Governing Through Competency: 
Race, Pathologization, and the Limits of Mental Health Outreach 

by 

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Abstract

This thesis examines how cultural competency operates as a regime of governmentality. Inspired by Foucauldian genealogy, institutional ethnography, and Said’s concept of contrapuntality, this thesis problematizes the seamless production of racialized bodies in relation to mental disorder. I begin by elaborating a theoretical framework for interpreting race and madness as mutually constructed ordering practices. I then analyze what cultural competence produces and sustains in a position paper published by the Ontario Federation of Community Mental Health and Addiction Programs. I argue the Federation dismisses ongoing institutional violence—suggesting it is simply the perception, as opposed to the everyday reality, of discrimination that causes problems such as low educational attainment among youth of colour. To further support this claim, I deconstruct narratives of low self-esteem, maladaptive coping, depression, and denial of mental illness in the community needs assessments of two of the Federation’s member organizations: Hong Fook and Across Boundaries.
This project was originally conceived during my years as an undergraduate student in the Women & Gender Studies Institute at the University of Toronto. During that time I was first introduced to the psychiatric survivor community through a mutual friend, Donovan, who worked at Out of This World Café at the Centre for Addiction and Mental Health (CAMH)’s Queen Street site. I began reflecting critically about my experiences with psychiatry and was especially interested in revisiting my social worker’s case notes during my youth in a predominantly East Asian neighbourhood in North Toronto. I expressed my interests to my teacher and mentor, Rachel Gorman, who was also interested in the ways in which diagnostic processes act to survey and criminalize racialized communities. Through Rachel I met researchers and activists in the growing interdisciplinary field of Mad Studies, including Shaindl Diamond and Jijian Voronka.

It was also through Rachel that I met other disabled women of colour interested building an anti-imperialist and anti-capitalist disability movement very different from the identity-based organizing that currently exists in Toronto. I am particularly grateful for the lengthily conversations I have shared with writer, performer, community worker, and dear friend Onyinyechukwu Udgbé. Without the subjective and brilliant insights of Nadia Kanani, Onar Usar, and annu saini, my analysis of white supremacy and the “psy” complex would not be what it is today.

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including Roxana Ng, in her class on institutional ethnography, and Martin Cannon, in his seminar on Indigenous-settler solidarity.

Finally, I am indebted to the patience and generosity of the people who help sustain and motivate me in the every day: my partner Jayson and sister Joanna. Thanks also to Jenna and Andy, for their candid support and for submitting my paperwork to graduate after I moved nearly 500 miles away to attend Rutgers.
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Psychological Explanations for Symptoms of Oppression

My consciousness around race and class was fomented by a body invasion: multiple psychiatric diagnoses during my teens and early twenties. One of my labels was neurasthenia or *shenjing shuairuo*, garnered during a period of crisis as an undergraduate student. Neurasthenia was historically used to diagnose the deleterious effects of modern industrialized life and social climbing in the West. This label fell out of use in the 1990s, with depression, hysteria and anxiety states replacing the term. For a time, neurasthenia was a prominent diagnosis in the East where distress in the body was a readily accepted paradigm rather than mental disorder, in particular China (Kleinman, 1986). Aside from its revival as a “culture-bound syndrome” in Diagnostic and Statistical Manual of Mental Disorders, neurasthenia no longer “exists” in the DSM today. It is now considered a “culturally sanctioned idiom for distress” used to describe symptoms of fatigue and impaired social functioning (Yew Schwartz, 2002, p. 258).

As part of my undergraduate thesis, I argued my doctor racialized my body as the overachieving immigrant archetype. Using institutional ethnography, I analyzed my medical records and social worker’s case notes, drawing relationships between the specifiers of my diagnosis and national discourse on the Chinese psyche, such as the commonly held stereotype of Asians “suffering for success” (Brown, 2010). Rather than explore the actualities of my experiences in higher education, I argued my doctor botanized my mind through the lens of a culture-specific illness, collapsing my “problems” with my phenotype, in which neurasthenia became code for Asian workaholism. Through this prior research, I became interested in exploring how psychology offers narratives to placate and even justify experiences of racism. My undergraduate thesis also brought to my attention the slippage back towards essentialist claims about the mind and body despite the inclusion of “diversity” and anti-oppression practice in mental health education and training. How do the politics of inclusion sanction interventions?
Or, to put it differently, how is inclusion made into an act of governance—a problem that must simultaneously have techniques and instruments to act upon it (Rose & Miller, 2008)?

In this Master’s thesis, I explore the political and material consequences of tethering anti-racist theory to epidemiology and the expanding domain of the therapeutic. Throughout my research, I ask three overlapping questions. The first question is, what rationalities shape our understanding of the relationship between race and mental health? According to Rose and Miller (2008), rationalities are styles of thinking amenable to calculation and programming, “to ordering things and persons under certain descriptions or labels, whether these be madness, pauperism, criminality” (p. 16). For example, in Chapter One, one rationality I discuss is the hypothesis of history-as-symptom. Titchkosky and Aubrecht (2010) believe that because colonial occupation was succeeded by increased mental health treatment, colonialism triggered higher rates of mental illness in postcolonial societies. I argue this prescribes a vague, overdetermining victim narrative, in which the authors fail to recognize how mental illness is constructed, and calculated in its construction, used in the deployment of international development programs (Howell, 2011). Related to my investigation of “rationalities” is my second question: what are the resulting instruments for realizing these rationalities? By instruments, I am referring to human technologies such as examinations, tests, assessments; therapeutic and pedagogic techniques of reformation and cure; and apparatuses such as classrooms, clinics (Rose, 1999).

For example, in Chapter Two, the Ontario Federation of Community Mental Health and Addiction Programs (2009) similarly believes people who experience discrimination are at higher risk of poor mental health outcomes. In response, they recommend that mental health agencies implement treatment programs to increase patients’ “sense of self-efficacy” or “self-image”. The Federation assumes that equity involves transforming the self and feeling good as opposed to acknowledging and resisting ongoing systemic violence. This brings me to my third
question, what are the consequences of these thoughts and interventions? What kinds of knowledge or experience are written out of the “reality” of racialized people’s encounters with mental health as an institution? In Chapter Three, I problematize the community needs assessments of two of the Federation’s member organizations: Hong Fook Mental Health Association (2003) and Across Boundaries (2006). One component of Hong Fook’s assessment is a community survey, in which East and Southeast Asian immigrant and refugee women are asked, among other things, to correctly identify the diagnosis in two abnormal psychology vignettes. The authors of the assessment conclude that participants’ beliefs in the efficacy of psychotherapy versus medications in the schizophrenia vignette suggest a gap in knowledge. I argue that given the inverse relationship between prescribing antipsychotics and long-term “recovery” (Harrow & Jobe, 2007), not only is it unsurprising that participants rarely believe medications are helpful: Hong Fook discounts existing nonmedicalized strategies for coping among women of colour.

Central to my inquiry is the organizational discourse of cultural competency. Cultural competency refers to a range of practices that employ studies of ethnocultural communities to sensitize mental health workers towards the challenges of ethnic minorities. Cultural competence has led to the assumption that patients will have a core set of beliefs about the body and illness according to fixed ethnic traits. Progressive practitioners have tried to remedy culturalist diagnostic practices by using race-specific illnesses to emphasize race-specific oppressions. For example, neurasthenia, a case of “weak nerves” once understood as the depletion of “qi” in Chinese medicine, is now associated with high rates of depression in Asian American communities. Proponents of cultural competency argue this is because marginalized populations are more susceptible to mental disorders, reinforcing psychological explanations for life experiences. Critical social workers assert that major sources of stress will contribute to emotional problems, which suggests that social inequalities cause mental disorders. Cultural
competence is the official language the Federation, Hong Fook, and Across Boundaries use to
dress their policies on diversity, equity, and anti-racism.

**In Conversation: Race and Disability Studies**

Currently there are very few people working at the intersection of critical race studies
and studies of disability across North America who use Foucault’s (2006) approach to
historiography, called genealogy, to examine the range of ways distinct populations have been
pathologized, locally and globally. In particular, genealogies of madness and genealogies of race
have infrequently been in dialogue with one another. In her cultural history of panic in the
United States, Jackie Orr (2006) traces the origins of “panic disorder” to the intensified
collective fear of an enemy other during the Cold War. Yet Orr (2006) does not examine the
ways in which harnessing “mass hysteria” impacted race relations within the United States. In
contrast, Ann Laura Stoler (1995) has written extensively on the mutual constitution of colonial
and sexual ordering practices in the Dutch East Indies, French Indochina, British Malaya, and
India. Stoler addresses the absence of colonial encounters in studies of state governance.
However, she makes scarce references to the presence of asylums in colonial spaces. There is
limited literature that interrogates the construction of mental disorder in relation to empire.

Those who do conduct transnational and postcolonial studies of psychiatric power are
often not located in traditional academic disciplines. Alison Howell (2011) and Roland
Chrisjohn and Sherri Young (2006) are a few of the interdisciplinary scholars who use
Foucauldian genealogy to examine the imperial politics of madness, working at the boundaries
of international relations, critical race studies, and Native studies. For example, Howell (2011)
argues that Western humanitarian aid enlists all community members in the management of
those suspected to be mentally ill, especially those positioned as an obstacle to ‘development’,
through educating whole post-conflict populations on risks for mental disorder. ‘Risk’ is a form
of international tutelage. Psychologists’ labeling of Indian Residential School (IRS) survivors as
“sick” is also a form of tutelage. Chrisjohn and Young (2006) warn the postcolonial diagnosis Residential School Syndrome (RSS) decontextualizes the feelings and acts of Indigenous people from their experiences of oppression. RSS teaches survivors that their anger and demands for accountability from the Canadian state are an excessive reaction that requires rehabilitation. I revisit the contributions of these scholars in my theoretical framework in Chapter One.

The following interdisciplinary project not only rests at the interstices of women’s studies, postcolonial studies, disability studies, anthropology, sociology, and history. I question how these disciplines have contributed to the “psy” complex, naturalizing bodily difference in new ways.¹ Beyond critiquing the limits of culturalist or trait-based approaches to cultural competency in mental health (knowledge borrowed from anthropology), I am interested in troubling when and how feminist and anti-racist theories of trauma and violence are ushered into clinical practice. Through examining the social organization of race and mental health, I hope to begin addressing the lack of critical anti-colonial perspectives on the psy sciences.

¹ “Psy” refers to the set of professionals who aim to intervene in and modify the behaviour of others, including, but not limited to, psychiatrists, psychologists, psychotherapists, social workers, and guidance counselors, as well as paraprofessionals such as peer support workers.
1. From Epistemology to Genealogy: Towards a Relational Approach to the Construction of Race and Madness

Cultural competency or culturally appropriate care refers to policies, education, training, and practice in the mental health system on client cultural needs. The call for cultural competence arises out of two criticisms of mainstream mental health: (1) psychologists tend to focus on intra-individual characteristics “suggesting that we all exist within the same dominant culture” and (2) the “medicalization of human problems” does not account for the major sources of stress that contribute to emotional problems (Nezu, 2005, p. 21). Progressive practitioners argue cultural beliefs and values influence the meanings people impart to mental illness and that poverty and violence have direct roles in the causation of many mental illnesses. However, little has been said about the relationship between culture, oppression, and mental health from the perspective that madness is a historical construction, relation, technique, and ordering practice.

In this chapter I elaborate a theoretical framework for interpreting cultural competency as a form of racial governance and examine how “psy” practices produce and organize race rather than how racial oppression psychologically causes madness. Psy practices refer to processes of psychiatric and psychological assessment, diagnosis, and treatment both within and outside of the mental hospital, including sites such as schools, prisons, settlement agencies, and international aid organizations. By “madness”, I mean all manner of language and practice that invokes the ever-shifting, porous division between sanity/disorder and rationality/sentiment in the treatment of thought, feeling, and behaviour. As such, “madness” is a conceptual tool for illuminating the pervasiveness of the psy disciplines across all areas of knowledge production, beyond the confines of the physical asylum.

The first half of this chapter adumbrates a relational, genealogical approach to theorizing race and madness. Reading Erevelles’ (1996; 2005) reconceptualization of disability and the dialectics of difference in conjunction with Clough (2000) and Massumi’s (2002) (non-)identity politics, I posit that madness, a discourse about bodily difference, manages populations and
organizes labor relations through the ongoing demarcation of non-white bodies as already less capable, less regenerative, in epistemologies of gender, race, sexuality, ability, and sanity—“identities [that] cannot so easily be cleaved” (Puar, 2007, p. 212). Interpreting epistemologies of madness and “psy” practices as a multiplicity of governing strategies, I highlight how technologies such as psychopathology work to manage the lives of racialized communities. I then review existing literature that investigates the power relations of the “psy” disciplines for the extent to which madness is understood as institutionally structuring lived experiences of race. If we reflect on how “race” is coded through our physical bodies, heredity, and routine habits and values (objects in our social world attached to the “self”), it becomes clear that psychiatric power (knowledge about the self) is fundamental to “race thinking” (Arendt, 1973).

Erevelles (1996) warns poststructural theory that merely analyzes disability as oppressive meanings and representations fails to address the political and economic stakes in the social constitution of disability. This polemic call is echoed by Puar (2007), who argues that beyond the harms of (mis)representation, identities/identifiers (such as race and disability) exact violence as the progenitors of ever proliferating national “sensorial and anatomical” forms of domination (p. 215). My objective is to delineate an approach to the “psy” disciplines that not only frames therapeutic interventions as methods for governing the self and governing citizens, but also accounts for such interventions as a part of contemporary settler colonialism and white supremacy. Erevelles’ (1996) contributions to disability theory facilitate my articulation of a politics of madness that moves from the disabled subject, imbricated in “Euro-American identity-based rights politics,” to “a subject of prognosis,” in which everyone is living and dying in relation to “risk coding” (Puar, 2009, p. 165). Put differently, I suggest that some populations are regulated for disorderly behavior more than others regardless of whether or not they identify as disabled.

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2 To borrow from Arendt (1973), race thinking is the structure of thought that divides up the world along bloodlines, in which values, character and culture are inheritable traits.
To Foucault, power is not only direct violence, the right to take life or torture. Power is implemented through normalized practices, “a constant visible but unverifiable surveillance,” and through the maximization of a population, whose constituents are commodities to be fostered and optimized (Howell, 2011, p. 54). These forms of power are called discipline and governmentality, respectively. To answer Erevelles’ call for a geopolitics of disability (1996), I situate these subtle, strategic forms of psychiatric power within larger discursive and material spaces, in the management of race, citizenship, and colonial encounters. A genealogy of this scope connects the formation of psy knowledge to political struggles over territory, security, and life itself. In this way, I hope to provide a framework that studies how race and madness are mutually constructed, but also how the mutability of their construction is purposeful through the shifting historical role of race and madness in the technical implementation of structures of power.

There are a range of cultural competence theories and strategies used to address cultural diversity and racial oppression in mental health organizations. These can be captured in a typology of cultural competency’s epistemological assumptions (beliefs about race and culture). The second half of this chapter critically summarizes a typology of cultural competence models, emphasizing models that resist culturalist diagnostic practices. I ask: What are the subjective and material effects of tethering anti-racist theory to epidemiology? I challenge practitioners’ revised recommendations for practice and suggest that self-critical service models such as “informed not knowing” or “lack of competence” produce mental health service users as informants on the incidence of oppression-as-disease.

Disability as Relational Processes of Becoming

From a dialectical material perspective, disability is not an essential property in the individual, but something conferred on that individual through interactions with the social world. For Erevelles (2005), “[t]o accept this definition entails exploring not only how disability is discursively constituted… but also how and why it is constructed as the abject Other by the social relations emerging out of late capitalist societies” (p. 429). In this context, the interpretive
lens of poststructuralists is useful for reconciling seemingly separate social categories such as race, gender, and disability. According to poststructural theorists, such categories are interpreted as shifting, floating signifiers describing the same social reality. These multiple oppressions are not in competition, but in conversation with one another. Consequently, the significance of disability hinges upon the dialectics of difference.

However, interpreting all difference as related does not imply that such categories are unreal, existing only in a “fictional discursive space,” as this fails to challenge the lived conditions under which difference is excluded or exploited within society (Erevelles, 1996, p. 524). According to Erevelles, this is a critical oversight by poststructural theorists. To engage an analytics of construction we must historicize those constructions and acknowledge their enduring material consequences beyond the realm of textual representation. In her study of social welfare in South India, Erevelles (1996) tracks how lack of access to accumulated capital, poverty, and inequity all label subjects “‘delinquent,’ ‘physically and mentally handicapped,’ ‘problem families’” due to the stigma of being unproductive as a result of non-participation in the market (p. 532). These labels function to rehabilitate “deviance” rather than mitigate the economic conditions that produce deviance. Erevelles (1996) argues disability, in this context, works to produce an industrial reserve army of labor through the idea and practice of rehabilitation.

Contrary to Erevelles’ (1996) claims, not all poststructural thought shies away from ontology. Technoscience critics like Clough (2000) and Massumi (2002) breathe organic and non-organic life, matter, and form into the indeterminancy of identities such as gender, race, class, and sexuality. Social and cultural determinations (positionality and identity) “feed back into the process from which they arose” (Massumi, 2002, p. 8). This complexity of process can be characterized as a “machinic assemblage” (Clough, 2000, p. 135). Component parts of our social reality such as race and madness take shape or “become” together on institutional and technological “plane[s] of consistency” irreducible to subjective desires or gridlocked identities (Clough, 2000, p. 135). Technological planes of consistency include “means of judgment
(clinical examinations, tests, examinations, assessments with their associated norms and normativities); the techniques of reformation and cure (pedagogic, physical, therapeutic, punitive); [and] the apparatuses within which intervention is to take place (design of prisons, classrooms, equipment, the connection of these into larger assemblages such as schooling or health visiting)” (Rose, 1999, p. xi).

Further developing Clough’s notion of machinic assemblage, Puar (2007; 2012) argues racialized, sexualized, and disabled populations should not only be understood as reactive community formations (intentional social movements): these marked differences are hailed against individual will, biopolitically in a multiplicity of merging configurations. For example, Puar (2012) observes that an “increasingly demanding ableism” produces the body as “always debilitated in relation to its ever-expanding potentiality” (p. 153-154). Through the introduction of new “degrees” of depression and the promotion of top-up medications such as Abilify, rates of depression rise (Puar, 2012, p. 156). In this context, Puar (2012) points out that poor and working class communities of color are doubly “disabled” as bodies already living in “slow death” (p. 152). Getting by with limited resources to afford medical bills, poor and working class communities of color are more permanently (in)capacitated (cornered as a highly productive, yet highly disposable workforce) (Puar, 2012, p. 152). I would add that racialized populations are not simply/additionally marked out for wearing out (“we suffer more”), fairing worse amidst rising standards for able-bodiedness: the ever-expanding work of symptom-naming and biological/affective “tweaking” anticipates culturally-specific “problems” such as neurasthenia (worker burnout syndrome) in Asian American communities. That is to say, highly exploitable populations are exceptionally medicalized; emergent therapeutic modulations help constitute racial taxonomies.

Labor is central to a dialectical material analysis. Erevelles (1996) contends that the study of labor will contextualize the political implications of disability because it will account for how disability benefits capitalism. Labor can also be thought of more generally as a lens through which we can temporalize the construction of disability into series of institutional work
processes and activities. By centering relational processes of production, it is this later notion of labor that I stress when using the term *dialectical material*. I now juxtapose studies that problematize negative representations of madness in society against studies that problematize how madness “orders” society.

**Defining Madness**

Contrary to a constructivist framework for analyzing disability, most critical writing on the power relations of North American mental health conceptualizes madness, at its core, as an infallible signifier of bodily difference. Motivated by an investment in the reality of madness as a universal feature of the human condition, scholars problematize madness through the politics of representation and self-determination. Because madness is understood as an inherent property of the body, scholarly analysis of madness is remiss of the historical uses of madness to construct and maintain racial categories. Instead, race and madness are theorized through two dominant trajectories.

One the one hand, Roman, Brown, Noble, Walner, and Earl Young (2009) claim psychiatric disenfranchisement is a new form of colonialism. The psychiatric violence experienced by institutionalized white settlers is like colonialism or like slavery, and therefore similar to, but distinct from, “race”. The experiences of Indigenous people and people of color are connected to psychiatric users and inmates through likeness or allegory. On the other hand, scholars such as Titchkosky and Aubrecht (2010) and Tsao (2010) argue psy practices biologize or individualize genuine psychological crisis, obscuring the cumulative effects of racialization and capitalism that essentially cause madness. Race and madness are related because racial oppression precipitates madness. Both paradigms rely on “an unrelenting epistemological will to truth” in their definitions of madness, in which madness either physically becomes (writes over or “whites” out) race as a symbol of persecution or explains race as an oppositional consciousness and resistant identity (Puar, 2007, p. 216). These authors invest in race as a radical truth that psychically mirrors or precipitates the emergence of mad people. Race is not enjoined with other logics of control; not conceived as artificial interpellation.
Contesting previous accounts on the birth of British Columbia’s first insane asylum, Roman, Brown, Noble, Walner, and Earl Young (2009) argue the Woodlands School (formerly the Public Hospital for the Insane) was an example of medicalized colonialism from 1859-1897. The authors form a connection between asylum-making and colonialism through describing the violent conditions experienced by Woodlands inmates as a unique form of colonialism. Dehumanization and disenfranchisement are made synonymous with colonization through their use of the term “juridical medicalized colonialism” to describe the conditions experienced by majority “white” inmates at Woodlands, estimated at 85% between 1872 and 1890 (Roman et al, 2009, p. 36). Rhetorically, inmates regardless of race are characterized as colonized. This rhetorical move is risky in the context of settler colonialism seizing Indigenous land, which differently positions the stakes of settlers from those of First Nations people.

As a metaphor, colonialism is used by Roman et al. (2009) to represent how “actual people were horrifically abused, many losing their lives” and to claim that survivors of the Woodlands school require reparation from the Canadian government that mirrors Prime Minister Stephen Harper’s “apology to all Aboriginal, Metis and Inuit former students of residential schools for First Nations” (p. 53). They state “[n]o such step has been taken with the survivors of Woodlands or any other residential school for people with developmental disabilities in Canada” (Roman et al., 2009, p. 53). Without explaining why they use the term “residential school” to describe disabled whites, the likeness the authors draw between the violence of colonial education and survivors of the Woodlands school construes Indigenous and disabled communities as two discrete populations, relatable only through comparison. Their choice of phrasing suggests that techniques and strategies used to justify Indian Residential Schools and later reconcile that history are not borrowed from, influenced by, or the endemic to scientific constructions of normality/abnormality. It omits important questions: How does psychiatric commitment co-constitute the construction of the “Indian” as Other?

By assuming the category of disability is separate from race, Roman et al. (2009) are limited to connecting disability and race through an additive model of oppression. To elaborate,
the authors remark that patient laborers, held against their will to pay off expenses they incurred as wards, provided opportunities for asylum managers to deport unwanted migrants—namely Chinese inmates. They note “racialized and gendered moral panics constructed particular groups of inmates as the greatest ‘burden’ to the cost-effective management of the PHI Asylum” (Roman et al., 2009, p. 36). Through conceptualizing disability as a punishable physical difference, the authors do not connect the production of deficit to race thinking in the development of psy practices, reducing race to an external anxiety influencing the actions of asylum staff (hence “additive”). Aside from commenting on the strategic development of Woodlands on unceded Songhees First Nations land, inquiry into the use of psychopathology to produce racial difference and rationalize European jurisdiction over Indigenous peoples would better substantiate the connection between madness and colonialism (Roman et al., 2009, p. 27).

Like Roman et al. (2009), White (2009) sees disability as discrete from constructions of race and compartmentalizes Indigenous and immigrant struggles within existing disability analyses. These authors appropriate the language of self-determination from Indigenous sovereignty and anti-racist movements, employing discourses of survival and cultural revitalization, while simultaneously writing out the complex systemic injustices faced by Indigenous and racialized people in their discussions of disability rights organizing. White (2009) argues that the Mental Health Commission of Canada (MHCC) affirms, rather than destabilizes, madness as a disease and mental illness as a national problem. For example, high profile news reports initiated by the MHCC are “marketing the reality of the ‘disease,’ [which] is more likely to formalize than transform dominant conceptualizations of mental illness.” (White, 2009, p. 231). She argues that MHCC’s refusal to use inclusive, non-medicalized language to describe people with mental health experiences3 “denies mad citizens and survivors the right to be self-determined… to locate themselves in culture, to reclaim their histories and assert a politics of identity [as mad]” (p. 242). While mad culture offers interventions on negative representations of people labeled with mental illness, a politics of inclusion that relies

3 “Mental health experiences” refers to experiences of the mental health system.
on an essential model of mental difference undermines resistance against the hegemonic and institutional production of those differences. In her study of the Mental Health Commission of Canada’s nation-wide anti-stigma campaign, White’s (2009) conceptualization of madness as physical difference undercuts her analysis of race and madness, subordinating racialized peoples’ experiences under a dominant discourse of incapacity.

MHCC anti-stigma campaign sites include homeless people living with addictions in Vancouver, non-English speaking immigrants in Toronto, and urban Aboriginals in Winnipeg. (p. 232). Noting how “poverty, race/culture/ethnicity, citizenship status and vice [are made] relevant to the manifestation and management of illness,” White (2009) opens her discussion with a critical observation: through actuarial knowledge, the campaign governs the labor power of people of color by especially characterizing them as diseased. People of color are educated on mental illness at these sites to encourage acceptance of mental health intervention. This includes raising awareness on the hazards of “adjustment disorder,” shorthand for depression, anxiety, worry, fatigue, anger, sadness, poor self-esteem, and self-image caused by “moving from ‘working to nonworking status’” (p. 233). White (2009) maps how anti-stigma benefits psychiatric intake, recovering productivity—particularly the productivity of immigrants and urban Aboriginals.

However, White (2009) does not go on to consider how aspects of the anti-stigma campaign construct these populations as racially different, which suggests she believes the “chosen” communities of the campaign are significant only in their lack of productivity (nor does she historicize these populations’ conditions of “unproductivity”). Instead, what promises to be a generative theory of racial governance is stymied by her subsequent explanation that the anti-stigma campaign is a “colonial exercise” to the extent that it privileges “dominant notions of universality/standardization, progress, science, reason, order, economics and citizenship/identity” (White, 2009, p. 234). Here her discussion of race abruptly ends in a conceptualization of colonialism absent of race and empire. In White’s (2009) view, the anti-stigma campaign is a colonial exercise because the notions of progress, science, reason, order,
and economics—the cornerstones of colonialism—each construct the capacities of mad people as diseased, a burden on society (and thus, non-citizens). Non-whites are targeted by this colonial exercise because they may also be read as mad and diseased by virtue of their economic marginalization. White (2009) problematically naturalizes the association between non-whites and poverty by omitting the historical relationship between race and unemployment. Because White (2009) theorizes colonialism as non-specific ideologies of sameness/otherness, normal/abnormal, and productive/unproductive, she reduces the targeted policing of immigrants and Aboriginal peoples to the MHCC’s pathologization of poverty. “Madness” takes rhetorical precedence over “color” in her conclusion that “Mad peoples have endured a long history as marked individuals: targets of discrimination, attack, exclusion, violence and oppression” (White, 2009, 235).

Although White (2009) mentions the socio-political, institutional, and historical phenomenon of mental illness provides “the tent poles to support numerous state-sanctioned initiatives,” fundamentally influencing the ways we “regulate ‘problem’ individuals and groups,” she fails to develop this claim by overlooking the racial project of “identifying risks, and segmenting and managing at-risk populations” in her articulation of mad identity (p. 232). How many community members from the three project sites of the MHCC’s anti-stigma campaign would challenge psychiatric interventions through self-identifying as mad?

Titchkosky and Aubrecht (2010) and Tsao (2010) also leverage their critiques of mental health outreach through a politics of identity, redefining and authenticating mental difference. Titchkosky and Aubrecht (2010) trouble the World Health Organization’s (WHO) mental health literature. They problematize the WHO’s definition of adaptive capacity, arguing that “resilient behaviour” naturalizes the history of colonialism as part of the “‘normal stresses of life’” (p. 184). Titchkosky and Aubrecht (2010) respond by providing an alternative phenomenological account of madness, arguing that the WHO “dichotomizes mental diversity into mental illness or not, and colonizes relations to anguish and to knowledge” (p. 180).

By focusing on the meaning of madness, the authors make a truth claim: madness is
anguish and mental diversity is non-Western knowledge. Control over the mind is generalized as “colonizing” in place of a complex depiction of the dialectical relationship between psychiatry and colonial rule, echoing Roman, Brown, Noble, Walner, and Earl Young’s (2009) concept of juridical medicalized colonialism. They argue mental health outreach is colonizing because it neglects traumatizing histories (“anguish”). In response to the WHO’s cost-benefit analysis of mental health treatment, Titchkosky and Aubrecht (2010) conclude:

> With the assumption that ‘[m]ental, neurological and behavioural disorders are common to all countries and cause immense suffering’ (WHO ibid.), the WHO begins the work of abstracting people from the location and history of their suffering. This work entails mapping minds as if they share a common unity in illness. (182)

Although critical of a globalized biomedical model of mental illness, this quote suggests the problem with international mental health outreach lies not in the diagnosis of psychological suffering, but in the universal interpretation of this suffering as a result of neurological/biological disease. By interpreting the WHO’s actions as abstracting people from historical reasons for suffering, the authors substitute one explanation of mental illness for another by theorizing “mental difference” as a response to external stimuli. Their social analysis of disability remains steadfast to a material body that ends in the individual, in which mental illness names an observable disturbance to the mind. They implicitly adopt a trauma model and advocate diverse treatments based on diverse traumas. If Titchkosky and Aubrecht (2010) “stretch[ed] the perceived contours of material bodies,” they would discover the technology of mental illness is not merely an interpretation of the body, but a series of stipulations directing the body (Puar, 2009, p. 165). The construction of the mind (madness, “mental difference”) does not stop at its interpretation (as if that “it” were fixed), but continues to assemble and disassemble through society’s jurisdiction over its perpetual motion.

The argument of history-as-symptom is itself a mental health discourse used to racialize people. A positive representation of disability as “wounded soul” can still be used to prescribe
social remedies, such as empowerment work and affirmative thinking—other forms of
governing the self. In their effort to challenge “how disability is constructed as nothing but a
problem,” Titchkosky and Aubrecht (2010) prescribe a vague, overdetermining victim narrative
(p. 181). They make two assumptions: (1) while constrained by existing diagnostic schema,
international psy workers correctly identify “problems” with the mental health of postcolonial
populations, and (2) because colonial occupation was succeeded by increased mental health
treatment, colonialism triggered these mental health problems. The authors reinforce the belief
that psy workers are reserved the right to determine who is healthy and who is not and the power
to rearticulate the causes of mental illness/diversity/difference. Their argument that the WHO is
institutionalizing a singular model of Western mental health across multiple non-Western
contexts is premised on the belief that this outreach is proactive and geographically even, rather
than reactive. They do not consider the possibility that disorder is constructed by international
authorities and calculated in its construction, targeting specific communities in an effort to exert
control over the activities of those communities.

Similarly, Tsao (2010) argues “the cultural ubiquity of economic logic” is a source of
psychological illness. She argues the rhetorical strategies employed by mental health patient
advocates in Toronto deny “the structural violence of capitalism as a primary determinant of
psychological distress” (Tsao, 2010, p. 83). Using corporate anti-stigma campaigns and
community-based bureaucratic literacy programming for psychiatric survivors as examples,
Tsao (2010) contends programs in patient education and ex-patient skills training form
“governmental subjectivity” through epitomizing patient self-control and productivity as
advocacy goals (Tsao, 2010, p. 86). Yet, her critique of productivity does not challenge the
assumption that patients are unproductive. In a circular argument that both relies on and rejects
capitalist definitions of labor, Tsao (2010) argues unproductivity is the result of worker burnout
in capitalist societies. She does not consider the possibility that higher rates of diagnosis
correlate with growing austerity measures, in which neoliberal regimes “produce the body as
never healthy enough” (Puar, 2009, p. 167).
Instead of determining that people are objectively ill, mad, or distressed because of poverty, as Tsao (2010) does, is it possible to take a different approach and begin with the assumption that “the poor are more likely to be diagnosed as mentally ill” (Howell, 2011, p. 94)? In lieu of claiming capitalist logic causes mental illness, an argument that uncritically relies on psychological reasoning, like Erevelles (1996) I wish to query how constructions of disability benefit capitalism or how human services (from community living to community mental health) govern populations.

**Historicizing Madness**

An epistemological analysis, one that evaluates the truth claims of madness or naturalizes madness, will not address the relational development of psychiatry. An approach to discourse analysis informed by Foucauldian genealogy—an approach that deconstructs the truth of madness and studies its facilitation of racial governance—is one strategy for answering Erevelles’ (1996) call to break the threshold of a politics of identity (politics that redefine or reclaim madness). According to Foucault (2006), those things we consider objective are backed by power and interest. Foucault (2006) is not interested in interpreting power as a negative vocabulary. In Davidson’s (2006) words, Foucault warns that those “apparatuses of normalization that are intended ‘to provide relief, to cure, to help,’ one should hear ‘the rumbling of battle’” (p. xvii). Through genealogy, researchers not only study the micro-relations of how madness is textually constructed (strategies, technologies, and explanations used to gain the psy disciplines the status of truth), but why and by whom. However, genealogies of madness and genealogies of race have infrequently been in dialogue with one another.

This next section first introduces theorists that situate madness as a method for conducting citizens through their mental capacities. Foucault (2006) and Rose (1999) conceptualize the psy disciplines as an exercise of power reliant on subtle persuasion and a perception of personal choice and freedom. However, their analyses privilege the metropole, failing to elaborate on the geopolitical relationship between the psy disciplines and empire. They do not fully address the range of colonial interests underpinning the development of the psy
disciplines. The later of half of this section reviews contemporary scholarship that maps the imperial politics of madness (Chrisjohn, Young, & Maraun, 2006; Jackson, 2005; Howell, 2011; Vergès, 1999).

In his lectures on psychiatric power, Foucault (2006) identified three techniques used by nineteenth century psychiatry to constitute illness prior to the physical body being incorporated into the concept of madness. These techniques suggest that determining who was mad or not mad was dependent on scrutiny by social peers and the patient’s own complaints. They include psychiatric questioning, confession, drugs, and hypnosis.

Psychiatrists use questioning to verify a patient’s madness through constructing their medical history, in which “one invents, one cuts out a sort of huge fantastical body of the family affected by a mass of illnesses,” as well as constructing “prodromes” or early symptoms indicating the onset of illness (Foucault, 2006, p. 271). As a technique, questioning establishes a past that suggests madness was inevitable through forming a narrative of abnormalities preceding the onset of illness. Confession is the acceptance of disease by the patient, in which the patient must actualize their madness. Foucault (2006) describes this technique from the perspective of the doctor: “The action by which you will be cured of your madness is also that by which I will assure myself that what I do really is a medical act” (p. 275). Drugs were used as a technique to authentically reproduce “illness”: doctors who took hashish used their experiences of intoxication as a way to theorize an evolutionary sequence to madness (including phases such as delirious convictions, irresistible drives, and hallucinations). Hypnosis, as a procedure that requires the patient to lie still, was a technique for gathering information from the body and to manipulate the body. Hypnosis is exceptionally powerful as a technology of observation because it did not depend on a patient’s verbal responses, but merely required the patient yield to the doctor’s requests (such as lifting your arm), from which the doctor could produce any number of conclusions. “[T]he patient’s body is finally available to the psychiatrist in, as it were, its functional detail” (Foucault, 2006, p. 287).

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4 “Their” is also a gender-neutral pronoun.
Foucault (2006) does not explore the wider social implications of these psychiatric techniques until his lecture on the neurological body and hysteria (6 February 1974). Here he distinctly connects the apparatus of trauma and the diagnosis of hysteria to “the medical, psychiatric and psychoanalytic take over of sexuality” (Foucault, 2006, p. 323). Neurologists between 1850 and 1860 returned to an impressionistic study of the surface of the body and its exterior movements. Neurologists searched for a theory to explain patients’ voluntary, spontaneous behaviours. Trauma is “something that provokes a localized and permanent hypnotic state,” the “general reactivation” of authentic, historically pin-pointed responses in the body by hypnosis (Foucault, 2006, p. 317). According to Foucault (2006), patient use of sexual behaviour to confuse the neurologist’s attempts to stimulate trauma enabled the neurologist to pathologize the hysteric’s own sexual history as additional signs of disease. Consequently, neurology, through behavioural stimulation, helped to discipline and control sexuality (by privately rehabilitating women’s sexual dissatisfaction).

In *Governing the Soul*, Rose (1999) expands on Foucault’s (2006) genealogy of psychiatric power by arguing that the psy disciplines are central to contemporary “government at a distance” through its construction of free, but responsibilized choice (p. xxii). Governmentality not only exists in psychiatric assessment and the patient’s solicited actualization of their clinical diagnosis. The psy disciplines articulate power through developing techniques for “self-inspection, self-problematization, self-monitoring” through which “we evaluate ourselves according to the criteria provided for us by others” (Rose, 1999, p. 11). Though Rose (1999) reviews how techniques of the “self” are used in corporate management strategies, war, and parenting, he does not particularly elaborate on how these techniques impact different populations in question. For example, in his chapter “The Gaze of the Psychologist,” Rose (1999) explores how techniques for normalizing behaviour in child development draw our attention to a few human features and not others, such as line drawings of child test subjects that reduce children to a few behaviours. Rose (1999) argues with the construction of perceptual systems, like line drawings, tables, and graphs that constructed norms relative to age,
subjectivity could be governed in a new way. These programs for disciplining the child would increasingly responsibilize the private family with the management of its offspring through the activation of guilt and promotion of ambition among parents.

Rose’s (1999) historicization of technologies such as “capacity” and “attribute” in intelligence testing illustrates to us ways difference in school can be managed, but does not illustrate *which* differences (p. 138). What differences are screened as unique, idiosyncratic? Here, Erevelles offers insight on the political economic stakes of developmental psychology. In her study of curriculum as a normalizing text, Erevelles (2005) argues special education, as an ideology of disability founded on meritocratic science, reproduces and naturalizes dominant class relationships, divisions of labor, and cultural hegemony in American public education. In special education, tools such as psychometric testing remove urban poor (new immigrants, Native Americans, and black students) from regular classes into curricula suited to their designated slot along the social division of labor. It is through being labeled “at-risk,” “learning-disabled,” and “emotionally-handicapped” that this reproduction of cultural hegemony occurs (Erevelles, 2005, p. 435). Erevelles (2005) contends disability is used as an ideological tool to justify social hierarchies produced and maintained within capitalist societies as “natural” (p. 521). Yet, an ideological analysis of disability as “modes of thinking” does not give a fuller account of the *work* of psychometric testing. I suggest a Foucauldian analysis of power not as ideological, but technological, would investigate the actual processes employed in psychometric testing and cognitive assessments, processes which reproduce race and class.

Rose (1999) asserts the “diversity and heterogeneity of psychology [enables] it to operate with a diversity of contexts and strategies for the government of subjectivity—different ways of articulating social power with the human soul” (p. 10). Recalling Erevelles’ (2005) example, it is possible to see how the psy disciplines, through explanations, technologies, and strategies such as medical history, intelligence testing, and behavioural observation, discipline and govern race and class using processes of individualization. However, Erevelles (2005) herself does not use genealogy to provide more concrete detail on the constitution of race and
class through technologies of the “self”—our personalities, habits, and behaviours. Postcolonial and anti-colonial empirical studies of psy practices demonstrate the kinds of material connections that can be made between the construction of the psyche and the management of racialized populations.

In the context of global politics, Howell (2011) argues that the psy disciplines are best understood as “strategies of intelligibility and technologies of security and order” which operate unevenly depending on a population’s location in the global order (p. 63). Howell (2011) argues the forms of power the psy disciplines take shift based on assumptions about who can self-govern and who cannot. For example, patients viewed as security threats often receive extreme forms of punishment and detention. Detention continues to be a relevant reality for “deviants” within liberal democratic states. As such Howell (2011) advises Foucauldian scholars to reconsider the dominant emphasis laid on discipline and governance, stating that these forms of power are articulated simultaneously with sovereign power. “Not only is governance at the national level dependent on sovereignty and on the system of sovereign states, but the exercise of sovereign power [the right to kill] is compatible with—and often justified by reference to—the biopolitical health [the need to improve] of national populations” (Howell, 2011, p. 57-58). This is reflected by the variety of psychiatric strategies and technologies used in colonial encounters, which include, more generally, ethnopsychiatry and asylum-making.

Ethnopsychiatry is used in thinly veiled criticisms of Third World nationalisms (Jackson, 2005) and in the psychologization of development (Howell, 2011). Ethnopsychiatry provides explanations of political unrest as ethnic tension, which psychologizes mass resistance against international economic arrangements as prejudiced attitudes. Theories of ethnic tension transform the international development of post-colonial societies into an intensely biopolitical project because international aid responds through a “‘relationship of tutorship’” (Howell, 2011, p. 92). Western development, as a disciplinary power, pacifies resistance through translating struggles for independence into the object of education on the cultural “problem” of violence. Conversely, asylum-making, as an example of sovereign power, has been used in the
segregation of black patients from their white counterparts in colonial Zimbabwe at the Ingutsheni Lunatic Asylum (Jackson, 2005). Black patients in urban psychiatric hospitals such as Ingutsheni received straight electroshock or electroconvulsive therapy (ECT) without anesthesia. To situate this form of torture, Jackson (2005) notes that where and who a person was and how they were mapped in that colonial space determined the process of ascribing madness. If you were a black colonial subject in the municipal center of colonial administration in Southern Rhodesia (colonial Zimbabwe), extreme measures were taken to contain your blackness within that space, such as ECT. Ethnopsychiatry and segregated asylum practices show us how empire is secured both through persuasion and force.

My theoretical interest in etiologies of madness as disorder lead me to consider examples of racial power articulated through mental health diagnosis and treatment, including risk assessment, post-traumatic stress disorder (PTSD), and postcolonial pathologies such as Residential School Syndrome (RSS). These technologies are examples of discipline and governance that maintain colonial order through pathologizing race. In “The Diagnostic Competition Over Post-Conflict Populations,” Howell (2011) analyzes the Guidelines on Mental Health and Psychosocial Support in Emergency Settings released by the United Nations Inter-Agency Standing Committee (IASC). These Guidelines recommend a move away from mass diagnosis of PTSD in communities exposed to civil conflict, instead preferring that societies be assessed for their risk of developing a wide range of mental illnesses or extreme manifestations of pre-existing mental illnesses. Howell (2011) notes that this establishes a clear division of labor between community workers, who are expected to provide frontline preventive psychological aid, and doctors, who are expected to treat severe mental illness and PTSD.

Interestingly, no one is exempt from this category of at-risk, which includes “women, men, children, the elderly, the poor, refugees, people exposed to extremely stressful events, people with pre-existing mental disorders, the institutionalized, those experiencing social stigma, and people at risk of human rights violations” (Howell, 2011, p. 102). The technology of risk assessment suggests that the United Nations believes widespread mental health intervention
will create peace, which reiterates the discourse of ethnic tension or ethnic strife—that conflict is an emotive state, under which everyone is at risk of developing mental health complications. Howell (2011) notes “[a]ll community members are enlisted in the management of those deemed or suspected to be mentally ill, especially once they have been positioned as obstacles to ‘development’” (p. 97). Although she does not get into much detail on what kinds of education and training are provided by aid workers, Howell (2011) emphasizes how “risk” related work is a project of teaching local community members how to care for themselves under the assumption that community self-care will prevent future conflict. As such, she brings us to question how psychiatry, as technologies of development, directly shapes possibilities for political independence.

While the IASC Guidelines mark a shift in the psychological treatment of post-conflict situations, from mass trauma to a “holistic” model of disease (broadened to include alcohol abuse, grief, depression, and anxiety disorders), the diagnosis of post-traumatic stress disorder and the explanations offered by trauma theory remain a powerful disciplinary technology through constructing the memory of historical events as the symptoms of a disease. High rates of PTSD diagnosis are suspicious when it is analyzed as a strategy for relocating distress from the social arena to the clinical arena, allowing for visions of war by survivors to escape from scrutiny. Citing Edkins (2003), Howell (2011) maintains that PTSD depoliticizes trauma and reduces political action into nothing more than an acting out of symptoms (p. 106).

PTSD’s construction of violent memory as disorder has also been used in postcolonial psychiatry in colonized pathology. Residential school syndrome, a unique form of PTSD, interprets the injuries of Indian Residential School (IRS) survivors through disorder. “When it came to understanding Indian Residential School, everyone, it seemed, wanted to be a psychologist” (Chrisjohn, Young, & Maraun, 2006, p. 20). Citing Goffman’s (1961) concept of total institutions, Chrisjohn, Young, and Maraun (2006) acknowledge that IRS used institutional tactics that caused a mortification of the self and deculturation. However, they also argue that responding to this history using modern social science can reproduce this destruction of the
inner life. Labeling survivors of IRS is mortifying because it decontextualizes the feelings and behaviours of Indigenous people from their experiences of oppression, isolating such feelings and behaviours into an excessive reaction rather than reasonable response. In this case, trauma is used in an individualizing and circular argument: the colonized must solve the problem of their own colonization.

PTSD’s ability to make anger and political unrest a bodily inability serves the dual purpose of erasing political accountability from view, which is a consequence of removing people’s activities from their relationships to one another. Chrisjohn, Young, and Maraun (2006) call this a game:

We will not call Aboriginal Peoples who suffered through the Residential School experience (whether they enjoyed it or not), nor those who have come to live in the toxic world it created sick, any more than we would call the hungry Aboriginal children who crept into the larder at night for food thieves. We will not play this game. (p. 96-99)

Besides pathologizing pain related to colonial history, postcolonial psychiatry can be used to maintain colonial rule through psychologizing the family. Vergès (1999) argues the pathologization of Creoles by European psychiatrists on Réunion is a patronizing violence. According to Creole postcolonial pathology, being of mixed race origin lead to confusion and weakness in identity, which hindered individuation—a fundamental passage to adulthood. In particular, European psychiatrists identified the high rates of Creole single mothers as the source of this problem with Creole identity, implying healthy individuals can only mature through white masculinity. This theory renders European dominance on Réunion into a matter of natural selection. It is through translating historical memory, community conflict, and mass political resistance into ethnic tension, trauma, risk, and self-harming behaviour that the psy disciplines constitute race. In this translation of political events into cross-cultural psychology, madness becomes a way to disqualify some people from determining their affairs.

**Governing Through “Competency”: A Typology of Cultural Competence Models**
Epistemology (a theory of justified beliefs about reality) and genealogy (an account of how beliefs are historically developed practices of power) bring two radically different perspectives to the interpretation of madness. Foucauldian genealogy resists causal narratives between race and madness because it critiques the assumption that the mind is an objective entity, examining the socio-political consequences of its construction. This distinction between studying what is true and what truth does is central to the second half of this chapter. In the following review of cultural competence models, I respond to the recommendations made by medical anthropologists, critical social workers, and psychologists through an approach to the psy disciplines as technologies and strategies.

Ethnographers, critical social workers, anti-racist and anti-oppressive practitioners, and poststructural therapists have urged the helping professions to consider historical differences between individuals and groups of people in response to the limitations of postpositivist practices (Nezu, 2005). Postpositivism refers to practices that employ a stable constellation of cultural traits (Williams, 2006). Postpositivists rely on universal “textbook” knowledge about different cultures because it is a feasible strategy in large institutional settings. In contrast, constructivism asserts reality is locally constructed in a dialectical process between people sharing the same lived experience (i.e. culture is a historically contingent, co-constituted phenomenon), implying that services “may be best provided by practitioners who are identified as cultural insiders” (Williams, 2006, p. 213). Medical anthropologists such as Kleinman and Benson (2006) promote this open, yet contextualized approach to cultural competence, in which learning a client’s cultural needs implies learning “what is [presently] at stake for patients, their families, and, at times, their communities” (p. 1676). Different, though related, is critical theory or anti-racist practice. Rejecting a culturalist framework, critical theory responds to distress through consciousness raising and activism, identifying the client’s location within social, political, and economic arrangements. Coached in self-advocacy, a woman might be encouraged
to reflect on her “despair and guilt as an unjust consequence of systemically reinforced self-blame for processes that were orchestrated beyond her” (Williams, 2006, p. 217). In the remainder of this chapter, I trouble the ongoing unequal power relations between psy institutions and service users in constructivist and anti-racist models of cultural competency.

**Narrative prospecting on the frontier of human suffering**

*(Pathology According to Ethnography)*

Constructivists are critical of cultural competency’s rigid stereotypes about what members of a particular “culture” believe, do, or want and its lack of recognition that culture has other dimensions of difference constituting life experience and identity, such as literacy and socioeconomic class (Taylor, 2003, p. 556). They argue that cultural competency reduces culture to a technical skill or a series of “do’s and don’ts,” where patients of a certain ethnicity are “assumed to have a core set of beliefs about illness owing to fixed ethnic traits” (Kleinman & Benson, 2006, p. 1673). This dangerous stereotyping has colonialist implications since antithetical knowledge about the Other is “essential to the regulation and discipline of the colonized” (Wong, 2003, p. 152). Narratives of cultural totalities deny how culture is “full of contending discourses, all of which are mediated by power” (Wong, 2003, p. 151). However, I argue the solutions constructivists propose, which try to promote a flexible, “practical understanding of a [client’s] episode,” do not acknowledge the governing implications of searching for precisely that: the episode, the abnormal, the pathological (Kleinman & Benson, 2006, p. 1673). Constructivist approaches include “informed not knowing” (Furlong & Wight, 2011), “mini ethnography” (Kleinman & Benson, 2006), and “lack of competence” (Wong, 2003).

Opposing medicine’s “hidden curriculum” of systematically discounting patient narratives, Taylor (2003) argues medicine’s practice of superimposing “plots” onto people’s lives is as “cultural” as the everyday practices of patients (p. 558). Taylor (2003) maintains that patient life experience is as valid as clinical knowledge on illness. Quoting Hafferty (1998), she
states, “the ‘psychosocial’ aspects of most patients’ illnesses, their social histories and emotional states, and their lives outside of the hospitals and clinics… [are] regarded as ‘inadmissible evidence’ [in medical school curricula]”, implying that the pathogenic origins of mental illness should be rescaled from genetic abnormalities to social inequalities (Taylor, 2003, p. 557).

Although the psychosocial model is sensitive to and inclusive of differences in patient experiences, it relies on a linear narrative between life history and illness that rearticulates and reinforces a discourse of bodily deficit. The psychosocial model constructs all social activities as possible factors in disease control, making mental health outreach a powerful strategy for governing undesirable populations. Taylor (2003) uses the words “emotional states” interchangeably with “illness” without considering how viewing life itself as a cause of illness introduces a different set of therapeutic consequences from those of the biomedical model.

Carpenter-Song, Norquest Schwallie, and Longhofer (2007) also discuss the significance of patient narratives. Unlike Taylor’s emphasis on power and oppression as sources of mental illness, Carpenter-Song et al. (2007) focus their attention on patient worldviews as the basis through which practitioners should map patients’ needs, describing culture as dynamic and indeterminate. Carpenter-Song et al. (2007) recommend psychiatrists attune to the “different cultural orientations to the nature and meaning of suffering” (p. 1363). By determining what is relevant to each patient’s own perception of illness, practitioners can establish “ethnically normative” behaviours when treating “unusual or unfamiliar complaints” from ethnic minorities (Carpenter-Song et al., 2007, p. 1364-1365). But are all complaints about “illness”? They do not explore the political conditions precipitating the encounter between the psychiatrist and patient.

Similar to the process-oriented and meaning-centered approach of Carpenter-Song et al., Furlong and Wight (2011) suggest social workers practice “informed not-knowing” to mitigate cultural essentialism (p. 48). “[A]n attitude of not-knowing as a starting point… signals the professional’s acceptance of their one-down status as a learner” (p. 49). In “informed not-knowing”, the helper-learner gathers cultural knowledge about the ethics and belief systems of other communities, such as Buddhist teaching or Indigenous interdependency in order to
transform their understandings of health and pathology and expand their perception of illness beyond the Western medical model. However, Furlong and Wight’s (2011) notion of health is still couched in the dichotomy of health/illness—specifically a deficit-model of illness—which may not be relevant or useful to the political concerns of patients. “Not knowing” is “wanting to know” alternative models of health. The search for alternative conceptions of pathology overlooks the institutional arrangements that culminate in the therapeutic encounter between helper and patient. For example, in their review of Australian Aboriginal cosmology, not once do Furlong and Wight (2011) problematize the disproportionate institutionalization of Indigenous people. A genealogical analysis of medicine as dialectical, rather than Taylor (2003) and Furlong and Wight’s (2011) analysis of medicine as cultural, would ask how medicine structurally intervenes on everyone’s experiences, rather than asking how medical knowledge is ignorant of different experiences.

“Informed not-knowing” parallels Kleinman and Benson’s (2006) model of mini ethnography. Kleinman and Benson (2006) advocate clinicians train in ethnography, “an intensive and imaginative empathy for the experience of the natives—appreciating and humanly engaging with their foreignness, and understanding their religion, moral values, and everyday practices” (p. 1674). The purpose of mini-ethnography is to map each patient’s personal definitions of illness, their social roles at home and at work, and their morals in order to reconstruct the patient’s illness narrative. While this eschews trait-based cultural competence by complicating identity, Kleinman and Benson (2006) interpret all habits and beliefs as artifacts of illness, in which the pursuit of individual bodily integrity registers as the only logic through which the patient’s personal views and motivations can be read (which jettisons the possibility that our heavy complaints, our search for reprieve, comes from a lack of livable community, not a lack of a livable body). The ethnographer’s objective, to “empathize with the lived experience of the patient’s illness, and try to understand the illness as the patient understands, feels, perceives, and responds to it,” collapses all engagement with the user’s “foreignness” into
information about illness (Kleinman & Benson, 2006, p. 1674). A person’s overall “needs” (ex. finding a home) are read as rehabilitative needs (ex. feeling at home).

Besides circumscribing lived experience to narratives of deficit, constructivist revisions to culturally competent practice also naturalize help-seeking behaviours as cultural traits. Wong (2003) argues the internalized oppression of ethnic minority practitioners leads to assumptions that first generation Asian Canadian women are ignorant of health issues. For example, one of her Korean coworkers assumed Korean women were not interested in their health due to filial duties in the home. Wong (2003) argues that there was, in fact, a large turnout of women at a Korean Health Fair promoted by her mental health agency, an agency that serves East and Southeast Asian women. She recommends social workers acknowledge their “lack of competence” or underestimation of their clients’ abilities to proactively determine their mental health.

Wong (2003) additionally believes clients who challenge acculturated practitioners by asking “How could you understand?” and “Why do you care?” would prefer to turn to their heritage culture (p. 159). Her reliance on a narrative of generational conflict is limiting. Wong’s thesis rejects the possibility that clients are resistant to ethnic minority practitioners because of their role as mental health workers and fails to comment on the politics of “care”. Through “lack of competence”, Wong (2003) hopes that ethnic minority practitioners will develop the skills to respectfully engage with East and Southeast Asian’s life experiences without making homogenous assumptions about their “own” or perpetuating paternalistic views of their clients. Yet she depicts all East and Southeast Asian women as interested, responsible clients. Her celebration of client resourcefulness and resilience portrays Asian women as naturally compatible with the objectives of mental health. Wong (2003) states that the communities served by her agency conceptualize mental health as something interconnected with other aspects of their lives, but this is an answer to something of a trick question given that she asks women to specifically comment on their “mental health needs” (p. 154-155). Her questions direct the possible answers. I propose we trace the historical development of approaches such as
the psychosocial model and situate its construction of mental illness within the political economic stakes of mental health. I.e. How is the transformation of systemic problems into health problems cost-effective in the context of continued cuts to other forms of social programming?

**The Sickness That is Inequality: Trauma and Distress, Ad Nauseam**

*(Pathology According to Critical Race Theory)*

Anti-racist critiques of cultural competence are not only critical of the broad generalizations cultural competence can produce about cultures, but warn that these generalizations detract attention from the institutional arrangements that form people’s social locations (Ortiz & Jani, 2010). Anti-racist perspectives borrow from the Foucauldian project of historical recovery, acknowledging that asylums were a way to control the idleness of populations, in which managing populations was a principle strategy by the state to generate wealth and income (Desai, 2003, p. 98). Rather than suggest practitioners develop more context-specific ethnographic methods to develop diagnostic procedures that take ethnically normative behaviours into consideration, anti-racist social work practice documents the use of illness to govern racialized bodies. For instance, high rates of schizophrenia diagnosis in black patients are justified by statistics that report that children of African Caribbean women who contract the ‘Asian’ flu between the fifth and seventh month of pregnancy give birth to babies who 20 years later become schizophrenic (Desai, 2003, p. 97).

Though critical of the psy disciplines’ history of pathologizing the physiology of racialized bodies, the alternative anti-oppressive models that anti-racist social workers suggest introduce their own technical difficulties. Ortiz and Jani (2010) propose Critical Race Theory (CRT) as a structural approach to addressing the problems of a diverse society. CRT accounts for the institutional arrangements and social location of clients’ lives by studying the “cumulative social effects” of race on the human psyche, embodied by people’s psychological “internalization” of racial assumptions as facts (Ortiz & Jani, 2010, p. 181). Ortiz and Jani
(2010) wish to radicalize therapeutic and behavioural goals by advancing the voices of the marginalized and rejecting “Euro-American ways of knowing” (p. 185).

They argue the pervasiveness of race throughout society is demonstrated by its negative impact on the psyche. Minoritization is, therefore, caused by “ideological dislocation” or the underrepresentation of non-white interests (Ortiz & Jani, 2010, p. 181). However, by theorizing the social reality of race as a suppression of the mind or a constant attack on the mind—by theorizing the social reality of race first and foremost as ideological currency—Ortiz and Jani (2010) do not reflect on how power is also productive. They state, “in the psyche of the dominant group there is no challenge to the idea that the world belongs to them, resulting in White privilege” (Ortiz & Jani, 2010, p. 181). Ortiz and Jani’s (2010) view that racist institutions are merely biased leads to the conclusion that people of color face “threats to self-esteem,” “fear,” “humiliation,” and “post-traumatic stress disorder” as the primary consequence of racism, which not only characterizes all people of color as helpless victims, but suggests victimhood is a state of mind (p. 182). This dangerously suggests privilege can be overcome through feeling better and diminishes the material implications of complex genealogies of knowledge. It seems that by “institutional arrangements,” Ortiz and Jani (2010) mean dominant/subordinate or the status quo, an oversimplification of power as conformity to “Euro-American ways of knowing” (p. 181). A general description of racism as an exclusionary white culture enforcing dominant societal beliefs hinders critical thinking about race as strategies for producing different subjects for a variety of political and economic purposes.

In response to ethnic minorities’ rampant “internalization” of racial ideologies, Ortiz and Jani (2010) suggest social workers classify their clients’ resistive behaviours. Reactionary, conformist, and self-defeating resistance are false or weak forms of resistance. These three types of resistance describe, respectively, the adoption of dominant values and behaviours, the use of anti-oppression rhetoric while still conforming to oppressive structures, and resisting through harming oneself (becoming incarcerated). Transformative resistance is the fourth and most idealized behaviour type. People who practice transformative resistance commit to “changing
existing structures while simultaneously attempting to create a better situation for themselves” and develop cooperative relationships with institutions in order to suggest changes within them (Ortiz & Jani, 2010, p. 186). I am suspicious of a theory of resistance that demarcates some acts of protest as self-destructive, warranting therapeutic intervention. On what basis are they measuring resistance for self-harm? How else have the psy disciplines theorized and used “self-harm”?

By problematizing constructions of disorder only when they racialize people’s physiologies, anti-racist approaches are uncritical of how they construct the link between people’s behaviour and social location. Desai (2003) recommends social workers respect racialized people’s expertise in determining when and how to treat distress. While well intended, theorizing “distress” can be as equally hegemonic as biological studies of racial abnormalities. Desai (2003) does not reflect on how the mobilizations of “distress” in community mental health, through explanations such as trauma, have the ability to discipline people of color.

To constructivists, culture is fluid, and as such, mental health problems and strategies must also be fluid, locally-specific, and historically situated. To critical theorists, distress is the result of oppressive conditions, and as such, mental health needs to be sensitive to the social location of clients. Both paradigms reconstruct difference not as biological or physiological, but as shifting ethnic norms and historical experiences of oppression. This reification of difference through a psychosocial model of diversity serves to identify the “real” problems and disorders experienced by people of color. Though I do not address community alternatives to psy interventions in this chapter, the argument that psychiatry’s racist practices lead to the misdiagnosis of real mental illness is highly problematic because it denies to those labeled with severe mental illness the right to self-identify, express, and respond to their experiences as otherwise. Howell (2011) warns that therapeutic governance persists in the rhetoric of “misdiagnosis” because this merely refines the governing technique and fails to challenge the overall injunction to treat the mind.
Wilson and Beresford (2000) question the possibility of critical social work as it presently appropriates user knowledge, constructs “clients” as passive, masks traditional professional power, and legitimates controlling social work practice. To elaborate, they argue anti-oppressive practice (AOP) can be oppressive due to the absence of “being a service user as a form of difference… with its own issues of power, inequality, discrimination and oppression” (Wilson & Beresford, 2000, p. 565). The authors argue that the absence of anti-disablist practice in AOP is a fundamental flaw, and they go on to state that social work has played a defining role in constructing and categorizing the “disabled,” “mentally ill,” and “mentally handicapped” (Wilson & Beresford, 2000, p. 564). They describe disability as a category of social division that is unique, unlike racism or heterosexism, which misses an important connection: AOP theorizes race as a disabling discourse. I wish to broach disability and distress differently in my analysis of culturally competent mental health by understanding race and madness as relationally constructed. This thesis does not explore how to theorize distress, but examines when “distress” is part of the architecture of governance.
2. Cultural Competency and Producing a Fundable Self

Borrowing from Smithian social ontology, Chapter Two investigates what work cultural competence accomplishes in community mental health at this moment in Ontario. Since 1985, the Ontario Federation of Community Mental Health and Addiction Programs (OFCMHAP), herein known as the Federation, has met to develop accessible community mental health and addiction services. A non-profit organization comprised of over 200 member organizations across Ontario, the Federation sets policy guidelines and works in partnership with the Government of Canada, its Ministry of Health and Long-Term Care (MOHLTC), family organizations and traditional institutional service providers. In 2009, several member agencies collaborated in the publication of a position paper on cultural competency, called *Embracing Cultural Competence in the Mental Health and Addiction System*.

To Dorothy E. Smith (2005; 2006), organizational discourses such as cultural competence are objectified ways of knowing—knowledge not designed from the perspective of everyday people, but from the standpoint of the institution. Investigating what cultural competence produces and sustains for the OFCMHAP is crucial because its concepts subsume the actualities (the everyday experiences) of people. For example, the language of “client need” reconceptualizes structural problems as the personal problems of the targeted population. This shift from institutional accountability to client rehabilitation ironically increases state surveillance of marginalized communities. What does the OFCHMAP’s definition of anti-oppression not account for in the actualities of racialized people’s lives? What does “discrimination and stereotyping” fail to describe about race as a source of structural oppression? A preliminary discourse analysis\(^5\) of Embracing Cultural Competence will answer

\(^5\) I say “preliminary” because for Foucault, a study of discourse cannot be separated from a broader analysis of power: “the consideration of history, materiality and the underlying conditions of possibility underwriting what counts as reasonable knowledge” (Hook, 2001, p. 542). Within the scope of my research, it is impossible to
the following question: Which analyses of power and oppression do not serve the interests of OFCMHAP and the institutions it is hooked into?

**Defining the Problematic**

**Oppression-as-Disease**

According to Smith (2005), a “problematic” refers the point at which people’s lives are hooked into a particular set of institutional relations (p. 227). A problematic describes the disconnect between the actualities of people’s everyday activities and the webs of budgets, administrative decisions, government funding, and professional knowledge we are subject to—those ruling relations divorced from our locally specific experiences. In my study of cultural competency in Ontario community mental health programs, the problematic does not arise because service providers stereotype culture in their encounters with non-white clients. On the contrary, the OFCMHAP stresses a definition of culture that is dynamic, changing, dependent on “climate, restructuring of neighborhoods, and patterns of migration” (p. 20). Critical social workers and medical anthropologists share this perspective (Kleinman & Benson, 2006; Williams, 2006; Wong, 2003). Instead, the problematic arises in the Federation’s technical domestication of power relations—in the psychiatric and psychological theorization of social inequality. Building on Smith’s (1990) study of women and psychiatry, I argue the problematic of cultural competency occurs at the juncture where the psy professions enforce the model “oppression → mental illness” onto the everyday lives of women of colour. The OFCMHAP reduces key features of oppression to cultural and linguistic needs and beliefs. In other words, the OFCMHAP severs life circumstances from life itself, interpreting poverty as a characteristic of the individual. By focusing on single symptoms, bodies, households, and/or racial/ethnic groups as their base unit of analysis, the Federation limits their attention to identifying and accomplish the genealogical work required to present the complete story of “cultural competency”. Instead, I am limited to analyzing a few documents in a chain of ruling relations.
placating dysfunctional or socially unacceptable feelings. The Federation “extracts states of subjectivity or behavioral indicators from the actual settings of the patient’s experience” (Smith, 1990, p. 136).

In a section of their position paper on barriers posing challenges for cultural competence, the OFCMHAP explicitly warn that “simplistic notions of culture and cultural difference need to be re-examined, as they may actually perpetuate inequities,” further cautioning that the “(false) message that poverty and discrimination worsen health through their impact on cultural beliefs may trivialize the larger problems of social disadvantage and deprivation” (p. 16). Here, the OFCMHAP give readers the opinion that they do not support overgeneralizing or oversimplifying culture or power as easily translatable or diagnosable; that health frameworks do not always answer questions of how to transform power relations. Yet, turn back to their opening discussion (in “Background and Context”), and the Federation precedes their caveat with the following justification for cultural competence:

“People who experience discrimination are at higher risk of having poor mental and physical health outcomes. A lot of evidence indicates a strong relationship between perceived discrimination and low self-esteem, low educational attainment, and poor physical and mental health outcomes among marginalized ethnic populations (Araujo and Borrell, 2006). A study in the Netherlands found that people who perceived they were victims of discrimination were twice as likely to develop psychotic symptoms over three years as those who did not perceive being discriminated against; further, more exposure to discrimination and exposure to multiple forms of discrimination made the development of delusions more likely (McKenzie, 2003)” (OFCMHAP, 2009, p. 8).
In this quote, the individual victim’s perceptions take center stage as the sole cause of low educational attainment, occluding an analysis of institutional racism in the organization of education. The perception, as opposed to the everyday reality, of discrimination produces negative bodily outcomes not because there is a constant threat of systemic harm, but because we develop delusions. This professional opinion demonstrates the same “false message” that the Federation claims to be critical of: that the real cost of discrimination is psychological and self-perpetuating. Mental health organizations, such as those represented by the OFCMHAP, can only reconcile anti-oppressive practice with their professional commitments by suggesting negative cognition causes mental illness.

Besides collapsing oppression and mental disorder into a causal relationship that automatically implies racialized bodies are always more prone to disrepair, the Federation asserts that mental illness is simply a dimension of all human experience, oppressed or not, because the transgression of cultural norms is behaviorally disordered. Quoting the Substance Abuse and Mental Health Services Administration of the U.S. Department of Health and Human Services, the OFCMHAP (2009) recommends mental health practitioners “acknowledge and incorporate variance in normative acceptable behaviors, beliefs and values in determining an individual’s mental wellness/illness, and incorporating those variables into assessment and treatment” (p. 22). Mental illness is universal because all societies pathologize and rehabilitate culturally abnormal behavior. The Federation reinforces the overall relevance of mental illness by stating “[r]esearch shows that different populations perceive illnesses, experience disease, metabolize psychiatric drugs, and comply with treatments and drug regimens in different ways” (OFCMHAP, 2009, p. 15). The Federation suggests that minority groups may not even be aware of the fact that their own culturally specific practices are consistent with the mental illness paradigm. That is to say, the OFCMHAP believes the
identification and rehabilitation of abnormal behavior may occur in a multitude of ways, but always in ways comparable to the objectives of “mental health”.

In addition, the Federation uses the term “population” repeatedly throughout the position paper to refer to marginalized, poor communities of colour. This is no coincidence. Population statistics do not reveal the processes through which people are labeled daily as different (ethnic, immigrant, minority) or inferior (sick), only that they are. “Population” is a word that groups people together by location and by type. In health statistics, researchers use the concept “population” to naturalize categories of people and the phenomena that happen to them. For example, the Federation notes that “[p]rojections show the majority of Canada’s future population growth will come from immigration, with the vast majority of these new immigrants coming from non-European countries where most are non-white and speak neither English nor French” and “immigrant’s health status ultimately declines to a level equal or less than that of their Canadian-born counterparts” (OFCMHAP, 2009, p. 7-8). These observations suggest that increasing numbers of immigrants are not getting the medical treatment they need by virtue of “sporadic attention” being provided to immigrants who already have mental health problems (OFCMHAP, 2009, p. 11).

Put together, the OFCMHAP argues that cross-cultural interventions are necessary not because of genetics or neurobiology, but because of history. Oppression and cultural diversity are the new risk factors for an ever-proliferating range of mental illnesses thanks to the etiologies of trauma and peer pressure, rather than congenital disorders or heredity. This line of thought is not unique to OFCMHAP. It is an iteration of a growing discourse in Western social work and clinical psychology (Furlong & Wight, 2011; Nezu, 2005; Ortiz & Jani, 2010). By regarding the mental illness model with global ontological veracity, the Federation does not
acknowledge how the psy sciences are not always a necessary, useful, or appropriate interpretive lens for different communities’ needs.

**Training Competent Workers or Recovering Competent Patients?: Educating the Patient**

The OFCMHAP recalibrates mental illness epistemology in the conceptual framework of its position paper, contributing to nascent literature on intercultural competency. However, unlike the scholarly writing of critical social workers, the Federation’s position paper does more than produce knowledge about the psychological effects of cultural dynamics and oppression. The Federation is actively translating this knowledge into strategies for service delivery. It is not sufficient for them to explain why immigrant and racialized communities require mental health treatment. The Federation must close the gap between their rationale for cross-cultural diagnosis and the perspectives of their intended clients in order to prove their theories are consistent with people’s lived experiences, as well as justify their calls for funding. One technique or strategy for closing the gap between theory and practice is patient education. Patient education naturalizes professional knowledge as common sense through establishing service providers as teacher and expert. One tenant of patient education is recovery-oriented programming. For the OFCMHAP, the concepts that constitute recovery help naturalize a nonconsensual process of cultural knowledge production.

Returning to the section of their position paper on barriers posing challenges for cultural competence, the Federation remarks that in general populations with histories of social exclusion and poverty mistrust service providers and thus, “even though services may be made available to them, they choose not to access them” (OFCMHAP, 2009, p. 17). The Federation neither elaborates on why these communities mistrust service providers, nor do they clarify whether or how the choice to avoid mental health services impedes the well-being of these communities. The quote suggests the OFCMHAP’s cultural competency agenda and the self-
determination of communities of colour are incompatible with one another. If immigrant and racialized communities deliberately avoid mental health services for reasons unknown, why is it critical for the Federation to change their minds? In order to characterize the development of cross-cultural mental health programs as a “need”, the Federation introduces “recovery” in their conceptual framework. The concept “recovery” tethers improved quality of life (“equity”) to the acceptance of mental illness. The Federation explains that:

People living with mental illness and the associated stigma need to reconstruct their perception of self and/or community as part of the recovery process (David et al., 2002). Psychologically, these people may have to learn to accept, understand, and manage their illness while simultaneously integrating the illness into their concept of self and/or community (May, 2001b; Campbell, 2001)… In essence, recovery helps people to reclaim a fulfilling, meaningful, and satisfying life that may or may not include symptoms and to learn to live with their illness (Roberts et al., 2004). (OFCMHAP, 2009, p. 23).

According to the Federation, fulfilled, satisfactory lives will only be realized if marginalized communities come to adopt the view that they are, to various degrees, mentally disordered. The words “to reclaim” are pivotal to the Federation’s recovery paradigm because they imply that all those things that we lack may be taken back through free will, beginning with our bodies, by “owning” our symptoms. How do we own our symptoms? Through overcoming social exclusion by “being included as a valuable and contributing member of society with an opportunity to work [because this] leads to better recovery, self-esteem, and quality of life” (OFCMHAP, 2009, p. 23). The rhetoric is circular: accept that you have mental health issues because you are excluded; contribute to the economy in order to recover your self-esteem. Missing from this
formula is a solution to the very reasons why particular bodies have difficulty finding work. The Federation has substituted meritocracy for accountability. How are disordered communities of colour expected to recover through contributing to the same society that marginalizes them? To add to the contradictions, the OFCMHAP goes on to conclude that the more mentally ill people participate in mainstream society, the less they are labeled, and labeling, like social exclusion, must be overcome or reclaimed in order to “recover” (p. 23-24). Yet it is service providers like those member organizations in the Federation that are dispensing “labels”. In summary: Marginalized populations, like ethnic minority communities, develop mental health issues because they are excluded and experience low self-esteem. They will only attain a better quality of life through seeking help, outing themselves as certifiably ill, and undergoing institutional recovery. Recovery includes psychologically accepting that you are mentally ill, but also includes overcoming the barriers created by your diagnostic label. To overcome your label, you must participate in society—the society that still excludes you. If the institutional will to diagnose symptomatic behavior overrides the actuality of the client’s expressed needs, service providers are only “competent” insofar as they are competent at educating cultural groups in psychiatric literacy.

Stating only that mistrust and stigma exist, the Federation rarely elaborates upon the consequences of having a psychiatric history. This is problematic given the numerous cases of non-criminal contact between police and Ontarians with various psychiatric histories since the publication of their position paper in 2009. There have been eight recorded cases appearing in the U.S. Department of Homeland Security in 2010 alone in which persons with mental illness on their medical records were barred from entering the U.S. from Canada (Fritsch, 2011). Since 2011, the Ontario Mental Health Police Record Check Coalition has worked to end discrimination based on the record of non-violent, non-criminal incidents with the police related
to mental health and intervene in the transmission of information entered in local police databases to the Canadian Police Information Centre. Mental health records not only affect immigration and travel; they also affect housing. It is for this reason that Edmund Place exists in Parkdale, Toronto. Edmund Place provides supportive non-medicalized housing to ex-users of psychiatry, who are typically discriminated against in other forms of housing when landlords conduct background checks. Edmund Yu, the namesake of Edmund Place, was shot and killed in 1997 after he raised a small (toy?) hammer over his head on a Toronto bus (Dubey, 2011). His death is remembered as a result of the police’s association of mental illness with violence and criminality. If we reflect on the economic marginalization immigrant communities already endure, as well as the modern apartheid of the criminal justice system, is it any wonder that racialized populations are suspicious of institutional forms of “help”?

The second half of this chapter outlines some of the tensions produced as a result of the Federation’s attempts to initiate progressive social changes within the mental health system while replicating health policy discourse in order to attract potential funders. Drawing on Eastwood’s (2006) concept of “documentary reality” and Smith’s (2006) conceptualization of texts in action in institutional ethnography, I argue that documents like the Federation’s position paper become the effective reality of community mental health, specifically ethnoracial mental health programs. The position paper partly dictates what can be made actionable or taken up in subsequent workings of the organization as “diverse”, “equitable”, and even “anti-oppressive”. I opened this chapter by exploring how psy discourse, in the form of the mental illness model, establishes procedures for telling narratives about racialized people that isolate them from the settings of their own lives and constructs what is going on with them as if it were an attribute not only of their individual personality, but of their race/ethnicity. The interpretive frame of the
mental illness model does more than misrepresent immigrant and racialized communities, it shapes the future actions spelled out in the Federation’s recommendations for practice.

**Mapping the Organizational Relations of Cultural Competency**

Up until this point, I have examined the theoretical implications of institutionalizing anti-oppressive practice in community mental health, using the OFCMHAP’s position paper as a case study. However, an analysis of the Federation’s definitions and conceptual framework will not explain how and where cultural competency fits into the objectives of their member organizations without an investigation of the conditions surrounding the publication of the Federation’s position paper. In the remainder of this chapter, I map the organizational relations between the intended users of the paper, national and supranational health policies and standards cited in the paper, and the paper’s recommendations. Eastwood (2006), in her research on Traditional Forest-Related Knowledge (TFRK) discourse in the United Nations Intergovernmental forum on Forests, argues that so long as concepts in forest policy remain disembodied from the actualities of Indigenous people’s lives, the UN’s ability to oppose the realities of globalization and development are minimized. She notes that policy-makers “while taking up the terminology of sustainable forest management, would actually support the interests of business and trade as the convention reflected neoliberal economic values” (p. 194).

Like Eastwood (2006), I am interested in the politico-administrative regimes at work in the creation of equitable organizational practices. In other words, I am interested in how people’s issues or needs are systematically incorporated into policy and subsumed by extra-local ruling relations.

**Intended Users**

The narratives that envelop the mental illness model in the Federation’s conceptual framework originate from two sources: the intended users of the position paper and the
influential organizations the OFCMHAP cites in order to hold the intended users accountable to cultural competency. Following the executive summary and introduction, the Federation encourages the following institutions to use the position paper for front line, policy- and decision-making: Local Health Integration Networks (LHINs), The Ministry of Health and Long-Term Care (MOHLTC), as well as other systems and funders “such as the Ministry of Health Promotion, the Ministry of Community and Social Services, the United Way, the Ontario Trillium Foundation” (OFCMHAP, 2009, p. 6). In particular the Federation stresses that:

In recent years, the MOHLTC has started a cross-ministry research initiative to address health equity in a more integrated and co-ordinated fashion (Rachlis, 2007). More locally, some of the Local Health Integration Networks have also started organizing diversity committees or task forces to work on eliminating health disparities (Rachlis, 2007). Such initiatives are long overdue.

The Ontario Federation of Community Mental Health and Addiction Programs hopes that these efforts to address the diverse needs of Ontario’s population are sustained, as inattention or sporadic attention to such needs can have real consequences on people’s health outcomes. Although there will no doubt be multiple challenges in addressing issues of diversity at all levels, including direct services, organizational practices, and systemic context, inaction can no longer be an option. (OFCMHAP, 2009, p. 11).

From this statement, it is apparent that the Federation is writing the position paper bearing in mind existing initiatives on health equity and diversity at the MOHLTC and the LHINs. For example, they quote the MOHLTC’s (1999) document *Making it Happen*, which recommends that family initiatives “reflect community needs and diversity and address locally relevant ethnoracial issues”. The LHINs are a function of the MOHLTC and they are the largest funding
source of ethnoracial mental health agencies in Ontario, providing 84% of Across Boundaries’ revenue and 75% of Hong Fook’s revenue (Across Boundaries, 2010, p. 10; Hong Fook, 2011, p. 10). These two agencies currently lead cross-cultural care in Ontario and both are member organizations of the OFCMHAP. Furthermore, employees from both agencies are part of the Federation’s Cultural Competency Steering Committee and Position Paper Working Group (OFCMHAP, 2009, p. 2). It is this contractual relationship between the Ministry of Health in Ontario and the Federation that first shapes the Federation’s definitions of oppression as a lack of adequate widespread diagnosis and treatment for mental illness and, more specifically, as a lack of rehabilitation from trauma.

Roxana Ng (1996), in her study of an immigrant women’s employment agency, explores how conflicts commonly characterized as interpersonal tensions in the workplace are the result of the Canadian government contracting out social services since the late 1970s, a pattern that enabled the government to cut back on the welfare state while simultaneously consolidating power over community groups. Despite the agency’s intention to advocate on behalf of immigrant women, counselors in their day-to-day work of securing women’s livelihoods enacted processes of class rule. “As a result of its funding arrangement, the employment agency… entered into a sub-contractual relationship with the state… the agency had to produce a ‘product’ for the state”, which brought the agency into a “cooperative, rather than confrontative stance” with the state (Ng, 1996, p. 30). Two decades later, this pattern in government-funded social programs mutually arising out of the economic needs of the state and the militancy or calls for social change in marginalized communities continues to take place. By funding mental health outreach in marginalized communities, the MOHLTC is able to reduce the costs of long-term inpatient services by promoting the development of self-sufficient peer-run recovery programs. At the same time, by cooperating with the MOHLTC, agencies such as
Across Boundaries and Hong Fook, while critical to some degree of the psy professions, are limited in their capacity to address systemic racism as they use the language of health to frame social problems, reducing the effects of contemporary settler colonialism and white supremacy to “cultural needs”. Through assuming responsibility as an extension of the state, the Federation inadvertently psychologizes racism as a matter of bad attitudes generating bad reactions.

**Selling Cultural Competency to the Government of Ontario**

One conflict Ng’s (1996) employment agency experiences is the pressure to demonstrate measurable improvements in employability. Likewise, the OFCMHAP is subject to demonstrating how cultural competency is a worthwhile investment to state funders. The Federation (2009) does so through including diversity and equity as two of the core principles of cultural competency (p. 18-19). Diversity and equity benefit the state in two ways: as a market discourse and regime of governmentality. According to Sara Ahmed (2012), diversity should be understood institutionally through market terms, in which difference has a commercial value, “something to be managed and valued as a human resource” (p. 53). Institutions use diversity/equity as a marketing strategy or aesthetic convention in order to characterize an organization as contemporary and global; institutions also commit to diversity/equity through hiring diverse elites or educated minorities, individuals who will contribute to an institution’s professional success.

More specifically, in the position paper’s section on the principles of cultural competency, the Federation (2009) states that organizations should recognize diversity through affirming diversity in their “organizational statements and policies, practices, staff composition, and social climate” (p. 18). Similarly, in their definitions of employment equity, service equity, funding equity, and socio-economic equity, the Federation (2009) proposes organizations eliminate barriers to the recruitment, student retention, career-pathing, general participation, and
treatment of all community members by mental health institutions (p. 19). Because the words diversity and equity are associated with adding new people and programs, the Federation is able to portray cultural competency as a practice in expansion, with little consequence to preexisting organizational structures, making cultural competency require minimal resources in the long run. The Federation promotes cultural competency as a cost-saving practice by demonstrating that equity increases the employability and self-sufficiency of marginalized populations in multiple ways: through hiring them as primary service providers, who will eventually help diagnose and treat other immigrants and racialized people, who will in turn provide feedback and recommendations on improvements to service delivery as a paid paraprofessional class of consultants and peer support workers. The Federation (2009) further characterizes cultural competency as a sustainable business model by supplementing its definition of employment equity and service equity with statistics: “Ethnic and linguistic matches between service providers and their clients are associated with a lower drop-out rate, more treatment sessions, and better clinical outcomes than when clients and providers are not from the same ethnic group or linguistic background” (p. 13). Equity does not burden; it facilitates government austerity measures.

By conceptualizing diversity/equity as a variety of “colorful sweets”, institutions like the OFCMHAP conceal the continuation of existing systematic inequalities because they believe they lack difference in their employees, instead of acknowledging they already actively and problematically produce difference in institutional knowledge and practices (Ahmed, 2012, p. 68). Consequently, when institutions use the language of diversity/equity, it casts them in the innocent light of inaction: racism is what the institution has failed to include, rather than what it is already doing. This brings us to the second way in which the state can capitalize on equity: *those who are included must comply with the terms of inclusion*. When marginalized populations
are included either as the workers or patients, they are “asked to submit to and agree with the
task of reproducing the nation” in “an invitation to live well, to flourish” according to the state’s
definition of happiness (Ahmed, 2012, p. 163). Proponents of diversity/equity include
argues that in the process of being included, ethnic minorities are expected to be happy
racialized subjects; inclusion governs subjects of diversity.

Building on Ahmed (2012), I believe that equity discourse in mental health cultural
competency does more than pacify feelings of marginalization or encourage immigrant and
racialized patients to accept racism is over because they are included. The OFCMHAP governs
immigrant and racialized patients under the license of “equity” by claiming the psychological
ramifications of racism justify their inclusion as sick subjects requiring rehabilitation. Diversity
and equity enter institutional discourse as a language of reparation not simply because different
ethnic groups are expected to get along, but because emotional and behavioral repair is the
business of mental health. People of colour are not only folded into reproducing existing terms
of exclusion in the state by accepting exclusion no longer exists; they are tasked with becoming
more responsible through regimes of self-care—“better” in every sense of the word.

The Master Frames: Human Rights and the Freedom-to-be-Diagnosed

The OFCMHAP makes a powerful case for cultural competency as equitable access to
diagnosis and treatment partly through referencing existing national and supranational health
equity standards. The OFCMHAP employs these regulatory or master frames in order to secure
the attention of intended users and funders, while at the same time acquiescing to the limited
courses of action that such texts endorse. Just as national/supranational policies or guidelines
can hold provincial administrative bodies accountable to particular kinds of organizational
behavior, so can national/supranational texts establish frames and concepts that control the
lower level text that is the Federation’s own position paper. The first frame I wish to examine is
human rights language. Human rights language paradoxically consolidates the politics of
multiple historically situated marginalized groups into the same universal needs, which conceals
the purpose and intention of activating rights narratives in specific contexts. Early in the paper,
the Federation cites two rights-related documents—the International Covenant on Economic,
and Legislation (OFCMHAP, 2009, p. 10). The position paper’s definitions of discrimination
and access partially originate from these documents and establish the context for the
Federation’s (2009) call for cultural competency:

Internationally, the right to health is recognized by the International Convention
on the Elimination of All Forms of Racial Discrimination of 1965 in Article
5(e)(iv) (WHO, 2005). As well, the Committee on Economic, Social and
Cultural Rights recognizes the right to a system of health protection that provides
people with equality of opportunity to enjoy the highest attainable level of health
(WHO, 2005). According to this Committee, entitlements include:

- Availability—adequate health care facilities and services must be available;
- Accessibility—health care and services must be made available to
everyone without any discrimination (including physical accessibility,
economic accessibility, and information accessibility); and,
- Acceptability—health care facilities and services must follow medical
ethics and be culturally appropriate (all WHO, 2005).

In fact, the World Health Organization (WHO, 2005) notes that discriminatory
practices in the provision of mental health services to minoritized populations
can be played out in several ways, including the following:

- Denial of access to community-based treatment facilities and referral to treatment in inpatient facilities instead;
- Higher rates of involuntary admission;
- Interpreting social and cultural norms of behaviour as signs of mental disorders that may lead to involuntary admission;
- Involuntary treatment when in mental health facilities;
- Mental health facilities’ environments not taking into account the unique cultural and social needs of various groups; and,
- Higher arrest rates of certain populations for minor behavioural problems, leading to higher rates of contact with the criminal justice system.

Working toward cultural competence in the provision of mental health and addiction care is one way for front-line workers, organizations, and the mental health and addiction system to address some of the exclusionary practices and services that systematically discriminate against various populations. By doing so, the basic human rights of all individuals can be better accounted for. (p. 10)

The kinds of rights entitlements cited in this quote produce anti-oppressive goals consistent with organizational growth and funding initiatives. Equity is “availability”, more outpatient services “in the community”, more culturally appropriate diagnosis that takes cultural norms of behavior into consideration. Nowhere is it indicated in their position paper that communities are expressing interest in these specific services as relevant tools for survival. Making services available to everyone and ensuring these services adhere to medical ethics does not inherently challenge health ideologies and can be interpreted as increasing patient intake in
smaller organizations and creating niche-like organizational growth. Medical ethics are not even defined in this position paper and are created by the medical institution.

**The Federation’s Recommendations: Constituents in Institutional Courses of Action**

The language of the OFCMHAP’s recommendations is the result of a complex intertextual hierarchy. The position paper is subordinate to ruling texts including the *WHO Book on Mental Health, Human Rights, and Legislation*; the Vancouver Ethnocultural Committee’s (2008) *Cultural Competency Assessment Tools*; McKenzie’s (2003) “Racism and Health: Antiracism is an Important Issue”; Cross, Bazron, Dennis, and Isaac’s (1989) *Towards a Culturally Competent System of Care*; and the Substance Abuse and Mental Health Services Administration’s (2001) “Other definitions of cultural competence”. These texts make the thoughts, beliefs, and/or ideology of the Federation observable: they establish the frames and concepts that mediate the Federation’s own social organization of cultural competency. However, the recommendations do not just replicate these texts; the recommendations in themselves coordinate institutional order and help constitute what Smith (2005) calls a regime of accountability or accountability circuit. Accountability circuits coordinate people’s work in multiple positions and act as a broad rubric or regime. By investigating the nature of the text-initiated next steps in the different recommendations, paying particular attention to active verbs and degrees of specificity, we can distinguish abstract/cosmetic changes from immediate, material changes the Federation is setting into motion amidst funders, researchers, policymakers, and service providers. Recommendations to critically reflect on something or develop a framework are significantly different kinds of work being endorsed compared to acts such as developing a procedure or allocating resources.

In the position paper, the Federation divides its recommendations into suggestions for direct service delivery, for organization and governance, and for health systems, using a series
of bullet points. The following is a list of all recommendations that refer to equity, inclusion/exclusion, and race/ethnicity/diversity—terms that are at the core of the OFCMHAP’s conceptual framework:

- Critically reflect on the assumptions governing your actions, locating and identifying the cultural and historical origins of these assumptions, questioning their meaning, and developing alternative ways of acting (Cranton, 1996)…

- Review all forms and procedures (such as intake, case management, complaint process, provision of resources, etc.) to see if they act to prohibit or exclude certain populations (Fisher et al., 2007)....

- Incorporate culturally specific messages to emphasize a positive self-image among clients in prevention programs or undergoing treatment for substance abuse, as this may boost their sense of self-efficacy (Fisher et al., 2007)…

- Develop a diversity task force to provide ongoing education about culture, inclusion, and diversity available to all members (e.g., conferences and/or online continuing education). The task force could also engage members to reflect on the reasons for and benefits of learning to work with diverse populations and could initiate recruitment of people of various backgrounds to work at all levels of the organization. The group could elicit timely and comprehensive feedback from members to challenge their thinking and assumptions about diversity issues. Such a task force could eventually become a standing committee within the organization (Yearwood et al., 2006)…
• Critically reflect on the systemic behaviours and ideas sustaining current disparities and inequitable practices (Cranton, 1996); this may involve challenging prevailing social, cultural, political, or professional ways of acting (Brookfield, 2005)…

• Prioritize cultural competence and diversity by ensuring that all member organizations incorporate ways of working with diverse communities into their service delivery plans (Registered Nurses’ Association of Ontario, 2007).

• Develop benchmarks to hold organizations to their commitments on improved services for the diverse populations they serve (Registered Nurses’ Association of Ontario, 2007).

• Develop procedures for announcement of funding resources, requests for proposals, and contracting that use culturally appropriate practices to reach all potentially eligible organizations (Goode and Suganya, 2000).

• Develop a framework for understanding the role of racism and discrimination in health and the health care system; such racism can include institutional racism, individually mediated racism, and internalized racism (Jones, 2000)…

• Allocate resources for cultural competence and diversity initiatives and related professional development (Goode and Suganya, 2000).

• Allocate resources for the creation of services or programs better suited to the diverse needs of various populations (e.g., family support groups, for which the current individually focused treatment system allows little room). [emphasis mine] (OFCMHAP, 2009, p. 26-28).
The Federation conceptualizes equity as atmospheric changes in the encounter between service provider and client, reducing inequity or oppression in the mental health system to a problem that can be solved by behavior modification. To elaborate, service providers are asked to critically reflect on personal assumptions and systemic behaviors. Based on their reflections, they are asked to develop alternative ways of acting or challenge prevailing ways of acting. The words “reflection” and “acting”, like “assumption” and “behavior”, suggest that service providers are oppressive as a result of personal bias; albeit bias that penetrates the professional culture of mental health. These words are attached to the individual. To reflect on, confront, or change the way you act is not the same as challenging professional standards or reorganizing structures of care. These words demonstrate that the Federation believes anti-oppressive practice is achieved through fostering professional sensitivity while abiding by the same professional objectives. Similarly, the Federation recommends service providers incorporate culturally specific messages in order to boost the client’s sense of self-efficacy and emphasize positive self-image. In other words, the Federation recommends service providers use cultural knowledge to ease feelings of inadequacy as opposed to affirming and further investigating real barriers to employment in the Canadian state. The words “sense of self” and “self-image” indicate the Federation’s belief that equity involves transforming the self and feeling good as opposed to acknowledging and resisting ongoing systemic violence and restricted mobility.

In contrast, recommendations for health systems to develop procedures or allocate resources endorse activity on a significantly greater scale compared to service providers critically reflecting on personal assumptions, challenging ways of acting, or emphasizing positive self-image. These recommendations call for substantive changes in: the announcement of funding resources, professional development in diversity initiatives, and the creation of services or programs better suited to diverse needs. Who are the beneficiaries? The
OFCMHAP’s health systems recommendations do not propose direct changes to existing practices, such as advocating changes in mental health incapacity laws that sanction forced treatment. Instead, health systems recommendations are built around the wellbeing of mental health workers: “eligible organizations” will be informed first and foremost of funding resources for diversity initiatives. The Federation is not suggesting a system be developed for the allocation of funding directly to independent community groups that might, for example, provide affordable and accessible acupuncture. Recommendations are designed to protect and facilitate internal job creation. Where immigrant and racialized bodies are included, they are informants for program development or trainees in the psy professions. The recommendations that “do” diversity adapt the concept of inclusion to the language of money and compliance, in terms of diversifying opportunities for organizational growth (“benchmarks” for improved services) and recruiting people of diverse racial/ethnic backgrounds to work at all levels of governance. Consequently, diversity, as a euphemism for poor, immigrant, or racialized communities, divorces equity from histories of anti-oppressive struggle. Most strikingly, diversity is used to signal accumulation: the accumulation of financial and human resources, such that minority workers become “token equity champions” (Ahmed, 2007).

Conclusion

The OFCMHAP’s choice of language carries a suppressed dialogue between speaker and hearer. The words “client”, “catering”, “direct service delivery”, and “stakeholders” all indicate the Federation’s interest in ethnoracial communities as a niche market to which it is delivering a product (OFCMHAP, 2009, p. 19). These words are found in the recommendation that “organizations should consider procedures to eliminate barriers to direct service delivery and to client… participation in the planning, delivery, and evaluation of services and programs”, as well as the proposal that the Federation “collaborate with all stakeholders wishing to develop
their cultural competency” (OFCMHAP, 2009, p. 19). However, what might the member organizations wish to make actionable “behind the scenes” in producing a fundable self? Without further investigating the activities of the Federation’s member organizations, it is difficult to draw conclusions about how their recommendations for cultural competence are materializing. According to the history of the OFCMHAP, their position paper on cultural competency is the result of pressure from three key member organizations over the last decade: Hong Fook, Across Boundaries, and Centre for Addiction and Mental Health in Toronto. Because I am interested in how mental health outreach/practice produces self-governing capabilities in racialized communities, these organizations are the subject of the remainder of my study.
3. Racism as Illness? The Problem of Anti-Racism in Cross-Cultural Mental Health Agencies

In Chapter Two, I used textual analysis to examine what the discourse of cultural competence produces and sustains in a position paper on cultural competence written by the Ontario Federation of Community Mental Health and Addiction Programs (2009). My objective was to explore and make sense of how texts like this position paper instruct the everyday activities of institutions and shape possible courses of action. I argued that the Federation governs immigrant and racialized communities under the license of “equity” by claiming the psychological ramifications of racism justify forced, or otherwise unconsensual, health interventions. As people of colour become caught in a proliferation of culturally specific diagnoses and as service providers accumulate new medical records, state surveillance of communities of colour increases. At the same time, the Federation (2009) dismisses ongoing institutional violence by suggesting it is simply the perception, as opposed to the everyday reality, of discrimination that causes low educational attainment among “at-risk” youth (p. 9).

Building on this discussion, Chapter Three extends this analysis by problematizing the construction of health problems in women of colour and youth of colour in the outreach activities of two of the Federation’s member organizations: Hong Fook Mental Health Association and Across Boundaries. The Federation’s (2009) framework and recommendations in Embracing Cultural Competence are partly a reflection of these agencies. Linda Yoo, the principal writer and researcher of Embracing Cultural Competence, is a staff member of Hong Fook. In addition, the position paper’s Working Group includes Raymond C. Y. Chung and Aseefa Sarang, the respective Executive Directors of Hong Fook and Across Boundaries (OFCMHAP, 2009, p. 2).

Working from an “empowerment” framework, Hong Fook provides services to East and Southeast Asian communities, including Cambodian, Chinese, Korean, and Vietnamese
Toronto. Their goal is to promote the mental illness model and overcome linguistic and cultural barriers to accessing mental health services. They envision “[a] multicultural community that understands mental health and accepts mental illness” (Hong Fook, “Mission and Vision”). Across Boundaries provides “a range of supports… to people from marginalized communities including immigrants and refugees who are experiencing mental health problems” (Across Boundaries, “Who We Are”). Primarily working with Black and South Asian communities, Across Boundaries provides services in Urdu, Hindi, Tamil, Farsi, Somali, Swahili, and Amharic—to name just a few languages. Like Hong Fook, they aim to increase access to mental health services in communities of colour. Additionally, their goal is to implement “anti-racism/anti-oppression” education, training, and practice in order to recognize how racism, discrimination, and oppression negatively impact the mental health of racialized individuals and communities (Across Boundaries, “Goals”). Hong Fook operates from a liberal, pluralist frame, foregrounding the full inclusion of East and Southeast Asians into mental health services. In contrast, Across Boundaries argues for the inclusion of mental health into anti-oppressive frameworks, suggesting resistance begins with recovering the self. Notably, both approaches reiterate the Federation’s justifications for cultural competency—that mental health is a universal right and that oppression causes mental disorders.

Prior to Embracing Cultural Competence, both agencies published needs assessments of their service areas. In 2003, Hong Fook issued a report called Promoting Mental Health Among East and Southeast Asian Immigrant/Refugee Women in Ontario, prepared by Y. Renita Wong, Josephine P. H. Wong, Kenneth P. Fung, and Raymond C. Y. Chung. In 2006, Across Boundaries released a study on behalf of Y-CONNECT called Mental Well-being and Substance Use Among Youth of Colour, written by co-researchers Alexander Lovell and Sara Shahsiah. A partnership between Across Boundaries and the Griffin Centre, Y-CONNECT is a mental health
program that supports transitional-aged youth aged 15-24 in northwest Toronto (Lovell & Shahsiah, 2006, p. 13). These reports provide context for the language in Embracing Cultural Competence. Through case studies of the research findings in both needs assessment reports, this chapter further traces the production of the Federation’s following assumptions—that (1) racial discrimination explains the etiology behind behavior disorders in people of colour; that (2) anti-oppression is achieved through improved self-esteem, specifically medicalized self-care and acceptance of mental illness; and that (3) equity is synonymous with superficial changes to professional standards, such as mimicking youth culture in order to increase patient intake.

**Reading for Traces**

As Hong Fook and Across Boundaries reinforce the professional narratives of oppression-as-disease, anti-racist empowerment, and feel-good equitable service provision, how can I, as a critical reader, pay attention to the “hierarchies and the power-knowledge nexus embedded in them” (Chowdry, 2007)? Several authors are useful for understanding what Foucault refers to as “the maelstrom of this battle” (le tourbillon de cette bataille) or the tactical, ideological, and institutional struggle over knowledge production that surrounds Wong et al. (2003) and Lovell and Shahsiah’s (2006) portrayals of the relationship between mental health and women/youth of colour (Davidson, 2006, p. xvii). Edward Said (1993), in Culture and Imperialism, develops the concept of contrapuntality for interpreting colonial texts. In contrapuntal analysis, stories taken to be “common sense” are questioned. Texts are read with an understanding of what is historically involved in their creation: the complex interplay between dominant, imperial powers and those subject to and resistant against them. Contrapuntal reading necessitates a conscious reflection both on what is included in the text as “real” and what is forcibly excluded.
My objective is to provide a contrapuntal reading of the authors’ summary statements and recommendations, as well as the authors’ representations of their own agency’s demographics, in order to make visible the erasures around racialized people’s experiences of disablement by racist mental health practices. By “disablement”, I am referring to the processes by which people become legally and medically rendered disabled and as a result, disqualified from particular spheres of citizenship and rights protections (Gorman, 2012). I argue that Wong et al. (2003) and Lovell and Shahsiah’s (2006) reports are examples of neocolonial texts and implicated in neocolonial violence. By appropriating anti-racist and community-based practices into mental health and psychiatric frameworks, both agencies come to redefine racist processes as individual risk factor and health indicator. These processes of cooptation are naturalized and facilitated partly by the assumed race consciousness of people of colour (Brush, 2001) and the non-performativity of anti-racism (Ahmed, 2005).

In her comparison of two generations of black women authors’ articulations of race and racism, Paula Brush (2001) argues women of colour who see themselves in a post-Civil Rights and post-Black Power historical moment “[fall] back on individualist explanations of racial oppression” “unable to identify and name their experiences as institutionalized practices of racism” (p. 172, 192). Yet, Brush (2001) shows us that most feminist literature assumes “women of color, oppressed by their position in the system of racial stratification, have had to be aware of race differences, have always dealt with the issues of race and racism, and are race conscious” (p. 173). This issue of assumed race consciousness among women of colour rears its head in culturally competent policy-making. As I have discussed previously in my analysis of constructivist approaches to cultural competence in Chapter One, one cornerstone of cross-cultural mental health practice is hiring “cultural insider(s) who are also insider(s) to the
institution” (Williams, 2006, p. 216). From a constructivist perspective, mental health workers who are culturally or linguistically closer to their clients will better understand their clients. However, this assumption of empathy collapses the inherent power differential between professional worker and patient, as well as homogenizing culture based on linguistic or phenotypical likeness.

Brush (2001) insists that we pay closer attention to the situations of women of colour who enter and climb economic, educational, and organizational hierarchies, of people of colour who cross class lines. Without doing so, we “short-circuit activism and ignore the need to raise consciousness—to identify, name, and strategize resistance to racial oppression” (Brush, 2001, p. 195). We assume people of colour always and everywhere resist racial oppression, when in actuality, racism responds and changes according to historical shifts in economies, politics, and domestic relations, and so must our strategies for resistance (Hall, 1996). In the following two case studies, I interrogate the positionality of the authors of each report and highlight the kinds of institutional commitments that short-circuit their “activism” from supporting collective resistance to endorsing individual mental hygiene.

Connected to this issue of the professional cultural insider is Sara Ahmed’s (2005) study of institutional speech acts that claim organizations are diverse or equitable. Drawing on John Austen and Judith Butler’s theories of performative speech acts, Ahmed (2005) argues that spoken, written and visual texts that describe institutions as diverse or committed to equality do not secure the effects they name. Diversity or equity-based speech acts are unique in their ability to satisfy in and of themselves the tasks they name; they are taken up as if diversity and equity

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6 In this chapter “mental health worker” refers to a psychiatrist, psychologist, psychotherapist, social worker, counsellor, family doctor, nurse, etc.

7 My intention here is not to dismiss the possibility that workers and patients might share an experience of racism or a sense of collective marginality in a white world. Nevertheless I believe that if there is bond of solidarity it is in spite of, and not because of, the organizational relations within which worker and patient maneuver. I wish to denaturalize the presence of mental health agencies in immigrant communities.
are already done, in effect doing nothing—hence the “non-performativity of anti-racism”. While Ahmed (2005) writes in the context of the proliferation of documents on race equality in the United Kingdom since the Race Relations Amendment Act (2000), it can be said that anti-racism, anti-oppression, and equity are likewise increasingly professionalized in community mental health as a viable strategy to increase funding ever since the MOHLTC and LHINs have developed health equity initiatives, diversity committees, and task forces to eliminate health disparities (Rachlis, 2007).

Ahmed (2005) categorizes institutional speech acts into three forms: commitments, performances and descriptions. The Federation’s position paper on cultural competence can be seen as a series of commitments. While I suggested in Chapter Two that the recommendations in Embracing Cultural Competence plant the seeds of a regime of governmentality, I also pointed out that some recommendations are mysterious insofar as service providers are told simply to reflect on or develop a framework for understanding racism. These later recommendations are commitments that do not specify substantive actions. Ahmed (2005) calls this a “tick box approach” to diversity, where the pressure to show signs of support (through gestures like “reflection” or “discussion”) is indicative of the institution’s unwillingness to actually do anything (para. 14).

Institutional speech acts are “performative” when anti-racism is achieved by changing people’s perceptions of racism in an institution, reducing anti-racism to an act of “image management” (Ahmed, 2005, para. 25). For example, in Lovell and Shahsiah’s (2006) report, a significant number of recommendations focus on changing the appearance or perception of Y-CONNECT. The authors suggest altering office layouts, meeting spaces, and communication styles. Similar to this notion that anti-racism can be a performance, anti-racism can also work as

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8 Understandably, Ahmed’s (2005) use of “performative” here is confusing given her description of all institutional speech acts that commit to equality as “non-performative”. An alternative to “performative” could be “staged”.
a description when it is equated with “having certain qualities, characteristics and styles,” such as the fantasy of anti-racism looking and feeling good (Ahmed, 2005, para. 30). To expand on Ahmed, I am interested in exploring how Wong et al. (2003) associate anti-racism not only with personal qualities and characteristics in themselves as service providers, but with modifying the personal qualities and characteristics of their patients. For example, Wong et al. (2003) associate racism with negative body image, therefore associating anti-racism with self-empowerment. Anti-racism is achieved when people of colour take control of their lives and behave as proactive agents interested in their own wellbeing. In Chapter Three I look more closely at the Federation’s treatment of anti-racism as a performance or description in the activities of two of its members, Hong Fook and Across Boundaries.

**Case One: Promoting Mental Health Among East and Southeast Asian Immigrant/Refugee Women in Ontario**

*Promoting Mental Health Among East and Southeast Asian Immigrant/Refugee Women in Ontario* is the culmination of a three-year project of the same name funded by the Ontario Women’s Health Council (Wong et al., 2003, p. 2). Hong Fook’s target population for this project included Cambodian, Hong Kong Chinese, Mainland Chinese, Korean, Taiwanese, and Vietnamese women from the Greater Toronto Area. The goal of the project was to assess the mental health needs of East and Southeast Asian (E and SEA) women and to empower these women through building awareness of mental health resources, treatments, and services. To do this, Wong et al. (2003) conducted focus groups, in-depth interviews, and a community survey, followed by “empowerment education” that included activities such as peer-to-peer-outreach. In their major research findings, a fundamental tension emerges between the authors’ desire to address women’s concerns with systemic racism in areas such as employment and the authors’ obligation to evaluate whether or not women adequately cope with these problems on
psychological terms. Consequently, what begins as a discussion on the “racialized Canadian labour market” turns into an assessment of their capacity to seek help from mental health professionals and colonial assumptions about what kinds of coping strategies are maladaptive and correlated to symptoms of mental illness (Wong et al., 2003, p. 12).

For the purposes of this case study, I focus on the results of their community assessment. I am interested in E and SEA women’s theoretical induction into psychiatric and psychological subjecthood, as it is the production of knowledge on E and SEA mental health that manufactures the reality of mental illness already and always existing in those communities. I argue the contradictions between the authors’ characterization of women’s experiences as life problems and as mental health problems are a consequence of two things: (a) the regulatory frames operating in the authors’ transformation of focus group and interview responses into professional summary statements and (b) the interrogatory devices they use in their community survey. Interrogatory devices are instruments used to transpose people’s experiences into institutional realities and in this case, the reality of mental illness; they include surveys and forms that “[transpose] aspects of [subjects’, clients’, or patients’] everyday worlds into shapes that fit the topic-assigned spaces provided” (Smith, 2005, p. 226). Wong et al. (2003) community survey consists of seven self-administered forms: Demographic/Employment Information, Situational Coping—Family Stress, Attitude Toward Seeking Professional Psychological Help Scale (Attitude Scale), Mental Distress/Illness—Explanatory Model (MDEMQ), Vignette I (an account of depression) or Vignette II (an account of schizophrenia), Acculturation, and the Brief Symptom Inventory (BSI).

While this case study provides a preliminary analysis of the overall findings from these seven forms, I pay particular attention to the roles of the Attitude Scale, BSI, and Vignette I in making E and SEA women diagnosable as mentally ill. Just as Ahmed (2005) observes “It is not
that you audit something that is already in place” in her critique of auditing diversity, I argue it
is not that you diagnose something that is already in the body (para. 25). Community needs
assessments are what make people diagnosable by inventing a host of diagnosable conditions
called symptoms to demonstrate evidence of mental illness. The abstract answer choices and the
constrictive use of ratings (for example, from 1—“I haven’t been doing this at all”—to 4—I’ve
been doing this a lot”) in surveys and forms generate desirable, institutionally legible data with
little room for participants to articulate nuanced responses to institutional interests (Wong et al.,

**Mental Health Literacy: The Problem (Vignettes I and II)**

“Institutional capture occurs when both informant and speaker are familiar with
institutional discourse, know how to speak it, and hence can easily lose touch with the
informant’s experientially based knowledge” (Smith, 2005, p. 225)

**Meet John/Mary: Between recognition and denial**

One of the key purposes of the community survey was to determine to what degree
different ethnic groups can correctly identify the diagnoses in the two vignettes (Vignettes I and
II), and to more generally determine what the attitudes of different racial groups were towards
mental health care and how those attitudes might correlate with rates of mental health symptoms
based on the BSI. In their sample of the E and SEA Immigrant and Refugee Women Survey
Vignette I is only made available to the public. Vignette I presents a typical case of the
diagnosis called depression:

John/Mary is 30 years old. He/She has been feeling unusually sad and miserable
for the last few weeks. Even though he/she is tired all the time, he/she has
trouble sleeping nearly every night. John/Mary doesn’t feel like eating and has
lost weight. He/She can’t keep his/her mind on his/her work and puts off making
decisions. Even day-to-day tasks seem too much for him/her. This has come to
the attention of John’s/Mary’s boss who is concerned about his lowered
productivity. (Wong et al., B1 at B-15)

Below this description is an abnormal psychology exam. Participants are asked what is wrong
with John/Mary (what is the most likely problem, the second most likely problem, and the third
most likely problem if any), followed by who could possibly help John/Mary (who is the most
helpful person, the second most helpful person, and the third most helpful person if any), and
finally what treatments are likely to be helpful, harmful or neither for John/Mary.

For the first question, participants are given a list of diagnoses, Western or non-Western,
with tick boxes beside them, and three spaces to rank the top three possible problems.
John/Mary might have a stress reaction, depression, schizophrenia/paranoid schizophrenia,
mania, anxiety, physical “weakness”/imbalance/illness, mental or emotional
“weakness”/imbalance/illness, personality or character problem, lifestyle/behavioral problem,
possess or state caused by other spiritual or magical influence, or uncontrollable fate or
destiny; or perhaps “there is nothing wrong with John/Mary” or “I don’t know” (Wong et al.,
2003, p. B1-15). For the second question, participants are given a list of different people, “some
professional, some not” who could help John/Mary and participants are asked to rank from a
scale of 1 to 5 how helpful each person might be: “1 = Helpful; 2 = neither helpful nor harmful;
3 = Harmful; 4 = Depends; 5 = Don’t Know” (Wong et al., 2003, p. B1-16). The people listed
include a family doctor, chemist/pharmacist, traditional
Chinese/Korean/Cambodian/Vietnamese doctor, counselor, social worker, telephone counseling
service, traditional or spiritual healer, psychiatrist, specialist (but not a psychiatrist),
psychologist, family member, close friend, neighbor, naturopath or herbalist,
clergy/minister/priest-monk/religious leader, or elder; or perhaps “deal with his/her problem on
his/her own” (Wong et al., 2003, p. B1-16). For the third question, participants are asked to rank from a scale of 1 to 5 how helpful different treatments might be. Some of the treatments listed are: becoming more physically active, attending courses on relaxation, seeing a traditional healer, being admitted to a psychiatric hospital, acupuncture, taking psychiatric medicines, and taking pain relievers. We know that Vignette II mirrors the questions of Vignette I, but describes a case of “schizophrenia”.

Wong et al. (2003) report that the majority of Chinese and Korean groups who answered their questionnaires identified “depression” (melancholy) and “schizophrenia” (unusual beliefs, multiple realities) as a potential problem (80 to 90%), while Vietnamese groups had the lowest rates of recognition (60%) (Wong et al., 2003, p. 15). However, these numbers are deceiving as the proportion of respondents identifying depression and schizophrenia as “the most likely problem” is only 10 to 30%, once again with the lowest rate of recognition in the Vietnamese group (Wong et al., 2003, p. 15). Asked whether they would seek help from a psychiatrist, more Vietnamese participants supported this option (40%), whereas Chinese and Korean research participants opted for a family member, friend, or other “non-professional” (Wong et al., 2003, p. 15). Based on these numbers, ethnic groups identified as exhibiting greater recognition of depression and schizophrenia chose to seek psychiatric intervention less often. In “Significance of Preliminary Findings of the Community Surveys”, the authors state that the questionnaire’s results are a sign of some exposure to mental health terms in Chinese and Korean communities and a “lack of knowledge” about mental illness in Vietnamese communities (Wong et al., 2003, p. 23). They argue greater “public education about major mental illnesses and treatment are needed if early recognition of mental illness is to be achieved” (Wong et al., 2003, p. 23). What’s worse to Wong et al. (2003) than underdiagnosis, however, is the refusal to be treated: Chinese and Korean preference for “non-professional” support is a sign of “denial” and cultural
shame (p. 23). Wong et al. (2003) add that E and SEA women’s beliefs in the efficacy of psychotherapy versus medications in the schizophrenia vignette “further suggests a gap in knowledge” (p. 23).

**Constructing ignorance and shame in Asian communities**

From the authors’ perspective, if the experiences, thoughts, feelings and acts associated with depression or schizophrenia resonate with immigrant/refugee women, but they choose to refuse professional help, they are merely hesitant to accept the reality of such a diagnosis as empirical truth. The authors also assume, based on their professional expertise, that the thoughts, feelings, or behaviors associated with schizophrenia can only be treated—removed—through medication. The authors do not support their assertion that “schizophrenia” must be medicated nor do they elaborate on when and to whom it is a “problem”. Rather than claiming these communities are in denial of mental illness or misinformed about the most effective course of treatment, is it possible to imagine that in spite of Chinese and Korean literacy in mental health, Chinese and Korean participants legitimately choose to name, explain, and “deal with” the signs and symptoms associated with depression and schizophrenia in different ways? Likewise, is it not possible that Vietnamese preference for professional help is the byproduct of social pressure on immigrants to become literate in mental health, regardless of whether or not Vietnamese participants actually agree with professional opinion?

The emphasis Wong et al. (2003) place on the fact that some communities are more literate in mental health than others is also misleading. Despite the higher recognition of depression and schizophrenia in Chinese and Korean groups than the Vietnamese group, the majority of Chinese and Korean groups—nearly “a third to half of the sample”—thought the depression vignette was a sign of a stress reaction (Wong et al., 2003, p. B2-39). Similarly, while the Vietnamese respondents rarely recognized either vignettes as depression or
schizophrenia, they did mostly attribute the schizophrenia vignette to stress. Although I cannot draw conclusions about the schizophrenia vignette due to the lack of an available sample, this warrants a closer examination of why the majority of all groups interpret John/Mary’s problems as a consequence of stress (Wong et al., 2003, p. B2-39).

Returning to Vignette I, we see a laundry list of descriptions about how John/Mary feels and what John/Mary is having trouble accomplishing in his/her daily routine, but with no rationale provided for his/her exhaustion, lack of sleep, poor appetite and no elaboration on his/her life circumstances. To Vietnamese, Korean, and Chinese participants, this list can generate a range of questions and speculations: What decisions does John/Mary need to make? Suppose John/Mary is trying to reunite with family members overseas, only to discover the medical history of one of his/her children is jeopardizing his/her entire family’s application due to discriminatory immigration policies. Is that why he/she is having difficulty making decisions? Should he/she drop the sponsorship of his/her disabled child? Did John/Mary begin a new job that requires shift work, affecting his/her sleep routine? Is the job an inconvenient commute from his/her home? Is John/Mary tired of the homophobia and/or transphobia he/she encounters daily in his/her workplace, afraid to confront his/her employer? The possibilities are endless.

While my counterpoint to Vignette I suggests a linear explanation for the “symptoms” presented, consistent with E and SEA women’s belief that John/Mary’s situation is caused by stress, there is also no clear reason why John/Mary’s feelings, regardless of their source (significant or trivial, “rational” or “irrational”), are “depressive”. Respondents to Vignette I are not asked what John/Mary think of his/her own story and what terms he/she would use to describe his/her “problem”.

All we know is that John/Mary’s boss “is concerned” about a loss of productivity and so the “problem” is most clearly linked in this depression vignette with John/Mary’s ability to
work. The problem is social and interpersonal: your employer has reported your poor performance, which puts your job at risk. Wong et al. (2003) assume that only by calling this problem “depression”, can your job security be restored. To Wong et al. (2003) depression is best treated through a combination of therapies and medications. But what kind of psychologist or psychiatrist can advocate for you in the face of barriers such as the plethora of hazardous, deregulated, and anti-immigrant temporary migration programs funded by Citizenship and Immigration Canada (Zaman, 2012)? In the context of strategy, trade-offs, and immediate survival, many would argue that medication has its place and attest to the benefit of drugs in leading normal lives—in functioning (Whitaker, 2010). However, we would be remiss to claim that medication in and of itself make our lives “richer and fuller”\(^9\), when our drug-based paradigm of care correlates with an explosion in the number of adults diagnosed as seriously mentally ill over the last two decades (Whitaker, 2010, p. 9-11).

Although Whitaker (2010) glosses over these statistics by arguing the joint rise in diagnosis and psychopharmaceutical revolution has simply pathologized the rites of passage of otherwise normative middle-class youth, “the goof-off in the fifth grade [who] might show up at his high school’s twenty-year reunion as a wealthy entrepreneur, the shy girl as an accomplished actress”, he makes the point that drugs are partly fueling an epidemic of chronic mental illness (p. 10). Drawing on anecdotal and clinical evidence, Whitaker (2010) observes that when patients stop taking selective serotonin reuptake inhibitors (SSRIs), they experience symptoms worse than what drove them to seek treatment in the first place, while antipsychotics cause side effects such as weight gain, tremors, cognitive decline, and brain shrinkage. In addition, increased suicidality has been associated with the use of various anti-depressant medications, like the SSRI fluoxetine (Licinio & Wong, 2005). Given the inverse relationship between

\(^9\) Taken from the words of American Psychological Association (APA) president Carolyn Robinowitz’s speech at the APA’s 2008 convention.
prescribing antipsychotics and long-term “recovery” (i.e. self-supporting, functioning) (Harrow & Jobe, 2007), is it so surprising that “[m]edications are very rarely believed to be helpful interventions in both vignettes” (Wong et al., 2003, p. 15)? East and Southeast Asian women may be onto something when more than two groups choose “talking with others” and “taking a holiday” as first-line interventions to cope with what they identify as stress (Wong et al., 2003, B2-39). Finding a community of allies and time for self-care in the neoliberal and racist present are both valuable commodities immigrant and refugee women are acutely aware of and privileges they sometimes live without.

**Mental Hygiene: The Solution**

“[T]he customary is associated with what is merely habitual rather than being understood as a form of creative action.” (Ahmed, 2010, p. 134)

**Resilience versus recovery**

Where East and Southeast Asian women do find innovative ways to reduce social isolation or marginalization, they are both applauded for their positive attitudes and disparaged for failing to access professional mental health treatment. In their in-depth interviews, Wong et al. (2003) explore the major changes women experience upon migration and their various coping strategies. Wong et al. (2003) write:

A number of women identified or created innovative venues to foster mutual support… These venues included study (reading) groups, network marketing groups, recreational groups such as line-dancing, tai-chi, as well as volunteer service opportunities. ESL and LINC classes were also significant venues for these women, especially newcomers, to develop new friendships and exchange information for their settlement. (p. 13)
Here, the authors recognize women’s “inner strengths” and affirm women’s “resilience” in spite of their difficulties and struggles as newcomers, with one caveat: activities such as tai-chi do not count as authentic forms of treatment, complete in and of themselves. In their section on the “Significance of Preliminary Findings of the Community Surveys”, they maintain that certain coping behaviors, “such as denial or disengagement, which may have important cultural relevance, may potentially lead to adverse outcomes” (Wong et al., 2003, p. 22). They argue this is especially true when women who “[perceive] less access to cultural, gender and linguistically appropriate care” and who opt for the support of a family member exhibit more mental health symptoms (Wong et al., 2003, p. 23). Returning to their in-depth interviews, Wong et al. (2003) conclude that non-professional strategies like spiritual faith are signs of potential collaborators of mental health programs, but not sufficient forms of coping in and of themselves (p. 13). Mental health workers should partner with faith organizations in immigrant communities because these venues are popular and well received.

This series of conclusions is problematic for several reasons. The authors perceive the exclusive use of non-psychiatric or non-psychological help as merely a byproduct of cultural norms and traditions that perpetuates immigrant and refugee women’s denial of mental illness. Which habits are good enough to reward you with sanity, and which habits are “merely habitual” (Ahmed, p. 128)? Wong et al. (2003) assume that faith and alternative health practices are merely signs of compliance with cultural norms, signs of “disengagement”. Women only assert themselves as individuals and make the conscientious decision to “get better” when they engage in therapeutic relationships. The relationship between psychologist and client constitutes “cooperative” health-seeking behavior, not the relationship between migrant women in general. Wong et al. (2003) only appeal to tools such as faith as mechanisms for client recruitment, which implies that spirituality is an inferior form of “care”. The purpose of
offering “cultural” practices such as herbal medicine and acupuncture is to facilitate providing “better treatment”. Alternatives do not depart from the psyche complex itself. So long as alternatives are solely viewed as superficial cultural amendments to psychiatric interventions, service providers use folk traditions simply to integrate them into the existing narratives and explanations provided by mental health. Few mental health workers stop to reflect on how traditional practices may politically or philosophically conflict with the methods and the objectives of psychiatry.

The authors go on to claim that women who do not receive diagnosis and treatment because they perceive a lack of available culturally appropriate mental health services are actually more symptomatic and therefore made sicker as a result of negligence. This last conclusion mainly refers to Korean respondents, who indicated they were both more skeptical of mental health services and more symptomatic according to their results in the Attitude Scale and the BSI. Viewed differently, what if Korean respondents exhibit greater “symptoms” because professional helpers cannot solve their problems, poorly described by the BSI? What if these women organize their own means of support outside of the mental health system knowing their “symptoms” are not within the scope of a mental health worker’s expertise?

I wish to complicate the statistical correlation between avoiding help and increasing symptoms with two questions: (a) why do E and SEA women distrust mental health services and (b) are all symptoms signs of mental illness or disorder? As for the first question, the Attitude Scale provides no satisfying answers (Wong et al., 2003, p. B1-9-B1-11). Its thirty scaled statements are designed to sort people into five types: believers in mental health, would-be believers, fearful non-believers, private non-believers, and collectivist non-believers. Believers are people who are unashamed of life’s difficulties, who welcome professional help, who find relief in mental health services, and who recommend the services of a mental health
would seek help if they could find a mental health worker who is fluent in their language, sensitive to their culture, and of the same gender. Fearful non-believers have no faith in the mental health system and think getting help is a blot on your life, a burden of shame. Private non-believers resent anyone who wants to know about their problems and want to work them out themselves. Finally, collectivist non-believers would rather live with their problems or seek the counsel of a family member or friend because they find mental health services expensive, time consuming, and difficult. The following table presents examples of statements from the Attitude Scale sorted into the five types.

Table 1

Examples of the Five Attitudes Towards Professional Help

<table>
<thead>
<tr>
<th>Attitudes</th>
<th>Statements*</th>
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<tbody>
<tr>
<td>Believer</td>
<td>“I would willingly confide intimate matters to an appropriate person if I thought it might help me or a member of my family” (A93), “A person with a mental or emotional problem is not likely to solve it alone; he/she is likely to solve it with professional help.” (A102), “If I were experiencing a serious emotional crisis at this point in my life, I would be confident that I could find relief in mental health services.” (A109), “Had I received treatment in a mental health agency, I would not feel that it ought to be ‘covered up.’” (A113), “If I thought I needed mental health services, I would get them no matter who knew about it” (A114)</td>
</tr>
<tr>
<td>Would-be</td>
<td>“I can find a mental health worker who can speak my language if I need help with a mental or emotional problem” (A116), “If needed, I believe that I can find a mental health worker who is sensitive to my culture to help me” (A117), “If I decided to seek help, I will be able to find a mental health worker of the gender I am comfortable in working with” (A118)</td>
</tr>
<tr>
<td>Fearful</td>
<td>“Although there are mental health agencies/clinics for people with mental or emotional troubles, I would not have much faith in them” (A87), “I would feel uneasy going to a mental health worker because of what some people would think.” (A89), “Having been helped by a mental health agency is a blot on a person’s life” (A100), “Having been mentally ill carries with it a burden of shame.” (A106)</td>
</tr>
<tr>
<td>Private</td>
<td>“Emotional or mental difficulties, like many things, tend to work out by themselves.” (A95), “I resent a person, professionally trained or not, who wants to know about my personal problems” (A103), “There are experiences in my life I would not discuss with anyone.” (A107), “A person should work out his/her own problems; getting mental health services would be a last resort.” (A112)</td>
</tr>
<tr>
<td>Collectivist</td>
<td>“Considering the time and expense involved in getting mental health services, it would not be very valuable for me.” (A92), “I would rather live with certain mental problems than go through the difficulty of getting mental health services expensive, time consuming, and difficult.” (A106)</td>
</tr>
</tbody>
</table>
services.” (A94), “There are certain problems which should not be discussed outside of one’s immediate family.” (A96), “I would rather be advised by a close friend than by a mental health worker even for a mental or emotional problem.” (A101)

*Respondents are asked to score the statements on a scale of 1 to 4: 1 = strongly disagree, 4 = strongly agree

(Wong et al., 2003, p. B1-9-B1-11)

These five types vilify non-believers of mental health as people who are ashamed of sharing their problems (fearful), incapable of opening up to others when they most need it (private), or misguided in their decision to live with their problems and/or look exclusively for non-professional help (collectivist). Only those who explicitly seek mental health services (who “believe”) get characterized as open, self-aware, resourceful, and ultimately, “sound”. The statements in the Attitude Scale suggest that if you are informed about your problems, you will seek mental health services and if you are uneasy about the mental health system, it is because you are ashamed of mental illness. According to the Attitude Scale, non-believers merely do not seek out professional help out of comfort or preference and have no sophisticated analysis of the mental health system. If, for example, the “problem” a woman is experiencing is caused by stress from deprofessionalization and labor market subordination post-migration, she might not find mental health services relevant or helpful and may in fact, view it as a “last resort” (Kelly, 2012). If an immigrant woman notices other racialized children at her daughter’s school are being streamed into special education classes, and those same children receive fewer resources and opportunities and fall further behind, she may want to prevent her from being labeled by only sharing knowledge of her daughter’s learning disability with immediate family. If a woman of colour on a temporary visa was aware that sharing thoughts of harming herself or feelings of aggression towards others could possibly lead to being “Formed” or forcibly committed to a psychiatric institution, and eventually lead to deportation, she might feel uneasy about going to a mental health worker and prefer to confide in a friend. As these scenarios
reveal, explaining a person’s motivations through abstract “feelings” can only convey so much (or so little) about someone’s social location or life experiences, which brings me to my second question. Are those feelings and behaviors called “symptoms” necessarily signs of mental illness?

The Brief Symptom Inventory (BSI) in the community survey presents 53 symptoms and asks participants to rate on a scale of 0 to 4 how much each problem has “DISTRESSED OR BOTHERED YOU DURING THE PAST 7 DAYS INCLUDING TODAY” (p. B1-20-B1-22). Examples of symptoms include “the idea that someone else can control your thoughts,” “feeling afraid in open spaces or on the streets,” “feeling fearful,” “feeling that people are unfriendly or dislike you,” “feeling inferior to others,” “getting into frequent arguments,” “others not giving you proper credit for your achievements,” and “feeling that people will take advantage of you if you let them” (Wong et al., 2003, p. B1-20-B1-22). What is remarkable about all of these symptoms is how easily they can be used to predicate an endless range of everyday social encounters. To borrow from Voronka (2008), “[w]e can all ‘see ourselves’ in this list of signs and symptoms, and are thus all implicated in our potential to become diagnosable subjects.” (para. 34). However, many symptoms also describe situations that reflect the real life circumstances of marginalized women of colour, circumstances that often bother us for periods that exceed “7 days”. If we were to reinterpret symptoms like fear or feelings of inferiority from figments of our imagination to actual threats to our survival, such as the threat of sexual violence or the threat of deportation, we can begin to comprehend immigrant and refugee women’s desires to organize resistance within their communities at the cost of seeking professional help from a psychiatrist. The BSI pathologizes understandable responses to living under oppressive systems of power. For this reason, as well as others outlined throughout this case study, the authors’ observation that East and Southeast Asian women are more
symptomatic because they have lower recognition of mental illness (Vietnamese respondents) or lower access to mental health treatment (Korean respondents) is unfounded.

**Opposing Standpoints**

The depression and schizophrenia vignettes and the Attitude Towards Seeking Professional Psychological Help Scale are interrogatory devices designed to extract East and Southeast Asian women’s behaviors out of context and categorize them into healthy help-seeking behaviors or maladaptive coping skills. Together with the Brief Symptom Inventory, these forms produce data that justify professional help through pathologizing reactions to everyday oppressions immigrant and refugee women do not necessarily interpret as problems of the mind that require reversal or removal. As I have shown, it is possible to present a different account of E and SEA women’s relationship to mental health through reading for contradictions and dropped or poorly elaborated discussions in the authors’ report. Women’s critiques of mental health are present from the outset of their research, in the results of their 13 focus groups.

The main objective of the focus group study was to explore how E and SEA women conceptualize mental health and mental illness. Women’s responses to the focus group questions include the desire to “be understood” to be mentally healthy, and the need for broader well-being (Wong et al., 2003, p. 10-11). Wong et al. (2003) further note:

The women in the focus groups have provided a range of positions on the tension between social conformity and personal autonomy or self-direction in their conceptualization of mental health. Some of them construed mental health as conforming to socially established norms and conventions, including moral codes, behavioral propriety… Many women, on the contrary, clearly espoused an
“individualistic” orientation, in that they valued autonomy, self-confidence, and self-development as key components of mental health. (p. 11)

The authors interpret women as either conformist or individualistic. On one hand, women lack agency and feel bound to their social roles and on the other hand women wish to be free and self-reliant. In both scenarios, “a mentally healthy person was generally perceived as someone who can cope with any difficulties and who can help her/himself and others in all circumstances” (p. 11). However, Wong et al. (2003) are alarmed that women rarely described a mentally healthy person as someone who seeks help. The authors conclude Hong Fook must promote mental health as knowing “when, where, and how to seek help” (Wong et al., 2003, p. 11). Conversely, I suggest the focus group results demonstrate women have an analysis of power and privilege and wish to assert their patient rights in the mental health system. What if their knowledge about the healthy body is a critique of normative health? By defining a healthy person as someone who conforms to social norms, as someone copes with any difficulties, is it possible that immigrant and refugee women associate a mentally healthy person with economic and racial privilege, with “success”—a person who therefore requires no help? Normative bodies do not seek out help because they are not the subjects of help. Rather than characterizing women who value autonomy and self-direction as necessarily individualistic, we might ask from whom we desire autonomy and demand self-direction. The desire for defining your own experiences and determining your own treatments are both fraught issues among marginalized communities who are frequently the subject of study for mental health workers. E and SEA women may wish to “resist, reinvent, and reclaim” dominant stories about them in mental health and part of that resistance may include challenging what constitutes “seeking help” (Recovering Our Stories, “Home”).

Case Two: “Mental Well-being and Substance Use Among Youth of Colour”
Diagnosing Reality: Youth of Colour as Authors of Their Own Misfortune

In Mental Well-being and Substance Use Among Youth of Colour, Lovell and Shahsiah (2006) introduce the topic of race, poverty, and mental health by first acknowledging psychiatry’s Eurocentric history, noting that black communities were highly pathologized—“deemed psychologically, biologically, genetically, culturally, and otherwise inferior by the 19th century” (p. 26). Although Lovell and Shashiah (2006) begin their report by providing a caveat on the problematic historical construction of mental illness, they assume that the construction of mental illness is precisely that—historical\(^{10}\). According to Lovell and Shahsiah (2006), today the role of culturally competent mental health workers is to “assist the client by recognizing the reality of the client”, which avoids “misinterpreting or minimizing emotional and behavioural symptoms” (p. 27). As if time and space could be neatly divided, the authors suggest contemporary definitions of mental illness are unproblematic and non-discriminatory and that the mental illness model is at its core beneficial and helpful to the lives of youth of colour. The authors assume that in order to seriously recognize the “reality” of poverty and racism we must recognize the “health problems and symptoms” affecting communities of colour. Yet, they do not problematize the cross-cultural, multicultural and/or “culturally competent” psychiatric and psychological frameworks they use to define “health”. Like Wong et al. (2003), Lovell and Shahsiah (2006) believe communities of colour do not easily seek help.

Helping racialized mental health users out of their “problems” as “symptoms” is an example of racial governance. Lovell and Shahsiah (2006) characterize self-help and self-actualization as anti-racist, suggesting that youth of colour can overcome their marginalization through positive attitudes. This meritocratic message fails to address the systemic violence poor

\(^{10}\) Lovell and Shahsiah (2006) also limit their historical analysis of psychiatry to its negative representations of black people. They could elaborate by identifying the multiple ways in which negative representations justified the continuation of practices such as slavery through diagnoses like drapetomania.
youth of colour encounter day to day. Instead, by making oppression synonymous with an assault on the human psyche, Lovell and Shahsiah (2006) imply that it is the individual who can overcome oppression. Not just any individual, but one with “market rationality, individual choice, personal responsibility, [and] control over one’s own fate and self-development”—the neocitizen (Berger, 2003).

What’s more, according to Y-CONNECT, youth of colour actually contribute to their own oppression because they “act-out” against systems of discrimination:

Our guiding principle is to provide services through an anti-racism/anti-oppression framework. This means creating programs that respond to emotional and mental health concerns arising out of discrimination against people because of their ‘race’, gender, sexual orientation, dis/ability, age and class. Oppressions are often part of social and political systems; but they are often acted-out in our personal interactions. Anti-oppression, therefore, moves to challenge our everyday assumptions, attitudes and behaviours that contribute to social resistance to systems that oppress, while confronting systemic forms of discrimination. (Lovell & Shahsiah, 2006, p. 13)

Lovell and Shahsiah (2006) further support this notion that youth act out in response to discrimination by citing a study in which Aneshensel and Sucoff (1996) argue youth who are perceived as dangerous or threatening exhibit increased symptoms of ‘oppositional defiant disorder’ (p. 22). Across-Boundaries and Y-CONNECT assume that in order to challenge oppression it is necessary to discipline (“respond to”) youths’ inappropriate responses to oppression, going so far as to claim that particular kinds of responses are detrimental to their well-being and exacerbate their experiences of oppression. This narrative sends the message that youth are the authors of their own misfortune and that anti-oppression can be achieved through
compliance. “Psychological distress”, “mental health issues”, “depression”, “suicide”, and “oppositional defiance disorder” are all clinical terms that Lovell and Shahsiah use to describe youth of colour throughout their study. While they may appear harmless, these labels are attached to violent institutional courses of action. The language they use to qualify the experiences of contemporary youth of colour indicates that they believe oppression is a struggle that unfolds within the individual psyche and through mental illness (Lovell and Shahsiah, 2006, 7-11).

Why do Lovell and Shahsiah continue to use mental illness and their affiliate euphemisms to understand the struggles and “realities” of racialized youth? Perhaps because they only problematize psychiatry insofar as it came to equate “the normal state of Blacks [emphasis mine]” with madness (Lovell & Shahsiah, 2006, p. 26). Here lies the exception that Across Boundaries and Hong Fook defend: objecting to the pathologization of people of colour in their “normal state”, they believe that psychology remains useful to treat the binary equivalent – abnormal states. This assumes there is an optimal state of being as a racialized person and that a deviation from this state somehow makes you exceptionally racialized or oppressed. The preoccupation with distinguishing between normal or abnormal ethnic behaviour—of diagnosing difference—is not exclusive to Lovell and Shahsiah’s (2006) report, but reflects a wider consensus in the discipline of multicultural or cross-cultural mental health practice. For example, Roysircar (2005) cites the two most common problems with treating ethnic minority mental health users: “When diversity is seen as extraneous to someone’s personality, behavior is misidentified and mistakenly pathologized. Or, if diversity becomes an exclusive focus, people of colour are assumed to be similar, within-group differences are ignored, and behavior is misidentified and underpathologized” (p. 22). This quote reveals that on one level, compliance with behaviors categorized as “ethnic” are mistakenly viewed as
mentally ill, while on another level, the transgression of “ethnic” norms should be viewed as mentally ill. The failure to be a happy, rational, and racialized subject is disciplined. What unique rewards or punishments are consolidated onto differently racialized bodies in Roysicar’s division between what is culturally appropriate and inappropriate behavior? Given that ethnic diversity is a discourse of racial alterity—a discourse of otherness whose referent always remains in the center—can “diversity” ever be neutral?

**Fitting the Actual to the Institutional**

Lovell and Shahsiah’s report contains ten pages of findings, which are divided into seven subsections: “Stress and Anxiety”, “Depression and Suicide”, “Self-Esteem and Identity”, “Fear and Aggression”, “Coping Strategies and Support Networks”, “Substance Use”, and “Oppression and Exclusion”. Across these findings, Lovell and Shahsiah draw on the firsthand accounts of helpers and youth working and living in Y-CONNECT’s service area, an area known for its high numbers of low-income earners and public housing tenants. Choice quotes from mental health workers, family counselors, youth workers, substance abuse workers, young men, and young women make up the evidence in their report. However, Lovell and Shahsiah (2006) obscure important analyses youth make of their living situations by focusing on their individual mental states. Disjunctures arise between the actualities of youth (documented in block quotes) and the recommendations of helpers in part because of Lovell and Shahsiah’s reliance on the regulatory frames governing mental health. Lovell and Shahsiah (2006) “select from the actual that which fits the institutional frame”—policies, discourses, and other textual devices originating from the psy disciplines (Smith, 2005, p. 199). This applies both to the authors’ interpretations of the problems in youth’s lives and youth’s attitudes towards mental health services. For example, participants’ “frustrations about privacy”, “[h]idden homelessness”, “crowding”, and the “pressure to leave school prematurely”—all signs of poor
public housing conditions are not adequately explored and instead Lovell and Shahsiah (2006) focus on how youth “sometimes [mask] deep emotional issues taking place in the home” (p. 40-41). Likewise, when youth outline experiences of daily violence, from police brutality to surveillance in schools, Lovell and Shahsiah (2006) conclude “some youth are cynical about the ability of community workers, or youth programs to alter their situation” (p. 49). Is this being cynical or knowledgeable about counselling strategies that are failing? Put together, the authors’ characterization of youth as cynical, self-destructive individuals masking their frustrations reinforces the perception that youth of colour are clinically depressed in spite of the important analyses they are making of their socioeconomic conditions.

**Signs and symptoms or expert knowledge? Constructing depression and suicide**

To Lovell and Shahsiah (2006), the problem with mental health is not diagnosis, but misdiagnosis, echoing Wong et al. (2003) in their struggle to define the experiences of East and Southeast Asian immigrant and refugee women. Do youth agree? Not exactly. Lovell and Shahsiah (2006) found that among focus group participants, “stress was the most acceptable topic of discussion for youth” (p. 40). Rather than identifying with particular mental health labels, youth described how money problems cause stress. Poverty has a domino effect: youth complained about domestic disputes from lack of private space, the need to quit school, and working low-wage jobs to pay household bills (Lovell & Shahsiah, 2006, p. 40). However, Lovell and Shahsiah (2006) do not use stress to describe youth experiences for the remainder of their report. Throughout their findings, stress is first narrowed to “social pressures” and “expectations, then “deep emotional issues taking place in the home”, and later to a definable, isolatable disorder—“depression”—in which community politics are further individualized by rates of men and women losing sleep (p. 41).
In the subsection on “Depression and Suicide”, Lovell and Shahsiah (2006) concede that:

In some instances, youth suggested that depression is a sign of weakness, or a condition that is not experienced outside of the White community. Furthermore, young men sometimes consider themselves unlikely to be depressed or viewed depression as a ‘feminine’ trait. (p. 42)

However, they consider this a sign of denial or stigma—of shame—concluding “Although many in the focus groups did not acknowledge depression as an issue affecting themselves or other youth, community workers saw this to be a key issue needing response” (Lovell & Shahsiah, 2006, p. 42). Conversely, I suggest this passage reveals youth’s beliefs that psychiatric records can pose barriers, that depression is a gendered discourse, and that mental health treatment is connected to assimilationist tactics by a white supremacist state.

Rather than acknowledge the critical thinking of youth of colour, Lovell and Shahsiah (2006) quote community youth workers and mental health workers who believe youth simply externalize their illness by hiding it or by projecting it as anger. The authors fail to socially contextualize patients’ feelings. For example, one youth worker states:

People are depressed every day around here, but you won’t even know. In the community, as a man, you have to maintain a soldier image, ‘cause it’s a hard community… People deal with it on different levels—sure you have people commit suicide, but in this community, people don’t run to you to tell you their problems, they usually keep it inside.” (Lovell & Shahsiah, 2006, p. 42)

Another mental health worker argues “For the youth that I work with, it is more socially accepted for them to be angry then for them to be sad. So that what they do is project their depression as anger. It’s still depression it’s just ‘angry-depression’.” (Lovell & Shahsiah, 2006,
p. 42). Helpers assert that youth are clinically depressed, but cope in different ways whether they keep their feelings private or behave angrily. What Lovell and Shahsiah (2006) and other workers fail to distinguish, however, is the difference between encouraging youth to openly talk about their stress and telling them they have a disorder that requires medical attention. These two agendas are collapsed onto one another. The authors presume that in order for youth to live well, they do not just require any kind of support, such as adequate housing, but mental health care. What Lovell and Shahsiah (2006) do not disclose is the kind of material consequences inherent to diagnosing youth with labels such as depression. The same sort of consequences that make participants “unwilling to identify themselves… as depressive, or having mental health problems [emphasis mine]” or “unable to easily relate their emotions of sadness, frustration or anger with depression [emphasis mine]” (Lovell and Shahsiah, 2006, p. 41-42).

Lovell and Shahsiah perceive anger, frustration, sadness, and “soldiering on” as signs and symptoms of depression. Anger as a teaching pedagogy and basis for action is not explored in their report. Wastasecoot (2000) provides a contrapuntal reading of anger as a tool for healing from pain. Instead of interpreting anger as a way to avoid accepting you are depressed, she believes it can be a safe way to share memories and lighten the emotional burden of a colonized past so that Indigenous peoples’ energies can be reinvested in political action. Working as an Indigenous counselor and healer, Wastasecoot (2006) believes Indigenous peoples are agents capable of determining their own needs. Comparing and contrasting the practices of sedation and seclusion in psychiatric hospitals with anger work in Native workshops, Wastasecoot (2006) argues the Western mental health model opposes her knowledge as a Native woman. She explores how being “offered the safety people needed to really rage and grieve” in a group where each participant is “held down by six to eight people as a way of providing something to

The authors, in their narrative progression from the subject of “Stress and Anxiety” to “Depression and Suicide”, uncritically construct self-killing as “suicide”, a clinical term used in psychiatry to help individualize death by claiming it is necessarily premeditated (Smith, 1990). Understood as a discourse that serves particular institutional purposes, suicidality helps maintain a closed circuit of accountability when lives are lost. The idea that cultural violence causes madness is not new. For example, postcolonial psychiatrists on Reunion Island thought Creole men were neurotic because they were attached to a belief in victimhood from a brutal, distant history; they also claimed Creole single mothers were the source of young men’s weak identities and lack of individuation (Vergès, 1999). By solely focusing on the attitudes of parents, rather than investigating the circumstances underpinning the motivations of parents, postcolonial psychiatrists and culturally competent mental health workers deemphasize conditions for poverty and hold family members accountable to the consequences of colonization and oppression.

This circular diversion of life problems as mental health problems conceals the systemic oppression of having your reality diagnosed as a disorder. At the time of this study, I am a advisory board member of a non-governmental organization that coordinates events by and for racialized, disabled youth. Several board members, including myself, agree that immigrant families often go out of their way to prevent children from being diagnosed and streamed into special education or mental health programs due to the barriers these institutional records pose on their children’s’ success in school, employability, citizenship status, and ability to travel. In their conceptual framework, Across Boundaries asserts that all human beings are “socialized into identities that correspond to categories of race, gender, and class” (Lovell & Shahsiah,
2006, p. 17). Yet, their definition of socialization cannot include the multiplicity of ways in which we are socialized into mental health because it is not within Across Boundaries’ mission to call out the “devastating effects” of having your experience diagnosed. Across Boundaries is funded to provide mental health programs. How can institutional workers take more risks against the constraints of their organizations’ mandates in allying with community members to minimize the detainment, displacement, and barriers created through diagnosis?

Affective changes

Lovell and Shahsiah conclude their report by outlining a series of recommendations for change. In accordance with Y-Connect’s mandate, their goal is to persuade youth to receive mental health treatment through fostering feelings of safety and minimizing the power differential between service providers and users. Below are several entries from a table Lovell and Shahsiah compiled on issues that impede mental health outreach and corresponding courses of action:

Table 2

*Across Boundaries’ Findings and Recommendations for Y-Connect*

<table>
<thead>
<tr>
<th>Issue</th>
<th>Recommendation</th>
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<tbody>
<tr>
<td>Mental health is not a topic that can be directly approached with youth, and many youth are resentful of authority figures prying into their personal lives, or assuming what their issues are</td>
<td>Develop trust and friendships with youth by opening up your personal life to them. Rather than questioning and focusing on them, at first, encourage youth to question you and your motives and begin to feel comfortable expressing their opinions with you.</td>
</tr>
<tr>
<td>Mental health language is stigmatizing</td>
<td>Avoid terms like “mental health”, “therapy”, “anger-management”, and “support group”. Name programs according to relevant symbols and ideas, or allow participants to name their own groups.</td>
</tr>
<tr>
<td>Youth dislike spaces that resemble clinical offices</td>
<td>Make spaces that are more like rooms than like classrooms or doctor’s offices. An effort should be made to create spaces that embrace democratic group dynamics, and oppose symbols of authority, such as classrooms, offices and clinics.</td>
</tr>
<tr>
<td>Youth are cynical of authority figures</td>
<td>Work to diminish symbolic and real power differential in service; avoid being seen as the authority figure,</td>
</tr>
</tbody>
</table>
Looking at the examples above, it is difficult to discern how Lovell and Shahsiah’s (2006) recommendations embody “approaches that are based on equality and fairness” (p. 53). Although Lovell and Shahsiah acknowledge that getting basic needs met is “critical to resisting the hopelessness that undermines the mental well-being of youth of colour,” the actions they recommend reinforce superficial, as opposed to substantive, changes to the mental health system (p. 51). So while they support making an effort to understand patients’ financial situations, the changes they wish to make to the mental health system itself only extend to the cosmetic appearance of the therapy room and the affective performance of service providers. They do not implicate themselves in the oppression youth experience. Their primary focus is “reducing the sense [rather than acknowledging the reality] of differences” (Lovell & Shahsiah, 2006, p. 53). It is not enough to be an ally and offer information about employment and housing. Lovell and Shahsiah’s objective is to convince youth that their immediate concerns are also mental health concerns, so that youth in crisis perceive Y-Connect as a natural frontline resource. By taking an “indirect approach to gain the attention of youth” through avoiding the overt use of clinical language, forgoing the distribution of printed materials, and relying on face-to-face outreach, Lovell and Shahsiah (2006) hope service providers will gain the trust of youth of colour (p. 52). They wish to perform as nonprofessional allies. However, these gestures are empty insofar as Lovell and Shahsiah (2006) make no commitment to changing the institutional processes that have negatively affected youth, such as Y-Connect’s policies on client record keeping, where psychiatric terminology is still likely used.

By interpreting youth’s needs as emotional needs, Lovell and Shahsiah (2006) reduce “equality” to modifying the sense that there is injustice so that youth of colour feel there are
fewer and fewer differences between themselves and mental health workers. Yet dampening feelings of difference will not eliminate difference. Phrases such as “being seen as” or being “more like” indicate Lovell and Shahsiah (2006) believe the hegemonic relationship between service providers and patients is merely a symbolic one, one that is illusory, imagined (p. 52). To Lovell and Shahsiah (2006), youth only avoid mental health programs because they are symbols of “authority” or “the system”. This “system” has no real negative consequences on their lives. Consequently, strategies suggested for addressing the power differential are contracted to “[u]s[ing] self-effacing humour to diminish your perceived and real power” and holding “group discussions… in circles, where the symbolic power of a leader is diminished” (Lovell & Shahsiah, 2006, p. 53-54). Are youth fearful of service providers because they feel interrogated or because answering a “barrage of questions” led to the last time they were forcibly medicated [p. 53]? Without expanding on the reasons why youth feel resentful and cynical of mental health workers, Lovell and Shahsiah (2006) collapse “symbolic” power onto real power and ignore the larger social relations of the mental health system.
Conclusion

In this thesis, I have drawn on strands of feminist, postcolonial, and Foucauldian thought to problematize the co-construction of mental health, deviance, and race. I began in Chapter One by outlining a dialectical or discursive material approach to understanding race and madness as mutually constituted ordering practices, insisting that only through a historical project can we acknowledge the enduring material consequences of any categorization of difference. In other words, without observing the ways in which texts are activated, our picture of social organization would be incomplete. Through the work of history, we can see how race and madness come or become together through institutional and technological planes of consistency (Clough, 2000), in which the ever-expanding work of symptom-naming and biological/affective “tweaking” anticipates culturally-specific “problems” such as neurasthenia in Asian American communities. Highly exploitable populations are exceptionally medicalized; emergent therapeutic modulations help constitute racial taxonomies.

This approach to an analysis of race and madness contrasts the work of most disability and cultural studies scholars, who problematize madness through the politics of representation and self-determination. In this body of literature, there are two interpretive trends. On the one hand, race is relegated to metaphor, in which control of the mind is universally qualified as “colonizing”. On the other hand, race is the source of psychological illness, in which the structural violence of global capitalism causes higher rates of diagnosis in minority populations. At the heart of these studies is the assumption that madness is objectively real and this truth forces scholars either to account for race as a determinant of illness or marginalize race as a lens for comparison. In order to denaturalize the supposed epidemic of mental illness in racialized communities, I draw on Dorothy E. Smith’s social ontology (2005; 2006) to conduct a close
reading of organizational literature on cultural competency and cross-cultural mental health outreach in Chapter Two and Chapter Three.

The first is a position paper on cultural competency, in which the Ontario Federation of Community Mental Health and Addiction Programs (OFCMHAP) advocates for increased funding of culturally-specific mental health programs in Ontario. The second is a community needs assessment of Cambodian, Hong Kong Chinese, Mainland Chinese, Korean, Taiwanese, and Vietnamese women from the Greater Toronto Area by Hong Fook Mental Health Association. The third is a report from Across Boundaries on the mental health conditions of predominantly Black and South Asian youth living in a large inner-suburban area of the City of Toronto, including the notorious neighbourhood of Jane and Finch, known for its poverty and crime. I concluded that agencies such as Hong Fook and Across Boundaries, while critical to some degree of psy professions, are limited in their capacity to address systemic racism as they use the language of health to frame social problems, reducing the effects of contemporary settler colonialism and white supremacy to “cultural needs”. In their attempts to make mental health “equitable”, the authors of all three publications unwittingly suggest the real cost of discrimination is psychological and self-perpetuating by implying negative cognition causes mental illness. Furthermore, through the language of denial of mental illness, the authors are able to void the contradictory opinions of women and youth of colour by stating, “these people may have to learn to accept, understand, and manage their illness” (OFCMHAP, 2009, p. 23).

Interpreting cultural competency in mental health outreach as a form of racial governmentality, I have argued it is not that you diagnose something that is already in the body. Technologies such as the Brief Symptom Inventory and Attitudes Towards Professional Psychological Help Scale work to manage the lives of racialized people by transposing people’s experiences of oppression and acts of resistance into the institutional reality of mental illness.
When fears of inferiority and suspicions of being watched become measurements for psychosis, worker exploitation and police surveillance are just some of the everyday encounters of women and youth of colour that get translated into disease pathways in the individual. In the context of cultural competency, outreach and inclusion have become tools for governing “diversity”, insofar as the language of equality becomes amenable to an argument for equal access to an ineffective, and sometimes violent, system of “care”.

Areas for Future Research

Together the position paper and needs assessments analyzed in this thesis represent a race during the early to mid-2000s by psychologists and social workers of colour to institutionalize mental health programming in communities with high proportions of immigrants and refugees in Toronto. I believe this was in response to the general lack of social programs in low-income communities of colour. With the popularization of health equity provincially at the Ministry of Health and Long-Term Care (MOHLTC) in the last decade came the opportunity to bring in much-needed resources to poor newcomers and diasporic youth. What remains unclear is when or how mental health became the preferred or self-identified avenue for support. Further research is needed on the historical changes in government funding structures and the subsequent effects on community groups. One dilemma is that racial minorities do want services of some kind urgently, whether this means advocacy or peer support. How can mental health workers be better allies and take more risks in a time when institutional accountability circuits are being tightened and refined by the MOHLTC? Currently, the province of Ontario has plans to create a legal and psychological risk profile in the electronic health records (EHRs) of some 13 million residents by 2015, which poses concerns to all residents (and non-residents) for the “many unanticipated ways” data can be used without clear controls on “secondary uses and disclosures” (Webster, quoting Khaled el Eman, 2011).
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