed to listen carefully to hear how she was describing her past events. She spoke very calmly and even laughed in the moments when she said "He was ready to by me the moon and the stars let me tell you." It was clear that she just wanted to express why she was "feeling suicidal", and perhaps have her father listen, offer an opinion, even ask questions as to what led to her feelings, instead of being bribed into happiness.

According to Gabrielle, she felt that her mother was a bit more comfortable with her expressions of sadness compared to her father. Yet, during Gabrielle's potentially fatal expressions to harm herself, her mother's responses suggested that ill mental health should remain hidden, which left Gabrielle feeling exposed and vulnerable:

> I didn't want to be vocal. My mom would say "I don't tell anybody anything". So I would sit there with my feelings and I try to deal with shit myself. But it just got to the point where literally I thought I would kill myself. So, I went to my mother in tears and she was like "what's wrong with you?" and I just had a meltdown. I think it was in the middle of undergrad and literally I just broke down and started bawling. I was expressing to her, I didn't want tell her, but then there was nothing else I could do. She was supportive but at the same time, I felt really vulnerable. In some ways, I kinda regret it. I dunno, for me it was uncomfortable because I don't really have that kind of relationship with my mom. So, it was weird.... [my mom] lived majority of her life in Canada and encouraged me to "go talk to someone, go seek help" ... but as much as she was saying to go get counselling, she was being extremely aggressive… Like, I was prescribed pills at the time and she was like 'Don't take the pills, if you don't have to.' It was kind of counter-productive.

Gabrielle narrated instances of "insensitivity" to mentally ill individuals as typical of her Caribbean household. While her mother was more supportive than her father, she was critical of other remedies and only approved and endorsed counselling. Supporting the use of medication, would have been admitting the intensity of Gabrielle's perceived unhealthy emotions. That is, validating the need for medication would mean acknowledging that Gabrielle could, in fact, be mad. It is also possible that Gabrielle's mother was afraid that the prescribed medication would have permanent effects on her daughter's overall health. However, the fear of her daughter's madness is the most plausible conclusion because Gabrielle narrated that she learnt about madness through countless referrals to her behaviour:

> The story, I think probably for whatever reason it must have been behaving in the way I do, probably awkwardly and being loud and behaving bad for no apparent reason and I feel like it was always "Are you mad?" the question was literally "Are you mad?"

The words "mad" and "vulnerable" come together when Gabrielle mentioned how she felt about discussing her illness with her parents. In Gabrielle's childhood descriptions of her behavor, the labelling of "mad" is not applied in a clinical sense, rather the words are used to scold unwanted behaviours. I argue that the non-medical use of language in a Caribbean context is a significant part of Gabrielle's story, as it dismisses more sever mental health experiences, as she described earlier.

I was curious why Gabrielle felt that her mother was more supportive than her father, even though their reactions to me were somehow similar. She explained, "I've seen my mother battle depression. So because I know it [depression] is there … I know my mother is not mad, she's just struggling". There is a shared struggle with depression between Gabrielle and her mother. It is also evident that her mother is aware that depression is concrete; it is felt in emotional and physical ways, hence the encouragement to access counselling outside of the family support. Nevertheless, her mother's own acknowledgement of ill mental health was also understood through her own perceptions Caribbean perceptions of madness.

Our conversation was light and in a matter-of-fact kind of tone, even though the topic was heavy at times. I noticed that Gabrielle was aware of the differences between what seemed to be Caribbean rooted knowledge and Canadian understandings of mental illness. Gabrielle explained how her Caribbean lessons, although overpowering, can still be negotiated with her Canadian meanings of mental health and mental illness:

> If you're Caribbean, it's hard to draw the line. Like it almost becomes a blur. You can pick and choose the parts that are Caribbean and the parts that draw on our Canadian-ness for that moment. So I feel like when it comes down to the treatment of [mental health], it's kind of a collaboration.

Gabrielle describes a complementary mix of two worlds in her grasp with ill mental health. Her narrative illustrates a tension between her meanings, her family's views of ill mental health, and how these views are transferred into coping practices.

In Gabrielle's story, her body becomes the source of conflict between her parent's Caribbean notions of madness and her Canadian concepts of mental illness and treatement. Gabrielle's grapple with suicidal thoughts are treated by her parents with both displinary measures "don't tell anybody anything" and/or simplified "Oh, just calm down", which supported by how madness is interpreted in their Caribbean communities. On the other hand, Gabrielle's wanting to

access therapy is normalized by her Canadian meanings of mental illness. I argue that even though this participant lives in the in-between meanings of madness (Caribbean) and mental illness (Canadian), she continues to struggle with how she should interpret and access treatement for her mental healthcare needs. Foucault (1977) argues that power is exercised in the body which produces knowledge of both desire and repression (Poole and Ward, 2013). For Foucault "power is so deeply rooted in the body [physcologically], the difficulty of elduing its embrace are effect of [various] connections" to knowledge – education, psychology, history, psychiatry, and so forth (p. 59).

Returning to Gabrille's interview, she describes her knowledge with mental illness as a "kind of a collaboration", where in her narrative it presents resistance towards her Canadian understandings of ill mental health. For instance, the blind-folding of depression existing in the Caribbean communities became evident when Gabrielle referred to depression as a "White thing." She quickly noted that she does not personally support her grandmother's claim that mental illness, including depression, is a "White thing"; however, she subtly returned to this terminology when addressing her own mental health. I prompted her to explain what she meant by depression or mental illness being construed as a "white thing" and she explained:

> Like in the Caribbean it [mental illness], "only white people suffer from dem tings" "Depression? What's that? Only white people suffer from that." Like how is that possible? And [my grandmother believes] it's only a white disease. Legit. So I don't know, you end up feeling like what the hell? I don't know.

While data indicates that Gabrielle questioned her Caribbean teachings of mental health and mental illness even further with her grandmother's claim, she seemed paralyzed or unknowing of the route to take to address her journey with ill mental health and care. The Caribbean based narratives that mental illness is only experienced by "white people" continue to impact how she explored her own mental health and wellbeing. The back and forth between seeing her treatment as a collaboration

between Caribbean and Canadian understandings of treatment and her Caribbean teachings that "only white people suffer from depression" influences her approach to her own personal care. Gabrielle's story demonstrates how language used to describe mental health and mental illness both in a Canadian and Caribbean context is a source of power that constructs how Caribbean people like her access mental healthcare.

Another participant, Storm, correspondingly highlights how language around mental health and madness is used differently in the Caribbean, specifically Trinidad, compared to Canada. She explained:

> I don't know if it is because of the way people in Trinidad speak, some of the words they use might be perceived as negative compared to Canada. Like calling somebody 'mad' in Trinidad might just be a word that you use to describe somebody who is mentally unstable. But in Canada, if you said that to someone they might be a bit offended just because they don't wanna be labelled as crazy in any kind of way. Like there is such a bad feeling about that people just don't tend to like that. So I dunno if it's just the way the language is or if it's because of specific terms that come up in Canada nowadays that were not accepted before.

Storm illustrates how language shapes people's perceptions. When Storm was asked how she obtained information about mental illness and treatment in Trinidad, she stated that her linkage was more second-hand in nature:

> The only experience I've had with mental health growing up, in terms of Caribbean spaces were my parents telling me it's not real, it is a bad thing, it is like you're crazy, it is in your mind, just think positively and you'll feel better. So those are the only experiences I have. Like hearing about mental health was never really good things.

Storm's parents' approach is her only lens to what it means to be Caribbean. She knows that their Caribbean attitudes seem more dismissive compared to her more positive Canadian views of mental health and illness and suggests that these differences are based on how language is used within the two different spaces. For Storm, the word mad is loaded with negative connotations that

deters Caribbean people's access to care or even the development of resources in these communities.

Storm sees the usage of the words: madness versus mental illness, as weighted and deters from being "open and trying to work through their issues." She believes that Caribbean people are uncomfortable when confronting issues that allude to madness or mental illness and it is evident in their everyday conversations:

> Being comfortable talking about it and being open about it. So I think if you apply that to Caribbean treatment, what I think Caribbean people get out of it, is the idea of openness because I guess traditionally people weren't very open about it [mental illness]. If you said anything you kinda look a bit crazy and made you look like you didn't know what you were talking about. Maybe like you were mad, you didn't know what you were saying. Like being open and comfortable without saying something and I think that's why therapy and counselling were always like a suggestion because that's what it's about, being open and talking and trying to work through it by just speaking about it so yea that's definitely an influence I see for sure.

Storm saw Caribbean communities as in need of conversation opportunities in order to rethink and/or better understand experiences of madness or mental illness. Not surprisingly, Storm's sister, Sway, similarly expressed that Caribbean people need stronger mental health education and declared that their use of the term mad is more than insensitive:

> I think in Caribbean spaces people talk about how people are crazy. And sometimes they even bring religion into it. The whole devil that aspect [what causes madness] is just really possession or something. People are a little bit more understanding in Canada they are more educated on the fact that mental health/illness can't always be controlled or people who don't understand 100% of mental state that they experience and how to control it. Here [in Canada] they [those who are affected by ill mental health] have options to get help.

Perhaps unknown to the participants, literature demonstrates that in the past Canadians, too, once frequently used the term "mad", as well as Christian beliefs, ostracize those who were deemed to be mentally unfit. Eventually the language was changed to suit a more politically correct landscape (Starkman, 2013).

In addition to appreciating Canadian mental health terminology, Sway has a deep appreciation for the Canadian approach to mental health perspectives. She says that in Canada, there are clearer categories of mental illness, which allows people to receive more appropriate treatment compared to those who live in the Caribbean, who are grouped into one single idea of madness. Canadians, according to Sway, are aware that mental illness is scientific and survivor circumstances can vary across the mental health spectrum:

> Caribbean people lump them [the mentally ill] into one category of being mad or crazy and they [Caribbean people] just really don't understand that there's different levels to being mentally ill. Whereas Canadians understand that a little more. Canadians are a little bit more educated on the different types of mental illness. We have the tools to actually treat the people who need the help and Caribbean people don't exactly understand that.

Sway's mental health Canadian knowledge is based on her Canadian post-secondary education:

> Like in my course—we get to pick one mental health issue and everyone goes around class and explore the treatments for it. So we had 30 different topics and they were all very similar. So I wouldn't want to disregard other things that other people are really feeling especially if they are having different issues but I also wouldn't know how to simplify it. Mental health is such a broad topic, it's kind of like I don't know how to make it any simpler- like a lot of people think that mental health is just depression and anxiety but there is so much more. I think that Canadians have done so much more research and education about how many more different mental health issues there are outside of anxiety and depression.

On the other hand, Sway's Caribbean remarks about mental health are based on the experiences of those who migrated from the Caribbean to Canada during the 60s and 70s and continue to facilitate young Canadian-Caribbean people's experiences today. For my participants, it does not matter if mental illness is granted more positive attention currently, their interpretations of how it is regarded is based on their personal experiences in their home circles. Sway and Storm's personal experiences and comparing – the two narratives presents a strong case of Canadians having a stronger handle on addressing mental health and mental illness compared to their Caribbean

counterparts. I argue that this seems to be the case with how language is constructed through power and the validity of knowledge.

I borrow post-colonial thinker Edward Said's (1985) construction of power and knowledge to situate how language and attitudes between Canadian and Caribbean approaches to mental health are more than a difference of language or sensitivity. Rather, the differences in the language between the Canadian and Caribbean approaches exemplify how power is read and authorised. Said advocates that there is a:

> …cultural relationship between the developed and underdeveloped world that spans over 4,000-years. This relationship also includes the validity of science and the fantasies of the world called the orient… The common denominator between [the cultural relationships, science and fantasies] is the line separating Occident from Orient, and this, … is less a fact of nature than it is a fact of human production, [or] imaginative geography (1985, p. 2).

Said's posits of how knowledge is produced and organized is often conducted in "non-dominative and non-coercive settings that are deeply inscribed with the politics, the considerations, the positions and the strategies of power" (1985, p.2). The production of knowledge is controlled and narrated by those who hold power.

In Sway's case, she credits the progressiveness of mental health knowledge and treatment to Canada and sees (her) Caribbean teachings about mental health as not progressive. The split between Canadian (progressive) and Caribbean (non-progressive) constructions as told in participant narratives is, however, problematic. For instance, in Sway's argument, part of her narrative highlights a contradiction in that those who are from the Caribbean (and hold unprogressive views) have experienced difficulties in accessing mental health services in Canada; consequently, they are forced to return to their Caribbean sources for self-help methods of care. Further, this Canadian definition of ill mental health (as seen by some participants such as Sway), omits the experiences of Canadian-Caribbean people who, as exemplified by Gabrielle's story,

value both. I argue that the Canadian medical framework, while more sophisticated than Caribbean definitions as described by Sway, does not acknowledge alternative views of mental healthcare. Furthermore, the Canadian mental health system and mental health literacy are both structured within a former colonial legacy that do not account for differences in treatment, language, or former colonial subjects' relationship to mental healthcare.

MEASURING THE STRENGTH OF THE STRONG BLACK WOMAN (SBW)

(b) Measuring madness in the SBW – resilience

Data in my study indicates that for some participants, composure and strength are central in defining them as Caribbean people. Additionally, some participants expressed tension in managing mental health by using the same practices as their migrant family members and embracing new (Canadian) ways of coping with mental illness. As a result, their own notions of strength and weakness are obstructed by living within these two competing narratives. For instance, when Gabrielle's grandmother heard of her prolonged battle with depression, she reacted in a scolding manner. Gabrielle explains:

> Like I could never tell my grandmother I'm depressed, [she would react by saying] "what is this?" "Wah happen to you? Yuh pregnant?" Like it's pure scandal, like you're pregnant, and the whole world comes to an end, how could you be depressed?

To be reprimanded for depression led to embarrassment, and in turn, Gabrielle learned to keep quiet about her depressive feelings. Gabrielle' grandmother would supress and belittle her emotions further. Gabrielle's tone of voice was somewhat whimsical when describing her grandmother's reactions:

> It's like, you're Canadian, why are you sad? Your life is perfect. That's a friggin' story. That's Caribbean people, let me make you sadder, let me tell you what is sadness. They [Caribbean people] are the worse. No friggin' compassion… And for days and days you'll hear about how you were sad. Just don't let anyone catch you being sad because until next week 'oh can you imagine the likkle pickney bout she sad.' It's awful... My grandmother would just keep going – 'wah happen to you, get up!' 'You want something to cry for?' 'Like what do you mean you're crying, what do you mean you're sad? And you living

> good, good life in Canada.'… She would ask 'what's hard in your life? You have everything set up for you like what are you sad about?' Your life is sweet, bout yuh sad. You better fix your face bout yuh sad.

Gabrielle's pain is overshadowed by what *"the good life in Canada"* means. The good life in Canada is a projected immigrant dream that too many people continue to long for. Sara Ahmed (2010) argues that the migrant's happiness is incorporated into an already established national ideal. To understand the role of happiness, she says, one must use imperial history as a lens "to consider the relationship between happiness, nationhood, and citizenship" (p. 133). For Ahmed, the promise of citizenship is the promise of happiness, and in order to strive for this ideal happiness, immigrants must compete to prove that they are worthy of citizenship. Thus, Gabrielle's parading of sadness (sometimes seen as a weakness) is presumed by her grandmother, as ungratefulness for the comforts, not to mention her status as a Canadian born citizen that presumaby offers her *"the good (Canadian) life"*. Her grandmother's sacrifices as the first to have migrated to Canada paved the way for Gabrielle's *"good life"* that she seems to not appreciate. Gabrielle's story raises the question, what happens when dwelling on historic social circumstances overpower the melancholic state of wellbeing?

Some of the participants in the study, such as Sway, echo Gabrielle's grandmother's sentiments of remaining appreciative of one's Canadian way of life. When asked how sadness was regarded in her home if prolonged for longer periods of time, Sway responded that she would feel guilty because of her grandparents' sacrifice:

> My grandfather in particular came to Canada just to support his family, not just for a better life for them for everything in general and for them [her and her family] to grow and have a proper education and build a life of their own. And he tells us that we have to fulfill that. So he came to Canada not only for his children but for us [his grandchildren] because no matter how hard school is and how hard you think it [life] is, it will all pay off. So you have to keep going.

Sway explained that in her household, madness and mental health are intertwined with striving for betterment through the use of heroic and resourceful migration discourse that includes sacrifice and survival (Ahmed, 2010). Similar to Gabrielle, Sway's narrations of migration are snippets of stories used to justify reasons to pick yourself up and "keep going" because the older generation made sacrifices that would help secure better lives. In Sway's family "just keep going", is an unwritten code that is embedded in struggles of migration. In this sense, to *keep going* denotes the idea that you can push difficulties aside in an effort to move forward:

> I was always taught if you're having an off day or if you're upset, you can be sad that day but the next day you have to pick yourself up and keep going. It's that mentality, that if you're sad, you're allowed to be sad for that day but after, you just need to keep going, living your life and keep going.

At the same time:

> Like a lot of times, Caribbean people feel that if you have this [sad] emotion, it can be controlled, you can control, how you express yourself and how you feel, but a lot of the times, the sadness—like you're allowed to feel sad but not for very long, after a certain point, you need to pick yourself up but they [Caribbean people] don't get that you can't control how you feel. Like depression, isn't something that you can just pick yourself up and keep going, you feel it but you can't control it. Like a lot of times, my grandfather would tell me 'ya, it's okay to be sad' but I don't think he understands the concept of depression, he just thinks you're sad for the day but then that's all. You are not supposed to keep feeling that way and you just continue with your life and you *keep going* so yeah stuff like that.

Sway zig-zags between her personal and clinical understandings of depression and what she knows sadness to be at home. Sway's story highlights obligations to her family, which necessitates keeping her emotions in check indicating appreciation of the migrant story and social success. Prolonged sadness is construed as moral weakness and personal failure. Literature shows that the interpretation of strength, to maintain resilience (or to *keep going)* and push through the hardships, is found within Caribbean people who buy into or believe in the idealized stereotype of strength (Edge, 2008; Jackson-Best, 2016) and happiness (Ahmed, 2010). More specifically, literature that

focused on women who migrated under the Domestic Workers' Scheme used notions of strength to cope and resilience was worn as a shield them against harsh conditions (Henry, 1968). My data illustrates that my participants, the descendants of Caribbean people who migrated during this period, also embody resilience to navigate through difficult periods in their life. Sway justifies the importance for pushing through the sadness because it could "hinder her schooling and overall personal attainments". She says, "I would probably feel kind of guilty, especially because I am not only doing school for myself but I'm doing school for my parents and grandparents. I want to make them proud." Sway recognizes that her commitment to achieve more than the generations before her is based on the opportunities she now has.

The benefits that Sway is able to secure has trickled down from generations before her grandparents. Sway's story demonstrates her ancestors' ability to endure harsh conditions and to push for betterment, which in turn celebrates their resilience. She says:

> I saw my grandparents as products of people who have come from those countries [India] all the way on boats and who worked their way into this country [Canada] and then worked really hard. My grandfather told me how he used to work and paid off the mortgage on his house one quarter by quarter and a dime by a dime. And looking at the life I have now, I'm really blessed and happy for the life I have, so I think that I've seen in that way that whatever those people did, the indentured slaves coming over, I haven't seen any negative thing from it, I've seen only positive because the way it affected my life. I always looked at it as a good thing and looked at them as strong people because of the opportunity that I was given today.

While it is unclear if her past relatives' sacrifices have impacted her own emotional wellbeing, her narrative indicates that she is goal oriented and driven to achieve more because she has been granted the opportunity to do so because of her grandfather's migration and survival stories. When asked where strength is drawn from, Sway responded that her strength is based on building goals and adding to family achievements:

> Both my mom and dad are the youngest in their families and I believe they are the only ones who went to post-secondary and they both went to college. That was a pretty big

> accomplishment for them because they really did try and work for everything they have, regardless of the situation, like money. My dad did not have the support from his family. He worked, paid for college all by himself. That's why my sister and I work so hard and we have such big goals- like she wants to be a lawyer and I want to be a doctor and it sounds so cliché. We set the bar so high and even if I don't meet the highest goal for myself, I know that's where I am working towards. I wanna make my parents proud too so they can tell their grandchildren 'wow I'm so proud of my daughter.'

The additional pressure to do well in their studies, as a way of fulfilling family expectations, is a common sentiment among most racialized students. My data contributes to studies that have examined the interconnection between racialized students' success, self-care and ultimately their mental health. Often, racialized students are the first in their families to graduate post-secondary school or be employed in white-collar jobs (Brody et al., 2006, as cited in McGee and Stovall, 2015). In addition to family pressures to succeed, McGee and Stovall (2015) state that these students endure daily blatant racism and discrimination because the academy is structured predominantly as a white environment. McGee and Stovall further argue that the "pressures often cause students to compromise on their sleep, exercise and other aspects of self-care, which resulted in the wear and tear associated with disproportionately high rates of health problems" (p. 498). Sway's strategy of *keep going* is a strategy that McGee and Stovall state as common among "high-achieving African Americans, who may unconsciously (and increasingly consciously) sacrifice their personal relations and health to pursue their goals with tenacity that can be medically and mentally deleterious" (p. 498). Similarly, Canadian scholar Camille Hernandez-Ramdwar (2009) indicates that Caribbean students often face specific barriers, including financial difficulties, assuming family obligations, and racism in the academy, which directly impact them differently from others attending university. She further states that the experiences of students of Caribbean heritage are repeatedly dismissed at the larger decision-making level, which is reflective of university programs and policies.

Both Gabrielle and Sway demonstrates the importance of maintaining strength, or resilience (to keep going). In both cases strength was modelled by the previous generation and in Gabrielle's narrative was reprimanded by her grandmother if weakness was demonstrated. This data shows similarities to previous generations who migrated from the Caribbean and seems like a historical trait for Caribbean people, as Gabrielle and Sway explained. The importance of strength and resilience is also reminded through migration and settlement stories.

CONNECTING MIGRATION STORIES TO RELIGIOUS LESSONS

(c)Using spiritual anchors to heal

Data in my study indicates that in addition to the use of migration stories as sources of strength, there are diverse ways that Caribbean people address mental health. Participants were asked questions about spirituality and wellness. These questions were purposefully asked because of studies that indicated the importance of the role that religion and spirituality played in mental health and illness for Caribbean people (see for example, Benjamin et al., 2010; Bobb-Smith, 2007; Waldron, 2003; Wilson, 2005). Gabrielle, Storm and Sway spoke directly to their Christian teachings, which spoke to how mental illness was addressed in their families.

In her response, Gabrielle indicated that her grandmother believed the church to be a necessary source for healing Gabrielle's depression. Her grandmother would say "you should get out of the bed and bathe, or you must start praying, these are the things that will rid your depression." In addition, Gabrielle's grandmother was known as a healer in her community, therefore, Gabrielle was constantly told:

> You must go to your grandmother, let her lay her hands on you and go and read the bible to you and beat down whatsoever on you and pelt any kind of water on you and light the incense in your house, light the candle and chant down the house like some kind of mad person. That is mad. That behaviour to me is disturbing. But yeah, that's the first thing you should do if you're feeling this way [depressed], you should ask God to help you… For sure, it has a connection to spirituality. It just means that, if you're feeling any of those feelings, you're on the wrong side of spirituality.

Gabrielle's conversations highlight that people within her community also believe that ill mental health is connected to a lack of personal faith. While Gabrielle is aware that both her mother and grandmother's approaches to mental health and wellbeing are problematic, she also found professional support inefficient and debilitating. She says:

> I was cancelling my appointments, I was like okay this is too much work and I have to sit here and talk….it just made me feel worse about the situation. I am deemed by the Canadian society as the angry Black woman, that also has its effects on my mental health. It always comes from somewhere that they can't say yeah I get that; I understand why you're feeling the way you're feeling. In the same way I'm showing Canada why I'm feeling the way that I'm feeling which comes down to me being an angry Black girl. I feel like that makes me not wanna subscribe to mental health at all because it's almost like a white invention in a sense. Like I know madness sounds bad but madness is just the Caribbean way of saying mental health. We just don't know how to say it and then people think that we're stupid. We're not stupid we just don't know how to say it, that's what it is [different ways of understanding mental health and illness].

Participants Storm and Sway offered a counter narrative to Gabrielle with regards to spirituality and mental health. Storm says:

> I think if you are struggling with something mentally and you don't really know how to cope, have faith and believe that all things are possible, and all burdens can pass away. I believe it is a really important asset of coping.

Storm continues:

> There is purpose of having the faith. Faith is having something that is beyond you and your capacity to understand and to do. So I think if you are struggling with something mentally and you don't really know how to cope, that's why you have a faith to lean on because you have that belief that all things are possible and all burdens can be passed away and that's a really important asset of coping. So I think spirituality can help and not to say there is a direct relation but I have some friends who don't believe in anything and they do struggle more mentally because it seems like a lack of stability. I mean I can't really say it's because of that but I can say that having it has shown me stability that I wouldn't have otherwise if I didn't believe.

Storm's Christian stories provides a source of grounding that she felt some of her friends lacked. Additionally, she positions her understanding of strength and resilience as rooted in biblical stories such as the story of David and Goliath, (Samuel 17:1-25):

> there were stories, like the David and Goliath story, being physically strong but yea definitely has to do with personality traits. I think of these stories as always being really positive… like it helps you put your head straight. Making you more well-rounded and being able to do what's good and defend your family, work really hard, those kind of things are what makes you a strong character. There are always positive qualities attributed with being strong.

Building character was an important part of what it meant to be strong:

> I heard a lot of biblical anecdotes tell of strong-willed characters mostly or like my nanny was a real important person in my life before she passed and what people would say about her as described in proverbs 3:1, which talks about a woman who is really well-rounded and strong-willed and resilient and they would attribute that to her because of her characteristics so if I heard any stories it would be about character, having a strong character.

These stories are significant for Storm because spiritual strength equals "physical strength", which she believes is also attached to "a person's personality traits." Religious teachings for Storm, are a template for maintaining physical and mental health. It is an outline of how one should conduct their life.

Similar to Gabrielle, Storm's story of ill mental health is connected to being a part of spaces that are not sanctioned by God:

> I know somebody told me like "you know you have to stop staying up late and you have to stop going out and hanging out with people that have these vibes because that's what has you depressed and is hanging on to you or whatever. You have to stop looking at certain things and purify yourself." Like this is what I need to do in order to not feel the way I'm feeling. To me it's hilarious and it's almost like you wanna feel like it has a sense of truth to it because so badly you want some kind of remedy so you're like okay maybe that is what it is.

And similar to Gabrielle and Storm, Sway connects spirituality, strength and mental health. She says:

> I think that spirituality and religion has a lot to do with how someone acts and how they control themselves. And God doesn't give you more than you can handle, which I strongly believe in to an extent as well. And I don't believe that people who have mental illness that they're possessed or crazy or like they have the devil in them. Like I know that a lot of Caribbean or West Indians believe that and like I've heard it first hand from family and stuff.

In the interview, Sway found it important to define the differences between having faith and being possessed and how that links to mental health and illness. She also wanted to illustrate that her interpretations of mental health are beyond traditional Caribbean definitions; as well, she felt that she needed to set the record straight – not all Caribbean people think the same way.

The discussions with Gabrielle, Storm and Sway reminded me of my own childhood teachings, where my maternal grandmother would constantly repeat that *“we all have our own cross to bear”.* In reflecting, I ask myself why these religious teachings are so common among Caribbean families? More importantly, I also asked, what were the hidden lessons in these teachings? I disagree with Sway’s statement that *not all Caribbean people think the same way* because the data in these three narratives show that most Caribbean people’s morality is governed by their religious beliefs, which may differ from other Caribbean people’s spiritual beliefs. The participants’ specific Christian teachings that they spoke about, do not leave room for the interpretations of madness as being spiritually pure. It is not coincidental that the mad person is seen as evil; it is a historical indoctrination that was passed through religious teachings during the colonial and industrial era to maintain a strong economic force (Foucault, 1977; Scull, 1979). These former European beliefs of madness were imprinted on most racialized people, including Caribbean people, reducing mental weakness to a lack of religious or spiritual guidance. Moreover, those who did not follow the Eurocentric, Christian doctrine were considered to be devil worshipers and faced severe punishment, including imprisonment and or execution. Timothy McMillan (1994) writes that many Europeans brought their assumptions of African people being of satan from the Old World to the New World. He says, "To many Whites, Africa was a strange and heathen land of rampant with demons and devils who were the objects of worship by its inhabitants...The belief that Blacks were inherently connected to the worship of satanic forces no

doubt greatly influenced many Whites automatically to suspect them of witchcraft" (p. 107). McMillan's piece on "Black Magic witchcraft, race and resistance in colonial New England" adds to Foucault's and Scull's work, exemplifying how Africans were regarded by Europeans in all aspects of day-to-day living, including their health practices. I am situating my participants' stories within this area of research as they all referenced religion as a strong connecting factor to sound mental health. However, Gabrielle's, Sway's and Storm's narratives were more pronounced, identifying how religion is intertwined with strength.

Gabrielle, Sway and Storm's narratives confirm studies that document the role that their Christian beliefs play in mental health and illness for Caribbean people. In *Racism and Well-Being: the lives, hopes, and activism of African Canadians*, Akua Benjamin, Carl James and others (2010) state that religion and faith are viewed as a coping mechanism for many African and Caribbean people living in Toronto. They found that "participants pointed to the historical importance of faith and the Black Christian church as key to survival of all Black people" (p. 160). Further, their study participants saw "spirituality or faith as a way that they could 'fix the broken spirit' and 'heal the brokenness and the shattered dreams'" (p. 161). Religion becomes the lens that narrates "everything happens for a reason" (Sway, 2017), thus, justifying the many trials and tribulations in Canadian-Caribbean families. Religious faith also suggests that their troubles are temporary and more prosperous times are around the corner, as mentioned in Sway's previous discussion to *keep going*. I argue that migration narratives and religious beliefs are not isolated from one another. Consequently, strong religious beliefs are important chronicles that are intergenerational and used as teaching methods to demonstrate how the previous generation survived more difficult times. Although this chapter specifically addressed Christian teachings (dominations undisclosed), other

participants in the later chapters also referred to religion, including Islamic and Hindu teachings, as being a guiding factor that helped to navigate the treatment of ill mental health.

THE POWER OF ANTI-STIGMA & MENTAL HEALTH DISCOURSE

(d) A new world of emotional apps

Data in my study indicate that popular media discourses and current literacy campaigns on mental health, play a role in allowing young people to decode their experiences with mental health. Storm sites her current understanding and experience with mental health to two sources. Her first resource is her migrant background and the second is her Canadian upbringing that has exposed her to popular media discourses and mental health literacy campaigns as a reference. She says:

> … the perspective of things are changing with the times, yeah but it's something that I think I see a lot. I know nowadays people are working to battle the stigma around mental health, whereas maybe 10 years ago it wasn't a primary issue [or focus] for many people or at least for the media. So yeah, I don't know if it's that [the media] or maybe they're [her parents] are older so they are taking it more seriously now, I am not sure what it is but it definitely isn't the same as it used to be and in a better way.

Storm's accounts regarding the current attention given to mental health and stigma are important. Canadian telecommunication 'text and talk' campaigns such as hashtag #BellLetsTalk are presented as a vociferous way of capturing awareness and mental health education. Although these campaigns are criticized for not being inclusive to racialized people (Haroutounian, 2016), they are still seen as efforts that attempts to reach out to most young people. There are also shows like the Netflix original series *13 Reasons Why*, that targets a younger audience and attempts to debunk myths that are linked to mental health at the high school level. Such shows are noteworthy because they offer space for essential dialogue around intervention, prevention and general education.

For Storm, Canada is a significant resource for mental health advocacy and care in comparison to her Caribbean heritage. Storm expressed that her parents were more open to discuss the impacts of mental health because both migrated to Canada as children:

> Like I'm really lucky that they are so supportive and while they do hold some traditional Caribbean ideals that we talked about earlier, they still are very reasonable in the way they approach things and they've always been supportive that doesn't have to be a Canadian thing where the support has to come from the Western society, they've always been really supportive and helpful… So yeah if they could have helped like they would've and they have tried… There's always a bunch of things that could affect you and your mental health. So, like, when I was maybe 11 or 12, I had some insecurities about how I looked and I was being bullied in school. So that was something that my parents could help me with because none of that [her experiences at school] had anything to do with them. So they were able to sit me down and talk to me about it and help me feel better about myself and that was really nice… But yeah, when it came to stuff that involved them, that was really hard because they couldn't really be unbiased.

Storm's teenage story seems "light," especially since she was able to talk through her feelings of insecurities with her parents. However, as a youth going through university, she emphasised that she found stronger support for her mental healthcare at her school – Queen's University. Still, Storm believes that her parents are generally more supportive than most Caribbean parents because they both emigrated to Canada as children. She says that people "'back-home' weren't very open to it [mental illness]." Her reference to *'back-home'* is grounded on experiences with her maternal grandfather whom she characterized as 'traditional' in his approaches to mental health:

> My grandfather on my mom's side, I'm closer to my mom's side than my dad's for sure and on my mom's side, yeah my grandfather is very traditional and he's got like really old ideals, growing up like provide for your family, which is obviously like a great thing to think. It is family first for me always but he thinks very old school I would say so mental health to him is not really a serious thing but I think if I were to say I have this problem and I have medication and everything, he would maybe not understand…

Storm's narrative compared *"to be Canadian"* and *"to be traditional"*. Storm saw her parents as more accepting and open to concepts of mental health and illness, however, when she disclosed her anxiety feelings, her parents responded that anxiety was "not her. She was not a mad person" (Storm, 2017). Her parents believed that her anxious feelings were more in her head. Her parents regarded her issues with anxiety as childhood growing pains, which she will eventually outgrow with age. She says:

> I can recall when I had some problems in high school controlling my nerves and anxiety levels and trying to bring it to my parents and them not fully understanding and thinking it's not real, it is madness, 'you're not like that' like it was a bad thing and them telling me that it wasn't real. And it wasn't like not wanting to understand it because they always tried to help me but when it came to that specifically, they didn't really believe that it was real. They just believed that it was just in your head and it could be solved. So yeah, that's like the earliest part that I had with madness, I guess back in high school.

Storm felt that going away from home for school at Queen's University allowed her to be more open and expressive with her feelings of anxiety. She says:

> I guess because I go to Queens I am able to have that community around me and having them so supportive. And a lot of people suffer from that same thing, either you were diagnosed or not, people share the same feelings and support. They share a community and support there. Like it is really common to find someone who is struggling with the same thing and to find support as a result. Pretty much looking to people around me for support who is going through the same thing is helpful.

For the fourth-year Queen's student, her Caribbean teachings de-legitimatized her experiences with anxiety that started since she was a teenager. Storm's parents went through a marital separation when she was a teenager and they felt that their marital affairs were protected from Storm and her younger sister. This family change triggered Storm's experiences of anxiety, which she felt her university resources were of importance. Nevertheless, Storm referenced her parents as forward-thinking when compared to relatives who are invested in static mental health views she associated with the Caribbean.

Compared to Storm, Gabrielle is not drawn to Canadian mental health methods because for her, in Canada, things are a bit too "politically correct, which brushes over the core issues" (Gabrielle, 2017). At the same time, Gabrielle perceives Caribbean people to be insensitive and says:

> I feel that Canadians are oversensitive and sometimes I feel like it [ill mental health] is promoted. In Canada, when someone comes to you and say they're feeling anything it's a problem… Anything and everything is associated with mental health…Caribbean people [on the other hand] goes to shame. They just shame you for your own feelings. But the shame works.

In parts of my conversation with Gabrielle, her words seem to be insensitive; however, I understood what she meant by "the shame works." Her story details this expected toughen exterior and although there are small windows for sadness, it is dismissed very quickly. Learning to cope and "brush it off" as her father said, are important characteristics exemplified in her household. Both her parents and her grandmother were dismissive of her issues. I think there is this unspoken understanding that Caribbean people are expected to "brush it off" and move forward.

Gabrielle explained what she meant by "the shame works":

> So, [mental illness] is shameful and nobody wants to be associated with that obviously and then what that means for the rest of your family, it's just a hot mess. So I feel like in the Caribbean yea it's definitely something that's associated with shame. It has a negative connotation so naturally you're not gonna wanna open up about it and sometimes I attest to that. I don't know it's weird, because I'm born here I understand and I know what I'm supposed to think naturally but also being Caribbean sometimes I'm like shut the fuck up! I don't know… It's so awful and I know it's not right but sometimes I think they [Canadians] overdo it here. I'm so sorry. I think [mental illness] is beaten to a pulp [in Canada] … Caribbean people are insensitive but sometimes I feel Canadians are oversensitive and sometimes I feel like it [mental illness] is almost promoted [in Canada].

Gabrielle's story exemplifies how discussions about feelings and other various states of mental health that may manifest into a subsequent illness, are often secondary or swept under the table because they are regarded as less significant or important to the more basic issues of survival and everyday life. She is instead forced to focus on the more immediate moments. Gabrielle is caught in the middle of competing ways of thinking, where she constructs both a negative – insensitive and oversensitive understandings of mental health and illness – neither is considered to be sensitive.

Storm also seemed to favour similar feelings about managing mental health as Gabrielle did. There are a number of make-do antidotes that students in their early 20's like Storm, use as strategies for managing their stress and anxiety. For example, Storm says:

> I channel all of my energy into my work, so when I'm feeling stressed out about something, I just put it into whatever I was doing at the time- either it was homework club or something like that. Like I did a rigorous active program in high school and I did a lot of extra curriculum so I just kept myself busy so I didn't have to think about it. But I now feel like I can look towards someone else who is going through something similar and helping them get the help they need.

At Queen's University, Storm considered her experiences as part of an on-going discussion that is contemporary among her peers. Storm's negotiation of mental health is unique as a Queen's student being inundated with mental health literacy and advertising; however, the extent to which the initiatives developed by the University connect students beyond their mental health circumstances is unclear. Admittedly, Storm found a community where she felt relaxed expressing her mental health concerns. However, there is little evidence that points to Queen's University expanding their team of registered psychologists, as a result of the increase in mental health literacy. On the other hand, there is substantial proof pointing to the increase of peer-to-peer support programs and mental health training certificates ("Queen's University", 2018), thus, potentially funnelling received funding into the university's profit margins. It cannot be assumed that campus initiatives are inclusive of students' "interpersonal experiences of gender, sexuality, race, ethnicity, and ability, as it relates to larger systems of power, oppression and social privilege" (Bilge et al., 2016, p. 114; Boylorn et al., 2014). One's mental wellness is not isolated from the intersecting factors of one's identity, nor from the social construction of power.

If North American popular discourses could bear to account for the multitude of ways that other cultures view mental health, there could be more breadth and depth employed in mental health treatment/approaches. There is enough evidence to signal a friction between what treatment means in Canada, compared to Caribbean peoples' interpretations of treatment. Participants learned cultural practices from their Caribbean upbringings, were often in conflict with the language they received at their various educational institutions. For instance, my data reflects that

the expression of mental health through storytelling is common among Caribbean communities. And although, telling a story may not directly be related to mental health, it can be a way of identifying that we are all impacted by the effects of mental health and illness. Moreover, having spaces where students like Storm can share their stories of migration and culture in relation to their mental health can open new perspectives in mental health discourses.

MIGRATION AND MADNESS COMES FULL CIRCLE

(e) We all have a mad story

Cecilia's story differs from Gabrielle's, Storm's and Sway's narratives because she describes her experiences with ill mental health through the experiences of her grandmother and aunt. Her story fits with the previous three participants by providing context to their family's reactions to feelings of depression, anxiety and other unhealthy mental health emotions.

At the beginning of the interview, Cecilia informed me that to prepare for our discussion, she had a conversation with her parents about madness and its usage both in Guyana and Trinidad (her parent's birth countries). Cecilia did not anticipate that her parents would reveal more personal family stories of madness that swiveled around both her paternal grandmother and aunt. The first part of our discussion fulfilled some of the questions I asked about the ways that a mad-person is medically treated within Caribbean communities.

Cecilia started our discussion with her paternal grandmother's story, which jolted what she previously knew:

> Yesterday, I was talking to my mom and dad about this study and that's when I found out that my grandmother on my father's side, experienced some sort of madness, which my dad actually called 'crazy' and they took [my grandmother] away for a little bit. She had shots or some sort of medicine and then they brought her back and I didn't know about this until yesterday.

In the retelling of the story, it became evident that there were moments that were either blotted out, or glossed over, or unknown. Cecilia relayed the story back to me using expressions such as

“they took her away”, “she had shots, or medicine of some sort” and “then they brought her back”. It is unclear if Cecilia’s grandmother was “taken away” to Guyana’s only asylum, the Berbice or Lunatic Asylum, established in 1842 by the British (Gramaglia, 2008), or if was she was taken elsewhere, like a local hospital, or a private clinic, or to another relative’s home.

While there were obvious missing pieces to Cecilia’s story, she was able to note that her grand-uncle provided the family with some support:

> In Guyana they [my grand-uncle] took her [grandmother] away possibly to care for the mental health, but I don’t know much about that. He [my dad] just briefly mentioned it yesterday. I think my grandmother’s brother tried to give her something but it didn’t work so they had to take her away. That’s the shell of the issue that they did try to help her.

It is hazy what Cecilia meant by her dad’s uncle’s attempted “to give her something.” Was the “something” an herbal or a more spiritually-based treatment? When Cecilia’s grandmother started to feel herself again, was she brought back to her home and resumed life as normal with her husband and her children? Did a health practitioner or spiritual leader follow-up with her care? When asked how her grandmother was diagnosed, she responded:

> For the Caribbean vibe, you don’t know unless you ask, like I didn’t know anything about my grandmother until I probed questions and was really interested that’s when they [parents] finally told me. So in Canada, it is freely talked about, but in the Caribbean it is not. Because of the whole stigma behind it I guess… I’m not sure if she [grandmother] likes talking about it though because she talks about the past too much, like she can’t get over the past, I’m not sure why. If it’s just because it hurts them [the older relatives] so much or is it a Caribbean thing? I dunno. I guess cause the past really influences your life and influences your mental health too.

For me, being immersed in Cecilia’s grandmother’s stories, gave the impression that there was more of a community that surrounded relatives care and healing process. Perhaps it was my own romantic view of Guyana and it could have been that Cecilia’s grandmother’s health was the centre of violence and chaos, which aggravated her to have fragments where she “talk about the past too much, [or] can’t get over the past” (Cecilia, 2017). I wonder, was it easy for Cecilia’s grandmother

to remove her story of *"crazy"* from her broken records of the past? If the *"past"* is always on repeat at Cecilia's grandmother's house, how was her story of *removal* misplaced among the family's general archives?

The ambiguity of Cecilia's story is a result of how previous events are remembered and retold. Prabha Jerrybandan (2015) found in her qualitative study "Unsilencing hi(stories) of Indo-Caribbean women" that silenced stories were either forgotten or denied because of shame are blotted out over generations. She argues that these "denied stories contain possibilities for understanding and contextualizing the pain and suffering that many Caribbean people have endured" (2015, p. 139). Her argument is grounded in data collected by six Indo-Caribbean women, living in Canada. their stories collected through a memory work technique pulled on the recollections of their memories in unravelling how aspects of women's histories are silenced.

On the other hand, Deborah Britzman (2009) explains in her book *Psychoanalysis and the Impossible Professions* that the memory and imagination poses a paradox "without imagination we cannot fantasize how others experienced past events we could not have lived through… The work of imagination permits us this affected history" (p. 120). Britzman goes further to explain that "the contradiction of the imagination also holds a failure through denial of painful events and a radical difficulty to believe the consequences of humanly created catastrophe as our inheritance" (p. 120). Cecilia's father's retelling of his mother's story pulls on his own imagined childhood memories, where some of the recollections may have been too difficult to recall. Cecilia digging through past collections of memories as an active listener, she also has to process new information along with what she previously knew about her family.

Cecilia seems to filter through her emotions of how the events of her grandmother remained in seclusion, even with her father who is a grown adult with a family of his own:

> He [dad] was the eldest of four. Maybe my dad was 6 or something [when his mother was diagnosed].… That was probably in the 70s, she [grandmother] got the medicine. In Canada though, I'm not sure if she got any help but I know my aunt did. I'm not sure what exactly my grandmother has but I know my aunt has schizophrenia. My dad says that she [my grandmother] is bipolar because one minute she's so happy with him and the next minute she's so angry, but she's not [medically] diagnosed here [in Canada].

When I asked Cecilia what she thought of the recent information that she uncovered about her grandmother, she explained how her father's past shapes how madness is observed in her family:

> My dad has that influence because of the experiences of his mother's madness. I feel like it might be a generational thing maybe, how it was passed down or maybe experiences that drove them [both her paternal grandmother and aunt] to that sort of state. But my grandmother and my aunt, both of them live together and it's an interesting time when they are together and the things they talk about and yeah I hope they both take care of each other. I'm not sure how two people coming together when they're both mad deal with it, but I think it could benefit each other.

Cecilia's family stories really differ from her Canadian ideals, noting that mental health literacy in Canada rests at the forefront compared to the Caribbean:

> I feel like in Canada they care more because it's becoming more serious but in the Caribbean, it's just like a regular thing. Like in Canada if you cared enough to learn about [mental illness] there are more resources. I mean, I didn't learn about [mental illness] in class or in a course but there are posters around the class and currently at my placement there's a mental health poster with like a website but people pass it and they don't really know what it's about.

Similar to Sway and Storm's reactions to advocacy of ill mental health in Canada, Cecilia believed that these discussions were more prevalent and open in Canada compared to both the Caribbean and within her Caribbean home.

In our conversation, Cecilia tugged between the personal and the impersonal language used in public mental health and illness campaigns around Toronto. She acknowledges that people may overlook resources that are readily available in Canada compared to the Caribbean, where ill mental health is perceived as a "regular thing" – meaning everyday experiences that Caribbean people learn to cope and no serious emphasis is placed on the ill person. For Cecilia, there is more

of a serioius emphasis placed on mental illness in Canada, yet, with all the information that presents itself in Canada, Cecilia's grandmother's ill mental health passes as a "regular thing" within her own Canadian family. In some ways, Cecilia seems aware that the Canadian treatment of mental health and mental illness also falls in seclusion, considering "people pass [by mental health posters] and not really knowing what [mental health is really] about." I agree with Cecilia in many ways, information around mental health and its resources are more visibly available in Toronto, but to what extent? At the same time, I question that people living in Toronto are desensitized to mental health campaigns. Rather, these publications normalize mental health and mental illness as simple, easy to treat, and non-life threatening. Cecilia's over exposure to Canadian mental health literacy is used to interpret and measure her own family's experiences of mental illness. Furthermore, the secrecy of her grandmother's health issues are minimized by her parents and presented as either past experiences or trails that they were forced to overcome. Cecilia's story in some ways is similar to Sway and Storm's stories where the family's success was attained through the process of migration to Canada.

Filling in the blanks

Cecilia's grandmother's healthcare is narrated through a number of economic and political shifts both in Guyana and in Canada. Her grandmother's ill health occurred shortly after Guyana gained independence in 1966. The newly self-governing state faced adverse conditions that impacted most of the country's health services. At the time, many programs were nationalized and public health services were deflated, resulting in a hemorrhaging of both human and medical resources (Walker, 2017). Despite the number of economic, political and social circumstances that stacked against Guyana's reality, Cecilia admitted that her grandmother received more care for her ill mental health than she did in Canada:

> I feel like in the Caribbean they probably didn't do anything for [mental health]. Thinking back to Guyana though, my grandmother did get medicine for whatever it was she was going through… Once my grandmother left Guyana, I don't know if she received any help in Canada. But I definitely know she seeks help through her faith-base.

Cecilia's grandmother was not re-diagnosed once she migrated to Canada, which might have been *"either in the late 70's or early 80's"* (Cecilia, 2017). Research illustrates that Canada during this period, primarily focused recruitment on healthy migrants, a process that is still practiced today (Benjamin et al., 2015; Edge, 2008; Fernando et al., 2009; McKenzie, et al., 2009). Hence, any signs of illness, including ill mental health would have deeply compromised the migration process. Studies demonstrate that most women who migrated to Canada during similar periods as Cecilia's grandmother, used prayer or *"faith-based"* practices to care for their health and wellbeing (James et al., 2012; Schreiber et al., 2000).

Cecilia's grandmother's story, validates how the immigrating to Canada narrative, can commonly be used to express gratitude for the ability of escaping and surviving harsh conditions. To be thankful also means self-sacrifice and strength, which was repeated throughout this study, as the main muscle that maintains family cohesiveness. Cecilia, like most participants in this study, highlights her grandmother's endurance, where the migration survival story is used to putty over the cracks existing in the family unit:

> After hearing her [my grandmother's] experiences [yesterday] and the fact that she came to Canada and she did her best to find a job and take care of her children because I know they were separated at one point. My grandmother was a stay-in nanny and all of her children were at different aunts and uncles' houses [in Guyana]. So her strength to reconnect with all her children and building a bond again, helps. Then the fact that she lost her husband and I feel like her strength definitely comes from her faith-base and connecting with her daughter because she lives just across the street from her daughter for the past few years. I definitely feel like family and her faith are two things that brought her strength up and the perseverance to continue and not give up – working hard and keep on striving, not giving up is something very important for her.

Nowhere in our discussion was it disclosed how Cecilia's grandmother coped during her time as a single woman in Canada away from her family and more importantly how she managed her mental health. She clearly maintained her role as a provider for the family that remained in Guyana, which included her younger children and husband. Strength is used to symbolize her grandmother's healthy mind and body of *"not giving up"*.

Unlocking iron doors

Cecilia explained that her grandmother's migration had some negative impacts on the family, particularly her youngest aunt, who is also considered by members of the family to be *"crazy"*. When I asked Cecilia to describe her aunt's psychological health in more details, she explained that her aunt's imperfect health is triggered by previous events that occurred in Guyana:

> After talking with my mom, I feel like my aunt might have been raped in Guyana because my mom was just saying how in Guyana the house was made of wood and there were barely any locks on the door. My mom just put in perspective that my aunt was living with a whole bunch of guys and my grandfather and my uncle at the time in Guyana would just drink a lot of alcohol and I feel like because my grandmother left for Canada and my aunt's sisters also left for Canada so she was the only one in Guyana still so I'm not sure if she was raped. My mom thinks it possibly might have happened or some other kind of abuse.

According to Caroline Bakker, Marina Elings-Pels and Michele Reis (2009), Caribbean "children who have been left behind by one or both parents are often at risk of abuse, including sexual abuse, and suffer from psychosocial problems" (p. 8). Their study further indicates that "the gender of the migrating parent have different effects on the family and a child's security...[Thus,] When the mother migrates, neglect or abuse whether it is physical, emotional, sexual is more likely to occur" (p.8). Cecilia's grandmother's decision to leave her youngest daughter behind in Guyana during the family's migration process, has had a serious psychological effect where Cecilia notes that "Like in the case of my aunt, there is definitely something wrong 'cause she's just doing her own thing. That's what they say mostly at family occasions that she's just doing her own thing?"

Cecilia's aunt's story further alludes to a family history of incest, an issue shrouded in most Caribbean families, combined with addictions—alcoholism. The impact of incest is studied widely in a North American context and although prevalent in Caribbean communities, research is slowly emerging (Reddock, 2014). It is important to note that although research around incest is limited, the issue within the region is observed differently among Indo and Afro-Caribbean families, though these heinous acts are criminal. Indo-Caribbean scholars, Paula Morgan and Valerie Youssef (2006) investigate how incidents of violence in Indo-Caribbean communities are often told through literary pieces. They explore various venues of violence in their book *Writing Rage*, and argue that the fuelling of violence among Indo-Caribbean people is rooted in the deliberate systematic power play that structured the Indian indentured labour force. Morgan and Valerie explain that "Patterns of wife-beating and violence against the self - suicide and alcoholism – in response to trauma were also directly related to male attempts to reconstruct a threatened patriarchal tradition on alien and alienating Caribbean soil" (p. 136, as cited in Mohammed, 2002, 132). The historical patterns of violent behaviours have not evaporated among this group and there is an unwillingness of family members to marshal tabooed topics such as incest into the open spaces. Morgan and Youssef state "guidance counsellors and social workers proffer numerous stories of father-daughter incest, particularly within impoverished rural Indo-Caribbean communities" (p. 142). Their research also determined that these same practitioners identify a "different dynamic within Afro-Caribbean households, where incest appears to occur most commonly within visiting unions when stepfathers, brothers and 'uncles' target vulnerable young girls for sex within their home" (2006, p. 142). Cecilia's story unpacks the obvious haunting of past events, where painful memories are covered over with more flirtatious settlement stories.

Cecilia's story shows how unresolved historical trauma follows families into the contemporary and to different geographical locations. Her story illustrates how mad family stories invite foggy answers that are thickened by past ordeals, sacrifice, and forced silence, which are all elements that move from one generation to another. Most times, vaulted secrets are not sites that encourage healing and can alienate a person from feeling a sense of belonging, even when Canada agrees to wipe the slate clean:

> …my Guyanese grandmother hasn't returned to Guyana since she's left and I don't think she wants to go back to Guyana to visit. I know we've always wanted to plan a family trip to Guyana because I've never been there but I guess it's the experience that she doesn't want to relive. Once all my aunts from Guyana left, they've never returned. The only people that have returned to Guyana are my dad and my uncle. My dad returned to do some Ministry work and my uncle returned to oversee the house that the family has there. But yea, the women never returned, I guess they have their reasons.

Similar to Cecilia's family, many Guyanese felt that leaving their country of birth was the only way to survive social and economic hardship. The return home erupts painful memories that impede on one's mental wellbeing but can also offer distorted truths to an upcoming generation of their ancestry. Cecilia's story identifies "how migration has been conditioned by political upheavals in Caribbean countries as well as specific migration policies of the receiving countries, [all] dictated by [the] need for labor..." (Kempadoo, 2004; p. 142). The idealistic stories told are flawed and many Caribbean families still continue to feel the effects long after settlement. Cecilia's family stories add dimensions to Sway and Storm's survival migration stories, which are discussed in this chapter.

Coming to terms with the past

In 1970, Guyana's Prime Minister, Forbes Burnham, declared the country as the world's first Cooperate Republic, whereas a developing nation, the primary commitment was to "build a new political path" for Guyanese by Guyanese (Burnham, 1970; p. 2; cited in Walker, 2017). The new

political direction by the self-declared socialist government was meant to instil confidence among the people. Alexis Walker (2017) argues that the major shifts of Guyana's healthcare system between the periods of 1970s and 1980s, as a result of socialist and neoliberal reforms, negatively impacted many Guyanese. As a part of her work, Walker raises questions around how social values were embedded in the technical and political designs of national state policies and programs. Walker’s work is one of the few published studies that illustrate some of the trends of the Guyanese healthcare system during the Burnham era and afterwards. She highlights that even though healthcare was free for all citizens, the limitation of resources and healthcare providers made it difficult to access adequate care. The socialist government at the time, encouraged its people to make sacrifices that theoretically would strengthen the development of a new post-colonial economy and reduce foreign imports into the country. However, the country was further scalded with the introduction of structural adjustment agreements and monetary devaluation introduced by the World Bank in the late 80s, which deepened poverty further (Walker, 2017). Walker’s documentation of this history is important to contextualize Cecilia’s story. Her family’s story is encrusted with rich meanings that is complicated and can provide a footing to how some Canadian-Guyanese families experience health, wellbeing and mental illness.

Guyana’s political and social history is also noteworthy in pointing to some of the push factors that drove families like Cecilia’s to seek economic opportunities outside of Guyana, opting to settle in Canada. Additional studies demonstrate that many Guyanese, particularly Indo-Guyanese, like Cecilia’s family, grew weary of their government and saw the changes as a dictatorship, that polarized the two major racial groups in Guyana – the Afro and Indo-Guyanese (Naidoo, 2003; Thomason, 1993). Most Indo-Guyanese fled the intolerable conditions and claimed refugee status in Canada in the early 80’s (Statistics Canada, 1991; Thomason, 1993; Naidoo,

2003). Though Cecilia's family did not claim refugee status, her family was a part of the wave of Guyanese who immigrated to Canada during the early 80s.

Cecilia may not know all of the small details of her family's experiences before settling in Canada but the history provides a backdrop to why her family members left with little desire to return home. The socio-political details of Guyana's former healthcare also create an opening of some of the prescriptions that were applied to mental healthcare in Guyana and perhaps how these remedies (or lack thereof) travelled to Canada. Cecilia's interview is shaped by both recent and formally told stories. In her retelling of events during the interview, Cecilia seems to re-stitch different meanings of madness, which touches on her Guyanese and Canadian values. Cecilia's story starts with her grandmother who *was previously taken away for medicine*. Cecilia's explanation of *medicine* is framed in a very loose way and due to the intolerable conditions in Guyana, peoples' access to national healthcare is structured very differently, bridging both informal and formal practices of care. Cecilia's narrative also identifies how Guyana's wobbly political system pushed large waves of migration out, disenfranchising many families. The separation of family members during the process of migration, inflicted different kinds of emotional and physical pain, as her aunt's story highlighted.

This chapter outlines how most Caribbean stories are told in splintered ways, leaving important markers out, as exemplified in all four of these participant's stories. The bits and pieces that are told through this study, can help to recreate a more connected story of how ill mental health was regarded pre-independence in Caribbean nations like Guyana, during the process of migration to Canada and finally how second and third generation Canadian-Caribbean people regard their own ill mental health emotions.

CONCLUSION

This chapter examined how Caribbean ideologies of mental health are maintained in Caribbean families through the process of migration. In doing so, this chapter used four participants – Gabrielle, Sway, Storm, and Cecilia – to illustrate the meanings of mental health. These participants stories reveal that mental illness among Canadian-Caribbean women remains hidden or is deliberated brushed aside as these women are taught to use expressions of strength, notions of pushing forward (or the ability to keep going), and other distractions to keep busy to ignore their depressed feelings. I argue that these teachings have been passed down from generations as women's stories of mental illness have been silenced, which Cecilia's story demonstrates. The chapter also highlighted different understandings of mental health based on generational differences, social location, and racial identities. In my findings, I have noted that most families painted their migration experiences as positive; mental health is something that can be maintained, ill health can be conquered, and migration has not affected the family's unspoken forms of communication, which are often viewed as cultural.

Two important findings come out of the participant stories: 1) migration stories are only told as heroic narratives with very little room for the emotional toll that the process had on the individuals who settled in Canada. Since, mental health is not openly discussed in Caribbean families, there are very few ways to determine the psychosocial effects of migration, and; 2) the process of migration resulted in economic stability that left very little room to tackle repressed experiences of how families were left fractured. Instead the push for economic survival in Canada forced many Canadian-Caribbean families to adopt the attitudes to keep going as a mental conditioning that forced them to move past the hurt in order to survive a life both away from former social networks and within a new life in Canada. The embracement of strength not only constructed

the illusion that Caribbean people do not experience ill mental health, but also creates a façade that Caribbean people, and more specifically Caribbean women, have an inherent strength to conquer anything as long as they uphold their religious faith. I argue that the ideology of strength is both a positive (as resilience) and negative trait (not being able to recognize that ill mental health requires professional healthcare). These assumptions are not only misinterpreted by Canadian-Caribbean people but by health professionals as well, as Gabrielle's story demonstrated.

CHAPTER SIX: FINDING THE MISSING LINK

Crack, crack, crack, crack… Is he moving?... 17 little pieces of metal sprayed through the sky. His lifeless, 15-year-old body caught in the crossfire, with 8 bullet wounds stripping his boyish frame. His backyard pushed towards an alleyway that steeped with trouble. Her small whispers echoed through the crisp summer night – 'where? Where is his shoe?' The grim reaper knocked, unannounced – first her husband and now... The circle around her grew thicker and the sirens sang louder. She drew him closer, rocking him to sleep. His warm blood dripped through her arms… The street lights spotlighted his 17-year-old brother, frozen in the middle of the ruthless road - "not him" he muttered... "anyone… but…him…"[17]

MASCULINITY, VIOLENCE, RACIALIZATION AND MENTAL HEALTH

The association of violence with Black and Brown people is well documented. There are vast amounts of literature illustrating the overrepresentation of criminal activity in Black and Brown communities, not to mention the over-characterizing of men from these communities as only violent and underserving to society (Cohen, 2007; Kitossa, 2012; McKenzie, 2009). In fact, 2019 statistics released by the Toronto police demonstrated that the city had experienced almost three hundred and forty shootings for the year, with twenty-eight being fatal. The same source also suggested that the majority of these incidents were gang-related (CityNews, 2019). Such reports beg the question, why are Black and Brown men's bodies seen as only violent?

This chapter specifically brings attention to masculinity and its relationship with violence. I deliberately use the terms Black and Brown to describe Afro- and Indo-Caribbean men's experiences to highlight that there are differences between these marked bodies, which are based on the history of slavery, indentured labour, migration and the formation of diaspora communities. The term Black and Brown are mostly used in a North American context, since Caribbean people are decribed mostly by both their race and ethnicity. Research published in Canada commonly ignores these differences; however, these social/political markers are often highlighted when

[17] The short piece describes a young boy who once knew me.

documenting violence (Henry et al., 2010). Participants in the study identified themselves as of Caribbean descent; at the same time, they also highlighted the importance of their ethnic (Indo-Caribbean or Afro-Caribbean) heritages. The piece that opens this chapter paints a particular characterization of Black and Brown men who are too often over sensationalized in news headlines.

British scholar and advocate for Black community mental healthcare, Frank Keating (2007) argues in his "Better Health Briefing Paper" published in the United Kingdom that "there is little known about the extent to which African and Caribbean men share or subscribe to understanding mental health… More work is needed to explore their views and perspectives on [ill] mental health and how this may affect their willingness to seek help when it is needed" (p. 2). It is worth noting that significant amounts of research have emerged on Black masculinity and Black men's experiences in the Canadian mainstream society since the publication of Keating's work. Yet, there is a deficiency in the research that focuses primarily on the mental health of Indo-Caribbean men and their experiences in the Canadian health care system. Dwaine Plaza (2004) states that the reason for less of a focus on Indo-Caribbean men's experiences in Canada is because "Indo-Caribbean people are often mistakenly classified with East Indians from Sri Lanka, India or Pakistan based on their physical appearance" (p. 242). Plaza further notes that most Indo-Caribbean people do not identify with East Indian groups "because they have a particular 'creolized'[18] culture, one that includes a set of material values and a history that is significantly different from that of the South Asian groups to which they are commonly assumed to belong" (p. 243; cited in Birbalsingh, 1993). This is an important area of focus as Indo-Caribbean men's

[18] As noted above, creolization is the blending of various cultural traditions, religions, languages and way of life. Creolization in the Caribbean context is complex, differs in each country, and is often referred to as fluid and as discontinuous series of reoccurrences (for full discussion see Benitez-Rojo 1998).

experiences with race, violence and its impact on their mental health differ from that of South Asian men[19].

Canadian mental health counsellor, Anjali Upadhya (2011) writes that Indo-Caribbean men reported being "incorrectly categorized as being Muslims and how such labelling influenced their experiences in the workforce, school settings and in police proceedings" (p. 67). Her study on "Indo-Caribbean-Canadian mental health service recipients" found that racial profiling and discrimination placed an emotional toll on Indo-Caribbean men. She argues that Indo-Caribbean men's negative experiences within "particular systems of social control…" further add to negative mental health labelling (p. 67). Research that focuses on mental health, Caribbean men and violence is a significant area of focus because there is a close correlation between the impacts of ill mental health and physical illnesses (Changoor, 2018). I contend that talks about Caribbean men's mental health need to be inserted into everyday conversations among Canadian-Caribbean people, in similar ways that discussions about violence are included.

This chapter details the stories of the following five participants: Rogue, Cyclops, Zordon, Havok, and Gambit to illustrate the connections between violence and mental health. Rouge is the only female participant used in this chapter. Her story helps to build a case that masculine behaviours are further sanctioned by women in Canadian-Caribbean communities. Her reaction towards her brother Havok's emotional health informs the value that is placed on being a man. Both Zordon and Gambit describe what Black masculinity means in the midst of defining madness and wellbeing. These two participants associate ill mental health with weakness and describe how violence in Canada is used as a tool to toughen up young Black men. Zordon's story is different

[19] Although both East Indian and South Asian are meant to share the same meanings, I am using the more politically term South Asian as a part of my own definitions. I am also using the term South Asian to discern my work from Plaza's.

from Gambit's; however, the common thread in their stories regards the way they both see violence as a defining feature in how they came to be "men".

Finally, Cyclops tells the story of how madness is defined through Guyana's history of violence, which is reflected in Caribbean popular culture and the endorsement of a "rum culture". Cyclops's story also highlights the identity of Indian-ness. He argues that madness and Indian-ness are enveloped with addictions, more specifically, alcoholism. Cyclops notes that madness is not a prominent discussion in his family but alcohol is approved by many as a way to process difficulty.

The chapter answers research questions that asked participants to define mental health and well-being; Caribbean notions of mad treatment compared to Canadian ill mental health teachings; and, family stories of ill mental health. The question focusing on family stories is further examined in Chapter Seven with emphasis on the Canadian-Caribbean female experience, as such, in this chapter only the male's perspective is centred. Overall, all five participants illustrate how being racialized men, who are seen as threatening, allows them to feel undeserving for adequate mental health care.

THE UNSPOKEN RULE OF BLACK MASCULINITY

(a) Black masculinity, media and cultural teachings

One of the narratives that I heard from the participants is that for them, manhood is connected to ill mental health or that to become a man requires boys to behave in ways that adults view as exhibiting strength, courage and addressing difficult/challenging situations on your own. As Gambit says:

> Overall, I think that mental illness is not addressed at home. It is not really addressed in social circles with friends either. It's an unspoken rule that you learn how to keep things to yourself and you should handle your own problems in secret. I guess because of that it gets to a point where you're overwhelmed and it becomes an illness. If we start to have discussions about general life, the good and the bad, the challenges we're facing and we're

> open with our feelings, that could be the kind of help to treat mental illness. But that's not really the case. And being men and maybe by extension, Black men, there's an image that you can't be soft and don't discuss your feelings with anyone.

Gambit suggests that it is important for young Black men to open up and share information about themselves with each other, which, in turn, may help to break-down the barriers (of toughness, for example) that men are socialized into. The question is, how can such conversations be introduced? Gambit explains that most men are schooled on how to be men both within the home and by the media; therefore, it is through these avenues that conversations can begin:

> The media paint images [of Black men] as inferior and that leads to behaviours where Black people are underachievers. Doing less, feeds into [North American media] images over and over again. So it's like a self-fulling prophecy. But overall, even this might be unrelated… I feel it is how the media is controlled. It is who sets these images and use it like a way to control people and society. It paints these images that we [as Black men] are the problem in society. Media hides the real or bigger issues of how problems are really caused…

Gambit touches on a crucial point in his discussion with media perceptions. These undesirable messages are internalized by Black men, especially when Gambit says that they start to see themselves as *underachievers*. His story illustrates how media not only constructs a malicious cycle of Black men and their community, but also how comparable destructive behaviours are then reflected from these communities and looped back into the media. Gambit's assessment of the media describes how it is a powerful vehicle for disseminating images and constructing how Canadian-Caribbean men view the world and respond to dominant news images. Media aids in defining the dominant's society values and social norms. These definitions are then ingrained into young men's ideas of how they should see themselves, as Gambit describe in his narratives.

Critical Race Theorists, Frances Henry and Carol Tator (2009) state in their book *The Colour of Democracy* that "Racialized discourses in the media involve repertoires of words, images, texts, explanations and everyday practices; when threaded together, these produce an

understanding and a positioning of people of colour. Negative stereotypes are commonly used to reinforce notions that the 'other' is both different and deviant" (p. 52). Gambit's storytelling of how Black men, like himself, are fashioned through media messages as *problem(s) in society* is significant, since it leaves very little room to critically question how Black men are also "products of depressed socio-economic conditions" (Henry et al., 2010, p. 52).

To combat harmful media narratives, Gambit explains that in his family, members take charge of their own narrative by learning how to "*man up*" through a mental "*toughening up*" process:

> I am the youngest in my family. I have a lot of older brothers... When I was younger, I was teased every time I cried. They [my older brothers] would say things like 'don't cry. Man up!'… The older folks [in my family] like to say stuff that are more along the lines to build up your emotions like 'sticks and stones may break your bones, but words will never hurt you'… It is kind of true within the context of what we see in the media.

He goes further to explain his parents' interpretation of emotional pain:

> … my parents would say if someone has something to say about you or something is wrong emotionally, it's not really a problem. [To my parents] You're not physically hurt so it's not really a problem to be addressed.

Gambit's comparison of physical and emotional strength is in line with Gabrielle, Storm and Sway's narratives, discussed previously in Chapter Five. I stress that Caribbean men and women are socialized differently; therefore, they have distinct social encounters and by extension unique relations to mental illness. I further argue that stories like Gambit's is important to pay attention in order to shift the narrative from how Canadian-Caribbean people should respond to negative media imagery – by "*toughening up*" to instead challenge why these negative images exists in the first place. Yosso et al., (2001) argues in their reflective practice piece "Critical Race Theory in Chicana/O Education" that "within the histories and lives of People of Color, there are numberous unheard counterstories...[which can be] a tool for exposing, analyzing, and challenging the

majoritarian stories of racial privilege" (p.95). I draw on Yosso et al., CRT lens in situating the importance of Gambit's and his family's stories. Gambit's story is useful in highlighting how negative images contrasted by the dominant media can imped on young men in his community's mental health – "The media paint images [of Black men] as inferior and that leads to behaviours where Black people are underachievers. Doing less, feeds into [North American media] images over and over again."

Gambit's stories are articulated in a more collective way, describing that ill mental health is not clear-cut but clouded by a number of adverse conditions that structure the Canadian-Caribbean community:

> I feel like it [mental illness] is secretive because in the community so many people have problems. In a sense discussing your problems brings everyone down. Problems are so prevalent. Like everyone have issues where they feel they're not being treated fairly. Or they're disadvantaged and if it [their problem] keeps coming up, it kinda brings the whole group [community] down. So it is easier to just sweep it [the issue] under the rug.

Gambit hints at some of the structural issues that Canadian-Caribbean people encounter on a daily basis, which make it difficult to build a strong support system. For Gambit, most of his community members are overburdened and are treated unfairly. Consequently, there are no benefits to sharing similar issues with others. His accounts for "*toughening up*" is a deliberate tactic that moulds boys into becoming men. I argue that there are consequences to this *toughening up* process, which can affect one's sanity. Nonetheless, for many Caribbean people they believe that learning to be tough is a vital coping method that helps one to deal with difficulty, build emotional strength and embody resilience. In other words, the "*manning up*" ideology forces young Black boys to become premature adults who need less nurturing, protection, support and comfort (Farley, 2018).

The colonial narrative historically frames Black men as physically strong and emotionally unavailable. These imperial characteristics of Black men are embedded in our contemporary social

structures, law enforcements and cultural norms. Henry and Tator (2010) argue that "Black youth, more than any other group, use sports to mediate their ways through the barriers of school" (p. 48). Rinaldo Walcott (2009) argues that Black manhood is "understood to be underperforming, in need of programs of efficiency… [particularly] because they are assumed to be poor, redundant and 'wasted' masculinities that appear to have nothing to contribute to the global engines of capitalism" (p. 79). Revisiting Henry and Tator, they state that stories where young Black men are taught to *toughen up* as a coping tactic to deflect racial profiling are not just anecdotal, rather vital narratives to include as research data. These stories, Henry and Tator argue, "are evidence of a body of systematic evidence of individual and systemic racism directed against people of colour not just by the police but by all of Canada's social institutions" (p. 121). *Toughening up* becomes a necessary process for Black men interacting with the social world because they always need to be prepared for battle. Gambit's parents are training their young men to be tough, thus emotional problems become insignificant or *not really a problem* (Gambit).

One interesting aspect of Gambit's story is his claim that "it is easier to sweep one's problems under the rug". It is not a simplistic solution because, as discussed in Chapter Five, there are repercussions to simply ignore pressing issues. Still, Gambit's statement is meaningful because he underlines that "sweeping things under the rug" is a common occurrence in his community. It is important to further assert Gambit's claim that most people's problems in his community result from systemic oppression. He declares that in order to address real mental health issues in Canadian-Caribbean communities, there needs to be an acknowledgement that people are "treated unfairly" in various ways and such inequitable practices are embedded in structures like the justice system, the employment sector, education and so forth. Thus, due to the racial inequities, people learn to not burden each other and not share challenges with family or community members.

There is literature that discusses some of the difficulties Black people encounter when opening up about their dilemmas to family and friends within Caribbean communities. This same area of research illustrates that many of these people fear if they do share their hardships, there is a burden on others or the fear of being judged (Berthoud, 1999; Bracken & Thomas, 2001; Treadwell & Braithwaite, 2005). So to compensate for this fear many Caribbean people develop a thick-skinned attitude or a *toughening up* tactic.

HISTORICAL NARRATIVES OF VIOLENCE, SUBSTANCE ABUSE AND MADNESS

(b) *Taking it back ol' skool*

Another narrative that participants shared, as represented by Cyclops' story, highlights how children are indirectly taught to supress their feelings through a history of abuse that is magnified by substance dependency. Cyclops' narrative also illustrates how trauma that is experienced by Indo-Caribbean people, and more so men, lead to intergenerational coping behaviours that were developed to deal with traumatic moments, such as, the historic use of corporal punishment and domestic violence, which are now normalized and passed between generations.

Cyclops identifies as an Indo-Guyanese man, therefore, his narrative draws from and speaks directly to the Indo-Guyanese experience. Cyclops believes that Indo-Guyanese people had historically learned unhealthy coping methods to deal with life stressors. Over time, these methods led to an array of other issues:

> ...so traditionally [during indentureship], people used alcohol as a way to cope. It was a way to express your frustrations, which eventually led to a lot of domestic problems. This caused a series of problems from domestic violence, to excess drinking… the alcohol leads to other bigger issues like homelessness and then you're out on the streets… losing everything – family, friends, money… And I guess that [the excessive drinking] is what people call madness like, especially in Guyana...

Cyclops touches on an important detail when he connects Guyana's history to alcoholism, madness and violence. His reflection on the "idolization of alcohol", is a symptom that stems from larger

political and socio-economic pressures, as Cyclops alluded to. In Chapter Five, in order to contextualize Cecilia's family experiences, I outlined a brief history of Guyana's socio-political landscape and post-independence that influenced some Guyanese to migrate. Guyana's history is also important in examining the country's overuse of alcohol, which is normalized in Guyanese diasporic communities. Foucault (1977) argues that in most societies, a system is designed to separate the "normal and the abnormal" (p. 69). In Guyana's case, the imperial project imposed the apparatus of separating those who are normal from those who are deemed to be abnormal.

In addition to Guyana's more recent history, Bridget Brereton (2010) argues in her article "The historical background to the culture of violence in Trinidad and Tobago" that in the Caribbean there is a historical evolution of a "culture of violence" (p. 5). Brereton focuses on Trinidad and Tobago and documents a timeline of violence with the Europeans' unjust infliction of brutality onto the Amerindian population (the region's first peoples). She also documents subsequent violence up to the mid-twentieth century. She argues that violent practices in Trinidad and Tobago included routine flogging and sexual abuse, which were all "sanctioned by both laws and customs" (p. 5). These inhumane acts fuelled a culture of "black on black violence" (p. 5). The deliberate socialization of violence in colonial Trinidad has brewed an intergenerational cycle of violence that is incorporated into contemporary Caribbean society. Naipaul (1973) argues that the "drama of the plantation whip was transmuted into community and family rituals of punishment" (cited in Brereton, 2010, p. 4). It is the violent experiences of slavery and related trauma (or madness, as Cyclops terms it) that has created a domino effect on other areas of society such as homelessness, substance abuse, domestic violence, unemployment, and high rates of suicide among Guyanese people (Laloë, 2004; Peck, 2011).

The unwarranted use of ruthlessness was not limited to the genocide of Amerindian people or the former enslavement of Africans, rather, these practices spilled over in the management of Indian indentured workers. As mentioned previously, many Indians arrived to the Caribbean during the period of indentureship through forceful tactics that included kidnapping, bribery and or sale into Indian slavery by their fellow Indians (Dabydeen, 1996; Samaroo, 2000; Trotman, 1986). For many, they believed that the Caribbean was going to offer the riches of the promised land, with very little expectations that they would be subjected to a similar threat of violence as their African counterparts. Brereton explains that:

> …a great deal of violence was inflicted on the bodies of the 'bounded Coolies' and the perpetrators were rarely punished, even when death resulted …violence against Indian workers on the estates, sanctioned not by law but by the brutal customs of plantation life and found all over the British Empire where Indentured Indians were employed under White management…The legacy of history and the nature of the colony's society bred a pattern of violence which was both impulsive and implosive for men and women…" (Brereton, 2010, p.6 citing Trotman, 1986).

Like the Africans, many Indians turned their experiences with violence inwards, exemplifying self-harm, overconsumption of alcohol and an uncontrollable rate of domestic violence. For instance, Brereton illustrates that:

> Between 1872 and 1900, there were 87 murders of Indian women, of which 65 were 'wife-murders'. The tragic 'Coolie wife-murders' reflected the skewed sex ratio on the plantations during the period of indentured immigration, the abnormal living conditions in the estate barracks, the disruption of traditional gender relations and patterns of marriage, and the concentration of young single males competing for the small number of Indian girls and women of marriageable age (1986, p. 7).

Brereton illustrates that wife-beating remained the same even after the period of indentureship. The accepted practice was later associated with the plantation's paydays, where men would over indulge in alcohol after work and abuse their wives, which is also informally known as "Saturday night beatings" (p. 11; also cited in Valerie, 2006; Mohammed, 2002). The abuse was assumed to be routine in most Indian households and it was uncommon for anyone to intervene.

Although Brereton's work is positioned in Trinidad and Tobago, there are similarities between the twin islands' and Guyana's histories, where former practices inform how some Indo-Caribbean people interpret and deal with difficulty. Cyclops' connection of alcoholism, domestic violence, and madness to history is compelling. His narrative illustrates that Indo-Caribbean people's experiences with substance and domestic abuse is, in fact, rooted in a complex Caribbean history. For Cyclops these experiences inform madness and how mad people deal or do not deal with ill mental health.

Bring de rum, bring it come…

Cyclops explains that substance dependency and violence is also found in Caribbean public discourses, such as in music. He explains that some music celebrates the attitudes of chronic substance abuse and instructs men on how to engage with both the rum and their wives:

> Even today… Guyana still has this problem [of alcoholism]. It [alcoholism] is in the music and people even sing about it - like 'I'm gonna drink but I'm not gonna beat my wife tonight.' Or 'rum is my lovah.' There are lots of songs, idolizing it [alcoholism].

Darrell Baksh (2014) argues that the generalization of the Indo-Caribbean population as alcoholics "originated out of the colonial conditions where rum was cheap and readily available... particularly because of their proximity to sugarcane plantations, of which rum was a byproduct" (p. 155). Baksh states that alcoholism is a significant problem within Indo-Caribbean communities compared to Afro-Caribbean communities, particularly in Trinidad, where the issue is even more pronounced among Indo-Caribbean men. He argues that the enjoyment of alcohol, especially during festivals like Carnival, "has been romanticized within calypso and to a certain extent but more so within chutney music"[20] (p. 156). For Cyclops, rum drinking, music and partying all go

[20] Baksh (2014) explains that the term "'chutney' originated from the Indian cuisine as the 'spicy mixture of condiments, fresh herbs, raw vegetables, and unripe fruits [prepared in] hundreds of variations and permutations.'" (p. 156). The musical coinage of chutney emerged out of Trinidad to suggest a "similar kind of hybridized, of words,

hand-in-hand and this can have toxic results due to alcohol's addictive nature. Cyclops provides examples of what he means by violence based on his experiences growing up in Guyana:

> There was a street party in Guyana. Like this family was really drunk and then I dunno what happened, but they all started breaking bottles on each other's heads - both men and women. Blood was everywhere and people just stood there and watched. I guess one of the guys walked off and went to the hospital. Or whatever, when he left, that was the end of that and no one seemed to care but the entire event was extremely violent.

He hypothesizes a different outcome if such an event were to occur in Canada:

> Over here [in Canada] people would have already been on their phones, calling the cops. It would have been all over the news… But I also think there is a sense of resilience [in Caribbean communities] because although it [the violent occurrence] happened, people will gossip about it for weeks until eventually the story dies down. We [Guyanese/Caribbean people] kind of use comedy to cope…

In Cyclops's street party story, there is a particular immunity to the intense display of violence. His nonchalant descriptions of the characters of the story presumes that he did not know the family but the event continues to linger with him long after into adulthood. The story is dramatic, layered with uncomfortable traces of humor and make-belief. And yet, there is a declaration of resilience in this messy tragedy. I could only imagine Cyclops as a child standing in the middle of the ruckus. Why was a child privy to such an unwarranted and tragic performance? What psychological implication can such an incident have on a young child's impressionable mind?

Canadian psychoanalytical educator, Lisa Farley (2018) argues in her book *Childhood Beyond Pathology* that there is a certain privilege in rendering the child as innocent and in need of censorship. She says that the universal category of childhood must be challenged to include how "differences in race, culture, history, gender, class, sexuality, and ability [can] impact how children engage with social worlds… In the presumption of a universal child in need of protection, there is a tendency to forget how children arrive to [their experiences] from differing social positions in

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secular and sacred symbols, and folk and popular cultural mythologies gleaned from memories of [India] and adapted to Caribbean context" (Rajan, 2006 cited in Baksh, 2014, p. 156).

relation to innocence, to each other, and to colonial legacies" (citing Gangi, 2014 cited in Farley, 2018, p. 89; Robertson, 1999; Silin, 1995). Farley's descriptions of the non-innocent child references children who were born into the colonial legacy that was structured as violent where the Other (including children) were regarded as savages, property and sinful. This is not to say that Caribbean people do not believe that their children ought to be protected and their innocence preserved; they do. It is to say that innocence is used as an exclusionary tool and is preserved for white children (Farley, 2018), begging the question of what it can mean to secure livable conditions for racialized children excluded from this privileged category? I am using Farley's argument of the non-innocent child to describe a Caribbean context because whitness or "ligher-skinned" is still privileged and protected in the Caribbean. Whitness in the Caribbean takes on a different meaning compared to how it is defined in Canada. Whitness in the Caribbean is defined through the intersectionality of class, which I argue also impacts the construction of the innocent child.

Historically Black and Brown children were not spared from violent acts. It is one of the reasons why young Caribbean men are forced to *toughen up*. Part of the *toughening up* process is a deliberate desensitizing of violence where people learn to gossip and use comedy to manage their stress. In other words, Cyclops's story demonstrates how children are taught to build strength out of troublesome occurrences. Cyclops's narrative provides a different context to Gambit's experiences of Black masculinity, violence and the media. In both scenarios there are components of violence that shape their meaning of manhood; these are overpowered by systems that present limited opportunities for economic success, not to mention the media mirroring what is taking place within these communities. In both cases, the hardening or *toughening up* process includes the use of poems, comedy or storytelling as strategies to cope with issues that press against one's mental health and wellbeing.

THE INTERPRETATIONS OF BLACK MANHOOD AND INTERGENERATIONAL TRAUMA

(c) The violent loop

Another narrative from the participants regards some of the ways that unresolved trauma is passed from one generation to another. Zordon describes his interpretations of manhood based on his childhood teaching, where violence was a learned behaviour:

> My childhood wasn't the greatest. I got the most beatings, left, right and center… I had to take beatings for my brother even though he was older because he would be like if I don't get in trouble for him, he'd beat me up for a week… So I got double the amount of beatings.

Like the participants in Chapter Five, Zordon used his faith in God to protect him from his violent childhood:

> I think what really helped me to be able to stand strong, is my trust in God… for three years my brother wanted to move out from my father's house and I moved with him. But then my brother was like, I'm moving again after I finish school' and I'm like 'well imma move with you.' He refused. He said that I couldn't follow him everywhere. Sometimes you gotta make decisions on your own… Then he gave me this bracelet which stands for 'Pray until something happens.'

Zordon craved for a sense of family to anchor him. He felt that he was deserted and left to fend for himself. The violence resulting from neglect forced him to become a man earlier than he had expected, but it also had repercussions, triggering moments of sadness and unworthiness in him. Zordon explains some of the ways that his brittle family not only pushed him out on his own, but he had to learn to find peace in the process:

> I felt like everybody abandoned me… I was living with my sister, but I felt abandoned cause I felt like my mom had already passed [during child birth] and I have to carry that [knowledge] every year. Knowing that she passed because of me, on my birthday. So it's like a bittersweet day for me every year for the rest of my life… But I have a new perception now but before it was bad. My mindset started to change around 13 to see that my mom is in a better place…

As a result of his feelings of abandonment, Zordon believes that he is incapable of building strong relationships with others:

> But I feel that I can't get too close because people leave me. Like my grandma, who I will always love, is gone. My [acting] mom who was my aunt, is gone. My sister left my dad's house and within 2 months, she's gone. My dad whose been neglecting me from time. I've pushed to build something [a relationship] with him and to be as open as possible with him… but he just kept on neglecting me. He is [now] gone. And then there's my brother, last but not least, who I was close with, just keeps leaving me. I'm just an abandonment…

The guilt of being alive when every other close family has passed on leaves Zordon questioning his own existence. He says:

> Everyone abandons me. So why am I on this earth? Why do I even care? Why should I even care? … But then I have to force myself to believe that my mom saw something in me that I didn't even know. How else do you explain my being here? That's the only reason. Like I can't allow the sacrifice of her life to mean nothing. Just to mean that I die?

Zordon is conflicted in his struggles, and his statement above implies his contemplation of death. He seems to replay the course of everyone's passing with very little resources to help him process the loss of both his immediate and extended family members. He also previously pointed out that his community is laden with their own unhealthy issues that diminishes their collective self-esteem. So where do young Black men turn when they need to unpack their own hurt and trauma? Participants in this study spoke about the importance of depending on family especially during difficult times. What happens to Canadian-Caribbean people who lack family support? Furthermore, there is ample evidence that illustrates how dominant narratives label Black and Brown men as dangerous, scary, inhumane, lacking emotions, substance abusers and so forth. There is little evidence suggesting that the mental health system would not be structured similarly.

The feelings of being alone overwhelms Zordon. It is interesting that he raises similar questions in his discussions around family as he does when he refers to the impacts of the media

on Black identity when he asks *why am I on this earth? Why do I even care?* I argue that the reflection of violence and self-worth are powerful narratives that are passed through generations. For Zordon's entire life, he was taught lessons about how to be tough and keep pushing through. However, in his story, it is difficult to keep pushing through when you feel all alone and the world is weighted so heavily on your shoulders. Studies that focus on Caribbean people and their families living in the diaspora, highlight issues of isolation and loneliness as they relate to migration (Taylor et al., 2014; Wilson, 2005). There are studies that indicate that the family unit is central to Caribbean people's social networks and can operate as assistance locally, nationally and transnationally (Taylor et al., 2014). Robert Taylor, Ivy Forsythe-Brown and Linda Chatters's (2014) study on "Emotional Social Support and Negative Interactions among African American and Black Caribbean extended families", found that among their American participants, Black Caribbean people were dependent on their families regardless of socio-economic status for emotional support. Taylor et al. study also found that Black Caribbean men were more likely to be estranged from their families due to the "cultural expectation of male independence" (p. 156). Their findings are based on their qualativative and quntative study conducted between 2001 and 2003 in the United States, where a total of 6,082 face-to-face interviews were conducted. Taylor's et al., study is significant since they argue that resources that measure emotional support is limited. They argue that there is a need for research that focuses on Caribbean-American men's needs as they compare to Caribbean-American women when offering emotional support. I borrow the ideas from Taylor's et al., study since it demonstrates how Caribbean men are, therefore, forced to process grief, hardship and other forms of difficulty on their own. My data and more specifically, Cyclops' story lends reasons for the high rates of substance dependency in Caribbean communities, especially among men.

Based on Zordon's story, he is surrounded by violence – both within his family and the community. His ideas of manhood rest completely on his socialization with violence. Nombuso Dlamini (2015) illustrates in her article "Youth definitions and strategies of addressing violence in their community" that the "structural problems of the inner city produced a street context in which violence becomes part and parcel of everyday lives… Children grow up witnessing the violence performed by adults on the streets; others experience this violence in the hands of adults in these communities, which in turn creates a sense of hopelessness and diminishes a sense of a meaningful future" (p.6). Farley (2018) argues that Black youth's identity is constructed along a spilt between "danger and deficit" (p. 70). She says that Black youth are often stripped of their childhood innocence at an earlier age and, drawing from Ann Arnett Ferguson, forced into "adultification" (cited in Farley, 2018, p. 70). Farley's argument really sits with Zordon's story where many pieces of his childhood were robbed.

I was curious to know some of the strategies that Zordon felt helped him to cope. He responded that music had become his hideaway place where he can just be himself:

> There's the chaos where everything is falling apart all the time. And then there's the organized chaos when it's falling apart but you're also putting it together to make sense to you. It is a type of creation that is unique to only you. So I think that to me, that's what music is, organized chaos. That's the reason why I feel like I can connect everything back to music. Music paints my life and makes it fun. Like carnival where people are always stressed but once a year, a bunch of people come out on the streets, dancing and having fun just 'free up' and let everything go. They can do and say whatever, right?... It's Caribbean people man.

Zordon's story highlights a number of intense moments. However, one of the significant high points is demonstrating that Canadian-Caribbean people and more specifically, men, carve out a space during carnival season as a way to release their stress. The family is formed on the street; everyone is happy and can find solace in the music itself. I maintain that there are positives and negatives to Zordon's remedy through music, which soothes his ongoing pain of loneliness and

abandoned feelings; however, music and the carnival space are not conducive to a sustainable redressing of painful moments.

In addition to intergenerational patterns of violence, like those experienced by Cyclops and Gambit, Zordon narrates another vehicle that perpetuates this intergenerational violence, which is North American media. Zordon discusses how media images attribute to his own community's lack of self-worth. His accounts are linked to other participants' narratives about the negative portrayal of Black men:

> I feel like, the way how Canadian and the United States' media is set up to look at how Black people are perceived and how they should be treated in society. I think it [media images] really affect a lot of peoples' thoughts and perceptions of themselves, especially young Black youth… Look, if you're told over and over again that you have nothing to offer, you start to see yourself as such [having nothing to offer] … Like there's no way they [young Black youth believe they] can make it… The system has them locked... Or maybe there's not enough opportunities. And if you do get an opportunity its already thrown in your face that you're not good enough. Like you'll fail…

He goes further to say these images provide young impressionable people with no hope for their futures:

> So you start to think that you'll never be good enough and you can't do this or that… When that happens, it's like "shoot why am I here?" … It goes right back to okay, I'll just chill in my neighbourhood[21] or my community… Like you start to believe that your family [or community] is all you got… But you still gotta eat and you still gotta make money so it's like you gotta help your family. And if no one else is looking out for me then my family [or the community] got me and that's how people get into gangs or violence and what not… All they really want are the opportunities to be seen. You know. To just be worth something! To be challenged and appreciated… You [Black men] just want to be able to be yourself. Your best self.

Zordon's rich depiction of how media images are reflected back into his community are valuable because it highlights how such messages are ingrained into young Black men's mental state.

[21] According to United Way (2007) Toronto has a total of 13 priority neighbourhoods, which are basically economically disenfranchised, densely populated places and are known for high crime rates.

Zordon's question of *"Why are we here?"* and the connections he made to one's self-worth is a key point worth noting, particularly in the examination of mental illness and wellbeing. Crichlow (2004) argues that "the depiction of manhood, masculinity, and hyper-masculinity in [American] films have a tremendous impact on how Black men should act, behave and treat women…" (p. 61). He notes that the "media continues to play a role in the formation of Black culture and Black identity" (p. 67) …where evil is equated with Blackness. More specific to mental healthcare, Keating (2007) argues that Black people's experiences in society have a direct impact on their emotional well-being. He says that any harmful experiences, both direct or indirect experiences, can influence how Black people interact with mental health services. For Keating, Black people's "position[s] (historical and contemporary) in society affects how they are treated in mental health services" (p. 6). It is challenging to see mental health services as a place that is of benefit to Black men when the public portrayal of them is as dangerous.

Zordon, points out that destructive markers of Black people are reflective in how young Black men love (or do not love) themselves:

> So when it comes to hearing about mental health, I immediately think of people who live in priority neighbourhoods and who definitely need care. I think of the campaigning that happens at colleges and universities and even sometimes on social media, where people are pushing for [mental health awareness] but the push is literally lacking of self-love. There are so many different areas that we [people of priority neighbourhoods] can be lacking that self-love in and we may not be aware that we are lacking in self-love. It's hard [to love yourself] ... Like I said before, when you're told you can't make it, you start to believe it, right? Until we learn how to be able to love those different areas of ourselves fully and unconditionally, mental health [illness] is always gonna be there.

Zordon's broken record that emerges from numerous sources repeats the presumed unworthiness of Black men. What is perceived as their threatening presence in society suggests that their bodies are collateral in abuse; that they are unworthy of adequate employment; and numerous other issues that continue to cripple Black communities and render them stagnant.

As discussed in Chapter Five, Zordon highlights that postsecondary mental health services administered on most Canadian campuses are completely disconnected from minority populations. Unlike Storm in Chapter Five, who depended on yoga as a stress reliever, those services are not accessible to a young Black man like Zordon, who is deliberately taught how to be tough. Thus, yoga becomes a White over-feminised space, thereby potentially reducing the choices of young men and repositioning the medical model as their only option. Farley (2018) points out that the main problem with the medical model is that it fails to account for "historically produced pain and negate(s) the relational quality of both suffering and healing" (p. 86). Zordon, Gambit and Cyclops in both different and similar ways, describe how their bodies are intertwined with aspects of Caribbean history that continue to inform their experiences in Canada. This knowledge is necessary when building effective mental health services and educational programs that aim at targeting all Canadian youth.

WHAT IT MEANS FOR CARIBBEAN MEN TO ACCESS MENTAL HEALTH CARE

(d) I have 99 problems n' journaling ain't one of them…

Another narrative linked mental health to acts of violence. Havok's story addresses how young men from the Caribbean community process physical acts of violence. Havok explains his moments of darkness after being robbed:

> Like I couldn't deal with certain situations without getting all nerve-wracking or swearing and getting angry. I would lose my shit so I prefer to stay by myself. That's how they [my family] realized I'm not myself because I'm not the type of person to not speak. I always have some dumb story to tell… I always have something to say. I am always usually energetic and I'm always doing something… So then all of a sudden I was in my room 24/7, everyone noticed. They [my family] then eventually realize this guy [me] is going through shit. And then eventually one day before my exam I told my older sister that my chest was killing me. Like I couldn't take it anymore and then I broke down. I couldn't go through my routine and try and make myself get better anymore...

Havok struggled to make sense of his feelings that seemed extremely unfamiliar to him and were impacting his normal routine:

> Recently, I had my sociology midterm and I was going through some stuff and my sister went upstairs and told everyone I was having an anxiety attack and I was trying to explain to my dad and my mom but they weren't getting it so I lost my shit and went back downstairs to my room. My sister came after me and after talking for a bit that kind of cheered me up. I still bombed the exam the next day.

Havok said he attempted to access mental health services offered both at the high school level and when he started university. He found the process somewhat helpful because he had someone who understood how his experiences were being interpreted both internally and externally among family members:

> I think for any Caribbean person I'm gonna assume that when they first accept that this person's mad, it's like we're judging you now this is how you're gonna be, you're judged and like you seem weak kind of thing… I don't mean to go off on topic but when I figured out I had anxiety and I realized like my teachers knew and everyone kind of knew and I spoke to one of my mentors and she's like, how does your parents think about doing therapy to help you get through it? She was like, I know you're from Guyana and she's from Barbados and it was like she became my family. She confessed that her family had the same issue [with not accepting ill mental health] where they were so sceptical about it and thinking "Are you insane?" Why do you need therapy? And it goes on to thinking of therapy in a bad light. Like I didn't need to tell her how I felt my family saw me as being weak and in a way it's hard for people with like very minimalistic issues [ill mental health] to be treated which can escalate and turn into something more serious.

It was after seeing his Canadian-Caribbean school mentor that he started to contemplate therapy to help with his anxious feelings:

> When I first found out about my panics and started to think about therapy, I was scared. I was really scared to talk to anyone about it. Even in my family group chat, I mentioned it, and everyone just reacted like 'therapy? Are you serious? Are you a fucking dumbass? Why do you need therapy?' It's like unless you're in that state of mind, I don't think people can understand and unless you're ready, it's not gonna work…

When Havok finally decided to give clinical therapy a try, he said he found the process useless:

> So at the moment I didn't want to go to therapy but then I went and she gave me this diary thing. I thought that it was complete bullshit so I threw it. Sitting and talking to her, yeah it was nice but I didn't feel like I got the help I needed. She was just there for me to speak to but she didn't help me… I didn't receive any kind of help and to this day I feel like, with what I had to go through with anxiety, I feel like I'm the worse enemy to myself… When I think of anxiety, I think of anyone who has anxiety, you're your own enemy. Cause you're the one that can control it and you're the one that can deal with it… I don't know if it's

> because I had a bad experience in therapy but that's how I think of it. You're the only one that can help yourself. That's what I've been doing [helping my self]. But sometimes I can't help it. When I have an exam, my entire body starts tingling and I lose feelings in my arms and my heart starts beating really fast and I get really hot and my face turns red and then I'm short of breath. Like I can't breathe at all….

His own reactions to stressful situations make him react in aggressive ways:

> Like I cannot deal with certain situations without getting all nerve-wracking or swearing or getting angry and losing my shit or I'd stay by myself.

Havok's story demonstrates an internal struggle whereby he is aware that there is an issue but does not know how to resolve it, even in times when he feels physical pain. He tried to go against the absolute reliance on his family's support in hopes that professional support will help him to process his experiences with anxiety. In Havok's opinion his family offered very little support after his robbery, which triggered a series of other experiences such as the absence from school, his feelings of anxiety and excessive aggressive behaviors.

His older sister Rouge, offers another opinion, which is that he simple needed family to help him through his emotional turmoil:

> So when my brother got robbed, he was sad for a while and then eventually everybody started getting mad at him because he wasn't getting over it and that was a month and he was supposed to be over it in a month…. See the thing is, my brother stopped going to school, he was sleeping all the time, he was just depressed and you could see it on his face and it got to a period of time where a month passed. It was well into, so it happened in December and we were well into March and he was still depressed… I guess it was frustrating for everyone else because not only did we think that he was supposed to bounce back because again, he's a man. He's supposed to man up! You know what I mean?...

Rouge continues to explain that her brother's neglect for school worried family members:

> Then he was neglecting school and all this stuff so we were on him like 'you gotta go to university, you gotta do this, you gotta do that.'… So we expecting him to recover faster than he was. That thing [the robbery] obviously affected him because he thought that no one understood what he went through or understood how he was feeling…. When he got robbed, he lost his jacket and I was like you know what, I could buy you a jacket… I could get you a new one. I'll take you shopping. It doesn't matter how much it costs I could get you a new one… Eventually he agreed, maybe to get me off his back. We went and we got

> a jacket but it didn't help… Such a depress situation with him to even buy the jacket too, 'not this one. not that one, this one's too expensive.' It was horrible.

My discussion with Rouge had me in emotional knots. In some ways, I completely understood what Rouge meant by wanting her brother to move forward and return to his regular routine. Rouge's reaction towards Havok, was not an attempt to brush aside his tragic experiences instead she wanted him to *toughen up* and be a man. That is, a horrible thing happened, sure. Now what? The absence of his jacket was a physical reminder that Havok was robbed one evening on his way home from school. For Rouge, replacing the lost jacket would give her brother something new to focus his attention towards. It was her way of making his tragic situation better, a similar approach that Gabrielle's father took that was exemplified in Chapter Five. Rouge was not expecting her brother to contemplate accessing therapy as a way to support in his recovery.

The introduction of regular therapeutic treatments was a visible indication that Havok's depressed emotions cannot simply be replaced with a new jacket. Rouge shares her view about therapy in regards to her younger brother:

> I mean because I never really looked at therapy for my brother as an option, maybe it could have helped him. My parents didn't see it as helpful. Isn't that what they are trained to believe. Because they [my parents] see it as just talking to a random stranger… The therapist would rather my mom used medication on him. How is that helpful? My mom just thinks it something you can heal yourself, that kind of thing... Physically he was okay. Why would he need medication? …And why would he need someone to talk to? He [my brother] could just talk to me or someone in the house.... I definitely don't believe in medication for my brother but talking to someone probably, not really. Me personally I wouldn't do that [seek therapy] because, I don't know I just don't see it as something that would be helpful. Maybe because I'm seeing it from my end. Whatever, if he chooses to go, I still don't see it as helpful.

Rouge holds strong opinions regarding therapy. On one hand she is trying to be supportive for her brother that he might find some healing within a therapeutic space. On the other hand, she does not see the validity in addressing one's personal problems with a complete stranger. The family is where secrets are held and she would rather cover her brother's depressive feelings with a new

jacket. For Rouge, the jacket symbolizes the loss and erupted a slew of unexpected events regarding her brother. She believes that replacing the material item of the jacket, it will replace his happiness.

Rouge raises some interesting points in her story when she wants her bother to ‘man up’. The violent occurrence that resulted in the loss of her brother’s jacket seems to have been normalized as everyday incidents in her community. Perhaps she thought Havok should have been more grateful that it was only his jacket that was lost and not his life. Canadian Black scholar, Ingrid Waldron (2003), draws specific focus on how mental illness is interpreted in Black Canadian and Indigenous communities. Her work gathered data from six African and Caribbean-Canadian women – four women identified as health providers and two spoke about their emotional and mental health concerns. Her research study drew on a critical integrative framework to help analysis how African-Canadian and Caribbean women engage in help-seeking behaviours, and/or enter into psychiatric counselling. In her qualitative study, she found that African and Caribbean women “are least likely to attend psychotherapy and psychiatric counselling, mainly because of the shame and stigma that is often associated with these approaches” (p. 51).

In her research, Waldron found that African and Caribbean women living in Toronto, are most likely to speak with their bodies than their emotions and “often visit their family doctor to treat physical ailments, [attempting to] camouflage their emotional problems...with complaints of 'my back hurt me', 'my belly hurt me', 'my head hurt me'” (2003, p. 51). Physical pain is more credible to identify and seek treatment for, than emotional distress. The cultural meanings of emotional pain forces people to pretend that everything is manageable until the physical pain starts to interfere with these women’s livelihood (Waldron, 2003). Thus, culture shapes Caribbean

people's experience to pain and illness, and it also shapes how they express their feelings and their understandings about these ideas (Jackson et al, 2012).

Waldron's research helps us to understand the experiences between Havok and Rouge and their interpretation of therapeutic spaces. Waldron's critical integrative approach to examining how "social categories like race, gender, culture, age, socioeconomic status and educational level influence beliefs around 'mental illness' and help-seeking" (p. 50) is useful in analysing how African-Canadian and Caribbean women engage in help-seeking behaviours, and/or what deters them from entering into psychiatric counselling. For most women in Waldron's study, the stigma and shame of mental illness limited their access to any sort of mental health care, similar to what my participant Rouge is attempting to explain. I argue that mental health literacy need to incorporate these various interpretations of how Canadian-Caribbean people understand mental health care. The open discussion is what creates a safe space where mental health and wellbeing are not treated as separate divisions that interact occasionally instead of having a cause and effect on one another.

CONCLUSION

In this chapter I have highlighted four themes that male participants narrated as contributing to madness or mental illness. The first is the socialization to "*man up*". *Manning up* results in young men learning to hide the difficulties they encounter in everyday life such as racism. Participants narrated how the meaning of "*manning up*" and its experiences can lead to ill mental health. Second, participants told stories of growing up witnessing or going through different abuses within their families and community, including being beaten up. These stories of abuse were said to be located in the history of their families and were magnified by substance dependency. Third, and related to the latter, participants discussed ways that (unresolved) trauma and violence are passed

on from one generation to another. And finally, participants' stories demonstrated how mental health can result from acts of violence such as being robbed, as was the case with Havok. Even in moments of mental distress, Canadian-Caribbean men are forced by family members to "man up" and move forward.

CHAPTER SEVEN: TURNING MADNESS INSIDE OUT

I had a plan. A well-crafted plan. Thursday, after lunch. I'll go to the mall with the usuals. We will complain about the fluffy issues in life, and laugh over our McD's. Then I will take a nap in law class.

Why is that man so loud and obnoxious? Is it necessary for him to complain about the waste of city's resources right next to me? And those sirens- my goodness, it's piercing. I can't think about that right now. I have to focus on my conversation with God. I couldn't wait to ask the fat bastard for a refund on this life. Yep, that's right! Mr. God, you cheated. I want a new life.

Wait! What's with all the pushing and tugging!! I am trying to sleep here. Is that Mr. Chan quarrelling with his girlfriend on the phone?

I can hear another friendly voice interrupting his call – "The person is 15 and we need to contact the parents…"

I'm so confused right now. You need identification for Heaven? They allow phones here too? Oh man, no wonder God couldn't hear my prayers before. I should have started with "dear God, Mr. & Mrs's child here. I'm having a rough time and I would like to cash in on one of my miracle cards, please."

Do you know where you are?" "Is this not heaven?" I said. "I'm waiting to see God. How long is the wait?"

"Well my child, you might have to pin that plan for now. Do you know your home phone number? You are a minor and we need to contact your parents. We need to have your tummy pumped. It's been 6 hours and we are having trouble getting a hold of someone."

Ha! Good luck with that one! My bet is no one will show… After 72 hours, someone did show. They didn't look for me or ask any questions. The person snuck in and signed over their parental rights. Madness is contagious. Handing me over to the state would protect me from being infectous. Yay!! Give me to the state, let them figure it all out.

The state was real nice. There was a warm shelter bed to sleep in. Hey, don't judge. It beats my previous sleeping quarters - subway trains, the condo lobby, my front porch. If you think winter is rough, try the streets in the middle of November, AT NIGHT!

It has only been a few weeks since my stomach has been pumped and my living nightmare seemed to have gotten worse. I was shuffled from doctor-to-doctor, who were all trying to 'fix me.' "Teenagers do not have real problems", they all said. Maybe I was a young addict - what else could explain the cocktail of prescription pills with vodka? Or was it biological? "A chemical imbalance. After all, he has a history of ill mental health in the family", one doctor concluded. Maybe I was just looking for the attention…

The instability of having no home while they all figure out my real problems, was purposeful. It was meant to teach me the harshness of the world. Apparently, learning to practice the art of gratitude will somehow save me from my own self-destruction…

"Tell me why did you do it?" "It's simple", I answered, "I was told - I'm worthless. I was called a dirty whore repeatedly. I was made to feel useless. No matter what I did, nothing was perfect." Within that moment, I was flooded with all the incidents when I did ask for help and received only stupid clichés. The clichés were consuming and destructive: talk about your problems- with whom? The family I didn't have? They all left when she got sick. The friends? How were we supposed to relate? Sleeping on the streets has never been

'cool teenager' chatter. My teachers? I was too busy keeping up with appearances. I needed to be the perfect student. The self-talk wasn't helpful either: 'what doesn't kill you, makes you stronger'. Eh, so strong my pretty cocktail failed! 'Have faith in the Lord, he will prevail'. And my all time favourite, 'we all have our own burdens to bear'- stealing food from grocery stores, was mine.

I was brought back to the room with dim lighting and the person with a notepad asked "what do you want to do with your life?" "Well Doc, I wanted to die but that didn't exactly workout, did it? Do you have any suggestions?" (Dust, 2017).

This chapter shares the insight of three participants whose stories are about living with ill mental health and/or growing up with relatives who experience mental health issues. Dust, the participant whose experiences are described in the recreated story that opens this chapter, focused on his suicide experience to the extent that all the responses to my questions centred around this single episode. The second participant, Surge, also attempted suicide as a teenager. Her story informs us of family barriers and supports to mental health. The third participant Phoenix, expresses growing up with a relative who suffers from mental health issues and the various ways that Caribbean culture shapes treatment.

DUST: WHAT IT MEANS TO BE MAD

(a) I am the walking definition of madness

I have crafted and reframed the bits and pieces of the narrative into a story with no further embellishments. This reframing illustrates how different forms of storytelling can not only be powerfully captivating but can also draw different types of audiences to an important and necessary discussion. Dust's experiences provide answers to two of my research questions: 1) do you remember the first told stories you heard of madness? And; 2) what does it mean to say someone is mad?

Dust narrated his suicide attempt as his first story of suicide. In other words, he did not hear this story; rather, he experienced it as those around him spoke about his suicide attempt as "madness". His only supporting parent signed over parental rights and asked the state to take over

this “mad someone”, Dust himself. On the surface, the story constructs a projection of Dust’s inner thoughts as he lives through a dramatic attempt of suicide; as well, it shows that ill mental health does not occur in seclusion but includes social services, family, education and other social structures. So much so, that when an individual comes to the point of accepting suicide, it is usually at a culminating point — the end of a road that holds a multiplicity of factors leading to suicide.

Dust’s story also shows the ways that external circumstances first affect the individual, leading to emotional distress and/or feeling a lack of control over one’s own thoughts and behaviours (Lee, 2013; Voronka, 2013). One such external factor is family relationships. Dust identifies that the denial of his ethnic background, religion and family structure are equally significant pieces in the story of his own mental health:

> ‘Tell me why did you do it?’ ‘It’s simple’, I answered, ‘I was told - I’m worthless. I was called a dirty whore repeatedly. I was made to feel useless. No matter what I did, nothing was perfect.’ Within that moment, I was flooded with all the incidents when I did ask for help and received only stupid clichés. The clichés were consuming and destructive: talk about your problems- with whom? The family I didn’t have? They all left when she got sick. The friends? How were we supposed to relate? Sleeping on the streets has never been ‘cool teenager’ chatter. My teachers? I was too busy keeping up with appearances. I needed to be the perfect student. The self-talk wasn’t helpful either: ‘what doesn’t kill you, makes you stronger’. Eh, so strong my pretty cocktail failed! ‘Have faith in the Lord, he will prevail’. And my all time favourite, ‘we all have our own burdens to bear’- stealing food from grocery stores, was mine.

Within this story, Dust describes the instability of the home that opened room for abuse of all sorts, feelings of isolation, not to mention the lack of day-to-day basic resources, such as food. The focus on the home environment illustrates that the family structure is another imperative influence on an individual’s mental health. The story hints to a history of madness, where the only parent in the home is living with mad behaviours that disrupts Dust’s wellbeing. The story speaks to the importance of larger social networks that are stronger if someone is diagnosed with a physical illness (such as the awareness of physical disability in schools) but maybe absent in the presence

if detected with a mental illness. The lack of social support is further exemplified for various reasons among other participants used in this chapter together.

After Dust's suicide attempt, he was forced into the state's care, where he described *The state* [as being] *real nice*, justifying the new reality. Dust is aware that being a child of the state is not an alternative that anyone aspires to for themselves. A young person in the custody of the state, either as a foster child or Crown Ward[22], exacerbates other issues, altering life at home, school, and family relations, which the story hints to but does not tackle fully, allowing the reader to form their own conclusions. He says:

> The state was real nice. There was a warm shelter bed to sleep in. Hey, don't judge. It beats my previous sleeping quarters - subway trains, the condo lobby, my front porch. If you think winter is rough, try the streets in the middle of November, AT NIGHT!

Even in the moments of therapy, there is no inference that any of the many doctors sift through the impacts of precarious living and how these events may have moulded Dust's outlook on life.

Dust's narrative indicates that he earned a Bachelor's in Sociology and Mass Communications and that this happened despite numerously hearing that it was only a matter of time before he would become a statistic to crime, or vagrancy, or trafficking, a liability that would overburden the state's welfare system, or a victim to drugs. The labels were endless. The circumstances of earning a post-secondary degree came with various challenges, including blatant attempts of being pushed out of the academy. A person who wears the title of 'former Crown Ward' and is also marked as racialized, does not present the confidence that they can become productive contributors to the economic labour force:

> I was shuffled from doctor-to-doctor, who were all trying to 'fix me.' 'Teenagers do not have real problems', they all said. Maybe I was a young addict - what else could explain

[22] A young person who is forced to leave their family's home for varying reasons and is under the age of fifteen, can be considered for foster care. A person who is termed a Crown Ward, would be considered to be owned by the state until the age of maturity (the age of eighteen), and would be entitled for student government assistance, if still attending high school (Ontario Association of Children's Aid Societies, 2008; Tweedle, 2005).

> the cocktail of prescription pills with vodka? Or was it biological? 'A chemical imbalance. After all, he has a history of ill mental health in the family', one doctor concluded. Maybe I was just looking for the attention…

Research illustrates that racialized post-secondary students have compounded pressures compared to their Canadian counterparts, as they are not only negotiating their new academic spaces, but they also navigate persuasive structures of racism, plus other invisible barriers such finances that limit their academic attainment overall (Dei, 2005; Gordon et al., 2012; Hernandez-Ramdwar, 2009; James, 2010).

Important to also unpack in Dust's story is the ambulance ride to the hospital, which shows flaws within the Canadian mental health system. The story reveals the emergency medical service (EMS) provider complaining about the *waste of city resources* to save a life that desperately wants to end. The first responder's resentment towards the young person supports the popular narratives that prioritize physical illness over mental illness (Jorm, 2012; Poole and Ward, 2013). The EMS provider struck a chord that hammers home how the stigma of mental illness is cultivated, even within the space of medical practices. That is, there is a language that wrestles with the importance of one's life over resources that are reserved for treating people who suffer from terminal physical illness and very little attention is awarded to more invisible conditions (Jorm, 2012), such as the attempt of taking one's life.

Furthermore, Dust's story shows how medical professionals are often at a loss of diagnosis and look for remedies from the very person they are supposed to 'treat'. The doctor asks, *what do you want to do with your life?* While this is a common question, under the circumstances, it can be interpreted to assign blame on Dust, and to neglect external circumstances that might have led to a suicide attempt. The question suggests a lack of purpose and discards what it means for a young person to be forced to settle into temporary states of living. Stephen Gaetz (2004), a leading

scholar and advocate for Canadian homeless youth, argues that young people, who are homeless, experience much higher levels of criminal victimization. He says, "when homeless youth are discussed during public debates on crime, it is usually with reference to their role as perpetrators", which is a perspective "rooted in popular and enduring notions of delinquent street urchins, typically characterizes homeless youth as kids who are 'bad' or 'deviant' or 'misguided' and who leave home for fairly insignificant reasons" (Gaetz, 2004, p.424). In Dust's story, other assumptions that he is deviant or lacks purpose are evident from statements such as "*Teenagers do not have real problems" … Maybe I was just looking for attention*. Thus, as discussed in Chapter Five, young people are assumed to have *fluffy issues* and to have no real concept of life and what they want in it.

SURGE: SUICIDE ATTEMPTS ARE ALL A PART OF THE GROWING PAINS

(b) Hush now, It's time to go to bed, for more grime rest in the days ahead…

In addition to Dust, Surge's and Phoenix's narratives addressed the research questions: 1) Were there specific mad stories told in your family? 2) How might stories of madness differ in a Caribbean space compared to a Canadian space?

Similar to Dust, when Surge was asked how the idea of "mad" was considered in her family, she accounted her personal teenage memories of attempting to take her own life. Surge is of Caribbean and African heritage[23] and has a comparatively stronger relationship with her African community. Her parents separated when she was a child, causing a gap in her Caribbean cultural references. Surge made parallels between the two cultures, because, at the time of the interview, she was at the stage of rebuilding an adult relationship with her once estranged father and step-sister. When Surge was asked to provide her interpretations of madness, her response was:

[23] For ethical reasons, some of the specific details to her heritage are omitted because these details are considered to be a 'tell-tale' – it would be easy to identify the participant if they were offered.

> At one point I actually tried to commit suicide, I think I was 14 or 15. I remember we were going to the tailor's and I had taken 30, either Tylenol or Advil pills and we went to the tailor and I told my mom because by the time we got there I started to feel like I was gonna faint. So I told her, what was happening and this is what I did. Her reaction was "oh my gosh you need to drink milk to coat your stomach and we're gonna go straight home." ... And I remember barfing in my entire room from my bed. I was on my bed barfing, on the side of the bed, barfing all the way to the bathroom, so the entire room was covered with barf, all the way into the bathroom… But for some reason, the whole night I was by myself, no one was there. I don't remember her [my mom] checking up on me, I think maybe once but then she went to sleep and that was that.

Similar to other participants in Chapter Five and Six, strength and sadness were primary markers that guided how Surge should handle her depressive episodes. Additionally, strength and sadness contributed to the attempt to take her life; as well, strength and isolation made it easy to brush away the incident altogether:

> So, the next morning, I remembered my stepdad came into my room, I guess, to clean the carpet and clean up the floor and that was it. There was no kind of "like okay clearly there is something serious going on, let's talk about this, what can we do to help?" So I kinda just realized well shit, I have to deal with it myself and I didn't die for a reason so maybe I should keep going and see what happens. So I guess, I kind of just grew out of it and learned okay it didn't work so let's just continue going on….

Surge explained why her mom felt it was important to test her daughter's strength in this vulnerable situation:

> Eventually, my mom told me why she reacted the way she did. My mom didn't want to take me to the hospital because if she took me to the hospital they would have formed me[24] and I would have had to be in the psych unit and she didn't want that because it would have been traumatic for me. So I get where she was coming from in that sense…. But now given my life and work experiences, if I had continued to be suicidal that would have been the most crucial time to get the kind of support I needed to help me. So I can look at it from a positive but also a negative lens, she [my mom] didn't get me the support I needed and I could have benefitted from.

[24] "being formed" is clinical term that is casually used among both social workers and mental health practitioners to describe being processed for temporary hospitalization. Temporary hospitalization or suicide watch lasts for a period of 24-48 hours.

Surge's story overlaps with language that participants Sway, Storm, Cecilia, and Gabrielle (discussed in Chapter Five) used to define tough moments in their lives, emphasizing what it means to "*keep going*." As previously mentioned, to "*keep going*" is useful in mustering the strength to cope with difficult times. To start, Surge's story highlights how deeply ingrained the notion to "*keep going*" is when she says: *"well shit, I have to deal with it by myself and I didn't die for a reason so maybe I should keep going and see what happens."* Is the old saying "what doesn't kill you, makes you stronger" really an emotional coping tool? Or does the literal meaning to "keep going" simply cover up unresolved emotional debris, which later compromises young racialized women's physical health? (Beauboeuf-Lafontant, 2003; Collins, 2000; hooks, 2005).

Second, Surge's explanation that she probably just *"grew out of it [suicide]"* is another example of how strength (or even resilience) is subtly reiterated in families like hers. Her explanation also leads to the question, is the experience of madness really just an idea that can be altered over time as one matures into adulthood? Nyasha Grayman-Simpson, Jacqueline Mattis and Nenelwa Tomi (2017) argue that Africana[25] women hold strength in various ways. They say that Africana strength is a repetition of performance where self-silencing and stoicism is crucial for warding off "opportunistic attacks" (p. 17). Meaning, racialized bodies are more vulnerable to physical and emotional assaults or what they term as "opportunistic attacks", which includes constructed stereotypes of racialized people.

Third, Surge's story presents a dilemma about "the system" and its relation to parental skills of the racialized. For instance, despite her mother's explanation, it is still not clear from Surge, why her mother did not take her to the hospital after learning about her overdose. It is possible that by refusing to take her to the hospital, her mother was attempting to protect her from

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[25] Authors Grayman-Simpson et al., (2017) use the term Africana to describe common experiences among both African women and those who are a part of African diasporic communities, which include Afro-Caribbean women.

facing the intrusiveness of what she understood about the medical system: *"she didn't want that for me because [she thought] it would have been traumatic…"* It is also possible that this was a basic survival strategy to protect from being reckoned as a "bad mother" (Calliste, 2001; Collins, 2000; Grayman-Simpson et al., 2017). Thus, by not taking Surge to the hospital, she was preventing mental health professionals from poking holes at her parenting abilities as a single parent. It also spared her inquisitive gossip among extended family. As Surge states:

> Culturally, if you have mental health issues it means you're weak. There must be something wrong with you, you don't have coping mechanisms, people will judge you. They'll think your parents didn't do a good job raising you and that's why you're like this. They'll blame everybody else and not try to look at what the root causes might be.

If Surge's mother was surrounded by a consistent dialogue that reiterated mental health was weak and the blame was directed to the family, why would Surge's mother assume the public hospitals to be any different? I was also particularly curious to know how Surge's mother "guessed" that her daughter would have pulled through the night without going to a hospital. Did Surge's brief brush with attempted suicide mirror her mother's own personal battles with ill mental health?

Both Surge and Dust seem to carry "invisible knapsacks" filled with their mad experiences everywhere they went, either tucked away or as badges of honor. When I asked Surge how she felt at the time of her 14 or 15-year-old incident, her response was:

> I think that, when I reflect it's hard to think about the fact that I felt alone but it's also good to talk about it like especially now and the work that I'm doing, I can understand where these kids [who I work with] are coming from and understand that maybe for an adult, they might think "oh you're just a kid, why are you feeling suicidal about this small, little, insignificant thing?" But I remembered being at that point and remembering exactly what pushed me to that point and although it might have seen insignificant to them [the adults], it was my entire world. So when you're talking about mental health and you're trying to help people who are experiencing that, you need to try and take yourself out of your body and try to understand how they might be feeling… So I think that's why it's important to talk about it for me to reflect back and remember how I felt at that point because it makes me think "okay I shouldn't minimize if someone is talking to me about this because I remember feeling just the same way."

In Dust's and Surge's stories the message was clear: a mad person's experiences are often gagged and dismissed. Even in Surge's present reflections of the past, she is still wondering how her experiences would have been shaped differently if her mother took her to the hospital. Surge's mother might have saved her from having a trip to the "psych unit" but she also robbed her of the opportunity that she *"needed and could have benefitted from."* I would suggest that although Surge's mom may have been familiar with the process of psychiatric care, she perhaps did not want the overnighting in the hospital to follow her daughter into adulthood. That is, for many racialized people living in Canada, it is difficult to believe that the process of care is free of systematic discrimination, especially when their bodies are positioned in fields of discrimination in varying daily experiences.

Fanon (1967) writes in his book *Black Skin, White Masks*, that the relationship that "Negro" families have with the practice of healthcare is directly aligned with how colonized subjects are viewed in relations to the European state. He argues that "In Europe the family represents in effect a certain fashion in which the world presents itself to the child. There are close connections between the structure of the family and the structure of the nation" (p. 142). That is, "As the child emerges from the shadow of his parents, he finds himself once more among the same laws, the same principles and the same values. A normal child that grows up in a normal family will be a normal man" (Fanon, 1967, p. 142). Fanon also makes a comparison, "For the Negro family in France, which is in his country, is made inferior… [thus, limiting] the connection with the European nation [and] has therefore to choose between the family and the state" (p. 143). As postcolonial subjects, the mental healthcare system for instance, was not historically designed to treat racialized bodies, but rather to discipline the madman (Fernando, 2002; Foucault, 1977).

Fourth, Surge's story informs us about the complexity of mental health treatment for the racialized. Now as an adult and practising professional, Surge narrates a story of how some parents seek mental health treatment elsewhere:

> In African culture, there's a big push for, you'll talk to the leaders of the mosque and that's enough. You'll pray and that's enough, you'll be okay… Even a case where I just went to the hospital with a client and the mother didn't seek any medical supports for the child who wanted to cut up her whole family. The child was hearing voices that told her to cut up her whole family into 64 pieces, she was losing control of her body and even though she wanted to put the knife down she physically couldn't because she felt like she was being controlled and the mother's response was to pray for the devil to get out of her body. Which I understand, that's what they feel would work but they were afraid of seeking that medical support.

Surge tangos between her own cultural background of madness and her professional training:

> People are very afraid of seeking medical mental support. When you say hospital they fucking jump, like "no, no, no, we can't go there. We're not crazy like that we don't need to go there." But what they're not realizing is they can get the right support they need there. Not always, sometimes it's not helpful but sometimes it could be helpful and I mean if you're experiencing severe thoughts like that I would think that you would at least try to exhaust all your options and see what will work best…

Surge admits that medical care for ill mental health may not be for everyone but it is a necessary option that should not be taken lightly:

> It's not for everybody but at least you know that you tried to connect to that support and if it didn't work then you move on to the next one until you find what works for you. But you can't just rule it out like "no, no, no, that won't work" without even trying it…. But that's the root of the problem right? "Nope counselling won't work, I won't talk to a stranger, no it will never work." … But when people actually have the courage to do it, a lot of them actually find it helpful because it's a third person, completely unbiased person to the situation so they could give you a perspective on all sides. So it's all about just trying to give it a try… And having people that will fight for you and say yes we need to get the support because if you're a younger person and you feel you need that support and you can't push on your own, it's really helpful to have someone that can help push with you. Someone that the parents would maybe trust more or respect more. Sometimes they can't do it on their own, but if their parents say no then that's it…

In some ways, her analysis of how groups of people view medical/hospital or professional mental health treatment are shaped by how they were viewed in their own homes. She notes her own mother's difficulty with how she managed aspects of her life:

> When I was younger, I didn't know why my mom would react the way she did. Like why she would swear and say really degrading things like 'I should have aborted you, this is what happens when you have unprotected sex, go live with your coolie father.' … Like all those things she would say, 'you're a bitch, you're a slut,' and things like that growing up. I didn't really know what was wrong. I didn't know what was contributing to her behaviour… Like I knew she had past trauma of being abused by partners and my grandfather because he was an alcoholic. My grandfather was verbally abusive, especially when he drank and his behaviour could be one of the reasons my mom behaves the way she does as an adult. I just thought oh okay that's just how she is, we have to learn how to deal with her and it has to be us changing our behaviour around her.

Surge acknowledges that as an adult, she views her mother differently now, compared to when she was just a child:

> Now as I'm getting older I realize that yes there's a reason for her behaviours and she has experienced a lot of trauma and I am not downplaying that but I feel like there's a point where you are an adult and you know what needs to change, it should be up to you to try and seek the support and if you're scared to seek it then people can be there to help you… But you gotta take that first initial step to know that, okay, I am suffering from something and I need that support. But again it goes back to the stigma right? If I say I have mental health issues, then that means that I'm weak. I'm stupid. I don't know how to handle things. I think that's why a lot of people don't seek the help they know they need and want because they fear how other people will perceive them; like being weak is not okay… But I think for me the beauty is if you are feeling weak and at your low point, the beauty is being able to look at the transition from being sad, low and weak to feeling happy and you feel okay.

Surge explains that the methods of processing difficulty are learned cultural behaviours that were transmitted from her family elders:

> Like whatever coping mechanisms you had then you would have passed along now. So like that concept of "you just kind of deal with it" has been passed down from generation to generation and when you think of all the supports that are out there they kind of think it's a joke because we got through all this stuff without having those supports before so why would you need it now? I could get why people would think that but the issues we are facing now are completely different than what they might have been facing before. Like we didn't have social media before and all these different outlets for people to constantly be judging other people and comparing themselves to other people and there being

> cyberbullying and being able to say all these nasty things over the computer. It's just we live in a totally different generation and I think that's why people will just dismiss people experiencing mental health issues now especially in the younger generation like, 'oh whatever it's just 'cause of this and that.'

Surge raises an important point illustrating how social media is now moving the younger generation away from cultural perceptions of difficulty. However, the expectation still remains from the previous generation where she explains who *"got through all this stuff without having those supports before so why would you need it now?"* In this scenario, the impression of *"getting through stuff"* like slavery, indentureship, forced and volunteer migration became one of the intergenerational teachings whereby older people used to regulate and teach the younger generation methods of surviving.

BODY (DIS)SATISFACTION IS NOT A ONE-SIZE FITS ALL KIND OF ISSUE

(c) *Doe judge meh fluffiness*

There is another angle that is evident in Surge's narration: the suicidal attempt through overdose might have been linked to perceptions of positive and negative female body images. For Surge, the meanings of wellbeing intersected with physical health, mental health and the perceptions of the body. Surge's characterization of mental health and wellbeing included the ability to love one's self and embrace change. Her descriptions of wellbeing extended beyond the measurement of positive outcomes to zero in on the complexities that she felt identifies as mental health. Surge expresses sentiments of how the description of physical health is an important part of one's mental state:

> Hmm that's a tough one. For me, it would mean not only being physically healthy but being able to control my emotions. For example, if I'm feeling really upset and really down, being able to know how to cope with it, what my coping mechanisms would be to help me get through it. That's how I would see my health and wellbeing now. Growing up it [wellbeing and mental health] would be being physically healthy, not really skinny but healthy looking. In my family, it was like if you look okay then you are okay and it wasn't always about what was going on internally. So I could be internally suffering completely but as long as I looked okay on the outside then that's what it meant. So I mean I can

> appreciate and understand things on a whole different level now that I'm grown up. And I think that I focused less on, when I'm talking about health, health doesn't necessarily equate to being a certain size or things like that. I equate health nowadays to not only your physical health but your mental state. Health comes in different forms. I feel like a lot of people [in Canada] might think it's okay if you're skinny and that means you're healthy, when that could be the total opposite. So I don't necessarily see it as physical health as much as your mental state. But I think that growing up, I was told that in order to be healthy you have to be a certain size, slightly bigger and that sort of stuff. Those meanings have shifted now that I've gotten older.

Surge is not alone, as most of the participants in the study spoke about the maintenance of physical health or being strong or "looking okay on the outside". Most noteworthy is that Surge conflated body size with mental health and wellbeing. I had not considered positive and negative body images to be part of my research findings, which shows that body image and eating disorders are part of mental health conversations. Therefore, it was not puzzling to learn that the pressure to be skinny is a significant point of focus for mental health and young adults.

There is limited research that includes a sociocultural analysis of eating disorders and body image (Cheney, 2011). In the Caribbean, skinniness is not equated to beauty in the same light as it is in North America. Rather, according to Clinical Psychologists at the University of the West Indies, Garth Lipps, Caribbean women are encouraged to have "more meat on their bones. Women who are excessively skinny are perceived as being less desirable as a partner" (Barned et al., 2014, p. 633). In the same study by Claudia Barned and Garth Lipps (2014), found that the "fluffy" woman is considered to be full-bodied, thick, big-boned or plus-sized and medically measured as overweight. To be fluffy is not just about physical appearance; it also exhibits qualities of self-confidence, with a curvaceous body, who is charismatic and has a positive sense of self. The fluffy concept is both gendered and age-specific, as "Elderly females are not referred to as fluffy" (Barned et al., 2014; p. 627). The fluffy concept emerged out of Trinidad and Jamaica and is resistance to the portrayal of the North American images of beauty (Dibb et al., 2014). The notions

of beauty in the North American mainstream socially constructs "desireable" women to be of paler skin, skinny, with blue eyes, and a smaller waist-line. Such images dominate mainstream media, stripping the positive attributes of the heavier body-type woman, thus, repositioning the fluffy image as women who are lazy, of lower socio-economic status, who make poor dietary decisions, and who should spend more time exercising (Barned et al., 2014; Dibb et al., 2014). Social media, has also contributed to the shaming of fluffiness in the region, driving more Caribbean women to crave a slender figure (Dibb et al., 2014, Cheney, 2011).

The body encounters between North American and Caribbean/African ideals of beauty that Surge describes, is a site that invokes anxiety, depression and other unhealthy mental issues. Surge narrated that weight is not something of concern in her family. Surge implied that her relationship to her own body image was nothing more than a childhood experience, which is also related to her overdose attempt and has since evolved:

> Growing up it [wellbeing and mental health] would be being physically healthy, not really skinny but healthy looking. In my family it was like if you look okay then you are okay and it wasn't always about what was going on internally. So I could be internally suffering completely but as long as I looked okay on the outside then that's what it meant... health doesn't necessarily equate to being a certain size or things like that...I feel like a lot of people [in Canada] might think it's okay if you're skinny and that means you're healthy, when that could be the total opposite. So I don't necessarily see it as physical health as much as your mental state. But I think that growing up, I was told that in order to be healthy you have to be a certain size, slightly bigger and that sort of stuff. Those meanings have shifted now that I've gotten older.

Body ideals are not naive notions, rather, these ideals are constructed out of subliminal messages embedded through various social structures such as the healthcare system and the media. And although the emerging research that addresses alternative views of dominant concepts of beauty are said to be cultural (Barned et al., 2014; Cheney, 2011), I note that the celebration of the 'fluffy', or '*slightly bigger'* woman is a site of resistance claiming the former colonial constructions of the mammy as more positive, opposing this construction as Black, big, and ugly (see Beauboeuf-

Lafontant, 2003; Collins, 2000). The fluffy or larger-body concept is not a matter of cultural differences. In fact, the North American ideal of beauty would rarely be referred to as cultural. Instead, the Western conceptualization of beauty is positioned as the social norm and the predominant marker of beauty. Language matters. Surge's family's support of the *"not skinny"* body is neither the lack of nutritional literacy or plain ignorance. It is a historical narrative that many families believed as a sign of wealth, access to food, being blessed with a comfortable life and so forth.

Although Surge says that her "meanings [on body-image] have shifted now that [she's] older", it is unclear what this shifts mean. In a similar grain of how language was used to describe mental health and madness in Sway's and Gabrielle's family and their stories, body-image as comparable in Surge's family. I argue that the various meanings of body image, mental health, and madness are important points that are specific to one's identity. Cultural theorist, Stuart Hall (2001) argues that cultural identity "is produced out of those historical experiences, those cultural traditions, those lost and marginal languages, those marginalized experiences, those peoples and histories that remain unwritten" – it is the root to one's identity (p.37). Our bodies and therefore our identities are positioned to give meaning in the order of power (Bhabha, 1994). Thus, dismissing the bigger-boned woman as simply unhealthy, also dismisses Surge's historical meanings of body-image.

Research demonstrates how Black and Brown bodies have always been a site of political contention (Collins, 1990; hooks, 2005; Morrison, 1990). The larger Black and Brown bodies are no different. The body itself occupies a position that is both political and historical. Therefore, it is necessary to caution an oversimplified view that the larger body as cultural reference to describe a particular group of people, in this case Black women. Such a suggestion dismisses that fluffy

women can also experience body dissatisfaction, similar to their skinnier counterparts (Barned and Lipps, 2014; James et al., 2016). Furthermore, framing rigid ideals of beauty perpetuates cultural racism in counselling discourses and practices, further limiting women who do access care. Thus, alternative views of body images among first and second generation Canadian-Caribbean youth is definitely an area requiring more attention, particularly as it pertains to mental health. My work contributes to those studies that present the fluffy body as socially acceptable and worthy of celebrating.

PHOENIX: TELLING MAD STORIES

(d) *Using old language to tell new stories*

> ***`But I don't want to go among mad people,' Alice remarked. `Oh, you can't help that,' said the Cat: `we're all mad here. I'm mad. You're mad.' `How do you know I'm mad?' said Alice. `You must be,' said the Cat, `or you wouldn't have come here.' Alice didn't think that proved it at all; however, she went on `And how do you know that you're mad?' `To begin with,' said the Cat, `a dog's not mad. You grant that?' `I suppose so,' said Alice. `Well, then,' the Cat went on, `you see, a dog growls when it's angry, and wags its tail when it's pleased. Now I growl when I'm pleased, and wag my tail when I'm angry. Therefore, I'm mad.' (Alice-in-Wonderland).***
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> ***`I'm not crazy. My reality is just different than yours' – Cheshire Cat (Alice-in Wonderland).***

Lewis Carroll's famous children's book, *Alice-in-Wonderland*, is a tale set in England during the middle of the Victorian era. In North America, children are familiar with the little girl who falls down a rabbit hole and encounters a world that is completely upside-down from her own reality. Yet, the usage of 'mad', 'madness', and 'being mad' seems to be politically incorrect today. Is the vernacular usage of mad outdated? By changing the language around mad and madness will it help to challenge the core issues of ill mental health?

I purposely use the well-liked story *Alice-in-Wonderland* because although most of my participants saw the use of mad as a term that is either "harsh" or "backwards", the word is

persistent in spaces beyond the Caribbean. As Storm highlighted in Chapter Five, it is important to note that the use of 'mad' has shifted over time. Furthermore, I am drawing from the well-liked *Alice-in-Wonderland* in relation to Anansi stories, which are often told orally in African and Caribbean spaces. Anansi stories and *Alice-in-Wonderland* instruct the child on the importance of the imagination. *Alice-in-Wonderland* represents a particular way that insanity is illustrated, which leads to the question: is the childhood classic tale intended to teach children about the importance of emotional differences?

Alice-in-Wonderland is also an antidote to introduce the importance of language. Phoenix, uses the term mad and madness to describe her grandmother's unexplainable actions. Phoenix's narrative ends this chapter because it highlights the tensions between the science of mental illness and the peculiar behaviours affiliated with madness, similar to *Alice-in-Wonderland*. Finally, this participant's story tips-off how both her personal experiences of madness and the cultural prescriptions to healing practices are veiled in shame. Phoenix's humor and candid descriptions of her grandmother's ill mental health truly alludes to the difficulty and lack of social support that one family experiences when caring for a loved one. Phoenix's straightforward reactions seem harsh, hilarious and at many times simply offensive. However, her story is an illustration of one's overextended family, who as Phoenix put it, feel "burdened by the madness". Phoenix's story provides some context to my research question - what are some of the ways that a mad-person is medically treated?

THE STRUGGLE BETWEEN TRADITIONAL & SCIENTIFIC MEDICINE

(e) everything ah farin (foreign) stay betta

Phoenix is born to Guyanese-Canadian parents and explains that neither of her parents have strong ties to Guyana. When asked what she knew about mental health issues in Canada and if and how these issues differed from her Caribbean teachings, she responded:

> My parents grew up here, they have been in Canada since they were very little. They have always been on board with the Canadian mainstream [care], since it is more developed than what is practiced or recognized in Guyana, especially when curing mental illness.

Phoenix explains some of the tensions around the treatment of madness in her household. She expressed how mad stories have been entrenched in her personal life for as long as she can remember:

> At a young age, my nanna was diagnosed with bi-polar disorder and [her disorder] has been [an] extremely hectic dynamic in our family. A lot of drama. Her mom [Phoenix's great-grandmother], I'm pretty sure was bi-polar too. I know that my mom has been dealing with it her whole life because she had to deal with both her mom and her nanna.

For Phoenix most of the pressures between her mom's siblings and her grandmother is around the meanings of care, especially since her grandmother snubs formal medical treatment and relies on more spiritual forms of healing:

> I don't know about all that old time thing or what they did in Guyana but my nanna is super involved in the obeah stuff. She would swear by it. She thought it worked. And of course, for her it [obeah] did seem to work because she's crazy. The only thing that we wanted for her is to get her on prescription medication. We know that's what she needs to fix the disorder, prescribed meds. All that obeah stuff is unproven. Like, I don't know about the praying and stuff. We [Phoenix and her parents] never believed in that stuff or that it [praying/obeah] could actually cure someone.

Phoenix's grandmother's self-prescribed spiritual methods are what identifies her further as crazy. For Phoenix, the relationship between obeah as a treatment to madness is more of a symbol of her Caribbean-ness:

> So they [my parents] didn't grow-up believing in all that obeah and praying and stuff. My family is a little bit different. We're Muslim but we're not really traditional and not typical to other Caribbean families, I guess. We're not really religious. So I don't know about Caribbean treatment. We're Caribbean yeah, but we're a little more white-wash.

Phoenix's disconnect from the region infers that spiritual practices, such as obeah, are the only forms of treatment to madness in Caribbean countries like Guyana. For Phoenix, obeah is a practice

only used by Guyanese people who are both uneducated and unexposed to more advanced ways of life. She says:

> Back-in-the-day, when they [Caribbean people and/or Guyanese] weren't educated about mental illness where they thought that you were possessed or that they could cure through religion, or through prayers only. I just don't believe that there is a connection between it. Because, I think it is all science, it is all medical. You have to look at medicine, chemical imbalances are not caused or related to spirit. Like I said, religion can give you faith in times when you need it the most. But I don't think that mental illness has a strong correlation to spirituality and stuff. Scientifically we have evolved and developed and we have come a long way. It is really an imbalance in you that can be fixed. And although that is what they [Caribbean people and/or Guyanese] use to believe in, back-in-the-day that it was spirit and faith and religion. We don't have to go back to that. And I am sure it [praying] doesn't work. It is not a bad thing to pray and believe in something other than just medicine when you are faced with this situation. We can fix this [mental illness] with science. It's not all bad to believe outside of medicine but I don't think that's the source.

The use of obeah according to Phoenix is nothing more than an act. It is not evidence-based and offers no relief to the discomforts caused by one's mental illness. During our discussion, Phoenix lumps her grandmother's ill mental health actions and the practice of obeah as a form of masquerading in order to gain family member's attention. Phoenix believes that her nanna uses madness to play tricks to evoke an emotional reaction from her mother:

> She (my nanna) would say and do the right things. She did it because she wanted to come back and live with us. She didn't believe she had an illness.

Phoenix expresses that her grandmother's unawareness of her own compromised mental health is a reflection of her use of *"unproven"* forms of treatment. However, as described in Chapter Five, Cecilia's grandmother's story, previously demonstrated that in the region, medical attention has always been awarded to mental illness, although limited. The substitution of alternative and spiritual rituals layered the limitations of medical remedies (Gramaglia, 2008; Sutherland, 2013).

Phoenix's story highlights some of the informal practices of medicine that Caribbean people have developed in the absence of primary resources. Her story also signifies the preservation of spiritual beliefs over generations, but its rationale may have been lost in translation

over time. Returning to Waldron (2003), she found that many African and Caribbean women believe that mental illness is caused by three main factors – it is "biological; a breakdown that results from the inability to cope with severe stress; and finally, an external force that is evil or punitive spirits" (p. 52). But where did the connection of mental illness to evil spirits derive from? Kenneth Bilby and Jerome Handler (2004) explain that obeah was originally practiced on British slave plantations during the seventeenth-century. Bilby and Handler's conducted a law review that examined the anti-obeah act, which was passed across the Anglophone Caribbean during 1760 to 1833. They specifically examined the anti-obeah provisions in relations to Barbados, Trinidad, Jamaica, Anguilla, Dominica, Antigua, St. Lucis, St. Vincent, St. Kitts, and Guyana. Their research found that after the post-emancipation period, the anti-obeah provisions "were subsumed under several vagrancy acts" (p. 171) and for most of these islands, the anti-obeah provisions still remain on the books.

Bilby and Handler's research is useful to my data as it illustrates that the practice of obeah was broadly related to an African belief system, which included "sacred traditions and medical knowledge, modified over the years by the New World environment, including its plant and animal life; European practices, beliefs and material culture (e.g. glass bottles, rum); and the social conditions that existed under slavery" (p. 154) that was often used to treat various ailments and mental illness. Bilby and Handler highlight that the practice of obeah is not recent but is "filtered through the colonialist racist lens. …European interpretations of obeah were shaped not only by their racist ideologies, ethnocentric religious beliefs, and their own cultural perceptions of witchcraft and sorcery, but also by the limited opportunities they had to gain more information" (p. 156). Research reveals that madness and the spiritual practice of obeah are deeply roped together as an alternative medical practice for those in the Caribbean, especially for those who

lived in remote villages with limited access to health resources. Moreover, many Caribbean people historically distrusted the colonial constructions of the Asylum, particularly when the institution's primary objective served as a violent housing facility for prisoners who defied the colonizer (Fanon, 1967; Fernando, 2002; Mills, 2000; Murrell, 2013; Scull, 1979). Acknowledging the history of informal mental health practices aids in illustrating that mental illness is a complex area of study, that stretches beyond science.

Phoenix's reading of her Canadian versus traditional practices is riddled by her North American formal knowledge of healing and by her parents' British-Guyanese scientific teachings of what it means to be mad. These teachings are threaded through a Euro-centric school of thought, where the process of colonialism has previously filtered out beliefs that opposed European dominant ideologies. Revisiting Fanon's (1963) book *The Wretched of the Earth,* Phoenix's invariable views on healing are situated within a broader perspective. "Colonialism" Fanon argues "has succeeded once this untamed nature has been brought under control". He continues that colonialization was a violent cleansing force that included "Cutting railroads through bushes, draining swamps, and ignoring the political and economic existence of the native population…" (p. 182). Thus, "…colonialism has not simply depersonalized the colonized. The very structure of society has been depersonalized on a collective level. A colonized people of individuals who owe their very existence to the presence of the colonizer" (p. 220). Fanon includes native health practices in his discussion of the colonized depersonalized process. In that breath, I argue that the structured and enforced meaning of health, education and science both in Guyana and Canada was imposed by old colonial schools of thoughts that have not shifted to include traditional mental health practices of healing. When other healing practices are omitted from dominant health and education literature, these practices are then dismissed as illegitimate customs of healthcare.

I further contend that there is sufficient proof that the former colonizers feared the function of obeah, thus, dismissing the practice as witchcraft. The colonizers' saw obeah as evil and primitive compared to scientifically based medicine (Bilby and Handler, 2004). The documentation of obeah as evil has since been embedded into most Caribbean nations' laws and regulated informally through the Christian church (to a lesser extent the mosque as well). I argue that we must create room to challenge these former colonial beliefs regarding the meaning of obeah practices. It is unfair to simply dismiss traditional forms of healing as unproven or invaluable. Thus, there is validity to how Phoenix regards her grandmother's treatment of mental health that is based on a history falling outside of the biomedical model. Phoenix's grandmother seems completely mad to her and her family.

<u>THERE ARE DIFFICULTIES FACED BY THOSE WHO LIVE WITH A PERSON WHO IS MAD</u>

(f) Madness bursting through the seams

Phoenix described some of the everyday difficulty of living with someone who is mad and how sporadic their behaviours can seem:

> My nanna is super mad. It is difficult because she lashes out and when she has an episode I would see her personality change. It was difficult to deal with; it was kind of hard for my parents to trust her with me when I was younger. They [my parents] didn't trust her in general. You know it's hard to trust someone who does crazy things. She believed in the craziest of things. Like she would think she's related to the Queen. And she would tell people that. She would just do things with that in your mind you know is not right. She's crazy and it's not her fault. She has an illness. And you can do all that you can to help but at the end of the day if they don't want to accept what can you do? If they don't want to accept it that they are mad and they have a problem, then there is nothing that you can really do. We've [her family] done everything to help her. I think just accepting it and see her [nanna] for what it is. So it was hard for us, especially my mom. My nanny is maybe in her late 70s, she's too old to be cured so my mom just needs to come to terms with it instead of blocking her out. It is hard because she's [her nanna] been bad to her kids.

Phoenix further states:

> My nanna lived in Florida for a bit but now she is here since a few years ago. She is always jumping back and forth [between Toronto and Florida, her kids' homes] … My nana was medically diagnosed here [in Toronto] but doesn't want help, she's not being treated. [Instead] She is treated with pity by strangers because she's an old lady. Like she would be walking around at the grocery store and they would be like 'oh why are you by yourself? oh do you need help?' Like she would be treated with sympathy not because she is sick, it's because she's old. She just fools people. Like people don't necessarily know that she is crazy when they first meet her because she can play like a good game. She will present as normal can be, you know … But once you get to know her or if she's staying with you, you realize she has to get out [of your space]. Because she's crazy and makes all sort of false claims…

Phoenix's story really expresses some of the difficulty that families who are caring for a loved one experience. The tone of her narratives suggests that her family is at their wits end and are starved for another direction. However, due to the limited resources, in both the Caribbean and Canadian communities, Canadian-Caribbean people like Phoenix are left feeling hopeless and tired.

CONCLUSION

Dust, Surge, and Phoenix describe their stories in ways that celebrate the openness of mental health in Toronto; as well, the stories show that living with madness is not only consuming but isolating. In my findings, I have noted that illness, regardless if it is physical or psychological, strains a family and in many cases leaves members fractured and traumatized. Family members do not leave their hurting loved ones alone, or deliberately ignore the severity of competing mental health issues. Canadian-Caribbean families often lack the resources and tools to – care for those who face more serious mental health distress. This chapter raises the questions: 1) If we told different kinds of stories around madness, would Canadian-Caribbean people's perceptions change regarding the meaning of ill mental health and treatment?; and 2) What are some of the ways that health practitioners, mental health educators and mental health support workers can build trust and encourage access to mental health services for those who carry a different belief system?

In this chapter I presented the stories of Dust and Surge to illustrate the dilemmas faced by those participants who attempted suicide. These attempts were treated in problematic ways by the healthcare systems and parents. For Dust, he was deserted by his parent and (although treated) he felt mocked and demeaned by healthcare professionals. For Surge, by her mother refusing or neglecting to take her to a hospital, her mother believed she had 'saved' her from the 'trauma' and racial innuendos that exist in the health care system. However, as an adult, Surge talks to the value of and the need for racialized people to try diverse systems of support in order to see what works for their situation. Surge's childhood experiences are still reflective in her everyday working practices. The cultural ties between how her own community perceives madness is entangled in similar ways with other groups of racialized communities that she works among. Surge's experiences point to the urgency of addressing madness in racialized communities. The distrust of the medical healthcare system and the struggle to remain strong and in control collide, and consequently shape the ways that a mad person can access adequate care. Surge advocates that as a community, the discussion of mental illness needs to move "*beyond the concept of working through it and we're gonna get over it and we're gonna deal with it*".

Phoenix is presented in this chapter to demonstrate treatments that differ from the typical mainstream and its effects. Her experiences with her grandmother's ill mental health is consuming for her family. There is a limited sense as to why she is refusing medication prescribed by Canadian doctors. Her story is advocating for more than just a simple prescribed script to be fulfilled at the drugstore, but rather a more holistic approach to family care. Phoenix's story is a strong example of some of the reasons why Canadian-Caribbean families keep experiences of madness hidden. To reveal such stories means an unpacking of other issues that go beyond the treatment of the illness.

CHAPTER EIGHT: REFLECTIONS, LIMITATIONS & CONCLUSION

Yuh hear? Shanty ketch-ah-fyah last night?

Who sai dis?

Yes, man. Big, big flames light up the sky, like ah Christmas tree.

I cyan't believe. Shanty? Shanty was a nice, pretty gyal. Married to a polite bankah man.

Umm, but after she get baby, like she just switch off. Dem sai she stop sleep with de man and dey wid candle up and down in de night.

So wah happen to de lil baby she get?

Spirit tekk de chile man. De baby cry'n non-stop and she muddah tell de gyal wrap-up de baby so the lil ting doe ketch due. Ah think she tekk de blanket and wrap the chile too gud. Nex' ting yuh know, de baby stop cry all together.

Police must come to investigate, nah Maureen?

Eh, eh. De baby fit into a shoebox, nice and neat. Shanty put the shoebox and burry um right in de front yard.

Nah! Ah story yuh tell, man.

Yes, gyal! Police come and meet Shanty burn up to pieces. She ashy body on top the ground, right where she put de chile. Meh nah tink Shanty was ready fah pickney. Shanty helper sai dem use to force de lil gyal to bade and come out ah she nitey. How yuh live so, eh?

But fyah man? Yuh sure? What a way to go.

Yes. Meh hear sai, she mekk dinner dat night fah de bank bai. First time since dem tekkup. He was thinking Shanty come back to she senses, yuh know. She went to get him some wata but reach fah de kerosene instead. Dey did put up everything since she get baby, eh. But true she waan cook. So de helper call she mudda. De mudda think 'oh maybe Shanty coming back' because de mudda use to bring food everyday, yuh understand. An' a nex' ting, Shanty go pun de varanda wid de kerosene and bade she self, well and prapa.

Meh nah know which demon tekk she ovah nah. Well ah nevah! … De mudda tekk in wid de news?

Well ah hear sai, dey blame de bank bai. Is just de two ah dem dey dat night, yuh understand. Shanty send home de helper so meh en know who ci what. But all ah hear, Shanty gone. Only ashes fah show.

Aie, aie, aie. Watch story hey Maureen. Well wha is dis…

TRANSLATION:

Did you hear? Shanty lit herself on fire last night?

Really? How did you hear this?

Yes, man. The flames lit the sky brightly, as if it were a Christmas tree.

I can't believe. Shanty? She was such a pretty girl and married to a polite man who worked at the bank.

I know. But after she gave birth to her child, something changed. She wasn't sleeping with her husband and spent most of the nights awake.

So what happened to her little baby?

The baby passed. The baby cried constantly and Shanty's mother told her to wrap the baby with a blanket to protect him from getting sick. Shanty accidently suffocated the baby with the blanket.

Maureen, the police had to conduct an investigation, right?

No. Shanty buried the baby in a shoebox in the front yard of their home.

I don't believe you.

Yes, girl. The police found Shanty burnt to pieces on top of where she buried her baby. I don't think Shanty was ready to be a mother. Her housekeeper would force her to shower and get dressed. Instead, Shanty wanted to be in her nightgown, all night awake. Who lives like that?

But fire? Are you sure? What a brutal way to die.

Yes. I heard that she made dinner for her husband that night. It was the first time since they've been married. He really thought she was starting to feel like herself again. She went to get him some water and reached for the Kerosene oil instead. After Shanty gave birth, they hid all of the dangerous products from her. But last night, she insisted on making dinner for her husband. Her housekeeper called her mother to ask if it was okay. Her mother was excited and believed that Shanty was starting to feel herself again. Usually her mother prepared the meals. The next thing, Shanty went on the veranda and poured the kerosene all over her body.

I don't know if she was possessed. Are you sure? How did her mother take the news of her passing?

Well I heard that her mother blamed Shanty's husband. The two were alone at home last night. Shanty gave her housekeeper the night off. So there were no witnesses. All I know that Shanty is gone and only her ashes left.

What a story, Maureen…

KAREN: UNPLANNED LESSONS THROUGH HEARING OTHER PEOPLE'S STORIES

Storytelling is meant to tug on chords of curiosity, give information, provoke emotions and capture an audience. In Caribbean communities, stories of madness are evident in various forums - through musical expressions, for instance. Most often fictional and nonfictional stories, are commonly told around the dinner table, the barbershop, at church, a funeral, or a family gathering. Every Caribbean family has an informal storyteller, who beautifully embellishes life events in attempts to gather an audience. In various spaces, Caribbean people of all ages, gather to talk, eat, and share their experiences. A story like Shanty's is not different in how it is shared among community members. At first glance, the story is dark and told in a fragmented way through idle gossip, but Shanty's story represents moments of stillness, of invisibility and the meaning of (in)sanity.

Shanty' story that begins this chapter is used to highlight the commonalities of the participants in this study. It also serves as a culminating reflection on my project. Shanty's story centres around a young Guyanese woman who suffered from postpartum depression, whose life

ended tragically. Her support system and caregivers attended to her physical needs, but her mental wellbeing remained mysterious, making her condition difficult to manage. Her story is a re-enactment of true events and it centres on a conversation between two neighbors who express their grief and disbelief over the occurrences that transpired the night before.

Shanty' story is based on the passing of a relative in the 1970s before I was born. I was told the story once, in my early 20's at another relative's wake and at the time, the story seemed fictional to me. However, this project awakened Shanty' story, stirring the stark reminder of how denial, stigma and shame continue to limit our understanding of mental health and mental illness.

Similar to my participants, specifically Cecilia in Chapter Five, it was after the reconstruction of Shanty's story that I realized there were members of the family, including my closest cousins, who never heard of aunty Shanty or any of her stories. Like in Gabrielle, Dust and Surge's narration, the secrecy and mystery of mental illness simply caused Shanty to be erased from our family stories. Stigma and shame are both powerful tools that help sweep peoples' mental health experiences under the rug. The dwelling of mad stories in Caribbean circles, is often in a space of contradictions, where, like in Cecilia's narrative, they are told as abstract events or feelings. These experiences are rarely seen as tied to one's personal occurrences.

Currently, there is limited information about postpartum depression within Caribbean communities because the focus remains on white women in North America and Europe (Jackson-Best, 2016). Fatimah Jackson-Best's (2016) research, *Maternal depression among women of Caribbean descent* is one of the first studies to focus on Caribbean women and their experiences with postpartum depression. Her study reveals that Caribbean women cope with various mental health conditions, such as postpartum depression, on a daily basis. Yet mental health stigma, in relation to postpartum depression and other illnesses, limits Caribbean women from accessing the

necessary care (Jackson-Best, 2016). If information around postpartum depression, which is a well-recognize health issue, is actively missing in contemporary research among Caribbean people both within the region and the diaspora, how then can we trust informal family stories that are often seen to be backwards or to lack credibility? I argue that informal stories should be included as devices for starting conversations about mental health and for expanding research on mental health.

Second, Shanty's story points to the need to further investigate and tell the mental health traumas to their fullest in order for meaningful solutions to emerge. Like in Shanty's story, as demonstrated in Chapter Five, Cecilia's grandmother's decision to leave her youngest daughter behind in Guyana during the family's migration process, has had a serious psychological outcome, which, however, remains unknown to family members. The story that Cecilia tells of her aunt further alludes to a family history of incest, which is another issue that is hidden in most Caribbean families. Similarly, as Cyclops described in his narrative in Chapter Six, despite the consequences, addictions such as alcoholism are either avoided or accepted as part of everyday living. For healing to begin, it is safe for me to suggest that family research is an important way make the connections to one's identity and open sharing these family stories could serve as part of the solution.

Shanty' story offers many parts which, at first glance, might appear dated, yet these parts are relevant for ongoing research. The use of kerosene oil, for instance, positions the story's setting as outdated, especially with the spread of electricity in many parts of the world. Self-burning admittedly is uncommon in North America and Europe, yet the practice of self-burning causing bodily harm and even death, is a common attempt of suicide in some countries such as Guyana (Laloë, 2004; Peck, 2011). Research illustrates that self-burning practices remain current in many South Asian countries, with Sri Lanka reporting to have the highest cases in the world (Balarajan

& Raleigh, 1992; Bhugra, et al., 1998; Laloë, 2004). These numbers further illustrate that self-burning approaches are gendered-base, pointing to higher rates among women compared to men (Jacob & Lloyd, 1998). This body of research, although inadequate, recognizes people of South Asian heritage living in diasporic communities, such as Guyana, with a primary concentration of the research emerging out of the United Kingdom (Balarajan & Raleigh, 1992; Laloë, 2003). I argue that it is difficult to pose conclusive evidence that people of South Asian heritage are more likely to inflict self-harm through burning, since this area of research has been sporadically produced over the last twenty years.

Third, Shanty's story presents complex issues of identity and the need to address them holistically as part of the Caribbean and the Diaspora. My project has underscored that ill mental health research that lumps Caribbean people collectively is misguided. Many of these writings do not acknowledge how the Caribbean is a space of multiple identities, experiences, races and ethnicities (Jackson-Best, 2016). The term "Black Caribbean" is popularly used by some authors to reflect the Caribbean as having a one-dimensional identity and therefore its people as having similar experiences, regardless of their social locations. The term "Black" falls short in capturing the experiences of Shanty's layered uniqueness (Allahar, 1993; Jackson-Best, 2016; Rodney, 1994), including West Indians who do not identify as Black.

In my study, Sway, Cyclops, Rouge, and to some extent Storm and Havok, all highlighted the tensions between their Indian, Caribbean, and Canadian identities. In framing my own work, I have struggled in contextualizing the various experiences that the participants shared. I personally endorse the term "Black Caribbean" both in my personal life and throughout my academic work, as a more political way of placing my Caribbeanness (Rodney, 1994). I do not advocate for Caribbean people and their experiences to be examined in isolated terms, such as Black or Indian,

since there are other identities that fall outside of these binary terms. Similar to Said (1994) and the "orient, I attest that the Caribbean is not monolithic; neither are peoples' experiences. Thus, I argue that various identities and cultural experiences matter in how people generate knowledge on wider social issues like mental health. consequently, this project has since forced me to work through the textures of peoples' various histories, political and socio-economic experiences that they use to navigate their own life events.

Finally, Shanty's story raises questions around healthy and unhealthy ways for coping with ill mental health; social and family pressures around the meanings of madness; how mental health experiences are further teased through lenses of gender, race, ethnicity, feelings of belonging, education, and social-class. As part of the solution to her mental illness, Shanty is not allowed to cook, and when she does, it is only to kill herself.

So why end this project on the note of suicide? Suicide marks an important reminder that mental health is more than a research agenda; it affects the existence of all of us. Sometimes it takes more serious actions, such as the ending of one's life, to acknowledge that there are repercussions if issues of mental illnesses are ignored. The misunderstandings around ill mental health further perpetuates acts of suicide or even vagrancy since it isolates people who have experiences that are deemed abnormal or strange. Ill mental health needs to be a conversation at all levels and across all disciplines of study, not just in the realm of psychology or health studies.

Furthermore, research indicates that Caribbean people experience lower rates of suicide in relation to the mainstream (Horn et al., 2003). With such limited research examining the Anglo-Caribbean collectively, it is difficult to conclude an assessment that speaks to the complicated history and multiple identities that Caribbean people live so fluidly in and out of. Admittedly, there is new research that is slowly emerging, advocating for the examination to the multiple ways

Caribbean people identify and therefore understand health practices (Sutherland et al., 2013). However, this research remains limited, partly due to the complications and stigma around mental health, mental illness and madness.

Most, if not all the participants, initially claimed that while growing up, they were never told stories that centered around madness. However, with the use of narrative inquiry as a methodology, allowed for deeper conversations among myself and my participants, which uprooted the recollections of what madness looks like surfaced. Some of the participant's stories were brutal, disturbing, aggravating, unsettling at times, funny, and meaningful. Each participant created characters of what they imagined the mad person to be. The illusion of madness embodied characters that were comprised of myths and isolation and were instructional for holding composure. I found commonalities in all the stories revealed since these accounts dictated how the feelings of mental health, ill health and madness have been interpreted. Using a theoretical framework that intersected critical race theory, post colonial, and cultural studies, it provided an apparatus to created meaning from the stories gathered for this study. It is with the many stories shared that my participants have taught me that mental health, ill mental health and madness are very sophisticated terms. The language surrounding mental health is science based as it is social. To what extent have we as a society sanitized and medicalized people's experiences and our own life histories? What can we learn from the telling of stories different stories than what is presented in our Canadian media and political discourses?

Limitations

Although the data gathered for this study was richly assembled, it is worth acknowledging the remaining gaps. There is a gap that results from the scope of my research, which did not include Canadian-Caribbean youth who identified as homeless or those living in severe cases of abuse. In

fact, all study participants were postsecondary educated and for the most part came from "stable family circles". I also did not recruit participants who identified as French, Spanish or Dutch Canadian-Caribbean. Nevertheless, the data could be used to inform practices within the community of the targeted group, which is an achievement. Most of my participants were torn between the mixed messages that madness constructed in their homes compared to their schools. This conflict allowed for spaces of uncertainty and stifled their own experiences of mental health and mental illness. Mental health education within the Caribbean communities is necessary and should be on most community health agendas in similar ways that diabetes and heart health has been prioritized.

Furthermore, I recognized that gathering research among postsecondary students may limit the scope of my research, since it regulates the discussion around socio-economic status. I argue that most of my participants did not view themselves as middle-class status or possessing socio-economic privileges. In fact, most participants voiced the difficulty of having to keep-up with their studies, while working to fund their education and contribute to family obligations. The added pressures to succeed through school and maintaining other responsibilities strained their mental health and wellbeing.

Wendy Moffatt's (2017) research drew from a qualitative case study, which examined how first-generation Caribbean students who are born into either lower or middle-class families, often lack the financial support to off-set the fees associated with obtaining post-secondary education. Her (2017) study highlights that Canadian-Caribbean students juggle more than the expense of paying for school. This group in many ways need to justify to their families why the expense of higher education is necessary. Her study also reveals that most people of Caribbean-descent, who have settled in Canada for over ten years, were more likely to see the value of having their children

access post-secondary education. All of my participants' families have settled in Canada over twenty years. My participants were also the first in their families to attend university, with the acceptation of Zordon, who was the first to attend college. Their experiences are unique from most non-racialized postsecondary students because students of Caribbean heritage are forced to navigate not only the financial burdens that follow education (Drummond et al., 2010; Engle & Tinto, 2008) but also other institutional hurdles such as informational barriers - educational options, career paths and systematic racism (Dei, 2005; James, 2010; Hernández-Ramdwar, 2009). Most of my participants identified a disconnect between their expectations to do well and not knowing how to pilot their academic paths (Moffatt, 2018; Payne, 2006). In many ways, carving their own paths became extremely consuming and necessary, something that Storm, Sway, Gabrielle and Hovak's stories highlighted.

Finally, my intentions to address issues of sexuality in this study posed its own challenges. I had contacted two people who were either transitioning as transgender or were dealing with the repercussion of admitting to be gay to family members. Both of these people opted not to participate in the study, for fear of being exposed. In many ways, and based on our initial conversations, their sexual identities and mental health were not seen as interlocking. In my opinion, the intersectionality of Caribbean identity and sexuality is an important area of mental health research that continues to be invisible and could have changed the direction of this project. Again, new research that focuses on sexual minority mental health is slowly emerging in the Caribbean region (Rambarran et al., 2016), even though still limited in Canadian-Caribbean scholarship. This study did address how mental health and mental illness intersects with Caribbean masculinity and feminity, as exemplified in both chapter five and six of this document.

Summarizing Key Findings

This project has highlighted some crucial points worthy of reminder:

1. Madness caries powerful emotional and cultural meanings for many people of Caribbean heritage.
2. Alcoholism is an important factor that participants Cecilia and Cyclops discussed as shaping their perceptions of what madness means. Yet in our Caribbean communities, we laugh and pass ill mental health off as something that will eventually fix itself; where 'rum-drinking' is referred to as biological, and/or madness is assumed to be a part of casual tales of idle gossip. I concur with Coulturess, 2015; and , *Kaieture News*, 2014 that mental health and illness are prevalent issues within Caribbean communities; they require effective solutions with collaborative and broader approaches.
3. My research demonstrates that health practices and cultural practices come together and are transplanted during migration as coping methods to navigate unforeseen experiences in the host country, as demonstrated through Cecilia, Sway, Storm and Gabrielle's stories.
4. For my participants, it does not matter that ill mental health is currently granted more positive attention in Canada; their interpretations of how it is regarded is based on their personal experiences in their home circles. Sway and Storm for example, present a strong case that Canadians have a stronger handle on addressing mental health and illness compared to their Caribbean counterparts. However, Hovak and Surge demonstrate that they preferred to handle their depressed emotions outside of the Canadian healthcare system because they did not feel that their issues were adequately addressed, thus, being forced to return to their Caribbean mental health methods.

5. The Canadian mental health system and contemporary mental health language are both structured within a former colonial legacy that does not account for difference in treatment and does not consider former colonial subjects' relationship to mental healthcare. Ignoring these key ideas omits Canadian-Caribbean people's experiences and marginalizes them from accessing care as Gabrielle, Havok and Dust's stories revealed.
6. Strong religious beliefs are important chronicles that are intergenerationally used to teach how previous generations survived more difficult times.
7. There are significant difficulties that families who are caring for a loved one experience. However, due to the limited resources coupled with history and culture related practices, Canadian-Caribbean people, like the participant Phoenix, are left feeling hopeless.
8. Finally, regardless of limitations to examine the structural implications of the concept of resilience, it is undeniable that Caribbean people are resilient. Study participants demonstrated that resilience is passed from generation to generation as coping tools to survive harsh life occurrences. Social conditioning such as *keep going* and *manning up*, as Rouge, Gambit and Zordon's narratives illustrate, are both positive and negative attributes to one's mental health. The notions of *keep going* and *manning up*, while positive, can result in young people learning to hide the difficulties they encounter in everyday life including racism and can lead to ill mental health.

FINAL THOUGHTS

In closing, this project has demonstrated how stories can stroke the imagination, constructing a visual canvas for the listener. Perhaps I have gravitated towards mad stories more over the years because I have been living with madness in very intimate ways throughout my life. I have always lived in mad spaces, where madness is a part of my norm. Shanty's tale is an expression of how ill

mental health impacts peoples' lives, not just the person dealing with ill mental health but their community and caregivers as well. In my own coping with the possibility of losing my mind, I subconsciously created characters that symbolized ultimate endings to madness. Over the years, these characters became more refined as my collection of mad stories grew. The participants for this study have added to my collection of both mad and healthy mental wellbeing stories, all proving to be invaluable. This project legitimized the many Anansi stories of madness that I have engaged with over the years. It is my hope that these mad stories eventually include openness and healing, thus, legitimatizing peoples' complicated experiences.

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APPENDIX

Guided questions for research:

1. Do you remember the very first story you were told about madness? And what about of a person who is considered to be mad?
2. What does it mean to you to say someone is mad?
3. How might stories of madness differ in a Caribbean space compared to a Canadian space?
4. What does mental health and well-being mean to you? How are they different from meanings of madness and mad-people?
5. Are told stories within your family of strength or the importance of being strong when someone is sad?
6. What do you think of when I say the word "strength"?
7. According to your family stories, what are some of the ways that a mad-person is medically treated?
8. How do you think Caribbean ideas of treatment for madness are influenced by Canadian teachings?
9. Based on family stories, if you were diagnosed with a mental health illness, do you think you would be treated differently in your family? Can you tell me how?
10. What were some of the stories you were told about what it means to be sad when you were going up? Do you think it is okay to be sad for long periods of time? Why or why not?
11. Based on what you know about mental health issues in Canada, do you think about your Caribbean teachings differently?
12. Do you think Caribbean stories of the past (perhaps indentureship, slavery, independence) have an influence on how you interpret the meaning of madness/mental health? Can you explain why or why not?
13. Do you think madness is connected to spirituality or religion? Can you define what these meanings represent to you (either together or separately)?