SUFFERING AND PAIN: RACIALIZED IMMIGRANT WOMEN'S USE OF MENTAL HEALTH SERVICES IN LETHBRIDGE, ALBERTA

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Dedication

To my wonderful mother and daughter for their persistent love and support.

Abstract

Drawing on in-depth interviews with 13 racialized immigrant women, this research explores experiences of using mental health services in Lethbridge, Alberta. The women's narratives serve as a thread linking psychiatric, neoliberal, colonial, patriarchal, and other power relations. The treatments focused on the women's concerns as individualized; the resulting prescription of antidepressants and psychotherapy required self-colonization to relieve their pain, complicating several women's experiences of using mental health services. Some women found medical interventions beneficial to their wellbeing, while others resisted psychiatric knowledge at various points because of the embodied suffering they faced, and their reliance on conflicting cultural beliefs and healing systems. By analyzing these women's experiences, I offer a rethinking of the biomedical conceptualization of mental illness as a natural and universally occurring pathology. Ultimately, I argue that current framings of mental illness obscure the intersectional power relations that played an important role in contributing to these women's distress.

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List of Abbreviations

ADHD	Attention Deficit/Hyperactivity Disorder
APA	American Psychiatric Association
BPD	Borderline Personality Disorder
CEO	Counselling, Outreach and Education
DSM	Diagnostic and Statistical Manual of Mental Disorders
FDA	Food and Drug Administration
ICD	International Classification of Diseases
LFS	Lethbridge Family Services
OCD	Obsessive Compulsion Disorder
PMDD	Premenstrual Dysphonic Disorder
PMS	Premenstrual syndrome
PPD	Postpartum Depression
PTSD	Post-Traumatic Stress Disorder
SSRIs	Selective Serotonin Reuptake Inhibitors
US	United States
WHO	World Health Organization

Chapter 1: Why Study Racialized Immigrant Women's Use of Mental Health Services?

Introduction

In this research, I examined why some racialized immigrant women[1] used mental health services in Lethbridge, Alberta, Canada, and how they have experienced interacting with Canadian mental health professionals. My interest in the 'mental illnesses'[2] of these women developed following my exposure to Foucauldian understandings of mental illness arguing that within the trajectory of the expansion of Western biomedical power, some social problems and ordinary elements of human existence have historically been constructed as mental illnesses (Castel et al., 1982; Foucault, 1965; Malacrida, 2003; Thoits, 2010).

Anti-psychiatry feminist and postcolonial assertions that psychiatric knowledge and treatments in North America are gendered (Berger, 2014; Caplan & Cosgrove, 2004; Chesler, 1972; Johnson, 2005; Linder, 2004; Marecek, 2006; Poland, & Caplan, 2004; Ussher, 2010), as well as imperialist (Fernando, 1988; Khan, 2017; Mollow, 2006; Westwood, 1994; Waldron, 2002), yet legitimized "through the normalizing discourses of 'scientific knowledge'," (Waldron,

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[1] In my research, women who are immigrants, are non-white and identified themselves as racialized are my participants. Please see a detailed discussion on the definition of racialized women in Chapter Two.

[2] It is important to note that from this point forward, when using the terms mental illness or any similar words I will not use quotation marks, but this is done for ease of reading, and it does not indicate that I am noncritical or accepting of the term. My position is that using these terms is a political statement and not an a priori category. By using these concepts, I am not placing any negative or immutable connotations on these people (Malacrida, 2015).

2002, p.1) further influenced my research on the experiences of women using mental health services.

I anticipated that the normalizing medical discourses would have detrimental impacts on racialized immigrant women's lives in Canada. Yet, most of the current research on racialized immigrant women in Canada is non-critical and has been founded on the biomedical notion of mental illness as an ontological thing that needs a medical cure. This approach tends to delimit understanding cultural norms and the ways structural discrimination contributes to individuals' psychic pain. Also, this approach typically fails to address the socio-political and cultural implications of constructing certain human conditions as mental illness and the ways in which bio-psychiatric treatments foster health professional and social control of such women in Canada.

Further, there exist criticisms that mental health services in Canada are not well equipped to provide services to culturally different people, noting that immigrants from the Global South generally have different historical and 'cultural'[3] backgrounds than Canada (Kirmayer et al., 2011, p. 959). For instance, in Canada, mental health professionals usually suggest biomedical mental health treatments and follow the dominant "socio-political and cultural perspectives" of Canada while they provide treatments to racialized people (Guruge, Collins, & Bender, 2010, p. 116). Researchers have noted that because the dominant perspective within health sectors in

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[3] Tradition and culture are controversial words for some scholars as they are not static, and vary based on class, age, religion, minor ethnicities, and other intersectionalities within a society (Said, 1993). Further, the dominant perception of tradition and culture have often been represented as the 'main' culture and tradition of a country, which often excludes diverse notions of these concepts held by marginalized people (Mani, 1987; Said, 1993). When I use these terms, I thus acknowledge the debates surrounding them. For the purposes of my study, when I use the term 'traditional', I am referring to the pre-immigration cultures of my research participants.

Canada is neoliberalism, treatments often depend on patients taking individual responsibility for their care, cultivating self-mastery, and also presumes patients to be white (Poole, 2011; Ted Brown et al., 2005).

Many racialized immigrants' socio-cultural perspectives are not similar to Canada, and people depend on their community for solutions (Waldron, 2002). Racialized women often move to Canada with husbands, and, in many cultures, women's independence is not valued or respected (Boucher, 2007; Fernández-Sánchez, 2020). Thus, the focus on individualism and self-mastery in mental health treatment systems prompts these women to adopt a neoliberal outlook, which, I anticipated, may complicate their experiences, putting them at odds with their cultural learning, family, and community.

I suspected that this focus contributes to health professionals' power in immigrant women's lives and enacts cultural imperialism by privileging Western ways of knowing and constructing some forms of subjectivity over other possibilities. Thus, the categorization of racialized immigrant women's mental illness and their use of mental health services are extremely complex issues, and it requires critical examination. In this chapter, first, I discuss why studying racialized immigrant women's use of mental health services is essential; in other words, the rationale of my research. However, I will begin with a brief history of race and immigration in Canada associated with such women's mental health challenges. Second, I draw upon discussions on four different fields of scholarships that have examined and critiqued psychiatry and its constructions of mental illness, including Foucauldian, anti-psychiatry feminist, postcolonial and postcolonial feminist scholarship since they have assisted me in formulating research questions as well as analyzing the stories of the women I spoke with in this study.

Situating My Research

Canada is considered one of the most diverse immigrant-receiving countries in the world. However, until the 1960s, immigration policies of Canada were “explicitly racist and favoured the entry of white” people over racialized people (Abu-Laban, 1998a, p. 191). Nonetheless, changes began when the immigration policies of Canada started to focus on professional and technical occupation skills of immigrants, introduced by the Liberal government in 1967. The changes have had an impact on the racial backgrounds of immigrants, such as during the 1970s, 90% of immigrants were whites, which fell to 25% in the 1990s (Abu-Laban, 1998a, p. 191).

Nevertheless, immigration policies in Canada are still contentious since they focus on labour needs, where labourers are selected based on point systems, which appear ‘neutral’, but contribute to inequality (Abu-Laban, 1998a). For instance, Canada focuses on educational merit, where some people have more advantages than others, and some would be excluded based on their ethnicity, class, and gender positions (Abu-Laban, 1998b; Boucher, 2007). Namely, Canada’s emphasis on certain types of paid skilled workers impacts racialized women’s migration to Canada (Abu-Laban, 1998b; Boucher, 2007; Fernández-Sánchez, 2020) because women, in particular from the South Asian continent, are generally less privileged compared to men in pursuing higher education (Fennell & Arnot, 2008), which is also true for their English language proficiency (Dustmann, 1996). As language and education are ways of getting more ‘points’ to migrate, these women are comparatively in underprivileged positions when attempting to migrate to Canada (Dustmann, 1996).

South Asian women generally migrate as a dependent spouse of skilled male workers and following the immigration policy of Canada, they need to remain in a genuine relationship with the primary applicants for two years to receive their permanent residency (Boucher, 2007). While the policy has attempted to prevent marriages that are solely arranged for migration purpose or as money-making schemes, it also put these women in vulnerable situations. For instance, many women experience domestic violence during the interim years but are bound to stay in the vicious relationships that will secure their immigration status. While these women can make a complaint about their violence to the Canadian authorities, they often lack power to do so because they generally lack knowledge of local laws and communal support that they could employ to fight against their violence (Alvi et al., 2012; Boucher, 2007).

Research shows that after migrating to Canada, a significant number of women often suffer from depression, anxiety, mood disorders, schizophrenia, and emotional distress (Delara, 2016; Guruge, Collins, & Bender, 2010; WHO, 2000). Although there has been an increasing interest in examining the mental illness of immigrant women in Canada, it often takes a biomedical approach. Thereby, while these studies explore immigrant women's distress arising from the pressure of cultural adaptation (Knaifel & Mirsky, 2015), a lack of language competency, under- and un-employment, gender and racial discrimination (Guruge, Khanlou, & Gastaldo, 2010; Noh et al., 1999), and conflicts arising from gender performativity (Alvi et al., 2012), they interpret these distresses, and women's situational reactions to the adversities, as chemical imbalances in their brains and suggest biomedical mental health treatments as 'effective' solutions.

Consequently, the studies generally focus on the barriers immigrant women face when attempting to access biomedical mental health treatments, with the aim to solve these barriers and fix the mental illnesses experienced by immigrant women (Jensen et al., 2013; Kirmayer et al., 2011; Teng et al., 2007). One of the significant barriers that has been explored is the stigma associated with mental disorders (Jensen et al., 2013; Kirmayer et al., 2011; Teng et al., 2007). Research suggests that many immigrant women do not use mental health treatments because they and their family members prefer not to disclose this issue outside of their families, as they fear being stigmatized as a 'crazy woman'; this labelling complicates their survival in a new country (Kirmayer et al., 2011; Teng et al., 2007).

Another impediment that has been identified is racialized immigrant women's lower income, which impacts their willingness or ability to pursue mental health treatments (Teng et al., 2007). In addition, immigrant women's responsibilities in their homes and workplaces sometimes are bases of not seeking out mental health services (Kirmayer et al., 2011). Immigrant women from South-Asia, in particular often do not express their personal needs, and often depend on their husbands; as such, they fear talking about something as personal as mental health, and fear asking their husbands' permission to seek treatments. Those who do seek treatments often encounter a language barrier, as they struggle to express their problems and needs to mental health professionals (Jensen et al., 2011).

Racialized immigrant women's reliance on their own beliefs, practices, and healing systems has also been identified as a barrier, which is often framed as their general reluctance to access Western biomedical mental health treatments in Canada (Jensen et al., 2013; Kirmayer et al., 2011; Teng et al., 2007). These studies thus suggest removing the hurdles in order to facilitate the use of biomedical mental health services (Chiu et al., 2005; Jensen et al., 2013; Kirmayer et al., 2011; O'Mahony, 2010; Teng et al., 2007).

While the above discussions focus on the barriers racialized immigrant women face in terms of accessing biomedical mental health treatments in Western society, many scholars criticize putting weight behind this approach. Instead, critics argue that it is not belief systems or a lack of willingness that impact racialized immigrant women’s use of biomedical mental health treatments, but instead, the approach of biomedical mental health treatments for such women in Canada itself has issues. For instance, there is a lack of mental health staff with a knowledge of other cultures, and willingness to listen to women’s stories (Guruge, Collins, & Bender, 2010).

Further, health professionals, in particular psychotherapists, often do not like to spend extra time with immigrant women solely for the purpose of listening to their stories, which produces feelings of negligence in immigrant women. Researchers thus suggest psychiatry should focus on providing culturally sensitive treatments to racialized immigrant women in Canada (Guruge & Khanlou, 2004). However, in my research, I have taken the position that a culturally sensitive approach is not the sole solution because structural inequities that these women face are needing to be addressed. Further, psychiatry’s current focus on providing culturally sensitive treatments to immigrant women is arguably a way of making biomedical treatments more legitimized.

The majority of research outlined in this section on racialized women’s mental health is arguably situated within a biomedical notion of mental illness, focusing on universal meanings of mental illness in relation to a putative ‘normal’ or ‘mentally fit’ human subject who can be identified, and whose qualities can be understood as real, enduring, objectively measured, and ahistorical. In turn, these understandings lead to a ‘natural’ response of working to develop treatment management systems accordingly.

This putative normal, as we will see, is based not only on a universal subject, but situates this subject as normatively white, European, and interested in pursuing Western concepts of mental health. Hence, understanding the geopolitical power of the West over the Rest (Hall, 2018) and the structural imbalance that racialized immigrant women encounter in their lives after immigrating to Canada is crucial. Also, it is essential to examine the ways psychiatric knowledge prefers certain ways of living over others. Thus, my research contends that it is worth exploring racialized women's views about the culturally sensitive approach, and their views about mental health from their own cultural, historical and geopolitical situatedness.

In this research project, I spoke with some racialized immigrant women who have used mental health services in Lethbridge, Alberta, Canada. I selected Lethbridge as my research location because it offers unique insight as a small city with a longstanding history of colonialism, racism, and religious conservatism, all of which impacted the women I spoke with. Lethbridge is located in southwestern Alberta, in the heart of traditional Blackfoot territory (Victor et al., 2018). The Blood Reserve is adjacent to the city, and the Peigan Reserve is roughly 80 kilometers away (Victor et al., 2018).

The city's founding is linked to the discovery of coal throughout the surrounding coulees, and the planned route of the Canadian National railways through southern Alberta (Barsh, 1997). Until the 1930s, coal mining in the area was known for its "ethnic mixtures of Anglo-American entrepreneurs with Scottish, Polish, Czech, and German mineworkers" (p. 205). At this time, neighborhoods were composed of middle-class Protestants, Catholics, and Orthodox Galicians. Over time, Latter Day Saint (Mormon) and Dutch Reformed farmers gained social eminence, while coal lost its gleam. Later, government services and a new regional university campus on the west side of the Oldman River became the new sites of municipal growth (p. 205). Until

2007, few racialized people moved to the city; however, the number of racialized immigrants has increased significantly in Lethbridge since 2008 (Government of Alberta, 2011).

Nonetheless, Lethbridge is still a white-settler-dominant city. There is an increasing focus on provide culturally-sensitive services, including mental health outreach, to its Indigenous population, who are displaced and suffering from generational traumas as a result of colonial violence, racist policies, and genocide (Gone, 2013). However, to my knowledge, the city lacks adequate, culturally-diversified services for racialized immigrants, and mental health services are further ill-equipped to provide services for this population, which can leave individuals feeling lonely and excluded. Further, research from a critical lens on the experiences of racialized immigrant women's use of mental health services in Lethbridge is absent. More specifically, there is not a single piece of research from the context of Lethbridge that is devoted to examining how different intersectionalities impact women's suffering and lead them to use mental health services.

The purpose of the research was not to examine and suggest the 'appropriate' approach or model of mental health service in terms of fixing immigrant women's mental illnesses. Instead, my research has been informed by Foucauldian, anti-psychiatry feminist, postcolonial, and postcolonial feminists' contestations of the biomedical notion of mental illnesses. Further, feminist standpoint theory has encouraged me to explore racialized women's stories as a basis for creating such women's knowledge.

However, I have not taken their experiences as the sole basis of my research knowledge. Instead, I have situated racialized immigrant women's stories of using mental health services in Canada within a broader discussion of gender, race, imperialism, and regulatory aspects associated with biopsychiatric knowledge. Also, I have examined their stories within the discussions that migrations and colonialism have a detrimental impact on racialized peoples' mental health. The following are the three broad questions of my research:

1. Why have some racialized immigrant women in Lethbridge accessed mental health services?
2. How have they experienced interacting with Canadian mental health professionals? and,
3. How have these women been diagnosed and provided solutions, and how have they complied with or resisted these diagnoses and treatments?

I am hopeful that the stories of such women – who are arguably situated in marginal, racialized, and precarious geo-political positions – will expose the subordinate relations that they encounter in their daily lives and in turn, will contribute to developing more appropriate scholarship on racialized immigrant women's mental health. In the following section, I discuss Foucauldian conceptualizations of mental illness, which is significant to understanding how constructions of mental illness are tied with power relations, and how mental health professionals' power is fostered through the notion of mental wellness or individuals' wellbeing. These discussions have informed my analytical tools for examining the stories of the women I spoke with.

Foucauldian Conceptualizations of Mental Illness

Within mental health studies, the most authoritative approach is the medical model, which considers mental illness as a biological and individual problem that needs medical remedy (Titchkosky, 2003). Poststructuralist Michel Foucault (1965), who critically examined mental health studies, claims that madness is not an a priori category, but rather, different social discourses and practices have developed over time to construct certain individuals as deviant and mentally ill.

This section examines two significant contributions of the Foucauldian approach within mental health studies that informed my research questions and analysis. First, the Foucauldian exploration of the history of mental illness categorization, and the ways this categorization fosters health professionals' power in individuals' lives, will be discussed. Then, I draw attention to the Foucauldian analyses on the ways psychotherapies foster and value neoliberal subjectivities of autonomy, self-direction, and decisiveness over other possibilities.

The Genealogy of Mental Illness and Medical Power

Michel Foucault's examination of how psychopathological and normal truths are constructed, the power relations tied to these constructions, and how such classifications discipline individuals, have provided a foundation for examining the medical power that plays out in the lives of the women in this study. Foucault's (1972) epistemological position on truth and reality is that they are constructed and the result of complex historical process and the production of truths and their effects are complexly intertwined with power relations. He posits employing the method of genealogy to examine the historical processes by which the truth construction of a particular subject, such as sexuality or madness, occurs.

In his famous book, *Madness and civilization: A history of insanity in the age of reason* (1965), Foucault examines the genealogy of the conceptualization of madness as illness in Europe. By examining many literary sources, as well as the documents of confinement houses, Foucault discusses changes to the conceptualization of madness throughout the Middle Ages and into the twentieth century. He claims that there was a historical break in the interpretation of madness during the mid-seventeenth century.

Historically, madness was not interpreted in a negative sense, and was instead considered to be divine insight or a symbol of wisdom. However, during the mid-seventeenth century, the ‘madman’ became a dangerous entity that brought about significant unease, similar to earlier constructions of lepers as dangerous and needing to be separated from society through forced confinement. During this period, confinement houses for lepers across Europe were emptied, and began to be occupied instead by the impoverished, vagabonds, and prostitutes, who were all categorized as mad; in essence, the fear of people affected by leprosy was replaced by the fear of madmen. Foucault argues that this new categorization acted as a strategy to govern the poor, needy, homeless, and otherwise ‘incompetent’ people, and their regulation was tied with the production of ‘rational’ or productive citizens[4] who could serve the needs of a newly industrialized western society. As such, the aim of the confinement houses was often to provide lessons or training to such individuals to make them ‘fit’, productive, and civilized.

During the mid-eighteenth century, considerations of the madman once again began to shift. Prior to the eighteenth century, religious leaders typically held the power to describe what should be considered normal versus abnormal, and prescribed solutions for achieving a normal

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[4] The meaning of dependency in this period differed from today’s post-industrial Western society; in pre-industrial society, the notion of dependency was not seen as problematic (Fraser & Gordon, 1994; Reindal, 1999). People were dependent upon each other, even though some individuals possessed more power, and there were hierarchal positions within society (Fraser & Gordon, 1994). In pre-industrial Western society, religion also played a key role in sustaining society, as the communal bond was important. Due to the expansion of science and technology, reason began to replace religion, and refocused society towards a goal of mastering the world (Reindal, 1999). Modernist views see independence as an essential criterion of humans; in this era, independence means self-control, self-reliance, and self-supporting (Reindal, 1999).

and ‘healthy’ life (Turner, 2002). During the eighteenth century, religious leaders’ power was offset by the scientific theory of health. Whereas illness had previously been connected with the moral status of individuals, with the process of modernization and the scientific theory of disease increasingly becoming prominent, the status of medical health professionals increased. During this period psychiatry was developed, and with this field came the institutional growth of modern asylums. Mad people became subjects of health professionals’ power and a site of medical knowledge, accompanied by rapidly developing innovations in the field of medical science (Dreyfus & Rabinow, 1982; Foucault, 1965, p. 271; Malacrida, 2015; Turner, 2002).

Mental health reformers such as Samuel Tuke in England and Philippe Pinel in France functioned on a manifest level to improve the treatment of individuals incarcerated as mentally ill, while on another level, these improvements legitimized health professionals’ authority to govern mad individuals by confirming their minority and immoral status, and by highlighting their ‘need’ of medical assistance. Tuke and Pinel were also pioneers in establishing confinement houses as a site of medical knowledge (Foucault, 1965, p. 271). Many confinement houses eventually turned into mental hospitals and medical clinics, where doctors began prescribing treatments for patients. The constitution of madness as an object of scientific knowledge meant that mad people became the target of a specific type of power enacted by doctors, which Foucault defines as disciplinary power (Dreyfus & Rabinow, 1982, p. 5).

To Foucault, disciplinary power permitted health professionals to diagnose patients as mad because of their failure to follow the ethics of universally constructed human standards (Dreyfus & Rabinow, 1982, p. 8). Patients were taught to render their bodies and minds docile and were under panopticon-style surveillance by health professionals in order to regain their normative consciousness and affirm the social standard (Dreyfus & Rabinow, 1982, p. 9; Turner, 2002, p.10). Foucault’s explanations of disciplinary power encouraged me to examine if these racialized immigrant women categorized their non-conforming social behaviours as problematic, and if they self-scrutinized and tried to modify themselves in accordance with the ways psychologists in Canada focus on self-improvement and modification. In my research, I also adopted Foucault’s definition of mental illness as a social construct rather than a pre-existing category. Thereby, I intended to understand the power relations operating within and through the construction of mental illness as a ‘truth’ in the lives of the racialized immigrant women in this study.

Claudia Malacrida’s work provided me with a nuanced understanding of the ways categorizations of mental illness are political and tied to the establishment of social control, particularly through her examination of how industrialization and demand for a skilled workforce were linked to the categorization of some children and adults as less than mentally competent, unable to take care of themselves and therefore unable to contribute to the economy as part of a productive workforce (Malacrida, 2015; Reaume, 2000). This categorization assisted in the segregation of these people from their society through institutionalization at the Provincial Training School (PTS), which was purported to cure them and allow for their reintegration into society as productive citizens.

As Malacrida (2015) argues, this categorization was also made possible by the birth of clinics, prisons, and orphanages, all facilities which made it possible to govern and discipline children and adults with intellectual disabilities and mental health challenges. The growth of medicine, criminology, social work, education, psychiatry, and psychology further functioned to construct the perception of intellectual and psychological differences as illness. In turn, this solidification of knowledge producers and experts on illness was able to grow and expand precisely because of the 'need' produced through the construction of madness as illness. The development of compulsory education, with its expectation of literacy-numeracy and the development of pedagogical experts permitted the sorting of children as fit-not-fit, and produced a process by which children labelled as not-fit were sent to 'special' facilities to cure them and help reintegrate them into society as productive citizens (Malacrida, 2015).

Malacrida (2015) contends that before compulsory schooling, children with intellectual and psychological difference were not viewed as a serious public issue, but that within schools many standardized systems developed to regularize the classroom expectations, and not all students met the newly developed standards (pp. 10-11). The sorting of fit and unfit children within schools was made possible by normalizing the acceptance of professionals and their tools of judgment. Therefore, schools provided opportunities for surveillance and judgment not only by teachers, but also medical professionals. Malacrida's exploration is useful for me in developing an understanding of how diverse social institutions work together to produce notions of 'fit' and 'unfit', and how such definitions can contribute to the discipline of certain groups of people who fall into 'unfit' categories.

The history of the categorization of homosexuality as a mental disorder by the *Diagnostic and Statistical Manual of Mental Disorders*[5] *(DSM)* further informed my understanding of how the DSM's categorizations are problematic, and largely shaped by social norms and practices. Ronald Bayer (1987) pointed out, historically, the categorization of homosexuality as a disease was tied with Christian culture, which rejects sexual pleasure and prioritizes sex for procreation.

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[5] It is noteworthy that the *DSM* is known as the psychiatrists' Bible because it categorizes and determines which phases and behaviours of human being should be considered as 'disorders' (Linder, 2004).

Throughout the nineteenth century, anti-homosexual bias was prevalent due to a declaration by the Archbishop of Canterbury that homosexuality was a grievous sin.

During the mid-twentieth century, homosexuality became a subject of scientific investigation; for example, based on the medical diagnosis of a lesbian woman's 'abnormal' genital size, a professor of psychiatry in Berlin claimed homosexuality to be a consequence of a physical 'abnormality' (Bayer, 1987). Later, homosexuality was argued to be the consequence of environment and weak institutions, and also identified as "an inborn predisposition to perversion, a 'hereditary taint' [with] factors ranging from poverty and climate to masturbation [precipitating the] manifestation of homosexuality" (Bayer, 1987, p.19). Homosexual individuals were categorized as in danger of becoming insane within "a state midway between reason and madness," and required institutionalization for their correction and their status was declared as a "lower stage of human development" (p. 19).

Sigmund Freud, the famous neurologist and psychoanalyst, also identified homosexuality as a problem and suggested solutions for its 'cure'. Later in the twentieth century, homosexuality was named as a mental disorder by (*DSM)-II* where it came to be classified as a sociopathic personality disturbance (Glass, 2018). Nonetheless, it was not until 1987, following the challenges by the gay rights movement, that homosexuality was removed from the *DSM*; the World Health Organization (WHO) took until 1992 to change and remove homosexuality from its International Classification of Diseases (ICD).

Changes in the medical status of homosexuality reflect how the construction of certain people as mentally ill is tied to the political and cultural sphere and highlights how those who do not follow the 'ideal' notion of citizenship have been pathologized by medical biopsychiatry. This discussion of how homosexuality was constructed as mental illness by the *DSM*, and then later removed from the *DSM*, certainly informed my use of a critical lens when examining the categorization of the women in my research and highlighted the importance of analyzing the socio-historical trajectory of their diagnoses.

Psychiatry and Neoliberal Governmentality

Inspired by various scholars' contentions that psychiatry and neoliberal governmentality are intertwined (Bondi, 2005; Poole, 2011; Rose, 1990; Teghtsoonian, 2009), in this research, my exploration focused on understanding if the women I spoke with were disciplined to be neoliberal subjects through their psychiatric treatments, and if the personal distress that arose from their failure to adopt a neoliberal outlook was categorized as mental illnesses.

Foucault's notion of neoliberal governmentality provided a foundation for understanding the ways neoliberal governmentality is assembled by psychotherapy. Foucault used governmentality to analyze the historical reconstructions embracing a period starting from Ancient Greece and into neoliberal modernity (Foucault, 1997, p. 67). Following Foucault, I define governmentality "as a powerful web of power relations that links together three distinct forms of power: sovereignty, discipline, and government" (Holmes, 2002, p. 85). Governmentality involves disciplinary techniques, as well as ethics of 'self-government' (McNay, 1994). In other words, governmentality encompasses all strategies, techniques, programs, and desires of authorities that work to shape the beliefs and conduct of a population, and is tied with state security (Nettleton, 1991, p. 99) and the market (Lemke, 2001)

Most importantly, in my research, Foucault's discussions of the ways neoliberalism works as a form of governmentality to discipline and conduct people through techniques of self-regulation and self-care (what he explains as 'technology of self') has informed my analysis of the ways psychotherapists implicitly endorsed neoliberal governments by encouraging patients to engage in self-care and self-regulation. Self-regulation and self-care are tied with the overall philosophy of neoliberalism, which generally is understood as a set of economic regulatory policies that include “the privatization of public resources, financial liberalism, market liberalization, and global economic management” (Melamed, 2006, p.15).

The philosophy of neoliberalism emerged in the 1930s following the Great Depression, when intellectuals from across Europe and the United States converged in Paris in order to plan how to overcome the economic depression and maximize profits (Lemke, 2001). Neoliberals argued for minimizing states’ interference through the establishment of a free market, and endeavoured to decree welfare state services by increasing the call for privatization of responsibility and focusing on individualism. The notion of autonomous, individualized, and self-directing agents became the core of policymaking in neoliberalism, wherein individuals were encouraged to be active and responsible subjects to enhance their own well-being in almost every institution after the 1980s. Self-care, self-maximization, self-improvement, and high productivity all became rational choices and normative ways of living within this governing system, and individuals were solely responsible for maximizing their productivity and managing potential gains and failures. Further, this system led people to see their failure to comply to neoliberal normative ways of living as their own problem and lack of wellness.

Within this trajectory, psychotherapists promise to reveal ways to boost motivation and to align with neoliberal ways of living by being autonomous, self-directing, and individualized citizens (Poole, 2011). Patients’ compliance with norms of neoliberal subjectivities that focus on high productivity is considered an attribute of their wellness. Because the logic of neoliberal subjectivity focuses on individual liberty and freedom on the one hand, and rights and responsibilities on the other, psychotherapists function not through oppressing patients' subjectivities, but by encouraging patients "to align political, social, and institutional goals with individual pleasures and desires, and with the happiness and fulfilment of the self" (Rose, 1990, p. 257). Today, it is not only health professionals who encourage individuals to work on their mental and physical health; such medical/psychiatric discourses permeate a range of agencies and institutions that encourage people to change their lives (Nettleton, 1997).

Encouraging patients or individuals to take control of their own lives is heavily tied with encouraging consumption of a range of goods and products (Martin, 2009; Nettleton, 1997). As Emily Martin (2009) points out, self-discipline and self-awareness originated as part of the requirements of industrialized society, which depends on mass machinery production, profit accumulation, and consumer creation. Corporate organizations wanted conformist, stable, and 'rational' employees, who will work on their own professional growth progress. Not all might reach their goals, but individuals should **desire** their own development. In this context, individuals are responsible for their own success or failure. American adults, children, and teenagers are prescribed mind-enhancing drugs, as individuals are forced to self-optimize and self-maximize to survive. Self-optimization simultaneously becomes an indicator of self-fulfillment, and those who could not allow themselves to self-optimize are categorized as depressed or having a mood disorder by psychiatry.

The *DSM-IV* definition of depression is "[a] pervasive and sustained emotion that colours the perception of the world" (as cited in Martin, 2009, p.43), and producing knowledge about depression has been criticized by a number of scholars (Martin, 2009; Teghtsoonian, 2009). Katherine Teghtsoonian notes that over three decades government, the media, and a number of international organizations have continuously produced the knowledge that depression has been increasing among people in Canada, a development she sees as connected with neoliberal governmentality that depends on peoples' highest performance. In turn, this has encouraged motivational professionals and psychiatrists to provide training and knowledge to enhance patient performance and as a side effect, to gain legitimacy as professionals in the public eye. Psychiatrists' efforts often encourage people to take charge of their lives and take responsibility for their actions. This analysis is useful in exploring how neoliberal governmentality operated in the lives of the women in this research through the mental health professionals they encountered.

In my study, while Foucauldian scholarship is important to examine how people who do not follow normative ways of living are at risk of being categorized as insane and how health professionals foster neoliberal governmentality in people' lives, the scholarship does not examine how normative notions of manhood and masculinity have generally shaped the 'ideal' notion of citizenship. As a result, women presumably are more at the risk of being labeled as 'abnormal' than men are. This is a critical gap in the literature in terms of understanding the experience of racialized immigrant women who have been categorized as mentally ill in the West. Anti-psychiatry feminist scholarship within mental health studies examines how psychiatric knowledge has been informed by patriarchy, and thus may be helpful for bridging some of the lacunae in Foucauldian approaches. The following section draws upon feminist discussions of mental health.

Anti-psychiatry Feminist Literature

Two feminist perspectives on women's mental illness are particularly applicable to my research. One is the understanding that discourses of femininity contribute to labeling some (gender non-compliant) women as mentally ill, and the other is that certain female life phases have been labeled as illnesses in and of themselves and thus medicalized (Berger, 2014; Chesler, 1972; Caplan & Cosgrove, 2004; Johnson, 2005; Linder, 2004; Marecek, 2006; Poland, & Caplan, 2004; Ussher, 2010).

In her foundational work, *Women and Madness* (1972), psychologist, psychotherapist, and anti-psychiatry feminist activist Phyllis Chesler explored how, in America, during the mid-nineteenth and early-twentieth century, the discourses of femininity influenced labeling a remarkable number of gender non-compliant women as mad. They were confined in asylums to put them away from the public's sight, with the aim of correcting them and training them to conform to feminine ideals and to be fit for society. This fitness, in Chesler's view, was evidenced by patients' successful adherence to normative, heterosexual femininity; for example, women were characterized as 'doing well' when they put on lipstick or attended to their dress. As well, psychiatrists did not acknowledge that it is society that drove these women mad through social norms that were limiting and punitive to women's lives. Chesler posits that in America, during the sixties, psychology was dominated by men, and they generally focused on the notion of female 'abnormality' and inferiority, using normative masculine traits as the yardstick for human wellness (1972, p. 61).

Thus, women who expressed emotion or dissatisfaction were seen as being in deficit from a rational, emotionally cool 'ideal' type (Chesler 1972). Chesler discusses that psychiatric knowledge is also informed by normative notions of womanhood, so that, for example, clinicians share the views that children need their unlimited mothers' care for their 'healthy' mental development. Mothers who have "'promiscuous' daughters" and "'criminal' children" are labelled as "schizophrenogenic" mothers (pp. 73-74) and are seen as responsible for all that befalls a family. To compound this problematic characterization, psychiatrists' constructions of women’s mental illnesses have been legitimized by their claim of “scientific and legal efficiency” (p. 62). From there, their views inform nurses, dieticians, social workers, patient/clients, and other people in the society.

Chesler (2018) further explains that during her graduate studentship in psychology between the 1950s and the 1960s the course curriculums were inherently misogynistic, teaching Freudian analyses of women’s mental illness that posited women suffer from penis envy, are morally inferior to men, and are innately dependent, passive, and monogamous. There was no critical analysis about the patriarchal oppression of women or the trauma this causes, and no acknowledgement that their reactions to persecution could be reasonable responses to adverse situations; rather, these responses were labelled as mental illness.

Inspired by Chesler, the critical examination of women’s embodied suffering deriving from patriarchal oppression has become important to my research. Other feminist scholars’ insights on the ways the *DSM* has categorized women’s lives and bodies as illnesses, and thus medicalized and objectified them (Caplan & Cosgrove, 2004; Linder, 2004), have also further driven my commitment to examining if these problematic forms of labelling have been enacted upon the women in this study.

Lisa Cosgrove and Paula J. Caplan (2004) examine the political and economic aspects of categorizing women’s premenstrual pain and other related changes as “Premenstrual Dysphoric Disorder” (PMDD) within the *DSM*, arguing that despite a lack of “evidence that a premenstrual mental illness exists” (p. 225), this categorization occurred nonetheless, in congruence with the explosion and normalization of psycho-pharmaceutical drugs (Linder, 2004, p. 4). During the 1970s, the Food and Drug Administration approved lithium to treat psychiatric disorders, which led many companies to produce as many drugs as they possible while apparently seeking the ‘accurate’ treatment of mental disorders (Linder, 2004).

During the same period, there arose a demand to define “disorders on the basis of observable signs” so health professionals could contend that they were providing evidence-based treatments—a strategy that aimed to legitimate the profession and the medical interventions alike (Linder, 2004). In 1980, the *DSM-III* broke the previous modes of classification by basing its taxonomy on symptoms instead of depending on presumed bases of mental illness, forming a list of symptoms for each mental disorder (Lock, 2010). For instance, for Post-Traumatic Stress Disorder, flashbacks, insomnia, nightmares, and severe anxiety are listed as associated symptoms; however, many mental illnesses seem to have symptoms that overlap with others. With this system of diagnosis, personal life experiences were no longer needed to label a patient (Lock, 2010). Women are encouraged to measure and manage their premenstrual emotions within this framing of psychiatric knowledge encouraging women’s self-surveillance of their minds and bodies. The classification of these emotional states – anger, pain, irritability – as solely the “by-products of (premenstrual) hormones” delimits recognition of how “social injustices, violence, and sexual harassment” and other gendered subjectifications contribute to the development of women’s agony and distress (Cosgrove & Caplan, 2004, p. 224). Following this discussion, in my research, I examined whether and how women’s personal life experiences factored into their diagnoses and treatments.

Having provided a brief sketch of the various misogynistic aspects of psychiatry, I will now draw upon discussions of postcolonial scholarship on mental illness. As my research involves racialized immigrant women, it is important to include scholarship that examines how psychiatry perpetuates colonial views, as well as the ways racism impacts a racialized immigrant's identity, to better understand how these may affect the women I interviewed.

Postcolonial Scholarship on Mental Illness

Postcolonial scholarship within mental health studies has been significant to my research in understanding the ways psychiatry perpetuates racist views and enacts colonialism, as well as considering the lasting effects of colonialism, racism, and structural discriminations on the mental health of racialized people. In the following section, I illustrate the ways that the rise of psychiatry upheld European sovereignty in the countries of the Global South and unpack how colonialism and racism first damaged colonized people and then labelled this damage as insanity and mental illness. Then, I draw upon discussions of the ways psychiatry today legitimizes not only its own expansion, but also contributes to the expansion of American-led colonialism by circulating American understandings of suffering and mental illness. These discussions are significant to my research as I spoke with women, all of whom— except one woman who was born in Canada— came from the Global South, and whose lives have arguably been impacted by Western psychiatric knowledge in the past and today. Finally, I examine the types of racism and colonialism perpetuated in the West today, which is critical to unpack in order to understand the nature of the women's experiences, and how these experiences may have contributed to their suffering.

Psychiatry, Colonialism, and Mental illness

While Foucault is significant to my research in terms of unpacking the ways that psychiatric power works in peoples' lives, a postcolonial approach is useful to understand how

Western psychiatry as a discipline fostered British and French imperial power within colonized people's lives by constructing them as 'immoral' and 'lacking intelligence' 'born criminal' during the seventeenth century and later (Fanon, 1961/2007; Fernando, 1988; Waldron, 2002; Westwood, 1994). This insight is important to my study, as the devaluation of colonized others still exist in social institutions in the West, often subtly through the distinction between white and non-white, and through notions of the racial superiority of white people (Fernanado,1988; Khan, 2017; Waldron, 2002; Westwood, 1994). As a result of these divisive processes, the racialized immigrant women in this research may have internalized notions of their 'inferiority' and 'abnormality', which would have had a detrimental effect on their self-esteem and contributed to self-hatred, particularly when they failed to perform in the ways expected and encouraged by white people (Chow, 2002; Westwood, 1994).

The intersections of psychiatry, imperialism, colonial violence, and suffering were explored by postcolonial scholar Frantz Fanon (1961/2007). His insights not only provided the foundation for my understanding of the ways psychiatry and colonialism upheld each other, but also the damaging aspects of colonization and racism on colonized people, and how these injuries were then constructed as colonized people's madness by psychiatry.

Fanon, a foundational postcolonial scholar who was himself a psychiatrist, defines colonization as imposing colonizers' values, beliefs, practices, and structures on colonized people, while extracting resources from the colonized land (Fanon, 1961/2007). Thus, the colonization process is a form of death of colonized people and has damaging psychological impacts on colonized peoples.

Fanon was the son of a middle-class Black father and a mixed-race mother (Keller, 2007, p. 826). He was educated in Lyon, France, gaining a psychiatry degree and later taking a residency at the Blida-Joinville Psychiatric Hospital in Algeria in 1953. The position placed Fanon in a precarious position between colonizer and colonized (Keller, 2007, p. 826). According to Fanon, under the direction of Professor Antoine Porot, the school comprised a group of psychiatrists and students who composed a number of works that obstinately produced and reproduced truths about North Africans as primitive and born liars, criminals, and slackers (Keller, 2007). This construction legitimized the colonial brutality towards them, and then constructed their responses to the violence as madness. Further, the psychiatrists also found a common and vague malaise among the North African Muslims, what they named as their 'culture bound syndrome'. The discomfort this group of people experienced, Fanon (1961/2007) argued, "was a somatic manifestation of psychological pressures placed on a marginalized people suffering in a contemptuous host society" (p. 827).

As Fanon discussed, psychiatric care and medicine were provided to 'cure' the colonized Algerian. The doctor was primarily a representative of colonial power and the patients were the powerless others (Fanon, 1961/2007; Keller, 2007). These medical services, as Fanon claimed, were Hippocratic commitments to patient care because colonization, unbearable and unspeakable violence, war, injustice, and dehumanization affected these people's personalities severely (Fanon, 1961/2007).

Fanon argued medical knowledge was the significant source of France's power in Algeria; the medicine and hospitals worked as a technology of colonial power and exploitation of colonized bodies (Keller, 2007; 2008). He saw psychiatry as enacting the worst of these violations to the colonized by inferiorizing them. Medicine worked as an instrument of civilization and assisted colonial surveillance and governmentality on Algerians. Fanon further argued race was used as a tool of depersonalizing and inferiorizing racialized/Black people, facilitating the degradation of colonized people through psychological pressures. As a psychiatrist, Fanon witnessed this imposing power at his workplace. Through a number of case studies, he argued that "his patients suffered not from a predisposition to mental breakdown what the colonial physicians claimed. Instead, their subjection to the unspeakable brutalities of colonial dominations" (Keller, 2008, pp. 3-4). The explanation prompted an examination of whether the women I spoke with experienced inferiorization processes in Canada, and whether they were affected by resulting dehumanizing and othering.

In his book *Race and Culture in Psychiatry,* Suman Fernando's (1988) examination of the genealogy of psychiatry and its influence on the process of producing knowledge about the 'inferior' other was also important for my research, particularly in understanding the imperialist aspects of psychiatry. Fernando (1988) notes that psychiatry as a sub-discipline of medicine developed during the mid-nineteenth century in the West, during the height of European colonialism, and argues that its theories and methodology have been primarily informed by the Western 'cultural framework' of (mainly) white people. Clinicians during this period were mostly white, and their work supported beliefs about the racial inferiority and backwardness of Africa, Asia, and South America as well as the 'natural' superiority of Europe, which became entrenched ideals by the nineteenth century.

Psychiatry in this sense was informed by "two sets of ideas"; one being that the brains of racialized others were inferior, and the other that they were not 'normal' (Fernando, 1988). For example, Lewis Terman (1916/1948) ranked all people by so-called 'hard' measures of intelligence established by the standardized IQ test. In his famous book *The Measurement of Intelligence*, Terman noted that "Negros, Spanish-Indians and Mexicans" lack "intelligence because of their race" (Fernando, 1988, p. 21). Charles Darwin argued that Caucasians were superior to all races, a belief so entrenched in his theory of evolution that it fed racist ideologies that led to the eugenic movement (Fernando, 1988). Fernando discusses that, Black inferiority was also produced through the negative representations of Black people by so-called experts, such as physician Dr. W. M. Bevis, who labelled the psychological traits of Black people as "cunning, superstitious, promiscuous, lacking initiative and living only in the present" (Fernando, 1988, p. 25).

The psychiatric/scientific construction of racialized individuals' brains as inferior was also accompanied by cultural theories about these people's inferiority (Fernando, 1988; Westwood, 1994). Historians and social scientists functioned significantly in discrediting the culture of non-white individuals through social research, and through disciplines, such as anthropology, sociobiology, and criminology (Fernando, 1988; Westwood, 1994). For instance, Black families and kinship systems, marriages, and child rearing practices were represented as problematic (Fernando, 1988).

The matrifocal system was constructed as pathological, and as having detrimental effects on the development of personality in the Black child, because in this system Black men were seen as absent, and lacking opportunities to play significant roles in the rearing of children (Fernando, 1988). Asian families were also interpreted as weak because of their hierarchical family structure, and because "Asian women are…isolated because of their traditional customs and views of the world, and lacking skill in Western life-styles" (p. 29).

A study conducted by Kardiner et al. (1966) demonstrated how Black culture was dissolved by white attitudes, as Black slaves were forced to mimic their white masters. This discrimination affected Black people's self-esteem and contributed to self-hatred. Surprisingly, the abolition of slavery and emancipation of Black people contributed to higher rates of diagnosed mental disorders. This may have simply been a result of freed Black individuals having improved access to healthcare or may have been the result of post-emancipation racism and poverty. Nevertheless, these increased rates were used to further lay claim to Black people's "inherent sense of inferiority" (Fernando, 1988, p. 24).

Psychiatry in the United States justified the slavery of Black people, as it had done in Britain, arguing that "slavery was seen as the natural condition for Blacks, a deviation from this norm was identified as 'disease'" (Fernando, 1988, p.22). It was argued that the best treatment for Black people's mental health was to return to enslavement. Many psychiatrists also argued that Black people benefitted from "slavery by receiving special care and supervision" (p. 24).

Epidemiological research was used to show that enslaved Black people had lower levels of mental illness compared to free Black people, producing the assumption that "slavery protected Blacks from mental disorders," which in turn "justif[ied] the extension of slavery" (Fernando, 1988, p. 24). Thereby, psychiatry served the interests of the slaveholders in its construction of freed Black as distressed and enslaved Blacks as happy and protected. Many psychiatrists who observed the mental health of Black individuals with experiences of slavery and colonialism even claimed that they did not find these people had mental health problems, arguing instead that depression was rare among Black people because they lacked responsibilities and were not capable of expressing their pain.

From the above discussion, it could be argued that different kinds of expert discourses have existed in relation to mental illness in racialized people. Nonetheless, all discourses function to confirm the inferior status of these people and the putative superiority of white colonizers and settlers. The above discussion is also crucial to understanding the ways psychiatric knowledge and colonialism work together to foster the colonization of others, which has profound effects on these peoples' lives. Further, it encourages an examination of whether the women in this study encountered any racist views when dealing with health professionals. The following section also gave me insight into the association of psychiatry and colonialism today, and how that could be detrimental to the women I spoke with in this study.

Psychiatry and Imperialism Today

Scholars argue that similar to the expansion of psychiatry in Europe, the *DSM* has contributed to the spread of imperialism in the United States and Canada in recent decades, by defining who and what is normal (Cermele et al., 2001; Khan, 2017). Further, as the majority of authors and consultants to all *DSM* editions have been white, cisgender males, a skewed perception of suffering has arguably informed its categories of mental disorders (Cermele et al., 2001). This has worked to position racialized women as more likely to be categorized as mentally ill, as they are generally compared against idealized Western subjectivities (Khan, 2017; Poole, 2011).

Furthermore, once racialized immigrants are diagnosed in the West, mental health professionals generally suggest biomedical treatments and follow the dominant "socio-political and cultural perspectives" on the nature, causes and treatments of difference (Guruge, Collins, & Bender, 2010, p. 116). As said earlier in the section on "Psychiatry and Neoliberal Subjectivity" the dominant perspective within Western health sectors is neoliberalism, and treatments often depend on patients taking individual responsibility for their care, and the cultivation of self-mastery (Poole, 2011). Conversely, many immigrants' socio-cultural perspectives differ from those of the West, and generally depend on their community for solutions (Poole, 2011). Thus, the focus on individualism and self-mastery in mental health treatment systems prompts immigrants to adopt a neoliberal outlook, which complicates their experience, putting them at odds with their cultural learning systems, family, and community.

On an international scale, discourses in the Global South related to mental health, wellbeing, illnesses, and related healing practices are typically different from the 'Western notion' of mental illness and treatment systems (Khan, 2017; Callan, 2005; Littlewood & Dein, 2013). For example, mental illness is seen as a result of spirit, sorcery, or sin, and healing generally focuses on seeking help from spiritual teachers, traditional healers, and prayer (Callan, 2005; Littlewood & Dein, 2013). However, due to the Movement for Global Mental Health (MGHM),[6] the biopsychiatric notion of mental illness has gradually replaced local concepts of mental illness (Khan, 2017). Further, the globalization of biopsychiatry has made access to western psychiatric treatments and mental health improvement an issue of human rights (Khan, 2017; Titchkosky & Aubrecht, 2015).

In 2001, the WHO reported that over "450 million people worldwide are estimated to be suffering at any given time from some kind of mental or brain disorder" (as cited in Khan, 2017, p.68). This has been represented as a global burden, as "40% of countries have no mental health policy, and over 30% have no mental health programme" (as cited in Khan, 2017, p.68). These reports work to justify the expansion of Western, biomedical treatments and medicine across the globe; in a somewhat troubling development, the United Nations' Millennium Development

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[6] In 2001, the mental health of people of the Global South became an issue when the World Health Organization published a report on mental health of people across the globe, claiming that 14% of people across the globe have neuropsychiatric disorders, less than 60% of countries in the world have mental health treatments services, and many people lack access to mental health services. WHO therefore initiated projects to enhance mental health treatment around the world. WHO's activities have been criticized by scholars who argue this is little more than imposing Western perceptions of mental health and psychiatric treatment throughout the world (Siddiqua, 2017).

Goals propose mental health treatments for all countries, calling for the provision of affordable psychotropic drugs to people of the Global South (Khan, 2017).

Further, mental health development projects led by the WHO have become part of the national development plan, by arguing that 'poor' mental health impacts not only the population and national development of countries in the Global South, but also international development (Titchkosky & Aubrecht, 2015, p.75). By promising psychiatric ways of attending to mental health and focusing on ensuring people are mentally 'fit' and 'productive' citizens in the Global South, the WHO has ultimately imposed Western/colonial forms of distress, along with notions of 'fit' versus 'unfit' and 'productive' citizens. The new ideas, practices, and technologies that the mental health projects have facilitated foster Western colonial power and governmentality over the Global South, while creating new Western markets for the pharmaceutical industry (Titchkosky & Aubrecht, 2015). Further, the implementation of these projects re-establishes the intellectual and cultural hegemony of the Global North (Grech, 2011; Grech, 2015; Meekosha, 2011). Succinctly, the discourses of human rights and mental wellness that accompany the Western intervention obfuscates its power and control over its people (Grech, 2011; Grech, 2015; Meekosha, 2011; Titchkosky & Aubrecht, 2015).

The above analysis encouraged an examination of how the women in this study were informed by the Western biomedical mental health treatments in their home countries, and also how this impacted their use of mental health services in Canada. It also prompted an exploration of whether psychiatry fostered neocolonialism in these women's encounters, and if the values of the Global North are privileged in treatments accessed by the women. This examination will also help me to understand if these women assimilated with psychiatric practices and ideas in Canada.

Postcolonial scholars' claims about psychiatry's tendency to classify socio-economic suffering as mental illness (Breslau, 2002; Khan, 2017) are also important in examining if/how the suffering of these racialized immigrant women has been categorized as mental disorder. In this regard, anthropologist and postcolonial scholar Nichola Khan's (2017) exploration is particularly useful. Khan contended that following many poor harvests in India during the early 2000s, there was a rise in farmers committing suicide. Psychiatric research suggested this suicide trend was linked to higher rates of mental illness in farmers, while Khan instead pointed to India's green revolution and the privatization of seed sales as the root cause[7]. Joshua Breslau's (2000) research on the Kobe earthquake also reflects the ways psychiatrists turn previously untreated issues into mental health problems. Breslau (2000) argues that following the 1995 Japanese disaster, many Western psychiatrists, researchers, and international organizations intervened through methods of psychiatric therapy. Psychiatrists posited that the disaster contributed to trauma, and by doing this, positioned disaster itself as a new subject of psychiatry, justifying their interventions.

Elzbieta M. Gozdziak (2004) also contests the bio-psychiatric medicalization of suffering, noting that in every society people suffer, but the "[m]edicalization of human suffering has resulted in the 'trauma model' and the diagnostic category of post-traumatic stress disorder" in immigrants and refugees (p. 206). The trauma model is dominated by Western models of a

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[7] The post-1970s green revolution in India saw the rise in private companies, such as Monsanto, circulating hybrid seed varieties to farmers. In 2004, Monsanto began selling cotton seeds to illiterate farmers with the promise of a high yield and greater profit. However, farmers were not provided instructions on the care of these new seeds, such as the need for pesticides, fertilizers, and adapted irrigation. Farmers experienced high instances of crop failure, and many had to sell their land. This agrarian crisis "[became] reconfigured as individual mental illness" (Khan, 2017, p.72).

value system that focuses on self-assertion and autonomy, which differs from many refugees' values, which generally focus on the notion of interdependence. Gozdziak (2004) further notes that although many psychiatrists acknowledge cultural difference, in response to adversity they still assume that "refugees and mass violence survivors must be traumatized" (p. 206).

Postcolonial scholars' perspectives on the recent development of the cultural competence, or culturally sensitive, model has also been useful for my analysis (Fernando, 1988; Khan, 2017). Critics argue that because the medical model of Western therapies is secular in its orientation, psychiatrists are generally not equipped to address culturally and religiously sensitive issues and often ignore that in many cultures, religion helps followers adapt to challenges. However, there is an increasing awareness to provide culturally sensitive mental health care in response to the increase of migration from the Global South to the West (Kirmayer et al., 2008). However, focusing solely on the culturally sensitive model is also problematic, as it obscures structural political-economic problems deriving from inequality, discrimination, and racism (Fernando, 2014; Khan, 2017). In a more foundational critique, they posit that such 'tweaks' to western therapeutic interventions simply help to make psychiatry more legitimized and authoritative.

Khan (2017) argues that to adequately address mental illness in racialized people, instead of focusing on the culturally sensitive model, it is necessary to create a structural competency model that will address the larger socioeconomic and racial inequalities that affect people. This analysis propelled me to examine if the cultural competence model was applied to the women in this study by their psychotherapists, and the women's views on this model, even though I acknowledge the relevant warnings in regards to the culturally competent model. While the above discussions informed me of the ways psychiatry has contributed to the spread of imperialism in the East, the following section draws upon discussions on how colonization as a system of violence and devaluation work today in the west and how that might impact the wellbeing of racialized and colonized people today.

Colonialism and Racism in the West

Studies examining how racism and colonialism are perpetuated in the West today and the adverse effects of systemic racism on racialized immigrants' lives in the West (Giroux, 2006; Melamed, 2006; Wiegman,1999) are also useful to understanding the nature of the colonialism and racism that the women in this study have experienced. To some postcolonial scholars, from the 1980s onward, the articulation of colonialism and racism depended on the formula of globalization and neoliberal multiculturalism (Chow, 2002; Melamed, 2006).

Neoliberalism emphasizes the right of everyone to succeed and recognizes differences through the inclusion of multiculturalism (Melamed, 2006). Multiculturalism, by definition, forms the basis of policies, programs, and practices aimed at the integration of immigrants and other minority groups. However, scholars contend that in many countries, multiculturalism instead becomes recognition of others' differences, and only allows immigrants to practice their culture and values as long as they are not seen as problematic to the dominant culture (Ahmed, 2000; Bannerji, 2000; Chow, 2002).

In the case of Sara Ahmed's study of multiculturalism in Australia, Ahmed asserts that multiculturalism becomes a matter of shared displays and consumption, and nothing more. Under this process of inclusion, immigrants become strangers after moving to another country, and often become ambivalent about their status; they neither feel at home in their new country, nor feel a sense of belonging in their 'own' community (Ahmed, 2000). Instead, multiculturalism is a new technology of white supremacy enacted to establish its domain, and this inclusion is in many ways rhetoric that does not have practical implications (Ahmed, 2000; Bannerji, 2000; Chow, 2002).

The civil rights dream of multiculturalism positions North America as liberal and accepting of all races and ethnicities (Bannerji, 2000; Wiegman, 1999). Additionally, some scholars argue that colonialism has taken on a superficially anti-racist stance by feigning inclusion of ethnic cultural diversities; nonetheless, racial discrimination continues through this "colour-blind" approach that often leaves people confused about identifying their racial discrimination, and acts to hide the centuries-long exploitation of racialized people across the continent (James, 2018).

Scholars also purport that such a focus on inclusion and multiculturalism has helped settler Canada to see itself as racially innocent (Bannerji, 2000), and thus, the women in this study might be confused about identifying their racial discriminations within a context that names itself as non-discriminating. In Canada, multiculturalism officially developed through the 1970s and '80s to become a crucial part of Canadian political discourses (Bannerji, 2000). Liberal Party Prime Minister Pierre Elliott Trudeau's official policies of multiculturalism favoured a rapid influx of immigrants from the Global South, which, as discussed earlier in this chapter, was rare before the 1970s. During this time, multiculturalism discourses helped Canada establish its claim of innocence in racist and ethnocentric practices even as "the nationhood of Canada [established a] hegemonic anglo-Canadian national culture" and assisted in muting state formation aspirations of Francophones in Quebec, and sidelining Indigenous peoples' movement of their land claims (Bannerji, 2000, p. 9).

Carl E. James's (2018) discussion of how the colour-blind approach fosters racism and classism is also useful for my research. James notes that the colour-blind approach like neoliberalism depends on the philosophy of individual rights and social welfare that everybody has equal resources and similar opportunities to succeed. This approach is colour-blind as it does not acknowledge that racial categories, classes, and other social locations impact individuals and group members' access to power and resources, and thus they do not have similar backgrounds and opportunities to succeed (276). However, in the logic of the colour-blind system, anyone who does not succeed is blamed for this, and their failure is labeled as a consequence of their poor choices or their own fault.

James (2018) notes that people today often say that they cannot see the colour of people and they only see people (p. 277), which is dangerous as it not only overlooks colour, ethnicity, or religious group-based discriminations, but also implies the speakers' innocence and non-racism. Thus, a colour- blind approach perpetuates dominant power relations and colonial politics which have been broadened and deepened through the tropes of countries like Canada as racially democratic, non-racialist and colour-blind. This discussion is useful to understand how the colour-blind approach to mental health service provision left the women in this study to blame themselves if they failed, instead of blaming the systems that perpetuate racism by ignoring racialized immigrants' needs.

While the above discussion explicates the way colonialism and racism perpetuate in the West, David R. Williams and Ruth William-Morris (2000) examine how the centuries-long negative image of racial minorities in the United States, particularly the suggestion of intellectual inferiority, is used to deprive racialized individuals' employment opportunities. Individuals are then only able to access low-paying, menial jobs, which contributes to residential segregation and negatively impacts access to quality education, resulting in racialized people's distress that can damage their psychological functioning (Williams & William-Morris, 2000).

The above discussion prompted an examination in my research of whether the women I spoke with encountered any racism in Canada and if that contributed to their psychological pain. That said, while postcolonial scholarship can inform my analysis of the colonial aspects of psychiatry and the impact of colonization and racism on the women in my study, these theories do not necessarily consider intersectionality and the compounding effects of gender and sexuality on psychiatric categorization. Postcolonial feminist scholars' exploration of how psychiatry holds not only racist but also misogynistic views, and how racialized women go through different kinds of experiences compared to men as a result of colonization, provided a foundation for locating these women's experiences of colonization and racialization in my thesis.

Postcolonial Feminist Scholarship

Postcolonial feminists note that colonization affects men and women in different ways and colonized women are often more vulnerable compared to colonized men (Gilman, 1985; Hammonds, 1999; McClintock, 1995; Waldron, 2002). For instance, the 'inferior' status of colonized people/others has often been produced by colonizers through women's bodies and their status in society (Gilman, 1985; Hammonds, 1999; McClintock, 1995; Waldron, 2002). The following section draws upon discussions on this.

Colonization and Racialized Women

Sander Gillman (1985) explores how nineteenth century art, medicine, and literature together produced the notion of Black women's sexual anomalies and their 'immorality' (Hammonds, 1999). For example, the buttocks and genitalia of The Hottentot Venus, Sarah Baartman, were crudely exhibited to European audiences to prove the notion that Black women were the antithesis of “European sexual mores and beauty and [were] relegated to the lowest position on the scale of human development” (Hammonds, 1999, p. 94). The high rates of syphilis in Black women provided a basis for scientists to “prove” the notion of Black women’s sexual corruption (Gilman, 1985; Hammonds, 1999; McClintock, 1995). These representations “[were] used to justify the enslavement, rape, and sexual abuse of Black women by white men” (Hammonds, 1999, p.94).

Images of Black women as happy nurturers and ‘super-women’ were also produced by colonizers in order to exploit their labour in the United States. As Doris Witt (2004) explored, the happy producer status was constructed by the Quaker Oats food company in particular; Witt analyzed the iconic Aunt Jemima and argues that her smiling face and maternal appearance produced specific stereotypes and assumptions about Black women, particularly that they were happy with their producer status, while delimiting understandings of the patriarchal, racial, and capitalist implications of her position. The image of the African super-woman, able to do it all, was also constructed by colonizers in the United States to legitimize the economic exploitation of Black women’s labour as cooks, caretakers, and nurturers (Mollow, 2006; Woods-Giscombé, 2010).

Colonization was also justified through creating beliefs about the cultural backwardness of colonized people, so that colonizers often focused on gender relations and patterns of sexuality to symbolize the ‘primitive’ cultural essence and difference of colonized people (Loomba, 2005; Mohanran, 1999). As pointed out by Radhika Mohanran (1999), young Algerian women’s practices of veiling after reaching their puberty were presented as their cultural essence by the French colonizers and the veiling practice was interpreted as symbolic of their backwardness and lack of freedom. French administrators before 1930 urged Algerian women to abandon the veil to establish their freedom (Mohanran, 1999). On the other hand, Algerian men considered unveiling an indication of cultural destruction and the destruction of their power. Algerian men thus protested the unveiling, which had detrimental effects on Algerian women's lives (Mohanran, 1999).

Lila Abu-Lughod (2002) explores the ways the U.S. uses Afghan women's status as an indicator of Afghan culture. For instance, after 9/11, Abu-Lughod, as a Middle East specialist, was often asked by American media whether there was any connection with women's subordinate status in Islam and the terrorist attacks. As such, it is arguable that the media's, and by extension certain politicians' and political groups' intent was to prove the notion that all Afghan people are terrorists by connecting the subordinate status of Afghan women to extremist ideals. Burqas in particular were, and continue to be, interpreted as demonstrative of Afghan women's subordination, ignoring entirely their cultural significance. Abu-Lughod notes that this type of construction is used to justify such acts the US invasion of Afghanistan, whereby an act of aggressive violence comes to be characterized instead as one of gender beneficence, an historically common strategy for ruling a colonized society.

Many who participated in British colonialism in India identified similar strategies utilized to govern Indian people during the British colonial period (Loomba, 2005; Mani, 1987). Colonizers banned sati (widow immolation), child marriage, and other practices by arguing that the practices were barbaric. By banning the culture, white men 'saved' brown women from their brown men and justified their ruling over Indian people. However, for the next few years after implementing the ban, the ratio of widow immolation increased as an indicator of Indian men's authority over their women and culture (Loomba, 2005).

This reflects racialized women's marginalization, in that they are site of power exercised by both white and racialized men. This analysis is informative to my understanding of the ways racialized women appear in different colonial representations and the significant impact that may have in shaping peoples' views about these women's inferior status in their culture and society. I suspect that the construction and portrayals of racialized women as inferior likely does have an impact on the ways they are categorized psychologically, and also that these representations might bleed into the women's experiences of counseling. This exploration also provides me with insight into how the women I spoke with could be subject not only to the power of white men, but racialized men as well, and how these pressures in conjunction with colonization may altogether complicate the women's lived experiences in Canada.

Racialized Women's Mental Illness

While the above section is worthwhile to understand how colonizers used and continue using colonized women as a site of knowledge construction of the 'inferior' other, this section is significant to explore if these stereotypes impacted the lives of the racialized women in this study.

Postcolonial feminist scholars note that many stereotypes of Black, Asian, and Middle Eastern women produced during the 19th century persist today in everyday interactions, socialized perceptions, and in the field of psychiatry (hooks, 1992; Mollow, 2006; Woods-Giscombé, 2010). bell hooks (1992) explores the ways self-hatred has been developed within her students by their internalization of white supremacy. hooks (1992) argues that this internalization numbs Black women's agency and contributes to their double consciousness in American society. This double consciousness and self-hatred have a significant impact on the mental health of racialized women (Waldron, 2002; Woods-Giscombé, 2010). Further, the stereotype that Black women are 'super-women' who cannot be vulnerable or needing support complicates their experiences of seeking mental health treatment in the United States.

Anna Mollow (2006) further contributed to the discussion of the ways that stereotypes affect racialized women by exploring an African American psychiatric survivor named Danquah's lived experiences in the United States. Mollow notes that while many survivors of psychiatric illnesses and disability scholars alike criticize the over-prescription of antidepressants and the overall control exerted by medical professionals on psychiatric patients, Danquah's case explicates the way intersections between her gender, class, and race complicated her experiences of accessing mental health treatment in the United States.

When Danquah initially sought treatment for depression, she was dismissed by a physician, who identified her experience as a result of hormonal imbalance. While she was finally able to access psychotherapy, the therapist abruptly left her and suspended her treatment. Here, Danquah's experience reflects that of many Black women, who find that therapists remain withholding in regards to the therapeutic needs of Black women, particularly those whose health insurance does not provide coverage. Danquah was finally able to see a doctor, but faced cultural barriers, as her doctor was a white male who had limited knowledge of the racism encountered by racialized people in everyday life, which were experiences that contributed to her mental distress. Although Danquah's doctor prescribed an antidepressant, ultimately the medication was too expensive, and complete care remained out of reach.

Mollow (2006) argues that from the beginning, Danquah's condition was not categorized as mental illness or depression, even though she self-identified and sought treatments for this specifically. The failure to recognize Black women's depression is tied with the public perception that Black women are capable of surviving any adverse situation. These stereotypes go against the public perception that Black women are born with the inherent ability to self-heal and drive to serve others. Further, when Black women express emotion, they are perceived as weak, which is unacceptable both in 'Black culture' as well as in the West (Mollow, 2006).

The genealogy of these stereotypes is tied with the history of Black women's slavery (Mollow, 2006; Woods-Giscombé, 2010). During this period, Black women in the US were represented as faithful and obedient domestic servants who survived significant hardships and disruptions while heading their families and holding communities together despite the rupture and violence of slavery. By producing the image of Black women as strong super-women, their material needs are denied and continue to be ignored by medical professionals as well as other institutions (hooks, 1992; Mollow, 2006; Woods-Giscombé, 2010).

While the above discussions identify racism as a detrimental effect on racialized people's lives, many postcolonial feminist scholars argue that it is not only racism and other inequalities that affect women's mental health, but also psychiatry itself is problematic. Because patriarchal, white racial dominance is embedded in psychiatry, it often categorizes women who do not conform to normative notions of womanhood, or who do not follow the ideal notion of personhood in society (Mollow, 2006). As previously discussed, Western psychiatry focuses on neoliberal notions of personhood, such as independence, productivity, and rationality; thus, many racialized immigrant women who are dependent on their family members could be categorized as problematic by this model of psychiatry. Hence, in my research, I have explored the ways women experienced double consciousness in a new society, and whether any racialization experiences contributed to their mental distress. I also examined whether the women encountered racism in the mental health services they used, and how "productivity" and rationality have been figured in the women's categorization and treatments, and how all those experiences affected them.

Combining Four Scholarships

Despite each of the individual contributions of the theoretical approaches described, it has been important in my research to combine Foucauldian, anti-psychiatry feminist, postcolonial, and postcolonial feminist theories as a way to produce a more comprehensive examination of some racialized immigrant women's mental health experiences in Lethbridge. Deploying a Foucauldian approach in my analyses has enabled me to take a critical and crucial examination of psychiatry's notion of mental illness as a biological and individual problem. Instead, a Foucauldian approach recognizes madness not as an a priori category, but rather as a result of different social constructions created over time.

A Foucauldian approach is also significant in exploring the ways psychiatrists and medical professionals' power plays out in populations through notions of health and disease, and through the categorization of normal and deviant behaviours. Foucault allows us to see that psychiatric treatment fosters the philosophy of the neoliberal economy by encouraging people to take control of their own lives and discipline their own bodies and minds in order to be highly productive citizens. However, my position is that the Foucauldian approach alone is not enough when attempting to examine the experiences of women in relation to mental illness, as it misses the misogynist aspects connected with psychiatric labelling.

Many anti-psychiatry feminist researchers fruitfully discuss how the discourses of femininity have generally informed psychiatric labeling, how women's suffering stemming from patriarchal subjugation and reasonable responses to adverse situations have been constructed as mental illnesses (Chesler, 1972; Johnson, 2005), and the ways the *DSM* categorizes certain female life phases as problems (Caplan & Cosgrove, 2004; Linder, 2004). However, these researchers primarily discuss the misogynist undertone of psychiatry and take only gender-based subordination into account when examining psychiatric categorization and treatments. Consequently, they fail to understand that other intersectionalities, such as race, class and ethnicity, could induce women's pain, and they do not acknowledge the ways psychiatric knowledge is not only misogynist but imperialist.

In this regard, I consulted with postcolonial feminist scholarship to understand racialized immigrant women's experiences of using mental health services, and their resulting diagnoses and categorizations. The postcolonial feminist perspective emphasizes understanding diverse intersectionalities that induce this group of women's pain, the multiple ways they are displaced, and how they are at risk of being categorized as mentally ill. Further, postcolonial feminist scholars explore how racialized women are often the subject in the colonial construction of otherness, as well as how stereotypes of racialized women that were produced during the nineteenth century still persist in public and psychiatric perceptions today, affecting the mental health of racialized women as well as their treatment seeking experiences.

That being said, although postcolonial feminists focus on gender, race, and class intersectionalities, when reading mental illness in women of colour this approach does not address, as anti-psychiatry feminists do, the ways the *DSM* categorize women's bodies as illness or the psychiatrization of racialized women's distress. Further, because postcolonial feminist researchers do not engage significantly in discussing the ways psychiatry has been informed by Western culture and how biopsychiatry has expanded neocolonialism, I consulted with the postcolonial approach to unpack the above issues in my analyses.

Postcolonial approaches add to a Foucauldian and feminist analysis in that they indicate psychiatric treatments and the system itself enact colonialism, by constructing colonized people as inferior and privileging Western treatments and ways of knowing the world over other possibilities. This approach is also pertinent as it explores the effects of colonization and decolonization on the mental health of colonized people (Fanon, 1961/2007; Waldron, 2002). However, I am not convinced that the postcolonial approach is itself sufficient to explore racialized women's experiences of mental illness as, similar to a Foucauldian approach, it does not account for gender analysis in examining the psychiatric construction of mental illness. Therefore, in my research, I have combined these four theories to read racialized immigrant women's use of mental health services.

Structure of the Dissertation

In this chapter, my motivation for researching racialized immigrant women's use of mental health services in the context of Lethbridge and my guiding research questions were discussed. The theoretical framework that informed my research questions has also been reviewed in this chapter. In the next chapter, I will examine and explain my methodological approach, which draws strongly on both feminist standpoint theory and a Foucauldian constructivist approach. As there is a significant debate around using a Foucauldian approach when exploring women's standpoint, I will discuss the ways these two insights have been combined in my research. Then, I will outline the bases for selecting Lethbridge as a research site, explain the initial research and scheduling procedures, provide a brief biographic description of the 13 women I spoke with, and explain the ethical consideration and reflexivity practices in the whole research process.

Chapter Three will examine the stories of the women's suffering and pain arising from the structural discriminations, cultural norms, and violence which propelled them to seek mental health services. In this chapter, women's experiences of humiliation and racism in Canada because of their identity, culture, education, and language will be examined. Women's stories of sexual abuse, intimate partner violence, domestic violence, financial precarity, and the overall conflict with their new and old culture which drove them to seek mental health assistance will also be elaborated.

In Chapter Four, the women's experiences of using psychotherapy will be focused on. As the women I spoke with came from different societies with diverse geo-political histories and structural and cultural systems, their knowledge and practices around mental health practices will be explained to determine the extent to which the knowledge and practices have influenced their use of Western biomedical mental health services. I will then turn to a discussion of the ways Canadian mental health services implored these women to colonize their minds and lives following the Western neoliberal ways of living. Through my exposure to literature on psychotherapy in the West, I learned that Canadian mental health sectors adopt and foster neoliberal governmentality by encouraging people to be willing to work on their lives individually. I will discuss how successful this individualizing approach was for relieving the women's distress.

In Chapter Five, I will examine how the suffering of racialized immigrant women has been categorized by mental health professionals, and how these women complied and resisted their psychiatric diagnoses and treatments. I will suggest that while these women sought mental health services due to pain, the pain is itself a product of neoliberal/colonial and patriarchal culture. The psychiatric treatments prescribed by their physicians functioned to further encourage the women to assimilate to these misogynist and imperial structures. Thus, multiple forms of medical power, intertwined with patriarchal and neoliberal/colonial power, were simultaneously enacted in these women's lives.

Chapter Six will conclude by connecting the main research questions with my research findings on racialized immigrant women's use of mental services. I will also draw on discussions of the epistemological and methodological contribution of my thesis. I will conclude by addressing some limitations of the research and the unanswered questions that emerged from it, which could open up avenues for future research.

Chapter 2: Methodology

Introduction

In this chapter, I discuss the epistemological and ontological concerns of my research as well as my research location and research participants. I then outline how I have practiced ethics and reflexivity, how I obtained research participants, and how I interviewed them, and I will introduce the women I spoke with in this chapter. Finally, I discuss some critical elements of my analysis and representations of the women's stories.

Epistemological and Ontological Concerns

As discussed in the previous chapter, my epistemological position about truth around mental illness has been informed by the constructivist approach that sees knowledge and truth as constructed (Schwandt, 1998, p. 236) and that there is no single truth (Guba & Lincoln, 2005). I specifically focus on Michel Foucault's notion of the truth, so that truths about mental illness are constructed as the result of complex historical processes and this production of truth and its effects are complexly intertwined with power relations. Foucault posits employing the method of genealogy to examine the historical processes of the truth construction of particular subjects. In his book *Madness and civilization: A history of insanity in the age of reason*, Foucault (1965) employed the method of genealogy and examined literature, professional discourses, art, theatre and academic knowledge production in regard to madness in the West in order to find how madness has been historically constructed as a problem and how certain people who do not follow normative ways of living (i.e. striving to be productive, rational, self-controlled, reflexive, and self-improving) that arose alongside newly developed industrial societies came to be at risk of being categorized as mad.

Following Foucault, I have taken the position that madness is not an *a priori* category but rather a social construction. However, I have not employed Foucault's methods of genealogy and discourse analysis to understand the nature of constructions of mental illness of immigrant racialized women. Instead, my exploration of immigrant racialized women's experiences of using mental health services has taken up a feminist standpoint approach. In this theory, women's perspectives matter, and each woman has her own truths (Belenky et al., 1986; Harding, 1993, p. 56; Smith, 1997).

In my approach, I seek to understand the experiences of racialized and geopolitically marginalized women who accessed mental health services from the perspectives of the woman themselves. In-depth interviews with such women are an effective method to explore each woman's truth and each woman can describe a 'reality' the way she experiences it in her life. Guided by my epistemology, I believe that multiple, yet crucial, truths can be known through women's personal narratives. However, there are challenges to exploring the standpoints of human actors when using a Foucauldian constructivist approach, and in the following section, I discuss the debates of using these two approaches together and my positionality of combining two epistemological positions in my research.

Constructivist versus Feminist Standpoint Theory

My research draws from literature on feminist standpoint epistemology, which has been developed during 1970s, in response to masculinist dominance and the absence of women's perspectives in science, social science, and other disciplines (Belenky et al.,1986; Smith, 1997).

To end this absence and to produce something called “women’s knowledge,” some argued for exploring women’s standpoints on their daily lives (Belenky et al., 1986; Collins, 1991; Harding, 1987; Harding, 1993; Smith, 1997). However, as I have been using poststructural notion of truths, I am aware of many poststructural feminists’ criticisms of standpoint theory.

These feminists caution against exploring the standpoints of human actors as unalloyed truths, because they view the emphasis on producing knowledge based solely on first-hand and observable experience as a remnant of positivism, arguing instead for a more constructivist position (Scott, 1991; Schwandt, 1998). They argue that subjects are produced by discourses and that humans can only be situated and located within discursive productions (Doucet & Mauthner, 2008). Thus, many poststructuralists emphasize the importance of exploring the discursive systems that shape experiences and moving away from simply reporting upon events and the “reality” of personal experience (Scott, 1991). For them, focusing on experiences is dangerous because, like positivism, it tends to privilege visibility and therefore risks missing the historical processes that shape those experiences (Scott, 1991).

However, following the assertions of some poststructuralist feminists, I argue that feminist standpoint theory is different than empiricism or realism, and instead I believe that understanding women’s standpoints can help to illuminate different power relations that women experience in society (Harding, 1993; Smith, 1997). The importance of starting from women’s perspectives can be traced back to Dorothy Smith’s notion of standpoint theory. Smith (1997) does not emphasize women’s standpoint as a way to ignore the material effects of discourses on women’s lives. Smith emphasizes that if we start with the question of why women are assigned certain kind of activities, and if we explore the consequences of social institutions proscribing women to particular activities, we will be able to understand society’s attitudes towards women and power relations in their lives. Overall, Smith argues that exploring women's stances is essential to learn how they experience the patriarchal world and its social character.

Following Smith, I examined the women's perspectives and stories to learn how they experienced the patriarchal and colonial world. My methodological approach was based in feminist standpoint theory, and I have used Foucauldian, anti-psychiatry feminist, postcolonial, and postcolonial feminist theories to analyze the women's truths about using mental health services within the mainstream discourses around mental health, illness, diagnosis, and treatment. More specifically, I have attended to the extent to which such women conformed to and confronted the discourses in their lives.

My research has also been informed by some poststructural feminists who are interested in locating human agency (Butler, 2004; Mahmood, 2001). They argue that while our subject positions are produced through discourses, they can also be critical about discourses and can constrain and resist discourses (Doucet & Mauthner, 2008, p. 401). In other words, subjects are situated and located within discourses; however, they "can be active agents taking up discourses" as well (p. 401). Thus, agency and the social world can be explored through women's standpoints and through narrative approaches (Doucet & Mauthner, 2008). For instance, in her discussions of gender, Judith Butler (2004) argues that gender is not an ontological foundation, but rather a normative sanction which is presented to people as an ontology in order to hide the political aspect of the normative injection of gender. Butler argues that gender is an act and not a noun, and gender does not exist without regulation and practices, and this regulatory ideal is reiterated and nourished through different authorities, such as media, medical science, and religion (Butler, 2004; 2015).

However, Butler (1997; 2004; 2016) argues that norms are not always reiterated by women; rather, norms can be taken up playfully in the spirit of resistance. In other words, the regulatory and reiterating processes of norms do not only mimic existing norms; instead, innovative ways are also articulated to materialize or disestablish the norms of a society. Taking a cue from Butler, I have explored how the women I spoke with reflected their agency in materializing and disestablishing gender and colonial norms and the psychiatric and medical power in their lives.

Saba Mahmood (2001) affirms the value of learning from women, arguing women have agency and thus do not always conform to the discourses around womanhood, but rather resist many discourses in their lives. However, to Mahmood, both women's conformity and their resistance to specific discourses have histories. Therefore, it is significant to emphasize not only women's perspectives, but also to historicize women's different perspectives about a certain issue. Mahmood's idea of historicizing women's different perspectives about a certain issue and under similar discursive arenas is important in my research as the women I spoke with have different perspectives about psychiatric knowledge and their practices were varied in regard to their mental health issues. I have historicized their different perspective, such as how certain women followed neoliberal notions of subjectivities while others did not and were comfortable with traditional notions of subjectivities during their use of mental health services.

In my research, Lila Abu-Lughod's (1990) caution about resistance and agency is significant. She contends that human agency and resistance have become the focus of a recent trend in academic research that she calls the romanticization of resistance. To her, too much focus on resistance can obscure our understanding of power relations. Yet, she does not reject the notion of resistance, but instead suggests using it as a tool to identify power relations that women encounter in patriarchal culture. As opposed to Foucault's (1978) claim, "where there is power, there is resistance" (pp. 95-96), then, Abu-Lughod (1990) inverts it: "where there is resistance, there is power" (p. 42). I also draw on Claudia Malacrida's (2003) argument against Foucault's notion of power as circulating and resistance as available to all subjects, but not all have material power to withstand resistance (p. 241). The racialized immigrant women in my study arguably lack material power to refuse patriarchal and colonial discourse and practice, but they can still engage in everyday forms of resistance to create a space for living without challenging or overcoming discourses and power.

In this study, I have counted women's acts that do not follow normative notions of Western subjectivities as forms of agency, and at times, as forms of resistance. As mentioned in Chapter One, mental health services in Canada focus on neoliberal values of subjectivity, hyper productivity, and personal empowerment, which differs from many racialized immigrant women's collective cultural backgrounds and values. Thus, I have examined whether mental health professionals have suggested the women should adopt neoliberal subjectivities and how the women complied with or resisted psychiatric knowledge. I also examined if these women have internalized modernized discourses that equate mental wellbeing with self-improvement.

The Research Location

Racialized immigrant women who have used mental health service after 2007 in Lethbridge are my research participants. I have selected Lethbridge as my research location because it offers insight into a unique situation, being a smaller center and because the number of racialized immigrants has increased significantly in Alberta since 2008 (Government of Alberta, 2011). As pointed out by Rural Development Institute's report in 2014, Lethbridge became the industrial and commercial hub of southern Alberta, and the city needs labourers for its nearby manufacturing plants (Rural Development Institute, 2014). Additionally, over the past five years, Lethbridge has become a place of asylum for people who are displaced environmentally and politically (Rural Development Institute, 2014). The largest number of Bhutanese refugees in Canada live in Lethbridge; the first group of Bhutanese refugees came to the city in 2009, and by 2016, 1300 Bhutanese refugees had immigrated to Lethbridge (Klingbell, 2016). In addition, between 2017 and 2018, the city of 101,482 welcomed over 400 Syrian refugees (Statistics Canada, 2019). Lethbridge is currently the fourth largest immigrant-receiving city in the province (Statistics Canada, 2019).

In 2003, the number of immigrants in Lethbridge was 655 (Government of Canada, 2013), which has increased to 15,365 in 2016, accounting for 13% of the total population, 113,920 (Statistics Canada, 2016). By 2020, amongst immigrants, 11,690 residents self-identified as racialized or visible minority individuals, which is 12.9% of the total population of Lethbridge (Community Social Development, 2020, p. 21).

Culturally, Lethbridge also has some interesting attributes in relation to my research questions. First, Lethbridge is a relatively small centre surrounded by small rural communities, with the nearest major city over two hours' drive away. As addressed in Chapter One, culturally-diversified services aimed at racialized immigrants are limited in Lethbridge, and are not as engaged with inclusive cross-cultural practices that may be available in larger urban centres. As well, the recent influx of immigrants and refugees to Lethbridge has literally changed the complexion of a city that has a longstanding culture of social, racial, and religious conservatism. Lethbridge is white-settler-dominant, and it can be posited that conformist attitudes, particularly those regarding race and gender, might impact the lives of newcomers and immigrants, and may even impact the quality of mental health services for immigrant women.

Nonetheless, despite the potential impact to contribute to the broader understanding of mental illness in immigrant women during a time where Lethbridge overall is seeing an increase in refugees and immigration, to my knowledge, research on the experiences of racialized immigrant women's use of mental health services in Lethbridge is absent. This is despite a burgeoning literature about the mental health and illness of immigrant women (Alvi et al., 2012; Guruge, Collins, & Bender, 2010; Knaifel & Mirsky, 2015; Noh et al., 1999; Panchanadeswaran & Dawson, 2011; Tewary, 2005). Within mental health studies, somewhat less attention has been devoted to examining how different intersectionalities of geopolitical contexts transect women's experiences.

In my research, I have been looking at how diverse social categories intersect women's experiences in using mental health services. That said, as I began my study, defining immigrant and racialized women was difficult and led me to unlearn the ways I defined racialized categories before entering the field. The following section discusses how I have sought to define immigrant and racialized women for the purposes of this study.

Who are the Immigrants and Who are the Racialized Women?

In this study, 13 racialized immigrant women graciously agreed to share their intimate stories of using mental health services in Lethbridge. I originally intended to hear stories from three categories of racialized immigrant women: refugees, who are regarded as a distinct class of immigrants; international students, who are considered as temporary immigrants (Hazen & Alberts, 2006); and permanent residents or citizens of Canada. I aimed to learn from these different categories of women how immigrants and racialized women are not alike; some are privileged over others and their experiences generally intersect with their education, class, ethnicity, gender, and also their immigration status (Gillborn, 2018). (Table 2.1 represents the women's immigration and living status in Canada).

Table 2.1: Participant Immigration and Living Status in Canada

Pseudonym	Immigration Status	Present Living Status
Amelin	Initially came as an international student, has since obtained citizenship	Lethbridge, lives with her family
Arvin	Came as an international student	Moved to another country for her Ph.D. degree and lives by herself for her study
Jasmine	Came as an international student, now on work permit	Moved to another city in Canada, lives alone
Jenifer	Came as an international student	Lethbridge, lives alone
Jillian	Immigrated with her parents and obtained citizenship	Lethbridge, lives with a brother
Jisa	Immigrated with parents and obtained citizenship	Lethbridge, lives with her family
Lamia	Came as an international student	Lives in Lethbridge with roommates
Lotus	Came as an international student, now on work permit	Moved to another city in Canada, lives alone
Mary	Came as an international student, has since obtained citizenship	Lethbridge, lives with her partner
Moumi	Immigrated with her ex-husband, has since obtained citizenship	Moved to another city in Canada; lives alone
Natasha	Canadian citizen, her parents immigrated before her birth	Lethbridge, lives with roommates, escaped from her home
Nila	Immigrated with her parents and obtained citizenship	Lethbridge, lives with roommates
Sasha	Came as an international student	Lethbridge, lives with roommates, has a family member in Canada

Although I tried to connect with refugee women through Lethbridge Family Services, the Lethbridge Multicultural Centre, and Bhutanese Association, I did not reach any racialized refugee women through these services. I suspect that there are three reasons underlying my failure to find them; first, my call for participants was in English and refugee women have limited English language skills. Second, their limited mobility outside of families, is a particular issue facing women who are from South Asia and the Middle East, which comprises the majority of refugees in Lethbridge. Third, when I contacted local friends from South Asian countries, they indicated that their people often do not like to disclose mental health issues and that mental health concerns are not prevalent in the community. On the other hand, I have been told by staff at Lethbridge Family Services (LFS) that refugee women have suffered tremendously after being displaced from their country and after arriving in a new country. It may be that these women would have made a strong contribution to my research, but I was unfortunately unable to recruit any respondents. Failing to include their experiences is one of the limitations of my research.

Several women in this study are international students who are temporary immigrants, and they generally experience high vulnerability compared to permanent residents and perhaps refugees in terms of accessing many benefits and helping systems for newcomers to Canada, even though they also have some privilege due to their literacy (Bonazzo & Wong, 2007). Their ability to speak the English language arguably provides them with the ability to adapt in an English-speaking society comparatively easily compared to those immigrants who lack English speaking language abilities. Nonetheless, many international students come by themselves for their study and thus experience isolation. They also struggle in their student lives enormously due to pressures to succeed and high expectations from their home and family.

In my research, as you can see in the Table 2.2, I have not included all immigrants, but have instead focused on immigrants from the Global South as they have different experiences compared to European and white immigrants in Canada (Abu-Laban, 1998a). My study does include one woman whose family moved to Canada before her birth. The woman, Natasha, identified herself as an immigrant and racialized woman because she feels her experiences are closer to those of immigrants than to (white) people born in Canada. Even though she is a Canadian citizen, she described being treated *as though* she is an immigrant due to her brown skin colour.

Natasha's story illuminates an example of how ethnic identity is problematically perceived as stable, static, and fixed. Thereby, immigrants are perceived as a fixed category and their children who were born here in Canada are also addressed as immigrants or as second-generation immigrants (Abouguendia & Noels, 2001). The integration of second-generation immigrants often depends on their assimilation into the receiving society, along with their feeling of preserving their national and cultural identity (Dustmann, 1996).

Although Natasha was unequivocal in categorizing herself as an immigrant, I was hesitant to include her in this research as she did not fit the standard definition of an immigrant as someone who has moved from another country to Canada. But because immigrants' children are also considered as foreign as they carry the bodies that are "perceived to be physically different" from white, and their religions and values are foreign, I decided to include her story here (Goldberg & Hodes, 1992. p. 52; James, 2018, p. 276). Natasha's explanation prompted me to rethink the definition of immigrant; for the purposes of this study, I have taken women's self-categorization about their immigration status, based on feminist principles of taking the insights and perspectives of women on their own experiences as legitimate and important.

Like their immigration status, I relied on the women I spoke with to label themselves as racialized. Before entering to the 'actual' field my conception of racialized women was informed by Black, Latina, and 'Third-World' feminist scholars' definitions of racialized women, but when I began recruiting participants, I had to rethink some of these perceptions. These feminists use the term racialized to separate themselves from second wave feminism that mostly developed focusing on middle class white women's lived experiences and overlooked race, class, and other intersectionalities that can complicate women's experiences (Anzaldúa, 2015; Collins, 1991; Lorde, 2015). As pointed out by the Black feminist, Patricia Hill Collins (1991), white feminists often focus on gender-based inequality whereas women of colour's racial identity is more prominent and politicized than their gender identities. Building on this, racialized feminists argue that imperialism, racism, and economic disparity are more resolute concerns than gender inequality (St Denis, 2007, p. 50).

Thus, when I circulated my call for participants, I perceived that all women from the Global South would categorize themselves as racialized women and would be my potential research participants. I approached all women from the Global South that I knew; however, some of them did not label themselves as racialized women, which demonstrates that categorization is problematic, and a researcher should refrain from categorization before going to the 'actual' field. Thus, in my research, women who are from the Global South and non-European in ethnicity who classified themselves as racialized women have been recruited as my research participants.

However, the categorization of non-white and racialized women is complex. As pointed out by my respondent, Nila, the definition of racialized women and white women is contextual, and time, place, and space dependent. Nila has stated that even though she categorizes herself as a racialized woman, she has diverse experiences in terms of her identity. For instance, people from South Asian countries often identify her as a white woman while white people label her as racialized woman. Further, she told me that in her country, she was perceived as white as the categorization of white and non-white is different in her country from Western countries.

Another woman, Sasha, told me that she did not know about the terms ‘women of colour’ and ‘visible minority’ before coming to Canada. Nila and Sasha’s explanations illustrate how categorization and identity are dependent on one’s political and social location. It is noteworthy that when beginning my research, I used ‘women of colour’ and ‘racialized women’ as synonymous terms, and I was using the terms alternately during the interviews. However, Nila suggested I use the term racialized women because, to her, the word is more incisive in understanding the experiences of racialization of non-white women, while the term ‘women of colour’ is more related to phenotype. As a feminist researcher, I foreground the women’s knowledge as important, and so I use the term racialized women to describe them. The following section discusses the profiles of the racialized immigrant women I spoke with.

Description of the Women

The women in this study migrated to Canada from different continents, including South Asia, Southeast Asia, East and West Africa, the Middle East, the Pacific Islands, the Western Caribbean Islands, and Latin and Central America. One woman was born in Canada as I mentioned earlier in this chapter. To maintain the anonymity of my respondents, the names of the continents/regions rather than the names of the countries or cities have been used in my analysis. Table 2.2 represents the women’s biographical information.

Most of the women I spoke with were single and a few of them did not practice religion. Their age ranged from 22 to 37. Among the 13 women, eight women, Amelin, Arvin, Lamia, Lotus, Jasmine, Jenifer, Mary, and Sasha, came as international students, and most of them struggled to adapt to new culture, foods, and education systems in Canada. Mary was born and lived in a Western Caribbean Island. She met her white Canadian ex-husband while he was working in her country where they were in a relationship; then, they planned to move to Canada to be married. However, Mary came as an undergraduate international student in 2011 because they thought it would be easier for Mary to move to Canada as a student and that further education in Canada would be beneficial for her career. For Mary's first few years, life was spilt into work and study; she is a psychologist as well as a user of mental health services. She has a good job and income in Canada; she divorced her husband in 2016 because of her experiences of racism in her husband's family.

Amelin came by herself before 2010 as an international graduate student from a South Asian country. As she said, she moved as a student to settle in Canada to have a better future for her family and kids. Later her husband joined her, and they received their Canadian citizenship and had children. Both she and her husband have good jobs. Arvin and Jenifer came by themselves for an undergraduate exchange program and later for their Masters as international students. Arvin came from Latin America, and for her undergraduate exchange program, she received funding from the government of her original country. Later, for her Master's program, she received funding from the University of Lethbridge. However, Arvin also worked in a liquor store when she was a student. After finishing her Masters, she moved to another Western developed country because of a very supportive Ph.D. supervisor and because she wanted to learn another language and culture. Jenifer was in her Master's program when I talked to her and she was stressed about her thesis writing. Similar to Arvin, Jenifer came through a scholarship to study in Canada.

Table 2.2: Participant Biographical Information

Pseudonym	Age	Education Level	Partner Status	Employment Status	Religion	Home Continent
Amelin	37	Master's	Married	Employed	Religious	South Asia
Arvin	29	2nd year PhD	Single	Student	None	Latin America
Jasmine	32	Master's	Single	Employed	None	South Asia
Jenifer	32	Master's	In a relationship	Student	None	Pacific Islands
Jillian	22	2nd year Undergraduate	Single	Student	Religious	Southeast Asia
Jisa	23	3rd year Undergraduate	Single	Student and part-time employment	None, parents are Religious	Central America
Lamia	23	3rd Year Undergraduate	Single	Student and part-time employment	Religious	East Africa
Lotus	31	Master's	Single	Employed	Religious	East Asia
Mary	29	Master's	Common-Law	Employed	Religious	Western Caribbean
Moumi	37	Master's	Divorced	Employed	Religious	Middle East
Natasha	25	2nd year Undergraduate	Single	Student	Religious	Oceania
Nila	23	4th year Undergraduate	Single	Student	Atheist	Latin American
Sasha	23	4th year Undergraduate	Single	Student and part-time employment	Religious	West Africa

Lamia and Sasha also came to Canada as international students for their undergraduate programs by themselves and both were students when I talked to them. Both are from the African continent and from extended families. Lamia's sister moved to Canada as an international student, and she then helped Lamia move to Canada. However, her sister lived in different city. Lamia’s father provided most of her living costs in Canada; however, Lamia also worked hard, as tuition fees were high. For Sasha, her aunt helped her to come to Canada and her aunt promised her that she would pay Sasha’s full undergraduate tuition fees. Nevertheless, her aunt only paid first-year tuition fees and refused to pay for the rest, putting Sasha in a precarious situation in a new country. Sasha then managed all her costs by working hard and took on all of the challenges of staying in Canada because it offered her so-called ‘upward mobility’. She perceived that Canadian degrees would equip her with the skills to succeed in the Canadian and international job markets.

Lotus and Jasmine came to Canada as international students enrolled in masters’ programs and finished their programs of study. Lotus received full funding; however, she has also worked part-time while studying since the second year of her program. She is from an ethnic minority community from Southeast Asia. Before coming to Canada, she lived in another Western developed country for five years. Then, Lotus went back to her country for a year but moved to Canada because her community had been encountering ethnic cleansing. Obviously, at home, a sense of space and the freedom of human and women’s rights were lacking. As freedom is her biggest concern, Lotus moved to Canada with her brother’s help. Her brother already lived in Canada with his family, so Lotus lived with them for the first year.

Jasmine moved to Canada as an international graduate student to avoid the insults and guilt she experienced due to her break-up with her boyfriend of many years. Jasmine received only partial funding, so she had to work in addition to her studying. However, she had financial support from her father. Jasmine and Lotus both had jobs in Canada through their post-graduation work permits and had plans to settle in Canada at the time of speaking with them.

Jisa, Jillian, and Nila were also students when I talked to them, but they immigrated to Canada with their parents during their childhood and they got citizenships later. Jisa moved as a dependent child (when she was 13 years old) to Canada with her mother and brother in 2011 to join her father who had moved earlier. Jisa's father had a good job and a good living standard in his country, yet he moved to the small city of Lethbridge because he was anxious about the recession in his country and hopeful that coming to Canada would secure his family's future. Unfortunately, in Lethbridge, he was only able to find low-paid work. Jisa waited for several years for her Canadian visa to join her father.

Jillian moved to Canada in 2013 with her father and siblings. Her mother had already moved to Canada by herself to work in 2007. Jillian, her siblings, and her father had all waited for many years to get a visa to come. Jillian moved to Lethbridge with her younger brother for their study at the university and her family lives in another bigger city in Canada. Nila moved to Canada with her biological father and stepmother in 2007 when she was 11 years old. Nila's biological mother got a divorce from her father. Her mother is an engineer who migrated to another Western country. Nila's father came to Canada to have a better future as there was an economic crisis in his country and he was able to find a very good job in Canada. By profession he is an engineer, whereas her stepmother is dentist. Nila has two half siblings. Nila moved to Lethbridge for her studies in 2015 and her family lived in a bigger city in Canada.

Natasha was born in Canada and her parents moved to Canada from a country of Oceania before her birth. Her parents live in a bigger city in Canada, and Natasha came to Lethbridge because she wanted to flee from her their abuse. Moumi came to Canada in 2008 after her marriage as a dependent spouse and she obtained citizenship through her ex-husband. Moumi came to Lethbridge in 2012 with her ex for his post-doctoral fellowship. Moumi had a master's degree from her country, but she went to a college in Canada. Then, when she moved to Lethbridge, she pursued undergraduate education. She divorced her ex in 2014 as she had been experiencing spousal violence, and in 2015 she moved to a bigger city in Canada.

The women's profiles illustrate that the ratio of women who immigrate by themselves has increased. Eight women migrated by themselves as a student. Therefore, the claim of some migration scholars that women from the Global South, in particular from the South Asian countries, move primarily as a dependent spouse (Boucher, 2007) is not evident in my research.

Ethical Considerations and Reflexivity

I strongly believe in ethical feminist research, which seeks to support the wellbeing of women, and I have endeavored to erase potential harms that might come from these women's participation in my research. I draw upon Marilys Guillemin and Lynn Gillam's (2004) notions of two kinds of ethics in my research; the first is procedural ethics, which involves getting approval from a relevant ethics institution to conduct research with human beings; the other concerns ethics in practice, which emphasizes the everyday practice of ethics during the whole period of research. Through procedural ethics, the ethics committee ensures and pushes researchers not to engage in any acts that could harm research participants, yet researchers' own accountability in practicing ethics day-to-day is essential. Further, in the social sciences, procedural ethics has limited control over the researchers' activities when they are in the field, as many unpredictable issues may arise in the field that are not covered under procedural ethics approvals.

Before I began interviewing, I submitted an ethics approval proposal to the University of Lethbridge under the Tri-Council guidelines to ensure that I would be protecting women from any harm that might result through their research participation, which is a clear example of procedural ethics. In the proposal, I described how I would recruit women; how I would ensure their anonymity and protect their privacy to ensure their safety. I also submitted my Call for Participants (Appendix A), Fact Sheet (Appendix B), and Consent Form (Appendix C) for racialized immigrant women. The rigorous reviewing from the ethic committee was helpful; yet, similar to Guillemin and Gillam (2004), I focused on practicing ethics day-to-day basis and thereby when some issues that came up in my "actual" fieldwork were not covered in the ethics application, I immediately contacted the ethics committee and my thesis supervisor for their suggestions in order to strengthen my ethical practices. For instance, I did not mention in my ethics application that I would do some online interviews because I did not anticipate that obtaining research participants will be that challenging. When I needed to do online interviews, my ethics committee has approved the option.

Further, following Guillemin and Gillam (2004), I have practiced reflexivity to keep critical eyes on my own steps in the whole period of research to avoid causing emotional, social, and other harm to women I spoke with (p. 272). According to Guillemin and Gillam (2004), reflexivity in research is "an active, ongoing process that saturates every stage of the research" (p. 274). This requires continuous "critical scrutiny and interpretation," and is not limited to the "research method and the data" but it is related to "the researchers, participants, and the research context" (p. 275). Being reflexive enhances researchers' capacity to be concerned about ethical issues since reflexivity develops "a means of addressing and responding to ethical concerns if and when they arise in the research" (p. 276).

Guillemin and Gillam (2004) posit that only reflexivity encourages researchers to develop skills to respond to emerging situations appropriately and that reflexivity answers every question arising in the field. The notion of reflexivity emerged during the 1980s. as a means of resolving the problems of representations of the other in research (England, 1994). Until 1980, the positivist paradigm was prominent in social science research; the notion of neutrality, objectivity, and detachment from the other was considered necessary in producing a more ‘accurate’ representation of them. However, the notion of neutrality and objectivity as possible or even desirable in human research was criticized by feminists, poststructuralists, postmodernists, and critical theorists.

Many scholars recognize that, as researchers are themselves parts of the social world, their representations of others are connected to the writers’ self-presence in the text (Denzin, 1994; Mauthner & Doucet, 2003). More specifically, researchers’ positions “in terms of the truth or reality of the text and the researchers’ values, norms, and institutional pressures” could affect the reading of the texts, the coding of the interviews, and the representations of the research participants’ narratives in writing (Malacrida, 2007, p. 1329). Thus, some feminist scholars propose the practice of reflexivity as a critical element in research that could serve to acknowledge researchers’ motivation, preconceived notions, assumptions, power, biases, and privilege (England,1994; Malacrida, 2007; Mauthner & Doucet, 2003).

In my research, I practiced reflexivity by disclosing the ways my social location and experience as a racialized woman in Canada has prompted me to do research on racialized immigrant women. Further, I acknowledged that my epistemological stances have informed my reading, coding of the interviews, and representations of women’s stories of using mental health services in Canada. Through conversations with my thesis supervisor and committee, I also critically examined whether my identity and experience as a racialized woman distorted my analysis. Mauthner discusses that her reflexivity was informative as she notes that her ability to practice reflexivity has been enhanced not only due to the involvement in a research group, but also in the discussions with other researchers about her issues and the impact of their insights in her analysis (Mauthner & Doucet, 2003). Likewise, I perceive that my reflexivity has been strengthened by my thesis committee members' feedback.

My thesis supervisor pointed out my primary analysis as at times informed by my norms and values and has also noticed I had some epistemological slippages in my analysis. Following my committee members' feedback, I have modified my analysis; hence, my research and reflexive processes have been iterative and ongoing. Alongside these insights, I also received feedback on how to engage in women's stories during qualitative interviews. My thesis supervisor's comments on my first interview transcript helped me to minimize my interference with my participants' responses. While I frequently spoke during the first interview, I engaged primarily in listening for the rest of the interviews.

Although I tried to be reflexive in my research, I am aware of Gayatri Chakravorty Spivak's (1988) and Wanda S. Pillow's (2013) criticisms about typical practices of reflexivity. To Pillow and Spivak, researchers often practice reflexivity in order to be a self-discloser, that is, by evidencing how they were able to know the other and how their approaches were transparent in their research. In other words, reflexivity has become the practice of telling researchers' confessional tales and making their positions transparent, which does not dissolve researchers' power over researched people. While I disclose my positionality, and acknowledge my power in my research, similar to Spivak and Pillow, I acknowledge that these practices are not enough to dissolve my power with the women in this study entirely, as I am the one who is analyzing the texts.

Additionally, following Malacrida (2007), I use reflexivity to protect myself. As Malacrida argues, reflexivity is mostly discussed to protect participants but has not been outlined as a means to help researchers. In her research project, Malacrida found engaging in emotionally "intense research has posed risks to student researchers' sense of well-being and their ambition as researchers" (p. 1330). To understand the impact of engaging in emotionally intense research, Malacrida focused on researchers' journaling of their emotional responses in relationship to the research findings, their transcription, and their interpretation. One of her student researchers, for example, noted that engaging in research with people with disabilities contributed to lose her fear of being disabled herself and helped her to view the world differently. Malacrida suggests that it is important to provide emotional care to the self as a researcher when engaging in intense research.

My research topic is intense, and it has been emotionally taxing for me. First, for several weeks, I felt guilty for engaging in research that elicited such strong emotions such as crying from the women I approached. Second, I found that my research work has had an impact on my daily life; in particular, when I was interviewing the women, I was forgetful and often felt emotional. Further, similar to Malacrida's student researcher, I found transcribing to be emotionally overtaxing as I need to listen, type, read, and code the stories. Nevertheless, the women's stories strengthen my commitment to work against the discriminatory policies and structures affecting racialized immigrant people that lead the women to use mental health services. In this intense time, I have had continuous emotional care from my thesis supervisor. I also received care from my thesis committee members. All of them were very concerned about my mental wellbeing during these stages, which helped me to engage with my work.

Call for Participants and Scheduling Interviews

Obtaining research participants was a challenge, which is speculatively linked with the stigmatizing and marginalizing attributes of racialization, gender, immigration and mental health status. I had to search extensively for research participants, and I made contact with as many as I could by using my personal networks and through several helping organizations in Lethbridge including the Multicultural Centre, Lethbridge Family Services, the University of Lethbridge International Centre, and the Graduate Student Association at the University of Lethbridge. Dr. Janice Newberry helped me connect with one of Lethbridge Family Services' directors and find my participants. Also, a few professors in the Department of Sociology, at the University of Lethbridge helped me by allowing me to speak about my research briefly in their classes to find women. I posted my Call for Participants on multiple sites (physically and virtually) at the University of Lethbridge. I also posted my information sheet and Call for Participants on social media platforms, such as Facebook and Kijiji (which often have local postings). I also created a Facebook page to find participants; some of my friends helped me to find participants by sharing my Call for Participants on social media and blogs.

In total, I conducted 13 interviews over a period of four months from February 2019 to May 2019 with immigrant racialized women who have used mental health services in Lethbridge after 2007. I received four responses through social media. These four women had experienced accessing mental health services in Lethbridge but had subsequently moved to different cities and countries from Lethbridge. As a result, I conducted these four interviews via skype and Messenger, and the interviews remained focused on these women's experiences while in Lethbridge.

Interviewing the Women

Since I have taken the position that each woman has her own truth about her use of mental health services, I have used qualitative in-depth interviewing methods to learn their stories. The structure of the interview was open-ended. Nonetheless, I had an interview guideline that focused on my main research questions, such as why immigrant women used mental health services, what kinds of experiences they had with mental health professionals and how they confronted and complied with those services. This guide was not an active part of the interview process, rather, it was there as a back-up to help prompt participants if the need arose.

The interviews lasted from 90 to 180 minutes, and all conversations were tape-recorded with consent. At the beginning of each interview, I completed a short fact-sheet with their permission, so as to obtain some basic factual data about country of origin, family status, and other relevant attributes. Before each interview I obtained informed consent following principles of confidentiality, voluntary participation and practices of doing no harm. During the interviews, I was prepared to answer personal questions on the research topic from the women I spoke with, which occurred at times.

I took a feminist-based interviewing approach that focuses on subjective, conversational and co-authored approaches and encourages a friendly relationship between the researcher and the researched in order to balance power relationships that often exist between them (DeVault, 1990; Maynard, 1994; Oakley 1998). The approach is opposed to quantitative research approaches, where the emphasis is on the detachment of the researchers and the collection of value-free and ‘objective’ social facts (Maynard, 1994, p.11).

The feminist approach has permitted me to learn in unanticipated ways from the women and build in questions based on their responses to previous questions (Burgess-Limerick &

Burgess-Limerick, 1998). However, while I have taken the conversational approach, I was aware of the debate around the conversational approach that it relies on the perception that all respondents have the ability to be conversational and active in expressing their standpoints (Obasi, 2014).

I began interviews by asking some background questions, such as, when and why did they come to Lethbridge. These conversations helped me to build rapport with the women. However, similar to the arguments of Nairn et al. (2005), I felt that, "the emotional, and often invisible work of establishing rapport is a process that occurs throughout an interview" (p. 230). I tried to go slowly and listen to the women's stories passionately and carefully. While I followed the interview guideline, our conversation led me to ask new questions. Sometimes, I had to explain my questions for the women's understanding, which reminds me of the discussions on the difficulty of cross-cultural speaking (Schutte, 1998).

As noted above, I did four online interviews; three interviews were conducted via Skype, and one was done via Messenger. The Messenger was used as the woman did not have a Skype ID. Skype and Messenger software are free to download, and audio, video, and text-based conversation options are available for both of the online communication apps. There is some concern that researchers do not get a similar environment and space to be involved or build rapport during online interviews as they in a face-to-face interview (Deakin & Wakefield, 2014). Further, the online interview is not embodied, and researchers can miss "all the subtle visual, non-verbal cues that can help to contextualize the interviewee in a face to face scenario" (p. 605).

Additional debates around online interviewing discuss how the interviewee can feel embarrassed in online conversation, and many people might not have the technical expertise to participate in an online interview, which potentially excludes some people who do not use these technologies. While building rapport is hard in an online interview, there is also recognition that online interviews might facilitate asking more sensitive questions as researched people often do not see researchers (Deakin & Wakefield, 2014). Further, when research participants are difficult to reach, the online interview is a viable and important option.

In my research, as I mentioned earlier, obtaining research participants was difficult and some potential participants had moved to other cities and countries, which is why I chose to do online interviews. This method is as important as face-to-face interviewing, although I am aware of the criticisms that involved and embodied research is not possible with online research. I agree that the environment of online and face to face interviews are not similar. For instance, when I did face-to-face interviews, some women cried when they were telling some of their difficult experiences in their lives, and I had an opportunity to hug them with their consent, which I did not have on online interview. It is noteworthy that in two online interviews, I did not use a video camera; thus, I did not see their facial expressions, which are considered as an important element of the qualitative interviewing methods (Deakin & Wakefield, 2014).

I acknowledge that doing interviews with people who have different languages and cultures is a bit challenging. Sometimes, I felt lacking adequate knowledge to fully understand the nuances of some women’s stories. I was wary about the risk of misinterpreting the conversation. I acknowledged that even though I am a racialized woman, there is still a potential for power imbalances in my interviews, as Chijioke Obasi (2014) discusses, particularly in terms of racialized women with disabilities.

Obasi notes that non-disabled researchers often perceive that racialized women with disabilities cannot speak for themselves leading researchers to select approaches for the research that often ignore exploration of the specially situated perceptions of racialized women with mental illness. This tendency generally can lead to the misrepresentation of such a group of women that delimits the understanding of the ‘actual’ vulnerabilities of such participants (Obasi, 2014). Obasi discusses that, similar to the superior and inferior statuses that often exist between white and racialized women within feminist scholarship, a similar power relationship exists between nondisabled racialized researchers and disabled racialized women. Therefore, racialized researchers need to have critical eyes on the structural inequalities not only among white and non-white researchers but also among racialized women researchers and racialized women with disabilities. In my research, I was conscious about these debates and tried to facilitate a respectful environment for women to tell their stories.

My stance during the interviews was non-judgmental and, in most cases, I did not interrupt them when they were talking. In my experience, most women seemed to be comfortable recounting their experiences of using mental health services in Canada. I tried to balance my power by demonstrating myself as racialized immigrant who they can trust and with whom they can share their stories. During the interviews, I always tried to use open and inviting verbal and facial expressions, such as eye contact, verbal cues to give to the women a sense that I was engaged their stories. This attention worked well, often acting as an “attention probe” (Rubin & Rubin, 2012) that indicated my care and respect for my research participants’ stories (p.140). I also kept Steinar Kvale’s (1996)’s discussion on communication with research participants in my mind when I did my interviews, recognizing that communication is not only verbal but also embedded in the tone of voice, expression, and gestures. I believed that my engaged listening encouraged the women to share their stories comfortably.

Transcribing the Interviews

In following ethical procedures, after finishing every interview, I immediately transferred the records to a password protected folder as promised to the ethics committee at the University of Lethbridge. I transcribed all the interviews myself in order to protect the women's privacy, and also as a way of coming to know these stories intimately. I did verbatim transcriptions and I listened to some parts of the conversations several times to understand the exact words and sentences. Although the work of transcription was very time-consuming and emotionally intense, I found it very useful as it helped me to recall all the memories of the interactions between the women and me that took place during the interviews. Additionally, when I was doing transcription, I was able to begin my analysis by sorting the recurring themes that came up in the interviews.

I endorse Bird's (2005) assertion about transcription that says, "[a] transcript is a text that 're'-presents an event; it is not the event itself" (p. 227). Hence, researchers' perceptions about transcriptions affect "their treatment of it and within their research methodology" (ibid). In addition, transcription is the act of representing original oral language in written form, but the act is political because when "transcribers fix the fleeting moments of words into written form, they evoke the social role and relations constituted in language" (ibid). Thus, according to Bird, transcription is a "nonobjective construct" (ibid) and each act of researchers' transcription becomes as an interpretive act. Researchers' personal values and ethos of world would have a significant influence on the interpretation of data. Therefore, it is very important for the researchers to transfer voices of the research participants verbatim.

I agree with Judith C. Lapadat and Anne C. Lindsay (1999), who posit that transcription is the act of representing original oral conversation between researchers and researched people in a particular context. Researchers in qualitative research select or develop some of their themes to discuss following their own epistemology, which is subjective. As well, the conversation takes place in a situated context and the knowledge produced in that conversation is situated, informed by researchers and researched peoples' values and norms. Verbatim transcription can represent the situated and subjective knowledge; however, that does not mean a value-neutral transcript ensures a value-neutral analysis, and in turn, value-neutral representations of the researched people.

In my research, pseudonyms have been used for the women I spoke with and other individuals, and places that have surfaced during the interviews. Namely, I have used pseudonyms for doctors, hospitals, relatives, friends and family members to mask the identity of the women in this study. I removed all the identifiers of the women when I transcribed. In addition, my thesis supervisor has reviewed some of the interview transcripts. The women who wanted to see their transcriptions were able to do, and they were given the option to edit their transcripts; one woman chose to do so.

Analysis and Representations

In my research, I acknowledge Norman Denzin's (1994) assertion that analysis and representation of women's stories are the most important phases for a researcher. In this phase, researchers generally have the power to represent research participants, their problems, and their crises. In my research, I acknowledge the power that I have to code and construct themes from the women's stories of using mental health services and that I make particular theoretical selections through which to conduct my analyses. However, my selection of themes has also emerged from these women's stories, which is similar to the approach of some grounded scholars; I did not, however, as many grounded theorists express as their aim, go into the field without worldviews.

Here, I consulted with Robert Thornberg and Kathy Charmaz's (2013) discussions on constructive grounded theories, which focus on reviewing literature before going to the field. Similarly, I reviewed the academic literature on racialized immigrant women's mental health, and I exposed myself to anti-psychiatry feminist, poststructural, postcolonial, and postcolonial feminist scholarship on mental health in order to decide what questions to ask during the interviews. In that sense, my research was not just letting women speak for themselves, but rather asking them to speak on certain themes that I found important to explore through my exposure to the four types of scholarship and literature discussed in the previous chapter. However, my preconceived notions did not force me to search for these issues in the field. Instead, I used the themes as a starting point of discussion and then I was open to any new perspectives or themes that arose from the interviews (Thornberg & Charmaz, 2013).

My caution was informed by standpoint feminist Mary Maynard's (1994) assertion that feminist research that seeks to "be politically neutral, completely inductive or solely based in grounded theory [is] a contradiction in terms" because "whatever perspective is adopted, feminism provides a theoretical framework concerned with gender divisions, women's oppression or patriarchal control which informs our understanding of the social world. It is disingenuous to imply otherwise" (p. 23).

Thus, my analysis is based on political interest, framed within Foucauldian and postcolonial feminist' conceptualizations of power, gender, racism, and psychiatrisation, and my analysis is not about claiming scientific neutrality and objectivity, but rather, is a combination of my own and my respondents' situated knowledge that relies on the conceptualizations that knowledge and interpretations are historically and contextually grounded and linguistically constituted (Haraway, 1988; Mauthner & Doucet, 2003, pp. 416-417).

During the beginning of my analysis, I approached coding by consulting grounded theory's two notions of coding: initial and focused coding (Giles, et al., 2016). However, I did not do initial coding during my actual fieldwork, as grounded theorists generally do. I only began initial coding during my transcription and data analysis. When conducting initial coding, I went through each of the interview transcripts line by line and coded women's stories by using several themes, such as language barriers, nervousness, lack of shared interest, and so on. I used ATLAS.ti qualitative data analysis software to code women's stories.

My focused codes or analytical themes are more selective and conceptual than the initial codes. The analytical themes are used to compare and contrast the women's stories of using mental health services. In that sense, a large segment of women's stories has been analyzed under a focused conceptual category, for example, resistance or adaptation to western psychiatric labels, or cross-cultural conflicts in beliefs about healing, and how those played out in the women's experiences.

I read the interview texts several times to understand all the possible analytical themes and recurring issues in the women's stories. For example, most women explained that their double consciousness, discrimination in workplace, and other experiences of racism were reasons for seeking out mental health assistance. Thus, I selected racialization as one of the key analytical categories. It is important to note that even if very few women used the term othering and racialization, I have nonetheless analyzed their experiences as such following my exposure to postcolonial literature. I am using standpoint theory, which focuses on understanding women's stories within the broader discourses of patriarchy and postcolonial feminists, which prompted me to understand racialized women’s standpoints within the broader discourses of race, racialization, and othering alongside the discourses of patriarchy.

Additionally, I embraced Marjorie L. DeVault’s (1990) advocacy for examining women’s use of language during interviews and, in turn, data analysis, as women often “learn to interpret their experiences in terms of dominant” patriarchal “language and meaning” (p. 100) and women often encounter problems in speaking within a male-rooted language. Following DeVault, I see language as a potential way of protesting male power; for instance, women’s talk that does not support male power can be seen as women’s resistance. I also read women’s language, their hesitation, halting, and tentative talk critically (p. 103), as they arguably face similar problems in expressing themselves within a white-rooted language.

I have observed that some women have discussed their experiences using the biomedical discourses of mental health services, while others critiqued psychiatric notions of mental health services and diagnosis and preserve their own ways of talking, arguably resisting the prevalent biomedical mental health discourses. I have been very careful to be as transparent as I can be in interpreting women’s stories, and I understand my interpretation of my research findings is one reading of many possible readings.

Within in this chapter, I have discussed the epistemological and ontological concerns of my research; in the next chapter, I begin to explore the women’s stories, with a focus on why they accessed mental health services.

Chapter 3: Suffering and Pain: Why the Women Accessed Mental Health Services

Introduction

In this chapter, I examine why the women I spoke with in Lethbridge used mental health services. The women's stories represent diverse reasons for seeking services, yet their experiences share remarkable similarities, among them a common experience of discrimination based on their race, ethnicity, and culture. All of the women described being emotionally damaged by their pain and suffering, which was triggered by interrelated social subordinations, intersected by their gender, class, race[8], ethnicity, age, educational background, occupation, and marital status in Canada.

Along with this reported suffering, some felt lost for reasons linked to their post-immigration struggles, such as encountering structural, institutional and personal racism, loneliness, financial precarity, and academic pressure. Other women's pain was triggered by gender norms, domestic and sexual violence, and discrimination in the workplaces in Canada. In addition, the women used psychotherapy and psychiatric drugs not only to mitigate their pain, but also to be empowered to act as self-motivated individuals in a neoliberal culture in Canada,

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[8] It is noteworthy that when I use the term race, I am critical of its connotations and perceive it to be a Western imperialist concept that produces inferiority and docility based on perceived differences among different colour of people. However, it is also important to note that the new conceptualization of race as detached from the notion of "race as phenotype" is embedded into culture, space, and signifying systems, which devalued some people's lives while fostering others' benefits (Melamed, 2006, p. 2). These new types of racial formations do not depend on the colour line; instead, privilege and stigmas are defined by "ideological, economic, and cultural criteria," which is addressed as racialization. In the regime of neoliberal multiculturalism, racism often occurs through racialization, for example through harmful stereotypes such as all Muslims are terrorists, all blacks are criminals, and Latina women are sexually available (p. 2). Such racism is fostered through preservation of the notion of cultural difference and stereotypes against others (James, 2018).

as discussed in the Chapter One. These women arguably have assimilated subjectivities that focus on becoming self-empowered and self-motivated individuals, and as we will see, they internalized the discourse that psychiatrists help people to enhance their motivation to be empowered, autonomous, and ‘productive’ citizens in Canada. It also represents how these women privatized their struggles in keeping with neoliberalism’s encouraging people to take responsibility for their own suffering and cure.

This chapter, divided into six sections, reflects on racialized immigrant women’s pain and suffering. It is noteworthy that in writing women’s stories, basing their experiences in one specific category is difficult and at times problematic; diverse social subordinations combine as they traverse their use of mental health services, and each is equally distinct and important. Thus, while I have written women’s stories under a certain category, I am neither suggesting the category solely contributed to women’s suffering, nor is it possible to make boundaries among different intersectionalities that impacted women’s lives.

In part one, I discuss how women were affected by post-immigration struggles, and how this was linked with their use of mental health services. In the second part, I focus on how isolation and loneliness at home, school, and in other spaces in Canada have impacted their lives. In the third section, I reflect on how racism and gender norms combine to damage women in Canada. In the fourth section, I discuss how the pressure to succeed in spite of financial precarity contributed to research participants’ anxiety. In the fifth part, I shift my focus to stories of women’s experiences of domestic and sexual violence, and how this moved them to seek mental health assistance. In the sixth and final section of the chapter, I focus on how women’s pain was linked to discriminatory workplaces.

To frame the following analysis, I briefly reiterate my arguments regarding “mental illness” as discussed in the Chapter One; I follow a Foucauldian notion of mental illness as historically constructed and culturally situated (Malacrida, 2003, p. 23), and argue that certain people are constructed as ‘mad’ and certain human states and miseries are categorized as mental illness by the development of psychiatry in the West (Foucault, 1965). In addition, I employ feminist and postcolonial scholarship on mental illness that focuses on how different forms of social subordination and relations contribute to peoples’ suffering and sickness (even while the conceptualization of sickness is culturally varied).

For instance, as discussed in the Chapter One, Frantz Fanon (1961/2007), a foundational postcolonial scholar who was himself a psychiatrist, states that mental illness does not have a biological basis, as is typically claimed by psychiatrists; instead, the colonial structures and systems affected colonized people and create mental instability and other sicknesses. On the other hand, feminist theory explores how sexism, racism, and other intersectionalities can and do induce women’s pain and suffering (Brown, 2003; hooks, 1992; Mollow, 2006; Ussher, 2010; Waldron, 2002). In psychiatry, such women’s suffering is often divided into diagnostic categories (Lester, 2013; Ussher, 2010).

As noted earlier, I have employed a constructivist analysis of mental illness which challenges mental illness as ‘real’ and instead sees it as part of a truth that is constructed by medical sciences, psychiatry and other related disciplines. Such an interpretation risks denying the real and material effects that are produced by the particular (though contingent) ‘truth’ of mental illness. In my research, I have addressed this risk by using feminist standpoint theory to understand how each of the women experienced the effects of the ‘truth’ of mental illness and, therefore, how these women both interpret their suffering and become motivated to use mental health services.

Post-immigration Suffering: Jisa's Stories

While most of the women I spoke with discussed experiencing post-migration struggles in some form, Jisa disclosed that her use of mental health services was specifically linked to confrontations with the new society, culture, and education systems she encountered. Jisa is a 23-year-old undergraduate student who migrated from Latin America to Canada with her mother and younger brother in 2011, when she was 13-years-old, to join her father who had moved to Canada in 2007. Jisa, her mother, and brother waited for four years for their Canadian visas in order to join Jisa's father. Before immigrating to Canada, Jisa's father held a senior position in a beverage company; however, anxious about losing his job due to the recession in his country, he moved to Canada and took a menial job.

When Jisa and her family immigrated to Canada, it was January and "the temperature was -43," which shocked Jisa as she had never experienced such cold weather before. Her family lived in a rented house in a small town of about 1000 just outside of Lethbridge, where "there was nothing to do" and they even needed to travel into Lethbridge for groceries. Public transportation was not available, and for several years they depended on Jisa's distant uncle for rides. While Jisa was initially excited to come to Canada, she became unhappy with their living standard and lack of facilities in the small town. To her, life was more comfortable in her country, where they owned a house with new furniture and a television, things they lacked in Canada.

Jisa mostly suffered at school due to her unfamiliarity with the education system and inability to speak English. Jisa recalls being sent to school with her brother alone the day after they had moved to Canada:

> We could not speak in English, we went there by ourselves and we were super scared. My dad told us, when you get to the school, just get out from the bus and we did, we walked to the school and we did not know what is going on. The principal saw [us], but she did not know who we are. She said: "are you here by yourselves?" We said: "yeah," and she took us to a room, and she called our parents, someone needed to be with us, but dad did not go with us because he wanted us to go by ourselves.

Jisa's father had sent them to school by themselves as he wanted them to be independent, reflecting his own internalized norms about the importance of independence in Canada. However, to Jisa, having just arrived in Canada she did not yet feel she was in a position to be independent, and going to school alone was frightening. While school in her country was a site of excitement, she recalls feeling nervous about school in Canada. She soon began feeling shame about going to school as she could not speak English or read and write like her peers, experiences that were compounded by the way her teachers responded to her:

> I was in the class, and the teacher was teaching, and everyone will be doing homework, and the teacher will give me like a picture, and asks that if I can call [describe] this picture. I was doing as the kindergarten student does. For a while, I did not get any textbooks. I did not speak any English, so I was not learning anything.

Eventually, Jisa received some support from her English teacher, who realized that the language barrier was preventing Jisa from learning. Over the course of the next year the teacher focused on helping Jisa learn English; on her own, Jisa spent time for years learning the language.

Jisa's experiences speak to Laurie Olsen's (2000) contestation that accommodation for diversified languages in schools is largely lacking, forcing immigrant children to learn the English language quickly in order to be assimilated at school, an experience they find shocking and difficult. Jisa's inclusion in the school community further depended on her ability to set aside ways of learning that she was familiar with and adapt to Canadian education curriculums and that jeopardized Jisa's culture and previous knowledge, impacting her self-concept and well-being significantly.

Jisa's stories also echo Sara Ahmed's (2000) assertion that multicultural countries situate immigrants as strangers in a new society, as they often do not receive adequate services and as a result feel isolated. Jisa not only lacked support from teachers at her school, but found it difficult to make friends as she was isolated by white peers for her accent and misconceptions about her culture:

> [They]like make a fun of me, of my accent, for while I did not speak English very well. So, being a bit quiet and people will make fun of me and my country. One girl asked me if I eat only the tacos. She was mean and also asked me, "Do you guys have washrooms in your country?" One day, a guy made a lot of comments about my accent and my culture, and my teacher did not say anything to him in front of the other students. She did not make the boy apologize to me. That means that boy did not do anything. I felt sad, disappointed and yeah, I would go home and cry for like every day to get better [Jisa began crying].

As the excerpt reflects, the microaggressions Jisa experienced in conversations with her peers went unchecked by teachers, which significantly impacted Jisa's integration into the classroom culture. While Jisa expected her teacher to confront situations of racism in the moment, she instead found herself being apologized to without other students present. Shockingly, Jisa further reflects on the humiliation she felt when her teacher conveyed the same negative attitudes and stereotypes towards Jisa's home country; at one point, her teacher recalled being told that in Jisa's country people do not know how to use indoor plumbing, conveying a perception that white 'culture' is clean and progressive, while other cultures are dirty and atavistic. This exchange deeply hurt Jisa, through such enactments of disciplinary power came to internalize the position of an outsider in her new country, and disappointedly learned to expect racism at school.

Numerous scholars argue that racialized people often experience humiliations and insults, verbally, nonverbally, visually, consciously, and unconsciously, and that although this is deeply harmful, these humiliations become so normalized that are hard to trace and racialized people often adapt to this normalized situation (Solorzano et al., 2000). Racialized people learn to see and evaluate themselves through the eyes of white people (Du Bois, 2007; Fanon, 1961/2007; hooks, 1992; Mollow, 2006), which creates a threat to self-evaluation and that produces deep "social-psychological predicaments" in their lives (Steele & Aronson, 1995, p. 797). Reflecting these ideas, in response to her frequent experiences of racialization, Jisa told me she developed a belief that she was worthless, and her self-confidence was ruined.

Jisa felt ashamed and angry as she often felt treated as though she was stupid and backward at her school, and she often cried at home: "I never cried at school, but I would go home, and cry and my parents would ask me what happened, and I would tell them." Because

Jisa was sad all the time, her father asked her if she wanted to return to her country, but she did not want to “give up.”

Jisa’s additional responsibilities in Canada contributed more to her suffering, as she was required to be the bridge to the white/English world for her family:

> When I first came here, my dad was always working, my mom did not speak English, my brother was younger. So, I was the one or oldest, who spoke a little bit of English. So, the responsibilities fell on me. For example: going to meetings, going to the doctor with mom, or going to the bank or making phone calls, and I remember, I was so stressed all of the time. It was really strange because I was trying to survive. Now, when I think about it I feel it was really bad. I remember being stressed and scared all of the time, every day, all day for maybe two years.

Jisa’s stories reflect the additional stressors placed upon immigrant children, particularly those of the working class, when they lack proper supports in a new country. In another passage, Jisa discussed how she felt nervous and scared, and how her heart pounded in the dominant culture:

> When I went to stores, I could feel my shoulder and my stomach get sick for a long time. I think when you are younger, people do not respect you as much I think, and when you have accent. I have to do things for my parents. I was always stressed. With friends, I was always self-conscious. We have lot of differences between us.

The feelings Jisa describes having in an English-speaking white space illuminates how speaking English is generally considered a fundamental requirement of inclusion. It is not just a medium of communication, but it is seen as “the social and political marker of *affiliation and belonging*” in the world (Olsen, 2000, p.197 [emphasis added]). Further, Jisa's nervousness in front of white people reflects the work of Franz Fanon (1961/2007), which explores how Black people feel nervous in front of whites, and how this is associated with the historical and colonial construction of Black people as inferior and backward. Fanon (1961/2007) explains that when Black people come into contact with the white world they go through an experience of sensitization, and their egos collapse because of their perceived inferiority. In the white world, racialized people develop double-consciousness; they see the world through both the lens of the oppressed and the oppressor, which alienates them from themselves as they come to view their identity as problematic and lacking (Du Bois, 2007; Fanon, 1961/2007; Gilroy, 1993). Jisa's stories suggest she has developed this form of double-consciousness in Canada, which was damaging to her identity and sense of self.

After years of hard work, Jisa received admission to an undergraduate program in 2015. Her last year of high school and first year of university went well; however, starting in her second year of university, life again became difficult due to her workload and study pressures. Jisa drove daily to the university from her small town, and in addition to her classes worked two menial jobs on a farm and in a restaurant. In the summer of 2016, Jisa's health got worse; subsequently, she began seeking mental health assistance, but she still suffers from her wounds. Jisa cried as she shared her stories of suffering with me, indicating the deep impact of her childhood post-immigration struggles as a member of a marginalized and racialized minority population in Canada.

Jisa believes that her experiences in Canada would have been better if she received more support, but "no one did anything to help to [her]." When Jisa told her father about her feelings of sadness, he told her to ignore it, which she did. After learning about the bio-psychiatric notion of mental health at university, she began labeling her sadness as depression; “now I think I was depressed. I think I had depression because I was sad, every day for like two years.” For a long time Jisa did not know about mental health services and did not seek help. Though Jisa’s family was loving, they could not provide her better support; in addition to the stress associated with her father working a menial job, all family members were themselves struggling to adapt to life in a new country and they “did not have time to think about” Jisa’s sadness.

Previous studies show that people generally migrate to Canada from the Global South because Canada is seen as a haven for migrants (Dua et al., 2005). Since the 1960s, Canada has claimed that it has a multicultural approach and that it welcomes immigrants and refugees and provides immigration support services to such people (Bannerji, 2000; Haque, 2018). However, as mentioned in the first chapter, people from the Global South often suffer after coming to Canada (Kirmayer et al., 2011).

While generally migration and settlement bring many changes in an individual’s life and the new social situations place people at health risk (Simich et al., 2005), racialized immigrants commonly suffer more because of their different cultural and learning backgrounds and because they often encounter racism (Kirmayer et al., 2011). Better settlement and social support from host countries are significant in reducing migrants’ stress (Simich, et al., 2005). In contrast to the dominant narrative, Jisa said that she did not get any immigration support in her small town. Jisa’s stories reflect experiences of structural, institutional, and individual racism, demonstrating how her age, class, ethnicity, language, and culture, alongside geographic inequities within Canada intersected to amplify her suffering in Canada, leading her to pursue mental health services.

Social Isolation and Loneliness

A sense of belonging is considered crucial for wellbeing, and people generally suffer when they feel themselves isolated from the mainstream (Hagerty et al.,1992). Several women participating in this research self-isolated from the dominant group in their new country as they did not feel they belonged because of their different identity, culture, interests, and because they did not conform to mainstream social 'ideals'. A few women described loneliness that was not limited to their new community, but that their loneliness at home caused considerable pain, leading them to use mental health services. Feelings of loneliness in the new community were amplified when they were alone at home, pushing some of the women I spoke with to pursue mental health services.

When I spoke with Nila, she was 23-years-old and a fourth-year undergraduate student. Nila moved to Canada from a country in Latin America with her biological father and stepmother in 2008, when she was 11 years old. Nila's biological mother is an engineer, who after divorcing Nila's father migrated to another country. Nila's father, also an engineer, came to Canada because of the economic crisis in their home country, and given his occupation found it easy to move and quickly find a good position in an Albertan oil company.

Similar to Jisa, Nila did not speak English when she first moved to Canada, and she discussed being considered "stupid" for not knowing English not only by her peers, but also by her teachers. However, unlike Jisa, Nila quickly overcame the language barrier in Canada. Nila discussed how her studious behavior helped her to learn English, and in only four months in Canada she began correcting the language of native English speakers. As she relays, "English people are terrible at their language." Nila categorized herself as a 'nerd' and said this was a benefit in her home country because her classmates relied on her for notes, which helped her make friends. In Canada, however, Nila's academic obsession became a matter of humiliation as her peers insulted her, calling her "dictionary girl" or saying she "talk[ed] like a dictionary," which was hurtful to Nila.

Nila had experienced loneliness in the past, notably triggering psychiatric care when she was six years old, although she described this as having been taken care of. She notes that these intense feelings returned when she came to Canada and her father put her into different activities, such as a gifted kids program, drama camp, and on a soccer team so that she could make friends. Nila says she was fairly good at these activities, but she "could not make friends, or even made a few, but those did not create a lasting bonding" as she and her peers did not have shared interest:

> So, there were a lot of phases during my junior high years, where everyone was interested in some YouTube videos, or there were people who were talking about a Second Cup VS. Starbucks. And I was like I do not go to either of the places and I do not know what you are talking about. So, because of that, I was not able to participate in general social behaviour, and because of that, it was fairly difficult for me to adapt socially. That is not saying that I was much more popular in my country, but it was different.

Further, Nila said that she felt excluded as her peers often focused on her 'origin' and accent:

> You know, there this kind of ethos of to be a Canadian that we are nice, we are accepting multicultural people, and then every time you introduce yourself to someone, the first thing come out from their mouth is "hey where are you from?" That creates an instant barrier, where you do not start the conversation as a peer of equals who want to interact.

In Nila's stories it can be seen that even though she had more family and community support compared to Jisa, she still did not feel that she belonged in Canada, specifically because she and her new peers did not have a shared culture, but also because of her peers' constant focus on her origin, ethnicity, and her perceived difference.

Additionally, Nila discussed feeling alienated from her identity in Canada; in her country, she was considered white, but in Canada she was told that she was "not white but a Latin American[9]." This distinction was not one Nila could accept, and she developed a fractured consciousness with her identity; to herself, Nila is neither white nor Latina. Nila was also disgusted by her peers' expectations of 'exotic' behaviours from her based on presumed cultural stereotypes. Nila noted that:

> I was not Latin American until I came here. So, given that, it is always like a surprise when people expected weird things from me. Like being able to eat spicy foods or being able to dance. I was hungry one time and a white woman gave me chicken to eat. Then after while I was like why is my tongue burning? Why is my mouth in pain? I was not understanding what is happening, I was having an allergic reaction. Then, she told "oh I am sorry it was spicy chicken." She gave me some spicy foods as she assumed that because I had darker skin, I would be eating spicy food.

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[9] In Nila's country, if people "are not black, not Chinese, not Muslims and not Indians, their class is white"; Nila further elaborates, saying "it does not matter if they have blonde [hair] and blue eyes." This distinction is notably different from Canada, where to be classified as 'white' assumes specifically European ancestry and is not solely linked to skin tone.

As the above excerpt represents, in social situations people often rely on skin colour to categorize ethnicity and cultural identity, which echoes some scholars’ assertion that skin colour/race, culture, ethnicity inform each other in labelling one’s social location (Haque, 2018). In other words, today human race is not only defined by one’s “phenotype” but the cultural practices by which one is labelled as Black, Latino, Middle Eastern, Indian and so on.

Nila’s stories also reflect Rey Chow’s (2002) notes on how racialized people’s inferiorization has been rearticulated in multicultural and neoliberal countries, such as Canada claims to be, through the notion of the exotic Other, a Western imperialist concept discussed in the Chapter One. Chow (2002) notes that white people produce knowledge about ethnic identity and then encourage ethnics to adhere to such behaviours in order to highlight differences between white people and the colonized, in a process which she defines as mimeticism. Historically, mimeticism operated by compelling ethnics, or colonized people, to mimic the supposedly superior colonizers’ culture and language and abandoning their ‘inferior’ subjectivity. Conversely, in the era of liberal multiculturalism, mimeticism operates by compelling ethnic people to act like the ethnic stereotypes that are held by the proponents of ‘liberal multiculturalism’, a process Chow terms as coercive mimeticism.

Through her experiences, Nila came to believe that although Canada is reputed to be a multicultural country, she would never fit in. In addition to social isolation among her peers, she was lonely at home as her “dad was very busy with work and stepmother was very, very busy with a one year old and then two-year-old.” Nila would pass her leisure time on the computer, by watching things in her room, or by babysitting her half-siblings, and she missed her parents’ care:

> I remember, my little sister was screaming, and I went to help her, but I could not help her because my head was shooting up in pains and I was just like crawling up against the wall. I started trying to breathe and I could not breathe, and my heart was going to explode, and I was crying may be ten, twenty minutes. My stepmother knew I was crying, but she was busy with the three-year-old. So, she could not do anything. My dad came in and he saw me freaking out and crying and he misunderstood me that I was freaking out as my sibling was crying.

Nila said that her ongoing feelings of loneliness contributed to “depression” and frequent panic attacks at the age of 13. Relating that at one point she asked her health class teacher how she could get over-the-counter antidepressants. Nila describes her teacher as being “horrified” by her question because she was only thirteen. The teacher subsequently took Nila to the school counselor, and Nila then continued to see the school counselor occasionally throughout middle and high school. However, Nila said that these mental health services did not help her to overcome her feelings of loneliness, which she continued to feel both at school and at home.

When Nila began her undergraduate program in the Spring of 2015 she describes herself as being happy, in part because she lived in student residence where she could enjoy a variety of activities at the gym and meet people. However, because of the high cost of residence she moved to an off-campus house with other students, where she was unable to make friends with her roommates because they saw her as “disorganized, hostile, angry, and intimidating,” even though Nila feels she is none of these things. Nila described these assumptions about her demeanour being common, and the reason behind why she could not make friends.

Several other women I spoke with, in particular those who came to Canada by themselves as international students, suffered from loneliness in Lethbridge. This was influenced not only by missing their families, but also by the diverse challenges they experienced as they adapted to a new society. Lamia's stories in particular are illustrative of this point. Lamia came to Lethbridge for her undergraduate studies. She is from an African country where she noted that she received huge family and community support in her life. In Canada, Lamia struggled with managing her day to day life alongside the acculturation challenges she faced, which often induced her pain. Lamia pointed out that Lethbridge is white-dominant, and she saw life in Lethbridge as individualistic; as compared to her country, people in Lethbridge have far fewer connections with each other. Lamia said that in Lethbridge, people often do not even know their neighbours, which was shocking to her as she came from a cultural background where community ties are significant.

Lamia told me she missed these ties and the cultural connections she was used to, and that she struggled with the need to be independent. She was used to dependency not being seen as problematic, and sometimes felt at odds with her cultural learning about dependency in Canada. Lamia did have some community connections in Lethbridge that provided her comfort, yet she noted that sometimes, she missed her home and the familiarity of things like the food she was used to so much that, combined with the other stressors in her life arising from school and work, she felt "depressed." Lamia sought mental health assistance for her "depression" as she thought it would be "a healthy way" to solve her problems.

Sasha also mentioned that one of the reasons she sought counseling services at the University of Lethbridge was a lack of family support, coupled with feelings of alienation and helplessness in Canada. Sasha came to Canada in 2015 to begin her undergraduate program at the encouragement of her aunt, who helped Sasha immigrate because "more qualification and more achievement are possible in Canada." Sasha's aunt completed all of the paperwork for

Sasha's Canadian student visa and university admission. Although Sasha received support from her aunt for the first year of her undergraduate degree, their relationship began getting worse during Sasha's second year. It was at this time that Sasha began feeling stressed and helpless, and sought out mental health services:

> I had to talk to a counselor how I could improve my confidence, my learning skills, and to know what is best for me. So, I have to do all of these by myself because my aunt was not there for me to talk. So, I had to coach to do better.

Sasha recalled being extremely stressed and alienated at the beginning of 2018, when her relationship ended with her aunt, who had asked for Sasha's banking password, which Sasha denied to her:

> I was thinking again and again; can I say no. I know she was looking everything of me. But I felt I will not give access this time. I did so much for them. I tried to please them all of my life even when my aunt asked me let's go to the [Christian] church. I did not want to go to the church, but I went because she asked me to go to the church, even, when it devalued my belief because I pray. I am a Muslim. I do most spiritual things and I don't like singing in the church, but I did not complain.

Sasha describes the fallout from her decision to keep private some things from her aunt as being "very ugly:"

> I always pleased every parties, and at the time, I did not want to please anybody because I know the only person I can rely on is myself. I can help myself. I felt like a child, and I do not want to feel like that way. I felt I should start taking

> some responsibilities for some decisions. That was how everything had cut. This time I did not give my password and it was really very ugly. Yeah, I am still technically in stress.

Sasha said that while she was raised in, and her family remained committed to, a more self-sacrificing culture, Sasha was learning in Canada to be more individualistic. Her community prioritized being a caring, submissive, passive, and loyal woman who prefers family members' need over own, whereas, in Canada, individualism, privacy, freedom are considered important for persons' wellbeing. As a result of learning self-reliance during her time in Canada, Sasha realized that she needed to prioritize her needs over her family. However, Sasha was stressed with these changes and the reality of balancing two different cultures, and the backlash from her family to her new independence only added to her loneliness and alienation.

Several other women I spoke with who also experienced loneliness in Lethbridge pointed out that they were unable to celebrate their culture in the small, white-dominant city, as they were unable to even find specific foods and supplies. Natasha and Jillian discussed how in the bigger cities in Canada where they had lived, they had options to celebrate their culture and foods, which gave them a sense of home and belonging in Canada that was absent in Lethbridge.

Sara Ahmed (2000) notes that in Australia, multiculturalism means nothing more than to share and display the culture of immigrants, and multiculturalism permits immigrants to practice their culture as long as they are not seen as threatening to the dominant culture. Conversely, it could be argued that when most of the rights of immigrants are devalued, having such opportunities to practice some of their culture and values gives them some comfort and feeling of social integration. However, even such options are also limited in Lethbridge, unlike the big cities, and several women I spoke with experienced cultural deprivation and that increased their destress, longlines, and alienations.

Racism and Gendered Norms: Mary's Stories

While most of the women described instances of being insulted due to their ethnicity and culture, two of the three African women I spoke with experienced pervasive racism in Lethbridge because of being Black. Mary described how she began using mental health services because of these racist experiences and her shame for failing to be a normative woman, and that later continued psychotherapy to empower herself.

Mary moved to Canada as an international student in December 2011 when she was 20 years old, to marry her white (now ex) husband, whom she met in her home country. An extremely competent, independent, and confident person, Mary earned her Bachelor's degree in Psychology in 2013 only two years after her arrival, at 22 years of age, and she accepted a job in the field immediately after. She also accomplished her Master's degree in counselling while working as an educational assistant in a local school division. When Mary finished her Master's degree, the school division hired her as a family counsellor because of her competence.

After leaving her home country in Africa, but before migrating to Canada, Mary lived in a large city in America for four years; when she came to Lethbridge, she was shocked at the city's small size and lack of facilities for racially diversified people. Mary did not think that it would be so hard to find Black people in Lethbridge, but "only 10 Black people were here in Lethbridge in 2011." In America, Mary had many African American friends and felt comfortable living there, but in Lethbridge she did not feel the same: "I remember, when I went for my social insurance number, I sat down and looking [around the room] I was the only Black person. Everywhere I go, I will be looking, oh, I am so nervous, it was so uncomfortable."

Mary was anxious about making friends with white people from Lethbridge in particular, as she found them to be "so cliquey and [they] do not like Black people." It was difficult for her even making friends with her white ex-husband's family:

> My husband's family never let me in because of my colour and race status; so, they were very discriminatory to me. Like when I met first with his sister, she thinks I am a gold digger. You know what a gold digger is, it is like women get married to get money from the husband. His sister told me I married her brother to get papers in Canada. Those things were very hurtful for me to hear. My husband said his mom was racist when she was alive. She did not like Black people. So, it was tough. It was really tough.

It was difficult for Mary to discuss the exclusion she felt in her ex-husband's family because of their continuous focus on her identity. To Mary, "[t]hey were not nice people; very two-faced, very manipulative, and he was aware of that. His sister would often roll her eyes at me." After her sister-in-law continued to make "more nasty comments" based on Mary's identity, she cut off contact and the two never spoke again.

The presumption that Mary married a white person to get Canadian citizenship was particularly hurtful to Mary's pride, as she worked extremely hard as an international student to build her skills and survive in Canada on her own. The comments made by Mary's sister-in-law arguably stem from the stereotype that acquiring Canadian citizenship is a huge opportunity for racialized people (Dua et al., 2005). Further, the humiliation Mary expressed feeling over her Black identity could be understood as a result of the centuries-long systems that value white people over Black, and historical fears of racial mixing. This political construction of racial superiority enforced the subordination of Black individuals as slaves, as discussed in the Chapter One (Sollors, 2000). Preservation of these perceived racial divisions and assumptions of the racial superiority of whites meant that interracial marriages, and even interracial relationships, were legally prohibited in many parts of the United States until the Civil Rights Movement of the late 20th century. Though Canada had no formal laws banning interracial marriage, the stigmas were just as common, and racist sentiments seen in the US were echoed in Canada[10] (Bielski & Chambers, 2017).

Prohibitions on interracial relationships were further imbalanced; stricter constraints on relationships between white women with 'negro' men compared to white men with Black women were common (Sollors, 2000). Stereotypes against Black women constructed them as sexually immoral, positioning them in the lowest category on the scale of human development, and granting white men a great deal of informal sexual access to them (Hammonds, 1999, p. 94). Although interracial marriage was federally legalized in the US in 1967, it was still relatively uncommon until the 2000s (Sollors, 2000). Situated in this historical context, the comments by Mary's sister-in-law can be read as part of a long history of anti-miscegenation and racism.

Mary was not only upset with her sister-in-law's attitudes, but also with her ex-husband's collusion with them, as he "never defended [her in the way] that the husband should do" as he was "was always scared" of losing his family. While Mary described him as "a clown of all

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[10] However, it is noteworthy that although there were no laws against interracial marriage in Canada, Indigenous women lost status through marrying out based on the Indian Act (Lawrence, 2003).

parties," she also notes that he "was an anxious person and was always drinking and smoking" and says that he could not confront his family members' racism toward her. Mary further discussed a visit by her mother in 2013, when her ex-husband failed to address racist behavior by his family during a group visit, shocking both Mary and her mother.

However, Mary said that not everyone in the family was racist; Mary's stepson and her father-in-law were accepting of her, but "other people in the family were just messed up. Like they did not have a proper attachment in their lives. So, they did not know how to be nice to people." Due to these experiences, Mary used to be "so anxious to go to their houses." For example, Mary recalls, "On Christmas morning, I would be walking back and forth, I do not wanna go, but we have to go to their house. I do not wanna go."

Mary "grew up in a loving household" with eight siblings on a farm with pigs, chickens, and goats. To Mary, family life was full of love and support; however, in Canada, family became a place of humiliation and fear. Because of her continuous experiences of humiliation, Mary even had suicidal ideation:

> I was really stressed with my husband's family. I never had thought to hurt myself, like I had a good family structure. Never had thought about hurting me even when things get really big, but I found when I moved here, and things got tough in my family life in my husband's family, I was like may be if I die all this will go away; sometimes, I thought I could run away to the mountains.

When Mary was in tremendous pain, she only discussed it with her ex-husband, because she was embarrassed to tell her friends and family that her "husband's family hates" her because she is a Black woman. Despite her pain, she received little support from her ex-husband, who told her to "just get over it." Due to such experiences Mary divorced her husband; however, afterwards

Mary began feeling guilt and shame for failing her marriage and she began feeling withdrawn and lost in her daily life. At this point, Mary decided to talk with a psychotherapist:

> Going through my divorce, I had so much shame and guilt; I was not a good wife, so I broke up with him. I was not a good wife, so I could not maintain my marriage. So, I had a lot of shame and guilt around my divorce, and in my culture, people don't get divorced. So, everybody is talking about it, like in my family, like, my relatives like 'oh my God she is breaking up'. So, I had a lot of shame and guilt around that, and I went to counseling and I was open to it.

Mary felt such guilt because in her community, a failing marriage is seen as a moral failing, even when husbands are abusive. Mary explained that her parents remained married despite her father having multiple affairs. Not only was divorce uncommon in their culture, but women are emotionally and economically dependent upon men. Further, Mary noted that women's sacrifices are valorized, and it is held that women should take care of their families even to the point of compromising their own needs. To Mary, it was culturally important to keep her husband and his family happy, however abusive he may be; through his happiness, she would achieve happiness.

While Mary appeared critical about women sacrificing themselves and seemed to value independence and autonomy, she still judged herself over failing to be 'good' wife, reflecting her internalization of her originating culture's feminine ideals. That said, Mary revealed another fear related to her divorce, demonstrating that social exclusion related to 'failed' relationships is not culturally specific:

> I was anxious about not only my community people, I was also anxious about Canadians. I worked in a religious school division, divorce is not a norm, and so, some of [my shame and anxiety] was because of here. If my boss knows about my

> divorce, obviously they will not fire me, but it's still frowned upon because it is a religious school. Yeah, it was not only my country people, it was all about this.

Mary's stories support Judith Butler's (2009) assertion that women suffer when they do not conform to gender norms, as these norms function as ethics and morality in society. When transgressing norms, people not only feel excluded, but become vulnerable in accessing elements of society at institutional levels, particularly those where heteronormativity, marriage, and motherhood are regulated and maintained. In Mary's stories, we can see how her suffering was intersected by racism and gender norms, which led her to seek mental health services.

While Mary initially began psychotherapy for her "depressive feelings" associated with racism and her failed marriage, she continues to receive counselling because she says it helps her organize her life in a better way, to be a strong person, and to make "boundaries in her job as a Black person":

> Yeah, I have always paid for my counselling. I treat my counselling and my mental health the same way that I treat my massages and spa. I think the main thing for me is self-awareness and empowerment. I go to counselling to know what I am adding to my life. So, that is a lot of empowerment, like self-awareness like who I am as a person, like lots of soul searching and also setting up boundaries and being able to maintain that. Like, in my job, not allowing people to boss me around and put me down, because I found that kind of stuff grew a lot when I went to counselling, you know these are my boundaries.

While on a personal level, Mary's continued use of mental health services to mitigate her pain but could be read as a story of empowerment, it is worth considering that it is also a form of assimilation with the Western notion of mental health. In this Western idealized subjectivity, the self-motivated individuals internalize the discourse that psychiatrists are required to help people enhance their motivation and be empowered, autonomous, and ‘productive’ citizens and therefore private (Teghtsoonian, 2009). Mary’s stories illuminate how the causes of mental health challenges were privatized, and not seen as the result of living under white supremacist heteropatriarchy. Mary’s stories also represent the ways that discourses of mental health can be enabling for women even if it constrains possibilities for what it means to be counted as a productive citizen.

Financial Precarity and Academic Pressure

While Sasha also discussed experiencing racism in Canada, she noted that other stressors including financial precarity, academic pressure, and emotional abuse contributed to her anxiety and led her to seek mental health services. Before discussing these issues, however, I will explore Sasha’s experiences with racism, specifically as a Black woman. Throughout my small sample, the Black women I spoke with experienced more instances of racism compared to lighter-skinned respondents.

During the first year of her undergraduate degree, Sasha lived in a student residence. She felt uncomfortable living there because of her skin colour and because her options for food were limited and entirely different from what she was used to. Sasha also struggled to cope with her white peers, and she believes some of them saw her as polluted: “One of my roommates was like: ‘Oh there is a Black stain in the bathtub in the washroom.’ I do not know what she was thinking. I have Black skin, so I put a Black stain in the washroom.” This microaggression, insinuating that Blackness is damaging or polluting, was extremely disturbing to Sasha. We can speculate that encountering such attitudes not only demonstrated to Sasha that she was perceived of as other or less-than, and also likely conveyed to her that she had no place in the community.

Sasha experienced hurtful comments not only from her roommate, but also encountered such racism from store clerks:

> In Walmart, there are people who were watching my friend and me. My friend is from [South Asia], and I am Black. We were stepping from the store. We did not have any bags, then the person stopped us and asked, “can I see the receipt?’ Like she came to us by thinking we are taking things out of the store. She came like a security guard even though she was a salesperson.

The clerk’s suspicion of Sasha and her friend represents Henry Giroux’s (2006) assertion that Black bodies continue to be deviantized as criminal in the West. Sasha’s experience could be interpreted as being a result of the century-long dehumanization of Black people in the West through the institution of slavery. As discussed by Giroux, after the Civil Rights Movement in the US, Black peoples’ dehumanization was fostered through the production of criminally prone images (Giroux, 2006). Such dehumanization against Black people is also prevalent in Canada (Walcott, 2003). Sasha was frustrated by the attitudes of the store clerk, as these attitudes distinguished her and her friend from white shoppers, and both produced and reproduced their perceived inferior status as racial minorities.

Sasha struggled with the education system as well, but tried hard to be successful as the following vignette represents:

> I knew that I was lucky to be here. So, I tried to do everything just to make sure that I do not have regrets afterwards. I was really into studying and I was stressed

> because my aunt was paying my tuition and I felt like I had more responsibilities because my parents had responsibilities towards me, but my aunt does not, but she decided to give me support. So, I felt the pressure of doing my best, and I was trying to please them in every aspect of my life, even the education, the way I behave, I talk, everything. I felt that they are doing so much for me.

Sasha's struggles were amplified in her second year of university, when she lost financial support from her aunt. Although Sasha's aunt had promised to pay the costs associated with her undergraduate degree, when her uncle's salary was reduced a result of the recession Sasha no longer received money for tuition. At that point, Sasha had two options; either earn money on her own and continue her studies in Canada or go back to her home country. Ultimately, Sasha's uncle helped her take out a bank loan, but the financial stress impacted her immensely:

> So, because of that I have huge health issues, I was just thinking every day, and every time I study, I thought about paying back the loan. The semester when I got the loan was so bad. I did so bad because I kept thinking about the loan. In the next semester, my aunt did not talk about me and then I started thinking about "why I am fearing for, I could be in my country and anywhere else and I had to figure out myself."

Despite the financial stress, Sasha decided to stay in Canada and take on the challenges by herself, as to her: "going back to [my] country will be a foolish decision" and she would "miss the opportunity." Sasha also "wanted to help [her] family; so, giving up was not an option… [and she] just [kept] going." For Sasha, the challenges associated with staying in Canada were worthwhile, as they offered her perceived upward mobility. The university degree she would receive would equip her to succeed not only in Canada, but in transnational job markets. In neoliberal economic restructuring, Western education systems are generally legitimized as the best education systems for developing oneself and obtaining economic opportunities in the world (Rizvi, 2007). Sasha and several other women mentioned this reasoning as a strong motivation for staying in Canada, and as such, did not give up despite experiencing considerable emotional challenges.

From her second year of university onward, Sasha's life was split between studying and work; she recalls: "I had family issues, classes, payments, working. I had to start working, I had been working throughout last year. I think, in the last year, I was working three jobs, taking three classes all throughout the spring." It was an extremely difficult period for Sasha to manage her stress. As a method of coping, Sasha tried spiritual outreach:

> During the time one of my professors invited me for prayer session; it's like spiritual kind of meditation, just praising God. I was losing all things and I did not want to think negative. So, that was the only hope. So, I just kept praying and going for a kind of prayer sessions if I could. I felt belonging.

Ultimately, in the Fall of 2016, Sasha felt overcome by her struggles and she sought mental health assistance. Although Sasha had accessed mental health services periodically in the past, she began using psychotherapy regularly until the end of 2018 due to her multiple stresses:

> In my third year, I did not do well in exam, that shuttered everything; I lost my self-esteem and my confidence. I had family issues, it was really, really bad; my aunt did not talk to me like all semester. At that time, I had a genetics exam and that was really hard, and I went to take the exam and I could not breathe. I was like really could not breathe. So, I had to use the accommodation centre.

Because of family and financial pressures, Sasha felt helpless and could not focus on her studies. As a quiet, reserved person, she did not like talking with people. She often had panic attacks during her exams:

> I believe it was almost every time I write exam, either I have a panic attack, or I feel numb, like I go to the exam and I can't feel anything. Like, if I'm anxious I will do well, but when I am not, and do not feel the exam, my brain is like giving up. I do not know anything, and my brain is blank. It happens frequently in the end of 2016.

Sasha was so stressed during this time that she had suicidal ideations: "At the year, I had all the struggles, I was like mad, I googled the easiest way to suicide." The stress further triggered painful memories of sexual abuse in early childhood at the hands of an uncle back home and Sasha found herself again feeling the shame associated with this experience. Although Sasha told her mother of the abuse after the second time it occurred, and the abuse subsequently stopped, Sasha still carries the pain associated with this experience.

Academic pressure and financial difficulties were highlighted in the stories of several other women I spoke with who moved to Canada as international students, including Lamia, Jasmine, and Jenifer. Jasmine states:

> I went to take mental health services because my mental health was deteriorating because my grade was deteriorating because I could not handle getting bad grades. So, at that time, what happened is my supervisor committee fell apart, they had a conflict with each other and it was abandoned and that cause me to extend my study by a semester and that really throws your life plan off and because I was a good student all through my life, so it was a very big feel.

As reflected in the above quote, Jasmine found it difficult to accept that she did not meet her self-expectations in regards to academic performance, demonstrating the pathologization of failure in neoliberal culture as discussed in the Chapter One and the associated over-valuing of success; when Jasmine did not achieve her goal, she felt as though she was a failure. Jasmine's story also could be read through the argument that because international students are often ranked a top academic level in their country of origin, the same level of academic performance is expected in the country they immigrate to, despite new educational, cultural, and personal environments. When expectations are not met, students experience a tremendous negative impact on their health (Misra & Castillo, 2004).

Finally, Jasmine's difficulties arguably reflect the heightened expectations and responsibilities of new immigrants to succeed, as they and their families have often heavily invested in their success in the new country. Namely, if we examine the immigration policies of Canada, they privilege skilled, independent, and productive immigrants over those perceived to be unskilled and dependent (Van Houtum, 2010). Additionally, immigrants who do not depend on the state's welfare are labeled 'good' immigrants, whereas those who depend on such benefits are perceived as 'bad' immigrants. These perceptions are ultimately linked with the processes of acquiring permanent residency and citizenship in Canada.

Jasmine further noted that she experienced settlement anxiety as she finished her degree:

> The last semester was really tough because I was facing uncertainty about the job, like what next. I was confused if I should live in Lethbridge, or should I move to another city. So, I think everything came together and I was ignoring all the problems, which was not healthy.

Jasmine discussed concern over getting a job in Canada, because of the difficulties international students often face when seeking employment in Lethbridge. Because permanent residents and Canadian citizens are often preferred, fewer job options are available to them.

Jenifer was also affected by high self-expectations of academic performance, which was her primary reason for using mental health services. Jenifer noted that she was stressed and could not sleep or work after failing to meet the expectations of one of her committee members in a meeting. She was embarrassed for not meeting these expectations, and at upset at hearing disrespectful comments from the committee member. Jenifer blamed herself for failing to be well-prepared: "I like to be prepared, I really do not like to take risk. Yeah, I preferred to be able to control the things I can. I do not like the feeling of not being able to, the vulnerable feeling, I really really hate that."

When talking to me about this experience, Jenifer cried, reflecting her deep sadness. Her discomfort with vulnerability and perceived feelings of weakness could be read as a direct response to pressures of Canadian culture, which values independence, self-fulfillment, autonomous, active, strong, and well-organized subjectivities (Rimke, 2000). Jenifer was preoccupied with a recurring fear of failing to satisfy her committee member and that impacted her sleep, work, study and other social interactions. Because she needed to refocus herself on her studies, Jenifer chose to see a psychiatrist.

Domestic and Sexual Violence

Several women identified domestic and sexual violence as the reasons for their emotional suffering and seeking mental health assistance. Natasha is one of these women and she said that she was completely 'lost' by her parents' violence, in addition to her experiences with racism.

Natasha was born in Canada, as opposed to other women I spoke with who were all immigrants. However, her parents immigrated to Canada before her birth from an Oceanian country and now live in the large Canadian city of Natasha's birth. Natasha came to participate in my research after hearing from a mutual friend that I was seeking immigrant women to speak with. Natasha immediately emailed me and expressed her interest in sharing her stories of using mental health services. When I initially met with her and learned she was born in Canada, I was confused as to her identity as an immigrant, as my perception of the term included only people who were born elsewhere and had moved to Canada. I was hesitant to include her in my research, a reaction that was observed by Natasha; she repeatedly assured me that her experiences are those of an immigrant and racialized woman because she is labelled as such in Canada. Natasha's experience reminds me of the challenges and potential problems with categorization in qualitative research; as such, because of her self-identification as a racialized, immigrant woman, I include her in my research.

Natasha described a poor relationship with her parents, who abused her and her brother from childhood. Natasha relayed disturbing instances of physical abuse, such as her brother being drowned in the toilet and locked in the bathroom as punishment, and herself being physically assaulted and locked in the house, in addition to a range of emotional abuse; "[m]y parents forced me to speak English when I was a little kid; I had a trouble with my English because I wanted to relearn ['mother tongue']; my mom was like you have to speak English because you are Canadian." Natasha was further forced to bear unreasonable responsibilities at a young age; "[w]hen I was a little kid, like three years old, my parents would just send me to cross the road and when I was five, I was told to take care of my two-year-old brother and I did." For Natasha, home life was profoundly hostile:

> Every single morning, my dad would be yelling, my brother would be throwing a plate across the room, my mom would be screaming, and they all would be fighting and then you go down, they start punching you, and you also punch them, and pretty much your dad also touches you at night.

As intimated, Natasha was also sexually abused by her father almost every night. When she informed her mother, she did not take it seriously as she believed, "as a father, he can do anything he wants". To Natasha, her "mother is a stupid person, who does not have basic things"; thus, she could not save her. "My mom is very anxious about everything and also very dumb. She believes crazy things and then go[es] crazy. My mother struggles with insanity, like my dad is a pedophile [laughing] but he is at least smart." According to Natasha, her entire family struggled with mental health issues, including schizophrenia; "[a] lot of them see and hear things and come up with strange ideas, like [my] uncle locked [my] grandmother in his basement with no food and water and that was his fun…They are just crazy Hindus." Despite recalling hearing the slur "crazy Hindus" used by her white peers and strongly disliking it, Natasha categorized her mother in a similar way, arguably reflecting her internalization of such stereotypes against her community, or at the very least using these tropes to distance her family from personal responsibility for their abuse.

Natasha said she became "violent and brutal" living in such an abusive environment, and as an outlet to her frustrations sometimes punished her cat. She also turned her frustrations inward and self-harmed on numerous occasions, in addition to attempting suicide:

> I just cut myself, like on my arm with the knife, or harm with a safety pin or scissors. I also tried to overdose a lot with my medication and a lot with alcohol,

> like combining the two. It says that it kills you, but it did not, but made me really sick. I was like, oh why I did not die.

Natasha said that she harmed herself to ease her pain:

> Because all the things I was going through. You have to take out your pains somehow. If you can't not take it out on your parents because they are physically too big, and you can't hurt them, you have to hurt yourself. Now I am older I have a better way of taking out pain. I used to do when I was younger because when you are younger, you don't know how to express your emotions very well. It's not a big deal, it's just my life. I know it's different than most people's, but I don't mind.

Natasha further describes telling her mother of her suicidal thoughts:

> "Mom, I wanna go bye bye. I do not wanna live," but my mother did not care. She was like "life is hard, honey!" That's how my mom and dad's mentality, life is hard. They were like you have to be tough. So, I guess they gave me really a hard life.

Natasha says her parents wanted her to be a tough person and have a successful career as a doctor, but Natasha did not succeed academically. Natasha eventually went to school for a nursing degree but left as this was not the career she wanted. To Natasha, her parents' approach to discipline and punish kids had a lifelong impact on her. Natasha identifies herself as having "borderline personality disorder," and suggests "maybe all the adverse experiences in my childhood led me not to trust people. I never trusted my parents because they did not provide safety and I never trusted friends because they can just leave, most of the time people leave." As a result of her tumultuous childhood, Natasha prefers to be alone and avoids people.

Natasha's struggles were not limited to her home life, but also occurred at school and in the community. She describes being isolated both from her white peers and from children in her community at an early age; because she could not speak in her mother tongue she could not make friends in her immigrant community, and beginning in kindergarten she was rejected by her white peers who called her a "dirty girl" because of her brown skin.

Later in life Natasha was sexually assaulted by a group of white men, which she attributes to that "white guys, some of them are really into exotic women; they will assault you." She recalls often being addressed as pretty and 'exotic' by white men.

> Lots of white guys did it with me. Once I parked my car outside my apartment complex and I was walking and there was five drunk guys and they got me in the corner and the guy started unzipping his pants, but I distracted. That time I was not assaulted as everyone was drunk. This was in [city name], which is the most dangerous place to live in Canada. It was happened to me so much times, so it is not frightening anymore. I got used to it. I am a kind of weird one, that is why I went to mental health services.

Natasha's stories illuminate an example of targeted sexual harassment; because of her skin colour and presence in a white space, Natasha was subjected to derogatory, racialized language and behavior. Natasha was not only treated as 'exotic' but also explicitly sexualized, eroticized and victimized at least in part because she is brown. In the excerpts of my conversation with Natasha, it becomes clear that she has numbed her emotions and response to the frequent sexual violence she has experienced.

In addition to the issues outlined above, Natasha notes that a car accident in 2017 further exacerbated her mood and depression:

> It’s gotten significantly worse – all my mental issues since my brain damage because the parts that got hit and destroyed are my emotional regulation part and short-term memory part. That’s why my memory is super-duper bad. There is a picture of my brain. There is actual visible hole, three millimeters across. The accident made my depressions exacerbate. It made it worse and to the point people can notice because right after accident, my mood was going like so happy; OMG everything is great and then five minutes after I hate myself and I wanna die [laughing].

In 2017, Natasha left her hometown for Lethbridge, fleeing an abusive relationship and seeking a better and safer place to live. At the time of our discussion, Natasha describes herself as being “completely mentally wreck[ed] right now” but says she was even worse in the past: “I could not function with anybody, I couldn’t even get out from the bed. I had to really push me to run away; it was scary. I ran away two years ago.” Natasha started working on herself after moving to Lethbridge. Frustrated with her life, Natasha sought mental health services in order to establish a sense of normativity.

Beyond her mental health, Natasha addressed an additional struggle she faced after moving to Lethbridge. Upon moving, Natasha began experiencing significant racism, which she attributes to Lethbridge being less culturally diversified than larger Canadian cities, and primarily populated by white settlers: “I came [to Lethbridge] and everyone thought I was Muslim, and everyone kept yelling out ‘hey where is your hijab?’ Also, they think that I am Syrian. They think that all brown people are Syrians, oh my gosh!” Further, Natasha experienced negative stereotyping based on presumptions about her cultural background, despite spending her entire life in the West. Natasha explained:

> When I came [to] Lethbridge, my landlord automatically assumed I can't speak English and I was poor. He assumed that I am not from here, he was like: "Where are you from?" I was like: "I was born here," "But you are brown." I was like "why do you think if you're a different colour you're automatically born elsewhere?" He thought I was oppressed, like how women in the Middle East are oppressed.

Natasha's landlord's assumptions about her class, language skills, and presumed gendered victimization reflects common racial stereotypes about many colonized societies (Abu-Lughod, 2002; Mani, 1987). Many postcolonial feminist scholars challenge presumptions of Middle Eastern women as oppressed, arguing such depictions are problematic and political as they shore up beliefs about the cultural backwardness of such people, and legitimate Western colonization and beliefs of Western superiority (Abu-Lughod, 2002; Mani, 1987).

According to Natasha, "these comments provide cultural distance because ultimately, they identify me as an [the name of her nationality], I guess." Such stereotyping certainly damaged Natasha's identity and self-perception and contributed to her pain and anger. This type of self-hatred calls to the of work bell hooks (1992) and Franz Fanon (1961/2007) who explore how racism contributes to self-hatred of Black people in the West. There are more stories of Natasha's racialization in Canada from her childhood. Natasha's story illuminates the multiple forms of violence and particularly sexualized violence that are intertwined from racialized women – while her issues originate in a family that clearly struggled with its own cultural and transitional wellness, those problems became amplified through experiences in the broader community that compounded her sense of herself as a sexualized and victimized racialized woman.

While Natasha traced the root of her struggles to emotional, physical, and sexual abuse perpetrated by her parents, Moumi linked her feelings of being lost, hopeless, helpless and uncertain in Canada to domestic violence. Moumi had an arranged marriage and moved to Canada from the Middle East in 2008. After migrating to Canada, Moumi faced adaptation challenges similar to those described by other women in this research, such as lacking friends, having no family or community support, not knowing how to access support systems, and struggling to speak to people because of her grasp on the English language.

However, Moumi's main source of suffering came from her husband's controlling attitudes in every aspect of her life. She said, "He had a lot of control in my life, where I go, what I do, who I see, what I wear, everything; he even beat me once as I was screaming." Moumi's husband did not want her to study or work, and when she wanted to apply to university, he lied and told her that the Master's degree from her country would not be recognized at Canadian universities. Moumi instead went to a local college; later, when she learned that her husband lied to her about the recognition of her academic credentials, she was upset because this impacted her desire to find a better career in Canada. Moumi suspected this lie to be tied to her husband not wanting her to become economically independent. Moumi further experienced financial precarity as she was not given money to eat or buy things by herself. As her husband lost his job due to the recession in 2008, their situation got worse; she felt helpless, hopeless and uncertain because of her financial dependence upon her husband and how he dominated her in the marriage.

Moumi said that she is from a Middle Eastern country that is patriarchal, and women's mobility outside home is still restricted and depends on their religious and class status. Historically, women in her county of origin were formally not permitted to work outside the home. Today, women do work in the community, however, many people still discourage this as they perceive women's place to be in home, providing care to family members. Further, according to Moumi, many women generally accept such subordinated roles. Moumi said that her father did not dominate her, and she had freedom as a woman before her marriage, but her ex-husband believed that it is his right to control her life.

Although Moumi accepted her husband's dominance for several years, she began struggling after the first three years in 2011 and brought up the possibility of divorce. However, her husband threatened her, saying if she pursued divorce "he would call to the government of Canada and stop [her] permanent residency." Moumi's experience reflects how immigration status can increase women's vulnerability, and how dependent spouses may be subjected to intimate partner violence because of their unfamiliarity with the culture and laws in a new country. This example, like some of the others, illustrates the overlapping oppressions of these women caught between gender systems.

Moumi recalls dealing with two conflicting cultures, a lack of understanding immigration laws and missing family support and community resources, which compounded her feelings of isolation and kept her from accessing the appropriate services that would assist her in leaving the abusive relationship. For a period, Moumi also feared disclosing her husband's behavior by seeking assistance due to the shame of being a victim of domestic violence.

Despite these barriers, Moumi managed to move to Lethbridge in 2012, and divorced her husband in 2014. In 2012, she began using counselling services and taking psychiatric drugs. It was her counsellor who eventually helped her leave her abusive marriage. She later moved from Lethbridge to a larger Canadian city. When we spoke in April 2019, Moumi was again struggling with her mental health and was on medical leave from work due to her severe "depression" and anxiety. Her father had flown in from the Middle East to take care of her.

Moumi's story reflects studies that suggest long-term spousal violence survivors have a tendency to self-blame and are likely to experience a range of negative mental health impacts, including suicidal ideation (Meekers et al., 2013). Such a tendency was reflected in Moumi's stories as she said: "I really feel bad because I think I can't manage myself. When I am talking to you, I figured that I am feeling about my marriage all of that. Now I figured that I am an anxious person." Moumi further noted that: "it often came to my mind that I do not want to exist."[11] Living with such abuse and lacking family support and communication was profoundly difficult for Moumi; she describes feeling lost and has struggled to recover from her experiences.

Arvin's experiences with mental health services in Lethbridge were primarily focused on moving past childhood sexual abuse trauma. Arvin came to Canada from a country in Latin America; she first arrived in 2012 to complete course work as part of her undergraduate degree through a government fund in her home country, then returned in 2015 for her Master's program at the University of Lethbridge. After finishing her Master's, Arvin moved to another Western

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[11] Following this disclosure, I asked Moumi if she had ever harmed herself, which she assured me she had not. I also asked if she had good supports in the city she had moved to; she told me that she has some friends, but they are not close enough to share her personal life with. Moumi further shared that when she became sick in 2019 her mother came to care for her, and after forty days her father arrived. Moumi loves her parents and describes her father as a nice person, but also says he repeatedly asked her why she does not have enough money and good job, even though she has been in Canada for a long time. His questions hurt her, and so Moumi stopped sharing her feelings with her family members. She also began seeing a counselor to discuss her thoughts. Because Moumi had disclosed suicidal thoughts to me, I followed up with her after our initial interview via phone to ask how she was doing, and she replied that she is well.

country for her Ph.D., and for the experience of learning a different culture and language. When I asked Arvin why she used mental health services, she identified two reasons; first, during her undergraduate degree in Canada, she struggled with the culture, system, education, and English language. However, during our discussion, Arvin mostly focused on the second source for having sought mental health services, that being to process traumatic feelings associated with childhood sexual abuse.

During the last semester of her Master's program, Arvin found herself continually remembering the abuse she had suffered as a child, and these thoughts began causing her immense pain. She was continually crying, could not sleep, and found it hard to explain to others what had happened to her:

> It was at a very early age and it's hard to hear all these stories. My parents were not at home and [my uncle] did it with me. It happened a few times when I was around seven, six, eight. My cousin also did such things with me. I told my mom, but she did not react nicely. So, I did not say anything for most of the time. You know it is a family thing and family members do not want to disclose it.

Research suggests that where cultural norms value males over females, girls' reports of sexual abuse by a male perpetrator can be discounted (Fontes & Plummer, 2010). Women are often discouraged to disclose their abuses as it is perceived that their and their family members' honour would be impaired by doing so. In addition, women are often stigmatized for the abuse, as 'bad' women are the cause of sexual abuse and men's lust; women may even be labelled 'insane/mad' for their disclosure of sexual abuses and punished (Chesler, 2009).

Further, in some cultures if children are abused by close family members, such as their father, uncle, brother, or cousin, they may be forced to remain silent to protect the honour of the perpetrators (Fontes & Plummer, 2010). This troubling silence operates within patriarchal culture, where men's sexuality and lust are often seen as 'natural' and a sign of their virility, and where women's passivity is encouraged. Such abuses, willful ignorance of its occurrence, and the associated silence all have a deleterious impact on victims' lives.

Arvin recalled that during the end of her Master's program, night after night the same event appeared to her mind to the point that she could not sleep, work, or even eat. She shared her story with her supervisor and her boyfriend with the hope that it would elicit some relief from her recurring memories:

> I went to my supervisor and said: "I am really not able to work because that happened to me. I do not know how to deal with it." Then my professor said: "Okay take time. If you need I will pay an extra semester for you."

It was Arvin's last semester and she was planning to visit her country after her thesis submission, but she was also scared to visit her family because of the persistent fear that her uncle would again harm her:

> I told my partner that he will kill me as soon as I go to my country, he will kill me. He will hire someone and shoot me, and in my country, you know there was always some robbery. My partner was like, "come home; you think the same thing again and again." I always told my partner to come and talk to me, he would talk that everything will be fine; the time was hardest time. Sometimes I shook and cried and it was hard to breathe; my partner would come and tell "it will be okay." It was a big support.

Arvin's partner was very supportive, and Arvin found some peace when she talked to him. However, her past remained a fundamental barrier to moving on with her everyday life. Arvin wanted to forget the experiences, and says she was desperate to heal from the constant suffering. Ultimately, she sought mental health assistance to help her process her experience. However, Arvin feels she might never entirely heal from what happened to her; the pain she suffers from was clear when I spoke with her. Arvin said that she often sought justice for her experience and when the #MeToo platform sharing women's stories of sexual abuse began to gather strength in her country, she told her parents that she was going to share her story on social media, but they forbade her from doing so.

> I told my parents that I am going to share my stories on social media. I am not going to use my name. It was very heavy for my family which was very weird. I needed support but I did not get it, and I forced my dad to talk to his brother too. He was my father's brother. But my father did not talk to him; my dad did not protect me. My uncle did not apologize and pretended that nothing has happened. So, I did share. It was a very hard thing for me.

Instead of protecting her, as she hoped, Arvin's father chose not to say anything to his brother for fear of impairing family relationships. Arvin's stories illustrated how women's rights are often ignored even by their close family members, and how seeking justice is not considered necessary. Even though Arvin felt an apology would help her healing process, she never got one; her uncle pretended that he did nothing wrong and "he never got punished."

Arvin's story echoes the work of feminist scholars who explore how, under patriarchal culture, male sexual aggression and sexual openness are seen to be 'natural' and they generally are not punished or made to feel guilty for committing sexual violence (Cahill, 2000). Women, however, are seen as needing to protect themselves from unwanted male sexual attention, and under this hetero-patriarchal cultural construction, if they fail to do so, not only does society see them as lacking, but the victims are led to feel guilty (Cahill, 2000). Arvin, while attempting to heal herself and connect with other survivors, was made to feel guilty for wanting to share her story; as a result, she ultimately suffered more as it became clear that her family members did not support her. As Arvin said, women in her culture learn to be silent even when they are harmed and their rights are violated; they are taught to internalize the shame and pain, and uphold the culture of silence even at a loss to themselves.

Arvin discussed that due to this culture of silence, it was hard for her at first to share her experiences of sexual abuse to others, and said that "for a long time I cried; even in Canada, when I want to talk about this, people do not want to listen; they do not want to know why you faced it." Due to her experiences with denial and the culture of silence, Arvin felt confused as to if she should seek mental health services, even as her suffering hampered her work and study tremendously during her last semester in Canada. However, she ultimately went to counseling services at the university when she began having frequent "panic and anxiety attacks" where she "was shaking and crying and was feeling that [she] would die."

Discrimination in the Workplace: Amelin's Story

While several women experienced racism in their workplaces, Amelin in particular realised that her use of mental health services could be attributed to confrontations with "the glass ceiling" at her place of work, where women's skills were often neglected by men, and promotional opportunities were not provided to her and many other women she worked with. Amelin came to Lethbridge as a graduate student in 2008 from a South Asian country. Though married, she initially came to Canada by herself, and lived with female roommates, as the society she grew up in enforced strict gender segregation. Amelin's husband joined her one year after she arrived, but before his arrival she was lonely and stressed; her roommates were Latter Day Saints and encouraged her to attend church with them, but Amelin was afraid of losing her religion and as a result was unable to develop close relationships with them. Amelin was also the only woman in her department from her continent, which further exacerbated her loneliness.

After finishing her Master's degree in Lethbridge, Amelin gave birth to a baby boy and accepted a job when he was one year old. However, she was stressed adjusting to her new job and caring for her young child with only her husband to help; in her culture it is common to have more extended family assistance with childcare. Amelin's son attended daycare and often became sick, forcing Amelin to leave work early and hampering the regularity of her work. Initially her boss accepted this arrangement and was happy with Amelin's job performance; however, he soon stopped communicating and giving her assignments. Amelin suspects this to be related to a male colleague who was from her continent, and who was sexist and rude to Amelin; "his main problem was with my gender that I am female and competitive and do not accept male dominance like other females in my continent." Amelin's suspicion of this colleague reflects how she was 'haunted' by the patriarchal culture of her home country, and by the local culture of patriarchy that valued a male immigrant's perspective over her own. Amelin further discussed that:

> The guy was angry, and he always tried to put me down. The guy told negative things about me. That's why I did not get any work from the project that was I hired for. They gave me some silly task. In meetings, I did not have a chance to speak. I was struggling with coping.

Amelin's story reflects the perception from men in her culture that all women are/should be submissive, and the expectation and encouragement that Amelin act as such. Occupying three disadvantaged social statuses, gender, race and ethnicity, the perception of Amelin by her colleagues was further influenced by a man sharing her culture who pointed out that Amelin did not conform to the 'ideal' social norms. Amelin expressed feeling uncertain, hopeless, and helpless that her white male boss had stopped communicating with her, and angry with her racialized male colleague for his ongoing harassment. These experiences impacted her self-esteem and pride:

> I am really like that kind of person who can adapt in many adverse situations, but if anything hurts to my self-esteem is tough to take. That took me to the depression. I was depressed because of the office environment; I had a cultural shock at the office. I was a good student in my whole life, and I received so much admiration from people. Here, their attitudes were like I was good for nothing. I felt like an idiot. I felt like that the things I have learned and the things I did [amount to] nothing.

Amelin wanted to quit the job, but in a new country it was important that she be able to support her family as she was the only one working at that time. Additionally, as an immigrant woman she would have faced significant barriers in seeking new work. Amelin said that she worked hard, but she "saw that there is no recognition for the good work. The guy from [my continent] did the most harm to [me]." Amelin went on to say:

> In the office, you have to keep your sixth senses open always. There is so much backstabbing at the office. You worked, and the others can claim that it's their work if you do not keep any written document. So, every work and speech needs

> to be documented. The guy who joined with me, at the time, my boss gave some work to the guy and as I knew about the work, I helped him. I did the whole design, but he did not mention my name. He used his name and never told that I did the work.

Amelin said that the office environment was not only demeaning to her, but to all female colleagues, who were treated "like they are good for nothing." Thus, Amelin was told by one of her female colleagues "to be a bitch to survive at the workplace." Amelin feared making a complaint against her male colleague as she wanted to survive the job, and because it was clear that in the past the company did not take any steps to remedy similar complaints.

> Like, one of my colleagues made a complaint, she faced a problem with the job. She saved her career as she was white and worked in more prominent companies before; so, she knew how to handle it. Also, as a white, they get privileges. Like, in our country, as we grew up there, we had a good network over there; if you are sent to a prison, you will find few people standing for your justice. Who will do it for me here? We do not have families here.

The above passage represents how Amelin felt gender discrimination crossed racial lines in the office, with the brown colleague and white boss sharing a worldview about female colleagues that she was unable to fight. It also illuminates that she felt unsupported in Canada as she did not have family and friends that she could rely on in difficult times, which also impacted her reaction to the discrimination in her workplace. The racially and gender-hostile office environment hampered Amelin's life and well-being.

Amelin also expressed being unhappy as racism in the Lethbridge job market is prominent, and she has had to "work hard and doubly to survive" at her office. She doubted that she “will ever get reward and promotion” in her job because she is brown. Amelin was hurt, felt rejected, and dismayed that her knowledge, competence, and skills were denounced at her workplace; for this reason, she struggled in her life outside of work, and ultimately sought psychotherapy and psychiatric drugs to cope.

Conclusions

In this chapter, I have discussed how women’s cultural and socio-political subordination is linked with their use of mental health services. The women’s stories demonstrate that immigration status, financial precarity, study pressures, racism, colonization, discriminatory working environments, and patriarchal violence contributed to their suffering. The women relayed feeling powerless, alienated, worthless, hopeless, anxious, sad, empty, listless, and as a result, unable to maintain their self-concepts, meet performance demands of integrating into a new culture, or building and maintaining social relationships. The complexities of the many intersections of forms of subordination these women experienced damaged them and made them doubt themselves, their abilities and their chances at a better life. These women believed the circulating Western biomedical mental health ‘truth’ that therapy can ease and cure distresses. Thus, the women I spoke with sought mental health services. In the next chapter I will reflect on women’s experiences of using psychotherapy.

Chapter 4: Experiencing Psychotherapy as a Racialized Immigrant Woman

Introduction

In the previous chapter, I discussed how the women were afflicted by pain and suffering induced by interrelated social subordinations, and how that led them to seek mental health assistance. In this chapter, I examine how they experienced seeking mental health services, in particular psychotherapy, in Lethbridge. These stories reflect how some women were reluctant to use mental health services primarily because of their cultural knowledge and associated practices, which led them to think that their suffering did not need biomedical mental health services. Later, these women sought psychotherapy because, on the one hand, they became familiar with Western biomedical mental health knowledge, and on the other, in a new social structure and culture their changing subjectivities led them to feel comfortable with new medical/psychological processes.

Some women reported experiencing difficulties in accessing mental health services and did not see them as useful, while others found them helpful for their self-improvement and self-empowerment in terms of surviving in a new country. Several women said that they first went to their physicians as they were struggling with functioning in their daily lives, including having difficulties of sleeping, inability to concentrate on work and their studies, and dysfunctions in their social and conjugal lives. Some of these women were directed to try psychotherapy, in addition to being prescribed antidepressants and other drugs. Other women went for counseling first and were suggested to see a psychiatrist or physician as their therapists perceived psychotherapy was not a solution for them which will be elaborated upon in the next chapter.

It is worthwhile to note that in this research, when women discussed their use of mental health services, they meant a wide range of services providers they sought out to overcome their distress, including family physicians, psychiatrists, psychotherapists, and counselors. Only four women saw psychiatrists either in their home country or in other cities in Canada, and among these four, only one of them saw a psychiatrist in Lethbridge.

All women except one used psychotherapy at least one time, and eight of the thirteen women were prescribed antidepressants, with seven of them actually using the medication. Several women used both psychotherapy and prescription medications simultaneously for a long period of time, while others either attended psychotherapy sessions a few times or took antidepressants for a short time span. Thus, the women's experiences of using mental health services is diverse. Table 4.1 represents the variety of mental health services used by these women. In the next chapter, I will further explore women's experiences with physicians, their categorizations, and compliance and resistance in regards to diagnosis and treatments, which is one of my key research questions. Drawing upon Foucauldian, postcolonial, and anti-psychiatry feminist understandings of how medical and psychiatric knowledge and power operate within individuals' lives, I also examine the material effects of these forces on each woman's experience.

In this chapter, in order to analyze women's experiences of using psychotherapy, I drew upon Foucauldian and postcolonial literature, exploring the ways psychotherapy and psychiatric knowledge foster neoliberal governmentality by encouraging patients "to align political, social, and institutional goals with individual pleasures and desires, and with the happiness and fulfilment of the self" (Rose, 1990, p. 257), a process that occurs through self-governing and self-monitoring (Bondi, 2005; Rose, 1990). Subsequently, this replaces other ways of

Table 4.1: The Women's Use of Mental Health Services

Pseudonym	Psychotherapy	Antidepressants and Other Biomedicines
Amelin	Twice	Used an antidepressant for eight months
Arvin	Used psychotherapy for "totally might be seven or eight time."	Never taken
Jasmine	For a long period of time.	Never taken
Jenifer	Never used	Had been using for the last six months (October 2018 to February 2019)
Jillian	Once	Never taken
Jisa	Jisa went to the counselor twice a week for the first six months of her treatments, and then biweekly or monthly for the next year	Anti-depressant for one year and half; then, birth control pills for a long period of time
Lamia	Several times	Never taken
Lotus	Uncountable, see pages 157-159	Never taken
Mary	40 to 50 times	Mary took antidepressants for a month to see if it would help
Moumi	Used psychotherapy for a long period of time	Six years with some intervals
Natasha	Around nine years	Two years
Nila	Around ten years	Eight years with some interval
Sasha	"15 to 20 sessions"	Was prescribed an antidepressant, but never used

living (Khan, 2017) since the definitions of personhood, subjectivities, wellbeing, and conceptualizations of a 'good life' vary significantly from culture to culture (Kleinman, 2008; Rose, 1992).

On this point, I acknowledge that the women I spoke with came from different societies, with diverse geo-political histories that may have been produced by different structural and cultural systems, and they may have different definitions of subjectivities, wellbeing, and a good life. In addition, such women arguably have different mental health practices, despite Western ways of living and biomedical notions of mental illness having increasingly expanded throughout the Global South through the processes of globalization, colonization, and medicalization (Khan, 2017).

I have also presumed that after coming to Canada, these women might have encountered other ways of living and understandings of mental health and illness, which may further complicate their experiences of interpreting and using mental health services. Building on these ideas, my interviews explored how racialized immigrant women reflect upon cultural knowledge around mental illness, in order to understand if and how this knowledge informed women's seeking and using of psychotherapy and other mental health services. Thus, in this chapter, I first explore some of the perceptions and practices around mental illness that exist in each woman's culture, and I reflect upon whether that knowledge had any influence on their use of psychotherapy in Lethbridge. Second, I examine how several women experienced hurdles in using psychotherapy. This is followed by a discussion of how some women saw psychotherapy as helpful for them in terms of their self-improvement and survival in Canada.

Women's Cultural Knowledge of Mental Illnesses

Most of the women I spoke with explained that their traditional ideas of mental illness are fundamentally different from Western biomedical notions of mental illness. However, the traditional ideas of mental illness have also been changing in many of the women's cultures, and several women indicated that perceptions of mental illness are diversified within any culture, and can vary based on class, age, religion, education and social and geographical location within a culture. Most of the women I spoke with were aware of biomedical, westernized mental health discourses before their immigration to Canada; indeed, four women among the 13 included in this research used such mental health services in their home countries. It is also worthwhile noting that five women I spoke with only learned about mental health services after moving to Canada. In the following section, I will examine these divergent experiences.

Several women said that due to their different perceptions of mental health, they did not initially consider seeking out services when they started to feel lost. Instead, they only sought help after being informed and encouraged by friends, school, and workplace colleagues about the psychiatric notion of mental health and the idea that psychotherapy and psychiatrists could ease their pain and suffering. Most of the women said that mental health is given far more importance in Canada than in their home countries, and they saw many campaigns on mental health in their workplace and schools in Canada. Because of this focus, they began seeing the value of taking care of mental health and seeking psychotherapy. Some women also said that they searched for and read online documents on mental health services and the value of using psychotherapy.

Most women explained that in their culture, mental illness is not perceived as a "real and important thing to consider"(Jillian); rather, they indicated that in their cultures, people generally see it as a result of sin, or the effects of spirits that require the intervention of traditional healers, priests, religious leaders and prayers. For example, Jillian said that: "…for schizophrenia, you are called crazy, they even do not know that they had schizophrenia, back home they are just crazy homeless people who talk to the air. People also think spirits are talking with these persons." In this regard, Sasha also reflects:

> …we see them in the street almost half naked because the government does not provide services for them. Sometimes people mock them. Sometimes people think

> it's their fault that probably they have offended God or someone before. In my country, it's very traditional, if someone caused something to someone, it happens. Also, people believe it's spiritual, spiritual could be good or bad. Bad energy transferred to the person and the person is a victim. We have mental health facilities, the country is growing, but people still believe that it could be negative. So, they take them to the spiritual people and let them take care of them. Some people use sciences' intervention and some people like traditional interventions. So, depending on where are you at, and I think some people like praying.

Jasmine also said that in her community people with mental illnesses are stigmatized, as they are seen as inferior, cursed people who do not know what they are doing and are potentially harmful to others. Thus, these individuals generally were kept locked up at home or lived on the street. Jasmine explained that:

> Before it was more stigmatized, and people used to go to the priests and traditional healers [and] if the person has schizophrenia, they do not go to the doctor's treatment, they just locked the person in the house pretty much so that the person does not go out and spoil the persons' family name.

However, Jasmine indicated that this traditional understanding is no longer universal, and that she does not see mental health in that way:

> Culturally it is considered a very big stigma; nobody talks about this. If you go for therapy, it is considered as a very big deal, like she has gone crazy or things like that. Because I was raised in a very progressive household; it is completely normal, my brother had depression for years and my parents are the ones who told him that you know what we can't handle the problems by ourselves because we

> are not equipped and trained. So, when I saw such a healthy attitude towards therapy in our household, I would go out for it. But that definitely was an exception. So, coming to Canada, the perception feels, more closely with the perception of my family, but completely opposite of my culture.

Jasmine's use of the term 'healthy' to describe the western, biomedical understanding of psychological distress is clear; she appears to prefer biomedical notions of mental illness, seeing them as more progressive and arguably, effective. Lotus also shared similar views:

> When I was in my country, I knew that mental illness means crazy people. When I came to Canada, I got to know that normal people can also have some mental health problems. I had something inside bothering me, I was struggling, and then I was like "Oh this is the mental problem." Actually, everyone can have mental health problems, from time to time…everybody has some kind of mental health problem.

In this excerpt, we can see how Lotus reflects positively on Western biomedical discursive knowledge because it has destigmatized mental illness – it isn't just 'crazy' or 'possessed' people who can have mental health challenges. This embracing of medical conceptualizations that 'everyone' can be at risk is precisely what Nikolas Rose (1990) argues is a way of thinking in which everybody is susceptible to the label/diagnosis, which is linked with the process of medicalization of human life more and has brought individuals under medical influence and surveillance.

Lotus's commentary also illuminates how she has come to value psychiatric norms as enlightened and progressive, in particular when she characterized her parent's ideas as related to lack of knowledge and backwardness. She noted, "My parents do not have higher education.

They’re kind of farmers in the village, they do not know. If I tell my parents that I have a mental problem, they will think that I am a crazy person.” In Lotus’s comments, we can see she not only values biomedical notion of mental illness but frames traditional cultural learning as inferior and atavistic.

Lamia, who came from an African country, stressed that her country needs to focus more attention on mental issues and legitimate them as real, saying:

> It is not considered as a real problem in my country. The problem is do you have food in your house, do you have a roof on your head, are you physically sick, do they have a real problem...[so people are] very reluctant to go seek help when it comes to mental health as they do not think it is real.

We can further infer from Lamia’s comments that she believes it would be a positive, even progressive step on the part of her home culture to embrace and promote the seriousness of mental health challenges, so that the people in her home country could learn ‘more appropriate’ or more medical ways of understanding their emotional and psychological problems.

While most women in this research said that in their home country the medical model of mental health has not taken a strong hold, Nila relayed that in her country the medical model is dominant, although multiple perceptions about mental illnesses operate simultaneously. She states: “Mental illness is usually seen a weird thing and there is a taboo that people should not talk about it. The other is religious perceptions that you have a demon inside you, but usually people go for the medical model.” As an example of dependency on medical knowledge, Nila said she was taken to a psychiatrist when she was six years old in her home country due to her struggles with loneliness, and she recalled being labelled a “weird kid”. As Nila had already been medicalized at such an early age, cultural knowledge of mental illness did not influence her use of psychiatric treatments in Lethbridge.

Informed by circulating psychiatric discourses on the importance of mental health and psychotherapy, Amelin said she actively sought psychotherapy when she was suffering due to the hostile environment at the office where she worked. Amelin gathered information from her office website on mental health services and booked an appointment with a counselor. Amelin said that it was in her best interest to seek the services to survive in Canada, even though her community generally views seeking such services unnecessary and a matter of shame. To Amelin, many of her community people have been struggling with mental health but ignoring services, which Amelin perceived as harmful. During my interview with Amelin, I sensed that she perceived herself as more advanced in her thinking than others in her community because she has sought mental health services, but she also feared disclosing her use of the services because she might be mocked and stigmatized.

A few other women in this research situated themselves as progressive subjects in terms of seeking psychotherapy. Sasha is one of these women, and she said she began using psychotherapy immediately after learning about the services in her first semester at the university, as she was struggling with her grades and having trouble adapting to her residence. However, her community friends criticized her because of her use of therapy, as in her culture it is not seen as acceptable. Instead, prayer, family, and community relationships are seen as significant ways to relieve stress in Sasha’s community; subsequently, using mental health services is not only seen as useless but also as a matter of shame. Sasha went on to say that:

> I am not ashamed about it anymore telling my friends that I go to counseling services because I am able to overcome the stigma about seeking mental health

> services. But before, every time, I told my friends like I am going to counseling, they were like, “Why are you going to a counselor?” Because it was not something that was advocated in my country. Among my friends, I am the one who goes to seeing counselors. So, yeah, I just stopped being ashamed about it, but a lot of people even if they are struggling and they do not discuss about it, [or] they do not even know [about it].

Conversely, Lamia said that she learned about counseling services in her first year at the university through the campus mental health week, and also searched online for and read documents on mental health, but did not seek counseling services as she initially held the belief that mental illness was not real. She said:

> I think that’s why it took me so long because I knew about the services first year, but I went in third year. Mental health you cannot see physically on someone. That’s one thing I realize…mental health is real. Students have a harder time I especially think when they come to university. I have seen a lot of international students who are struggling with mental health, especially in Lethbridge as it is a small city and we do not have enough space to come together.

The understanding of mental health that Lamia demonstrates here is significant, as it illustrates that she perceived international students’ mental distress to be the product of a new culture and structure in Canada. However, she also categorizes this stress as a mental illness, which arguably represents an embrace of psychiatric ways of seeing distress as pathology. Her disappointment regarding the neglect of mental illness and pain experienced by women in her community further illustrates her internalization of medical ways of seeing and treating women’s distress. Lamia said that:

> Like postpartum depression, no one likes to talk about mood swing, PMS,[12] Menopause. Oh, she is crying because she is a woman. She has been sad because she is a woman. No one is going to the hospital because we have one mental health hospital which is really, really for bad cases. I don't know if we have therapists. When it comes to therapy, women talk with each other. That's how people cope with mental illness. Back home, women talk with neighbors, with their aunty and cousin and like here, no one talks to anyone because they think it is weird.

The above quote demonstrates that Lamia perceives women's premenstrual discomforts and menopause as pathologized states, requiring medical care that is absent in her community. However, she notes that women cope with such pain by supporting each other.

Jisa also said she did not seek mental health assistance when she felt lost after immigrating to Lethbridge due to her experiences. She noted that her young age, class, immigration status, family background, and lack of knowledge about Western biomedical mental health services in Lethbridge delayed her seeking assistance. Jisa was only 13 when she moved to Canada, and in their post-immigration period her whole family was struggling to survive and were not financially in a position to seek services. Jisa had been informed about mental health and mental health services during high school but gathered more knowledge about it when she began her university studies. As a student, finally, the financial barriers to accessing help were no longer there. Most of the other women I spoke with echoed Jisa, in that their traditional

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[12] Premenstrual syndrome

cultural definitions of mental health were of little influence in their use of mental health services in Lethbridge.

The above discussions reflect how some women have varied traditional, cultural perceptions about mental health, including having no knowledge of it at all. Some of the women had traditional ideas that made it seem more stigmatizing to seek help or admit a need for it, and others stopped engaging with mental health services as the services conflicted with their religious beliefs and as such they felt Western biomedical mental health was not beneficial for them. However, to some women, there was no such tension between traditional and biomedical preconceptions due their family support for western mental health discourses, even when most of their culture was reluctant about using mental health services. Ultimately, although all the women I spoke with used mental health services, several stopped as they were not satisfied with the treatment systems they encountered (these experiences will be further explored in the next chapter). In the following section, I discuss what kind of barriers women experienced in seeking psychotherapy.

“Psychotherapy Was Not Fulfilling”

Most of the women I spoke with used public and free counselling services because they could not afford private psychotherapy. Only three women, Amelin, Mary, and Jisa, used private counselling in Lethbridge and all of them were happy with the services for several reasons, including getting appointments when they needed them and the therapists’ willingness to listen to them carefully. However, the cost of private therapy was high; Jisa reported her father paying $150 CAD per hour for her therapy because she “was desperate to seek help” to overcome her pain. To Jisa, the cost was high because the counselor her aunt found for her was reportedly the best counselor in Lethbridge. Jisa went to the counselor twice a week for the first six months of treatment, and then biweekly or monthly for the next year, meaning her total outlay for counseling came to more than $8500, an amount few would find manageable. Jisa knew about free counseling services at her school but decided not to use public services as her university friends did not find them helpful. Mary paid partially for her private counseling as her workplace only covered the cost of 12 counseling sessions, while Amelin had full coverage through her workplace.

On the other hand, women who used public counseling services experienced interrelated barriers, including not getting an appointment when they needed one, the counselors' insufficient knowledge about women's struggle as racialized, immigrant, and international students; and a lack of willingness to listen to the women's stories. Due to these interrelated barriers, several women said they could not connect with their therapists, which was a significant problem for them. Additional issues the women mentioned included the therapy being mechanical and individualizing; mechanical because of therapists' focus on preplanned documents and solutions for all people regardless of their diversified experiences and backgrounds, and individualizing as most solutions emphasized the responsibility of patients in taking care of their own lives and minds to solve their distress. In the two following subsections, I will discuss the diverse hurdles women encountered. First, I explore why some women could not connect with their therapists. This is followed by an examination of why some women saw counseling as mechanical and individualizing.

“There Was No Connection There”

Most women in this research explained that a feeling of connection is important in psychotherapy, but very few were able to experience that necessary connection due to the systemic barriers they encountered with public counseling services. Jasmine said that while the counseling services in Lethbridge were helpful in reducing her study-related stress, anxieties, and task avoidance, she could not make any connection, develop trust, or bond with her counselor, something she expected she would be able to do following such a connection with her prior psychotherapist in her home country. For Jasmine, the need to bond was something she saw as key to being able to disclose her issues with her home country therapist, given the nature of her personal suffering. The therapist in her home country also empathized with Jasmine’s pain when she shared her stories of humiliation after her breakup, which, Jasmine noted, might be because “she knew the cultural context of potency about women have to be pure and untouched.” Jasmine said that the “empathy aspect of the counseling was not really there in Lethbridge,” relaying:

> I don’t know whether it’s a cultural difference in counseling, but when I went to the therapist [in my country], they helped me to handle the emotional part of it, like how to handle my emotions, how do I handle my stress, how do I open up again, but in the Canadian model, its more practical. So, it was more like an academic strategic meeting than the therapist meeting. So, I was advised like, plan your time, manage your assignments, but it was not as focused on how I handle panic attack when I see grades uploaded on the Moodle.

Jasmine further explained that the campus rules of using only 10 counseling sessions per year was a barrier in making a connection with her therapist, saying: “there is so much of a load of so many students on one counseling centre on campus...so, they are in a rush to help you as [quickly] as possible." Jasmine noted that some of her friends who went to the same counseling centre felt that they could not disclose their private stories because the model did not allow them to take enough time to be comfortable to share. Jasmine further elaborated that she had only academic issues; thus, strategic plans from her therapist helped her, but "someone having deep psychological and emotional problems, needs to create a bond of trust with therapists before they can do any work."

Lamia, Sasha, and Nila had similar reflections. Lamia felt that the counseling services need to be expanded at the university "because only four, five counselors are like for seven thousand students. That means they don't have enough time to meet with students and get to know them to be able to solve the problems." Thus, most of the time, Lamia felt she was given generic solutions.

Similarly, Sasha states that she was given basic solutions; further, she often had to wait for three to four weeks to get an appointment, at which point she sometimes felt that she no longer needed speak to someone. Sasha was also disappointed that she had to switch between four counselors, either because they were not available for her next session or because they left the position which certainly contradicts a need for trust, and for having a relationship that fosters disclosure and deep understanding.

Besides these systemic barriers, Sasha felt that her therapists could not understand her suffering arising from her gender, ethnicity, and other intersectionalities because they were all white people who had limited knowledge about other cultures and the distress of international students in a new setting in Canada. Sasha was frustrated with her first counselor because she was an intern and lacked enough experiences to connect with or help with her suffering. Sasha said: "I was a subject of her practice. It was weird because I was trying to see a professional, but

I was talking to someone who was just there for her own benefit, not for me. So, I stopped going."

Sasha said that she expected to receive advice and strategies to overcome the stress related to her studies and other suffering as a newcomer in Canada, but the counselor just listened her without suggesting anything. Sasha suffered from financial precarity in Canada, and therefore she could not seek private specialized mental health care. Thus, she went to public counseling services, but her needs were not adequately addressed. Sasha's experience provides a clear example of how social class can impact access to adequate mental health care, and the inequities that exist in Canada's provision of mental health services.

Later, in her therapy, Sasha did get scheduled with a different, more senior therapist, who was reputed to be better in terms of understanding the experiences of international students, but Sasha described that this counselor also lacked knowledge about Sasha's cultural background. Nonetheless, Sasha was happy to see this new counselor. Unfortunately, this 'improved' service ended shortly, as the counselor received a promotion and no longer saw patients. Sasha then met with another two counselors, who mostly gave study related advice:

> The only thing they could relate with was my schoolwork. So, everything has to be like school life, school stress, school anxiety. I did not feel that sense of belonging because every time I had to start by telling my background; they can't understand your background. I had issues with foods, and I was sick. It was just shattering my world. So, I wanted to know if there is anything wrong with me or maybe [this was a normal part of] transitioning from my country to Lethbridge, but they did not understand how the transitioning affected my psyche. So, it was not helpful in that way. It was more like generic.

Sasha went on to discuss how her counselors did not understand how a person at her age was responsible for being loyal to elder family members yet still treated like a child. As such, they did not understand, and could not provide helpful insights, relating to some stresses Sasha was experiencing, such as that arising from her denying to give her aunt her bank password.

Further, Sasha was not comfortable with most of her counselors, and suggests that they could have researched her cultural background before meeting her so that she felt welcomed, comfortable, and connected with. While this may seem like an unreasonable request for a therapist, it is also not reasonable that a client's therapy time should be taken up by the need to bring a counselor up to speed on culture, particularly given the constantly changing roster of therapists and the limited number of sessions that Sasha was able to access. While Sasha did not feel that she immediately benefited much from therapy, she nevertheless continued to use it on a regular basis based on the belief that one day she will eventually see a benefit. Nonetheless, she ended using therapy in 2018 as she did not see it as much helpful.

Natasha also felt very distant from her counselor because of their different backgrounds, noting that: "They are like the opposite of me. Old rich, white lady, how they are gonna relate to me, a poor brown student with racial issues? There was no connection there." Natasha expected her counselor to ask about her cultural background in order to understand her issues, particularly in relation to her identity and ethnicity, saying: "They do not ask anything about colour, culture, nothing, almost like they are afraid to bring up that I am a different colour and talk about race." Similar to Sasha, Natasha here appears did not receive the care she expected from her counseling because of her class, cultural and 'racial' difference as she said.

While Natasha said that her therapists did not want to talk about racism, Jisa experienced bigotry enacted by her therapist. In December 2018, Jisa was upset after losing close friends following her speaking out against racist comments at a party. Because none of her friends defended her when she spoke up, Jisa decided to cut off contact with them. When Jisa shared the distress of this experience and losing her friends with her therapist, her feelings were undermined and dismissed. Further, Jisa described how her therapist referred to the 'natural' superiority of white people: "She said they are superior. I can't remember the exact wording, but her wording was bad." Whether or not Jisa is accurate in her recollection of her therapist's words, she is certainly accurate in her feelings about the encounter, and the negativity Jisa felt from her therapist is very likely the reason that Jisa stopped seeing her for treatment.

Jisa's experience aligns with scholarly findings that in North America, the majority of therapists, being predominantly white themselves, often hold mainstream values regarding cultural and 'racial differences' between whites and non-whites and the superiority of white people (Greene, 1985). As such, Jisa's therapist could indeed be influenced by and hold these same ideas. While Jisa had depended on her therapist for a year and a half, she could not accept her therapist's bigotry. She had already suffered greatly from the extreme racism she faced during her post-immigration period in Canada. Jisa's stance against racism was not respected nor handled appropriately by her therapist, which may be due to the fact that, as a white person, her therapist could not fully understand the damaging effects of racism (Greene, 1985).

The stories in this section represent that to several women, having a sense of connection with their therapists and counselors is important, and that can be developed over time using a number of sessions if needed. Some women felt empathy was absent in their sessions, which may have been related to class and cultural differences, while others said they were not given time and a comfortable environment to share their stories. Other women said that they were not heard carefully, and their suffering was not taken seriously because the therapists could not connect to the women's suffering arising from diverse, intersectional identities.

Several women were also given generic solutions rather than given time and attention for the specific problems, as their counselors lacked knowledge and experience in providing services to culturally diverse women, reflecting some scholars' assertion that counseling services in Canada are not equipped to serve cross-culturally and to provide culturally and class appropriate services (Guruge, Collins, & Bender, 2010). Finally, some women experienced what they perceived to be racism and xenophobia in their counseling encounters, to the extent that they discontinued therapy or turned to more traditional forms of succour in order to address their concerns.

Psychotherapy Was Individualizing

The professionals who provided psychotherapy to the women in this study generally took an individualizing approach, and the women often found these tactics to be overly perfunctory. Lamia explained that "the whole process of counseling services was so mechanical and individualistic." When she first went to the counseling centre, Lamia was given an iPad to record her personal information on and then given a list of problems, such as "suicidal thought, lack of concentration, addiction" and directed to choose one to discuss with her counselor. It was hard for her to choose an option, when she was struggling with several issues.

When she met her counselor, she explained how she was struggling with many things including loneliness, craving home foods, adjusting to a new environment, and study pressure. To Lamia, the counselor listened to but did not feel her struggles. Lamia was surprised when it was suggested she "try to be involved into different workshops on campus and go to Seven Cups of Tea[13]," as a solution to her loneliness, strategies she was neither familiar with nor interested in. As Lamia said, she is from a collective society and relied on collaborative solutions; working solely on the inner mind was not Lamia's intention. It seems that Lamia's counselor operated on the assumption that Canadian practices and norms would be an appropriate foundation for the treatment of all people, regardless of their cultural and historical variances. Lamia's experience is a clear example of how Canadian mental health services depend on approaches and suggest solutions that rely upon the acceptance of mainstream Canadian individualistic culture.

However, Lamia said that she found the International Student Centre to be more supportive, as they are aware of how international students struggle abroad:

> I feel the International Centre asks you how you are finding classes. Are you making any friends? Are you finding the foods, are you settled in? But when you go to the counseling, all these are disregarded. So, they just imagine you are okay. She did not ask about my religion, my cultural practices, nothing. She did not ask me how it supposed to be back home or how we deal with this thing back home. She just focused on Western ways, individualistic, take a bath, go for a walk, read a book, moisturize, everything is by yourself.

To Lamia, the therapist just listened and gave some one size fits all advice that would possibly suit a white, western student but that absolutely failed to take into account how her suffering arose from different intersectionalities, including culture, immigration status, and class. She said:

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[13] "An on-demand, 24/7, text-based, worldwide Internet support network, 7 Cups of Tea provides targeted and specialized support to students who need help when they need it most" (University of Lethbridge, 2016). Lamia tried this, but she did not like the text-based support system. She was seeking a more collective-based solution to resolving her pain.

> Most of them like a generic solution, you have depression, try this, that's how it is. You are a student; that's what it was. Everything they gave me is like pre-printed out. So, she was just taking thing like you should try this one, try that one here you go, and that was like five sheets of paper.

Lamia was frustrated by this approach, saying: "I did not see it was fulfilling, wholesome, and comprehensive that I thought it would be," because all the advice put the responsibility for seeking wellness and finding the tools to get there on Lamia herself, rather than offering a collaborative process of support to get her to wellness.

Lotus was also advised one-size fits all approach when she was trying to mourn the deaths of her two of friends by a car accident. Lotus was scheduled with a male counselor first, which she was not comfortable with: "My stories were sad, and I was uncomfortable to tell and cry in front of him. I cried because it was very difficult. I felt like it's better to talk to female to tell all my stuff openly." Lotus changed to a female counselor, but did not find that treatment helpful either, as all of the counselor's advice relied on the premise of Lotus taking accountability and actively going over her grief. Lotus described how this counselor drew a picture on a whiteboard to explain how difficult it is to forget everything completely. Then, Lotus was suggested to process her feelings as follows:

> Take time to heal. You can go somewhere, where you and your friends went, sit there think about what kind of funny things your friends and you had and what kind of conversations you had. Think about your memory. And other times remind yourself time to time, concentrate and do some stuff that you like. Listen to music and study a book, yeah kind of relax and take a deep breath. [That was] kind of it. She taught me some techniques like how to relax and concentrate.

As the excerpt represents, all advice from the therapist was focused on Lotus working on her emotion by herself, and she was seen as ‘any other kind of bereaved person’, without considering her cultural, social, and normative ways of relieving pain and grief. Further, the therapist’s choice to draw a picture to explain how the human mind and brain work certainly suggests that the therapist sees the mind as a universal concept, and thus understands a unified psychotherapy model as beneficial for all people.

Nila also recalled how her therapists focused on individualistic solutions in her treatment. Nila expressed her annoyance that even the therapists did not take her anxieties regarding her body shape, hair, and identity as her ‘real’ problems: “[t]hey had some tendency to think that nobody has a real problem.” Nila had to convince them that she was really suffering discussing “you could not just tell them I had problems and they would believe me. I had to provide them a fucking treatise.” Nila explained how in psychotherapy, individual fixing is focused upon:

> The counselors mostly working under the assumption that the outside does not have to change, but to fix yourself and not anything about the world, that can be useful, but it also can create problems because it helps feel like outside is justified and the outside is not justified, you know, where I should be asked where are you from five hundred times and people should give me spicy foods and not tell me and be surprised, “oh Nila, why are you screaming in pain?”

In this vignette, it is clear that Nila suffered from her frequent experiences of racialization and ethnicization in Canada. Nila expected that her therapists would reflect on these issues, but unfortunately, her feelings were not taken seriously. Nila’s therapists did not respect the significance of her concerns—a problem similar to Jisa’s experience with her therapist, as discussed earlier, as white therapists often fail to understand how damaging colonization is for the self-perception and identity of racialized individuals.

Nila concluded that most psychotherapists “are not good at their jobs,” which she can assess because she is a “psychologically literate person” who had spent much time involved with counselors, having begun seeing a psychiatrist at the age of six. Additionally, her major is psychology, and she knows “all of the basic tricks and had successfully prevented more of [her] psychological problems.” Echoing some of the concerns raised by others about one-size-fits-all approaches in western therapies, she noted:

> Most of the counseling advice that exist today is behavioural therapy is counseling advice that has designed that alleviate false beliefs and many people in my situation have true beliefs, you know it is true that I feel x, y, z because this thing happened.

Nila’s story illustrates how structural and cultural violence instigated her suffering, which lead her to seek help from a therapist to mitigate her pain. Nila was advised to ignore her pain by focusing on the best things in her life, but that did not work for her. Her stories reflect the claims of some scholars that psychotherapists train and encourage clients to fit into the discriminatory societies that create their suffering (Bondi, 2005; Chesler, 1972).

For Nila, the combination of not being heard culturally and being treated with generic ‘help’ was deeply frustrating, and although she went to counseling on a regular basis, but did not get the help she expected. In response, she kept switching psychotherapists:

> I’d be with one for three or four sessions and it became increasingly clear that this person is not helping me. And then instead of wasting my time, talking to

> someone who wants to help me the way they help other people even though the other people are lot easier to help than I.

Nila was repeatedly advised to list three to ten things she was thankful for to feel better by her psychologists, but said: “the tips never helped because the problem was never I do not know my life is great, the problem is I still feel like shit.” Nila went on to discuss how:

> They have you rely on executive skills, make a list, keep track of X, do blah, blah. I was like okay now I am behind of my real homework and my cognitive homework, awesome. Those tools do not work if you do not build up the prerequisite executive skills.

This therapeutic suggestion seems put more pressure on Nila instead of providing her with a solution. Still, Nila is ultimately searching for a therapist based on the expectation that she might find someone who could connect with her pain.

Natasha also said that she had gone to 50 counseling sessions with different therapists in the last ten years, but she found most of them perfunctory:

> They cannot help you; they ask you preplanned questions, like, what supposed to be the problem, how is life being going. They showed a chart to me, which is one chart that I have been shown for forty times, which is like you have your emotional mind and your rational mind and you are like draw them in two circles and a part in between is called wise mind, where you can think rationally about your emotions and stuff like that. I was like yeah of course I would love to be able think rationally about my emotions but tell me how. They don’t tell you how. They will just tell what, I don’t want what, I want how. Like they showed me

> diagram, pictures, and lot of stuff. I felt like I am at electronic classrooms. It was individual counseling and she was writing on a board and I was sitting there, and you have to listen, and she asks you how you feel. You are like, I guess, I feel better, I don't know.

In Natasha's stories, we can see how her therapists' interventions rely on the notion of a rational and logically controlled mind, which Natasha experienced as both oppressive and unhelpful. Natasha further stated that "it's great to hear about mindfulness. But for the fiftieth time, I do not need to know about deep breathing. I know that deep breathing helps your anxiety. All counseling sessions were the same." In the end, because these sessions were focused on procedure rather than content, Natasha's therapies always fell short for her, and because they led her to constantly seek a new therapist who would recognize her deeper, structural burdens, she was never able to receive the help she craved.

Similar to Natasha, Arvin was told to take control and work on her inner mind to get over her sexual abuse trauma. Arvin explained that:

> She had three suggestions; she told me if one does not work, try another one. I can't remember, but she touched my one finger and touched the other finger and suggested me to think about the present things. So, what the message is that the past does not exist now, it existed before, and we are often stuck with the past, but we can change it. She suggested let it go and go to the most traumatic time and then come back to the present to feel the moment and I will go to the child stage and bring her to the present room. Then, she asked me, "do you want to tell anything to her"? But I was not that much aware. I did not know what the

> meaning of their techniques is, that's what she thinks. But I feel that the method was to give lesson that the child does not exist anymore, you are here and safe.

Arvin's stories illustrate that she was not ready to receive the suggested strategies and how her therapist overlooked Arvin's state of mind that the practices might not make sense to her due to her different cultural backgrounds. Here it is important to draw attention to the work of scholars who note that the problem with the psychotherapy in the West is that they believe in the universal notion of minds, and consequently, generally advise the same practices to everybody, regardless of individuals' different backgrounds (Christopher & Hickinbottom, 2008). The tendency is associated with the expansion of positive psychology, or the idea that the mind has the power to overcome all situations by thinking 'rationally', a Western concept that some scholars view as problematic because it presumes that there is a fixed essential and universal notion of self who will think in similar ways and/or the notions of rationality will be the same for all societies (Christopher& Hickinbottom, 2008).

Arvin and several other women's stories illustrate how psychotherapy focuses on the "Western atomistic and interiorized self" which relies on the notion of Cartesian assumptions of self that the mind is separated from the outer world, and body from the mind, and prioritizes to an "I" that think" and cuts contact with an external source, such as social orders, or God (Christopher & Hickinbottom, 2008, p. 566). In other words, psychotherapy focuses on the concept of an inner horizon, that is to say that individuals alone are responsible to determine the nature of the good life and "often through doing nothing more than being" their selves (p. 567).

The above discussions illuminate how psychotherapists encouraged women to take responsibility for their own cures, which aligns with the assertion that therapists in Canada prescribe solutions following a neoliberal culture that relies on self-governing and self-disciplining (Poole, 2011). Finally, this individualizing approach dismisses a recognition of structural pressures as harmful to women in general, and racialized immigrant women in particular, failing to offer meaningful ways to address those issues beyond advising women to personally ignore their experience of structural marginalization in order to achieve mental health.

Some women I spoke with specifically identified how their cultural perspectives on relieving psychic pain differs from an individualistic approach, and described how their cultures stress depending on community connections and solutions. For example, Mary explained that she is from a collective society and has strong social and family support, where people depend on each other and share things. If people are stressed, they can share with their family members, and along with this they have a fulfilling grieving system:

> Our grieving process is fantastic and wholesome; if somebody dies, I am at their house, I am sitting there, laughing about good and bad stories and holding that person. So, I find that grieving process so more real, so more fulfilling. So, we have a really, really good support system. Like when my grandfather died, we had people we hadn't met before. The entire community was at the funeral, we had the bands playing, the music thumping and the guitars going, it was just so wholesome, people just feeling what they feel. Here, I have gone to lots of funerals in Canada, it's not like that, it's rare to see someone openly crying.

Mary further explained that such a fulfilling system is absent in Canada as it: "…is an individualistic country, where people have to fight their struggle by themselves and they lack social support and social ties and can't just open up to anyone what they are going through, but to the counselors." To Mary, her mother was her best counselor, but now she does not know what to suggest for Mary, living in a structurally different country. Mary explained that she thus needs a therapist, who has been helping her survive in a new system. Several other women also found psychotherapy beneficial and empowering, which will be elaborated upon in the following section.

“Psychotherapy Was a Lot of Empowering and Soul Searching”

Several women in this research noted that although they were initially reluctant to use counseling services and did not find it beneficial, they eventually found it helpful. A few women even described that they became dependent on psychotherapists. For diverse reasons, psychotherapists were significant to the women, including reasons such as getting valuable information for moving out of an abusive relationship, surviving in a racist workplace, and working on self-improvement. Additionally, a few women said that therapists listened to them with care, understood their suffering coming from gender, race, ethnicity, and became their friends and guardians in a new country. Overall, these women felt fully supported.

Moumi said for a period, she feared disclosing her husband’s violence against her and seeking assistance, but finally she decided to go to counseling when she moved to Lethbridge. Moumi saw three counselors in Lethbridge, among them Jenny (pseudonym), who was very kind to her. Moumi was first scheduled with a male counselor at the university, but she was hesitant to share her personal experiences with him because of their gender difference and because she felt a male could not empathize with her pain.

Further, Moumi explained that during this time she was very sensitive in her dealings with males, which might have contributed to her discomfort with a male therapist two sessions with him, Moumi, however, was able to request a change. The fact that Moumi was directed to a male therapist reflects a lack of understanding about the likely reasons a female might seek counseling – i.e., body issues, gender frustrations, and victimization via sexual or domestic violence. This seems like a very basic consideration, and counseling agencies are remiss not to provide that safety to clients automatically, rather than forcing women to request/demand it. Moumi was then given an appointment with Jenny, with whom Moumi felt very connected:

> Even when I talk to somebody from my country I don't feel like a connection because sometimes people judge you, but I think [Jenny] was open-minded. My English was not very good at that time that sometime, I struggled to explain things in English, but Jenny tried to understand me, and she did not judge me and categorize me. You know it gets harder and harder to express yourself when somebody discourages your English or judges you. [Jenny] did not treat me like I am from another culture and she is Canadian and white. I really felt comfortable and easy. I was really open talking about anything.

Moumi further addressed that: "…even Jenny understood me when my conversation did not go anywhere… I see other counselors wanted conversation in a specific way, but when I talk to Jenny, I was more myself and I was encouraged to be more myself." Moumi's stories reflect scholars' assertion that immigrant women often face language barriers in expressing their pain, and there is a lack of mental health staff with patience and willingness to listen to these women's stories (Guruge, Collins, & Bender, 2010). However, Moumi found a therapist who was very caring and spent time to understand her. Moumi also explained how resourceful her therapist was, noting:

> She helped me a lot about learning the social services: if I can find a shelter, if I can find the legal services, if I can call the police if I have a problem at home. I was afraid of my husband that he could harm me at home. I got a relief to think

> that I have some support in the community and somebody to talk and I can go to the shelter when I need.

Moumi's stories represent how a psychotherapist could be a source of information about their new culture and its resources for racialized immigrants, who often lack family and social networks and information in a different country. Jenny's kindness to her and help with finding the appropriate services assisted Moumi in leaving her abusive relationship.

Moumi described how Jenny was so helpful that despite the counseling centre policy that stated Moumi could only attend 10 sessions per year at the university, "Jenny never said no," illustrating how her counselor was able to understand that some help seekers, particularly those in severely stressful situations, might need more time and sessions compared to others. Depending on Moumi's needs, Jenny always showed willingness to help her, something most women in this research unfortunately did not experience.

Despite these positives, Moumi only could access Jenny for two and half years during her graduate studies, as her eligibility for those services came from the university she attended. During our conversation, Moumi reflected on her cherished relationship with Jenny in Lethbridge, saying: "[i]n my last session, we painted together, and Jenny gave me a printed letter. I have them with me." Moumi's story reflects how a therapist's empathy could help a person to survive in a new country. After her graduation, because lost her access to university counseling and could not afford private therapy, she used Lethbridge Family Services'(LFS)[14]

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[14] The Counselling, Outreach and Education (COE) Department of LFS provides counseling services who in need — which is funded by Alberta Health Services, Family and Community Support Services, City of Lethbridge, and the Together in Action program, the Annual Bishop's Appeal of the Roman Catholic Diocese of Calgary (Lethbridge Family Services, 2021).

counseling support. However, Moumi did not find LFS's services as helpful as Jenny, and relayed that she never again found a suitable therapist like Jenny in Canada.

Mary also made a deep connection with her therapist, Lima (pseudonym), that was built over time. With Lima's culturally sensitive counseling approach, Mary said: "I took around 40 to 50 sessions with [Lima] and it probably took me until the fourteenth session to tell her like the bigger trauma that I had in my life." Mary initially explained her culture to Lima so that she could understand Mary's struggles well and would not interpret some of Mary's cultural behaviours as awkward. Lima also "spent a lot of time to get [Mary's] culture and some of [her] stuff." Alongside these conversations, Lima's disclosure of personal experiences to Mary made their bond stronger. Mary said that: "even though there was still a cultural gap, we built such a good relationship that she gets it."

Mary began using psychotherapy because of her feelings of loss due to her divorce, but continued the therapy for three years as she saw it as empowering and useful for her self-awareness, understanding that her new self-knowledge was adding to her life and career. Mary's stories of using of psychotherapy could be read is a form of assimilation with the Western biomedical notion of mental health, as well as the Western idealized subjectivity, which internalizes the discourse that psychiatrists help people by enhancing their motivation to be empowered, autonomous, and 'productive' citizens (Teghtsoonian, 2009; Rose, 1999). That said, as Mary describes her experiences, it seemed clear that she sees these changes as positive.

Further, Mary said she shared most of her life plans with Lima, who met her ex-husband and supported Mary in removing her guilt and shame around her divorce. Lima is now helping Mary's new white partner, with whom Mary plans to move in. Mary said that "this is not a big stuff," but she still depends on Lima. Further, Mary said that Lima also found Mary to be an interesting person because Mary is proactive in working and journaling her own goal, plans, and achievements, and this typical, western attachment to self-inspection and introspection is in Mary's telling something she is proud of, as well as a sign her friend and therapist recognizes as indicative of her wellness.

The above discussions represent how Mary began relying on her therapist for help with most of her life plans, which calls to mind the work of scholars who explore the growth of the therapeutic consumption culture and the professionalization of even the most routine aspects of daily existence; in this Western-specific system, individuals begin relying on professional expertise in their daily life, work ethics, and goals (Foster, 2016). Before this shift, family was the place where people used to learn about the most routine aspects of daily lives, reflecting how the new therapeutic consumption culture has replaced previous learning and social systems (Foster, 2016). This is particularly relevant to Mary's situation, as she described how she previously depended on her family and community ties in her home country, whereas in Canada she found herself relying on psychotherapy. As discussed in an earlier section, Mary said explicitly that the new social structure and culture, combined with a lack of social and family support in Canada, made counseling services essential to her.

Lotus sought psychotherapy in 2017 and in 2018; the first time, her white Canadian guardian, Peter (pseudonym), who is a psychologist, helped her to overcome her "depression." The second time, she went to professional psychotherapy at her school after losing two friends in a car accident. However, Lotus found Peter to be her best counselor as he knew everything about her; "[h]e kind of sees me as an adopted daughter, helping me to live a good life in Canada." Lotus was also comfortable talking with Peter:

> I think Peter is the best counselor for me because other counselling was one hour or forty-five minutes, and for Peter, we do not have time limits. Every day I talk [with him], I describe what I did today and how I am feeling or something and he can sit and listen and listen to my story. So, he knows what kind of situation I am going through, and he can relate myself, my background. He can analyze more what kind of feeling I am having and then he can give suggestions.

Lotus described suffering during her first year in Canada due to her hostile family environment and academic stress saying:

> At the time, I was not comfortable to live at my brother's place because the relationship between me and my sister-in-law was not good at the beginning. I was there extra person at their home, and we hardly talked. So, I was stressed, and I wanted to have my own apartment as I told you I like freedom a lot. Then the stress at the university and I lost my connection with my family and parents back home due to the government's intervention in our ethnic community. So, all came together. I was in a big depression. I told Peter I really want to concentrate, but my brain is very foggy and is not clear and I told him I could not concentrate. I really want to take my brain out, wash it and put it back and he said I think you have depressions and we need to find a way to solve it. We went through brain washing process.

Then, Peter made a document on self-confidence and self-respect, and they met over Skype every weekend. Each meeting, Peter taught Lotus how to relax, be happy, and build self-confidence, and also how she could learn to let go of things that irritate her. Lotus further said that at the time she was very sensitive and was even disturbed by the sound of her sister-in-law "making noise with plates and slamming the door in front of [her]." With Peter's help, Lotus learned how to let go, and "letting go helped [her]." Lotus's experiences illuminate how caring attitudes, making a connection, understanding one's client's personality, culture, and family are significant aspects when providing psychotherapy.

In many ways, the counseling relationship Lotus describes with her counselor and friend Peter is more reminiscent of non-Western traditions, with its value on personal connection and community support. However, it is also evident that Lotus' experience was in some ways individualising, as she was prompted to take control of her own mind and self. Lotus was able to adopt these methods, and as a result her personality has moved away from her traditional culture towards Western neoliberal ideals due to her time spent living in Western countries, where Lotus noted she began valuing autonomy and freedom.

Amelin is another woman who saw psychotherapy as extremely helpful, and perceived herself as a responsible and progressive subject who was ahead of friends from her country who also immigrated to Lethbridge in terms of seeking biomedical mental health services. As Amelin pointed out, many of these friends struggled with mental health. Still, they neither disclosed nor sought mental health care as there is shame attached to using mental health services, and they do not see mental health as something that needs professional assistance. Amelin said that she was able to overcome this shame by taking care of the mental health issues caused by her negative experiences in the workplace.

Amelin was pleased that her therapist listened to her with care and without interruption and provided a comfortable environment wherein Amelin felt she could share her stress without hesitation. Amelin even felt comfortable enough to cry when discussing her experiences. Amelin was advised by her therapist about how to understand her office culture, how to go about creating a good relationship with her boss, finding a person who would support her in the office, and meeting and hanging "out with white folks" in order to learn Canadian culture. Amelin actively followed the advice of her therapist and said that it helped her, relaying how she made friendships with two racialized female colleagues who later supported her significantly in coping at her workplace.

At the advice of her therapist Amelin also spent time with white Canadians in order to learn their culture. To Amelin, this was helpful beyond just learning their culture and sense of humor, and it helped her to adapt in her white dominant workplace. She recalls, "[t]hey will tell you a rude thing with a smiling face and by making jokes. You cannot catch their jokes until you hang out with them." Unfortunately, Amelin was criticized by her friends in her community for meeting with white Canadians. Amelin said that "relationships with my country people here is a heart relation," but she had to spend much time with whites to survive in Canada." The above stories illuminate how assimilation is important to survive in the Canadian workplace, how this assimilation is encouraged by psychotherapists, and how individuals can pay a price in terms of their home community and self-identity when such assimilation is 'successful'. However, Amelin said she also preserved her cultural values when hanging out with white friends. As an example, Amelin noted, because "drinking alcohol is prohibited in [her] culture," she always avoided drinking alcohol by using the excuse that she had a medical condition that prevented her from being able to drink alcohol.

Amelin was also advised to learn self-love, self-care, and to work on self-esteem to survive at office and at home, something Amelin did not learn in her culture: "I grew up in a society where we learned that sacrificing is life. We women satisfy people. We learn about satisfying people. The idea has been deeply rooted in our brains; that is why we suffer."

For example, Amelin pointed out that in her culture women were expected to cook every day for the family, even when they felt sick, and would feel guilty if they were unable. By focusing on self-care, Amelin has learned to overcome the feeling of shame and the guilt associated with not satisfying people. According to Amelin, psychotherapy helped her to bring about changes in her personality and become confident in handling things by herself, something that she lacked before.

Amelin's stories depict how she was motivated to embrace a self-caring, independent, and self-loving subjectivity, reflecting her internalization of the importance of these personality traits in adapting to life in Canada. For Amelin, psychotherapy was empowering in terms of working on her personality. Amelin's stories further illustrate how she practiced her agency by combining Western neoliberal and traditional culture strategically to find her wellness.

Jasmine also discussed how counseling helped her to focus on her studies when she lost all motivation. In her therapy sessions, Jasmine was taught how to deal with problems and unpleasant emotions. She was told that she had "flight reflex and freeze reflex, which means [she] do[es] nothing and runs away [from] the problems." The counselor taught her how by ignoring her problems, she was in turn only creating more problems, and explained that: "the body goes into a flight because of a sense of threat and you have to tell yourself that this is not a threat and a small thing and how to focus and just do it." This was a turning point for Jasmine in learning to focus on one thing at a time, complete tasks systematically, and stop feeling so overwhelmed.

Jasmine was also given reading materials on "flight reflex and freeze reflex," and further researched the topic to learn about what she was experiencing. Jasmine was given tools to break down her work into small parts and focus on "separate problems in separate days and take one day completely off" which she says helped her: "Monday, I concentrated on my conference, then on Tuesday on my research, Wednesday was finding a job and I took one day completely off." Jasmine acknowledged her therapist's suggestions as helpful even though, as discussed earlier in the chapter, she found difficulty connecting with her therapist, suggesting that despite this lack of connectivity due to cultural differences, therapy did help Jasmine solve her study stress through practical rational-instrumental interventions.

Jisa noted that psychotherapy was helpful in that it enabled her to discipline her "intrusive thoughts" and help her think "rationally." Jisa was happy talking with her therapist as the environment was non-judgemental and there was not any structure to discussions; Jisa was given space to talk about whatever she liked which was empowering for her:

> I think it made me more self-aware. I always needed to talk to someone to feel better. Through counseling, I learn to make myself feel better, like talk to myself. I tried to trace where my anxiety or sadness are coming from. She told me to be aware about my present, like my surroundings, also to focus on those things that are good and be more, like, rational. So, when I feel anxious, I write down why am I anxious. Also, where that's coming from. I really had like intrusive thoughts. They were very unrealistic, and she makes me write this down and how impossible for those things to like to happen. So, that helped a lot.

Clearly, what Jisa describes here is an embrace of western values in her new ability to manage feelings through logic and discipline with the help of a psychotherapist, which reflects Nikolas Rose's (1999) contention that psychotherapy fuses western and neoliberal forms of "technology of the self" to recruit people to be willing agents in governing their thoughts with notions of 'rationality' and autonomy.

The above discussion illustrates how careful listening and displays of empathy by their therapists helped several women to reduce their pain. After moving to Canada, most of the women missed and lacked family and friend connections and support, and they felt lonely and unsupported in a new country. This led some to actually achieve relationships with their psychotherapists that replicated the level of care they had counted on from family members, but these women were exceptional. Very few women described feeling supported because of systemic barriers that prevented them from creating solid relationships.

Conclusions

This chapter explored how racialized immigrant women experienced using psychotherapy in Lethbridge. I first examined how women reflect on their traditional cultural knowledge of mental health and mental health care practices in order to explore if there were linkages between women's cultural practices of mental health and their experiences of using psychotherapy in Lethbridge. The women's stories illustrate diversified and varied their and their country of origins' cultural perceptions and practices are in regard to mental health. The most common cultural knowledge among the women I spoke with was that mental illness is not real, and they should rely on community solutions for their stress, grief, and pain.

Only a few of the women I spoke with did not know about Western biomedical notions of mental health before coming to Canada; these few women, as a result, did not seek services when they initially began suffering in Lethbridge. The others knew about the Western biomedical notion of mental health, but their traditional ideas made it seem more stigmatizing to seek help or admit a need for it. Some stopped seeking mental health services as they conflicted with their religious or community beliefs, and they did not find biomedical mental health services beneficial to them. I will further address these experiences in the next chapter. Finally, to some women there was no such tension between traditional and biomedical conceptions, and they felt comfortable seeking and engaging in a variety of mental healthcare practices.

However, most of the women experienced a range of difficulties in using psychotherapy in relation to their age, class, gender, immigration status, and other intersectionalities. The encountered hurdles were interrelated, each hindering the process of building a connection with the counselors, which was seen as very important to most of the women I spoke with. Many women found their therapists did not have adequate knowledge about other cultures and did not accommodate or even acknowledge diversity in terms of the women's gender, race, class, ethnicity, age, and immigration status and how these contributed to the women's suffering. As a result, women were often given basic, preplanned, general advice that did not work for them. Some women expected emotional care from their therapists, who seemed unaware of this need, perhaps due to cultural differences.

The psychotherapists generally emphasized an individualistic approach and encouraged the women to take responsibility in finding and implementing their own cure. This approach was difficult for many of the women to manage, as prior to coming to Canada, they were used to depending on collective systems and solutions to reduce their stress and unhappiness. However, because of a pressing need to survive in Canada, several women chose to follow this Western, individualist, logical-rational way of managing feeling and reactions, and they embraced learning to work on themselves. In a sense, they took up and internalized core concepts of wellness that dominate Canadian culture, which focuses on motivated, independent, self-governed, and self-fulling personalities as healthy. This could be read as the women's assimilation to neoliberal subjectivities, but also, it gives some support for the beneficial and empowering aspects of psychotherapy. Women’s experiences in using psychotherapy are thus diverse and dependent upon their immigration status, age, class, cultural perceptions, and their internalization of psychiatric discourses.

Chapter 5: Diagnoses and Treatments: Women's Compliance and Resistance

Introduction

This chapter reflects on one of my key research objectives by examining how the suffering of these racialized immigrant women, which I argue is actually initiated by diverse structural discriminations, had been categorized by mental health professionals, and how these women complied and resisted their psychiatric diagnoses and treatments.

In the stories presented, most of the women's distress was categorized as mental illness by their physicians through the biomedical lens of suffering as an individual problem. While these women sought mental health services due to pain that I suggest is itself a product of neoliberal/colonial and patriarchal culture, the treatments prescribed by their physicians functioned to further encourage the women to assimilate to these misogynist and imperial structures. Thereby, multiple forms of medical power, entwined with patriarchal and neoliberal/colonial power, were simultaneously enacted in these women's lives, pointing to what Foucauldian scholars claim are the ways that psychiatry and medicine align with social norms to construct subjectivities and govern people (Castel et al., 1982; Foucault, 1965; Thoits, 2010), as well as feminist and postcolonial scholars' assertions that psychiatric knowledge and treatment in Canada is gendered (Waldron, 2002) and imperialist (Poole, 2011; Waldron, 2002).

What emerges through my examination in this chapter are the processes by which the women either fully complied with the medicalization and psychiatrization processes associated with their diagnoses, strategically selected which information they chose to comply with, or opted to reject medical diagnoses and rely on traditional and religious practices instead. I suggest that the ways these women actively reflected upon, complied with, or rejected psychiatric knowledge illustrate the post-structural feminist stance that women are produced through discourses, but are also active agents of critiquing, constraining, and reformulating discourses (Butler, 2004; Doucet & Mauthner, 2008; Mahmood, 2001). Nevertheless, it appears that most women's resistance did not challenge medical power, but rather, created their own space to survive within the broader power-relations, which could be read as their daily forms of resistance as Claudia Malacrida (2003) and Lila Abu-Lughod (1990) explored in their research, discussed in the Chapter Two.

This chapter has been divided into two broad sections. First, I have examined how the women's pain, resulting from diverse intersectionalities such as race, gender, class, age, and immigration status, was categorized by their physicians, and how these women complied with the categorizations and experienced medical power in their lives. Then, I examine how and why some women resisted the experience of psychiatric categorization, instead opting out of biomedical, Western ways of understanding and treating their experiences.

Before entering into a discussion of the women's stories of categorization it is important to briefly outline the general theoretical framework which grounded my analysis in this chapter. As previously discussed, within mental health services the medical model is dominant, arguing that mental illnesses have an individual, biological, and biochemical basis (Foucault, 1965; Malacrida, 2003; Thoits, 2010). Thereby, diagnoses and treatments generally rely on the idea that mental illness is a naturally occurring pathology existing within sufferers that can be objectively defined and measured following the *DSM's* explanatory model of mental illnesses (Ussher, 2010, p.12).

However, my analysis is informed by a Foucauldian understanding of mental illness, contending that many social problems have historically been constructed and politically defused as mental illnesses, a process that is linked with the expansion of medical science and psychiatrization of human lives (Castel et al., 1982; Foucault, 1965; Malacrida, 2003; Thoits, 2010). Globally, the American Psychiatric Association has increasingly expanded diagnostic categories and their influence on individuals; in the *DSM-5* more than 400 distinct mental disorders are listed, and today not only psychiatric professionals encourage individuals to work on their mental health. The problem of psychiatrization is that it medicalizes individuals' lives and expands health professionals' power (Crossley, 2004). However, health professionals' power is framed as nonviolent, and conveys knowledge to people as an expression of their own desire, encouraging them to draw on personal moral beliefs to govern their behaviours, thus enacting what Foucault (1978) conceptualized as biopower. Biopower continues to operate today, stressing individual responsibility and conveying a moral load wherein 'wellness' is characterized as a moral good, and seeking it is seen as the mark of a good citizen (Rose, 1992).

In addition to Foucauldian literature on psychiatrization, I drew from anti-psychiatry feminist, postcolonial, and postcolonial feminist theoretical work on psychiatric diagnoses to analyze categorizations of the women in this study. Feminist theories argue that psychiatric categorizations are gendered practices that pathologize women's lives (Chesler, 1972; Marecek, 2006; Ussher, 2010). Women who fail to conform to gender norms encounter violence or become self-destructive and unhappy, for their powerlessness and helplessness in discriminatory hetero-patriarchal culture is often identified as evidence of mental illness, while simultaneously, a refusal of gendered norms is seen as pathological (Chesler, 1972; Marecek, 2006; Ussher, 2010). This categorization is linked to 'correcting' women to follow gendered norms and training them to be happy with gendered culture (Chesler, 1972). Additionally, certain aspects of women’s lives are automatically deemed illnesses by the American Psychiatric Association’s (APA) Diagnostics and Statistical Manuals of Mental Disorders (DSM), such as premenstrual and menopausal ‘disorders’ (Cosgrove & Caplan, 2004; Linder, 2004). Numerous feminists critique the long history of medicalizing women’s misery and see psychiatry as a profession that acts to regulate women (Cosgrove & Caplan, 2004; Linder, 2004).

I consider postcolonial scholarship to analyze how psychiatry has gradually categorized the victims of colonialism and other violent acts as suffering from medical conditions (Khan, 2017). For instance, “psychiatry transforms the horror of Cambodian genocide or the numbing routinization of poverty in urban ghettos into major depressive disorder or posttraumatic stress or sociopathic personality disorder” (Kleinman & Kleinman, 1991, p. 275). The psychiatrization of human suffering as pathology and distress as mental illness dismisses alternative ways of understanding pain in diverse contexts, simultaneously erasing alternative knowledges of life—a form of colonialism that deems others’ knowledge as inferior and western ways of living as naturally good for all people (Mills, 2017). Further, postcolonial feminist theoretical work has been useful to analyze the ways racialized immigrant woman generally suffer more than men do in Canada (Alvi et al., 2012; Guruge, & Khanlou, 2004; Knaifel & Mirsky, 2015;), and as some feminist scholars’ work would suggest, this pain is likely to be categorized as mental illness (Chesler, 1972; Marecek, 2006; Ussher, 2010).

Categorizations and Women’s Compliance

Most of the women I spoke with were diagnosed with mental illnesses by their physicians, though a few self-diagnosed and applied a label according to lay discourses on the mental illness, illustrating their compliance to the psychiatric ways of seeing their distress as pathology. Table 5.1 represents the women’s categorization of mental illnesses. Among the women I spoke with, the majority were diagnosed with depression or anxiety disorders. These diagnoses were often combined with one or more of the following; Borderline Personality Disorder (BPD), Post-Traumatic Stress Disorder (PTSD), Autism, Obsessive Compulsion Disorder (OCD), Attention Deficit/Hyperactivity Disorder (ADHD), and Postpartum Depression (PPD)[15].

Table 5.1: The Women’s Diagnoses

Pseudonym	Diagnosis
Amelin	Postpartum Depression
Arvin	Post-Traumatic Stress Disorder (PTSD)
Jasmine	Depression (self-diagnosed)
Jenifer	Depression and Anxiety Disorders
Jillian	Has not been diagnosed
Jisa	Depression and Anxiety Disorders, PTSD
Lamia	Mild Depression
Lotus	Depression (self-diagnosed)
Mary	Has not been diagnosed
Moumi	Depression and Anxiety Disorders
Natasha	Borderline Personality Disorder (BPD)
Nila	Autism, Generalized Anxiety Disorders, Depression Disorder with Bipolar, Attention Deficit Disorder with Obsessive Compulsive Disorder
Sasha	Depression and Anxiety Disorders

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[15] It is important to note that I am critical of all the psychiatric categorizations, as psychiatry pathologies peoples’ social suffering and normative feeling as neurochemical or biological problem. However, in my writing, I am not using quotation marks when writing different terms of mental illnesses.

Most of these women complied to their diagnosis and followed their physicians' prescription medicine in hopes of feeling better, reflecting some of the process outlined above, where individuals themselves seek 'wellness' and take up a psychiatrized identity. This also points to a process of colonization by Western psychiatric ways of knowing distress. In the following three subsections, I discuss how the women were categorized with several mental illnesses, and I examine how they were affected by the power of psychiatric categorizing discourse and practice, took up and complied with those psychiatrization.

Depression and Anxiety Disorders

Within psychiatry, depression is seen as a biological condition "which can be objectively defined and measured" (Ussher, 2010, p. 10), though it is important to note that the following analysis has been informed by scholars who critique this biomedical definition. In this regard, particularly significant to the discussion is Ann Cvetkovich (2012), who argues that our everyday life produces feelings of despair and anxiety, sometimes extreme and sometimes "the feeling that gets internalized and named as depression" by psychiatry (p.16). There has increasingly been promotion of depression literacy in everyday life by different institutions, along with pharmaceutical companies' active engagement with the medicalization of human misery as depression (Ussher, 2010).

Recent developments and implementation of science and technology, such as applying machine learning algorithms, brain scanning, and Google's installation of an online tool (the PHQ-9) encouraging people to screen their distress and start conversations with their health care providers immediately, have further contributed to the increasing number of depression diagnoses (Vaswani Bye, 2020, p. 5). Technologies such as these also widen the scope of categorization and further legitimize medical intervention into social problems (Marecek, 2006; Ussher, 2010).

Almost all of the women I spoke with were aware of the category before seeking help from mental health professionals, through their consultation with psychiatric discourses on depression by way of social media, schools, clinics, and other institutions, or their prior use of mental health services, and several of these women perceived that depression has an ontological basis. Some women were diagnosed with depression after going to health professionals, while others self-categorized their distress as depression before being labelled by mental health professionals. Regardless of whether they self-diagnosed or were diagnosed by professionals, these women displayed a willingness to take up common discourses about depression as a legitimate descriptor for their feelings.

Nonetheless, it is important to note that the women in this research used the term depression in different ways, which produced different meanings based on their uses. For example, sometimes depression was used to explain stressful life experiences, while other times, some women used the term to indicate that they had a depressive disorder, affirming their psychiatric categorizations by health professionals. This speaks to Janet Stoppard’s (2000) contention that due to the expansion of psychiatric discourse, the word depression has become a part of the vocabulary of lay people. However, researchers contend that there is a connection between using psychiatric terms in describing quotidian suffering and women’s diagnoses, being that those who use psychiatric terms to describe their daily suffering are more likely diagnosed with depression by health professionals than those who do not (Currie, 2005, p. 8).

Taking up lay discourses of depression, several women in this study categorized their diverse injuries, including those related to patriarchal/cultural/colonial violence, as their depression and sought a bio-medical solution for their pain. Moumi is one of the women who labelled the distress she felt from her poor relationship with her husband, financial precarity, and post-immigration struggles, as depression and therefore sought mental health assistance in Lethbridge. Her physicians also diagnosed her suffering as depression and anxiety disorder, exemplifying the process outlined above through which those who use psychiatric language to describe their distress are likely to be diagnosed with mental illness by physicians (Currie, 2005, p. 8).

Moumi said that anxiousness was a common problem for her, even when she was in her home country, saying: "I went to a counselor because I was suffering from guilt and shame for my premarital sexual relationship with my ex-boyfriend as it is taboo in my culture." Nonetheless, as Moumi noted, her anxiety had been amplified after moving to Canada:

> I did not know that it is hard to move to another country as an immigrant because everything is changing. I didn't know the culture, education, everything is different. I even could not talk for several months. When I came here, I figured out that I am shy, I can't talk. I ignored my feeling maybe for years then I figured it out I am not really happy; my relationship wasn't good with my ex. I was anxious about everything. I couldn't sleep well at night and when I woke up, I had to study English. Sometimes due to my anxiousness, I could not walk and work as I felt dizzy and suffered from bad nausea. I feel bad as my stories did not have a good ending. I really feel bad that I am in Canada for a long time, but still I do not have enough money and a good job.

As the above vignette demonstrates, in Canada, Moumi experienced multiple forms of displacement. In Canada, she found herself a split colonial subject, distressed by her inability to express herself; at home, she became fragile due to intimate partner violence. She also suffered due to modern, neoliberal notions of a 'good life', which encourage individuals to take control of their own lives to be successful economically (Martin, 2009; Nettleton, 1997).

While patriarchal, colonial, and neoliberal structures of the context contributed to Moumi's anxieties, she harshly judged herself for her inability to be a 'strong' woman and cope with the demand of the new culture in Canada, which further exacerbated her insecurities and anxieties that she began labelling as pathological conditions. Not only Moumi, but several women in this study said they are from collective cultures wherein lack of women's empowerment or individual achievement of goals is not seen as a problem because caring and passive womanhood is valued.

However, in Canada, some of these women valued goal-directed and economically successful life and therefore saw their inabilities to fit in with this neoliberal culture as their inherent, individual problems. This provides a clear example of the ways these women's perceptions of self were colonized by the adoption of western values. Further, these women were arguably at increased risk of being diagnosed, because the same neoliberal approach is also prevalent in the health care system and implores patients to take individual responsibility for their cure (Poole, 2011; Ted Brown et al., 2005). Moumi's categorization and her self-blame for not being able to solve her suffering on her own both occurred within these neoliberal structures.

Moumi relayed that due to her anxiousness she could not sleep, and sometimes could not even walk, often suffering from dizziness and nausea so severe that she went to "several doctors, one neurologist, and a psychiatrist and had a CT scan" of her brain to identify the "root cause."

One of her doctors explained that dizziness is a “middle age problem” of women and a result of women’s hormonal changes, and provided treatments based on this assumption. Moumi submitted to the health professionals’ gendered knowledge and used antidepressants for six years with occasional drug-free intervals, along with using counselling services in an effort to quiet her mind and emotions; nonetheless, she did not recover. Moumi expressed her guilt and shame for her ongoing anxiousness: “I am really shy and ashamed that I still have anxiety disorders, you know. I do not want to talk about it to other people. I wanna hide it. I do not want to accept it.” Again, Moumi seemed to see her anxiety as a pathological condition and her personal issue.

Taking up lay discourses on psychiatric categorizations, Amelin also applied a medical diagnosis to the distress she experienced in her racist and misogynistic office environment:

> During that time, I had depression. I did not enjoy anything. I was crying for a small thing, perhaps nothing. Before I had some struggles, but I was not affected that much. I have a really good adaptation ability, but at the time, I got angry easily and used to fight with my husband without any reasons. I scolded my son without any reasons. I often burst into tears after coming home from the office. What I felt was that I did not like to talk anyone. I did not like to be social. I did not like to go to a party. I did not like anything. If I saw people, I got irritated. I was so upset, and sometimes I felt like if I could die. Then, I searched for the services and found our company provides counseling services to its employees.

When Amelin went to a counselor, it was suggested she see a doctor because of her headaches and difficulty sleeping. Amelin then saw her family physician, who did perform blood tests, but because Amelin also had a 14-month-old child, the doctor simply diagnosed her with postpartum depression and prescribed her an antidepressant without any further consultation. When we spoke, Amelin echoed medical knowledge that situates postpartum depression not as a social or even emotional issue, but one of a pathologized body, saying that, “Women can have postpartum depression at any time within three years of delivery because it takes three years to settle down the hormones of women after giving a birth.”

The above quote illustrates that Amelin took up biomedical notions of postpartum depression, which focuses on an etiology of the category that sees depressed mothers as a victim of their hormones rather than acknowledging the social and structural forces that may affect women. Natasha Mauthner (1999) contested this model, as it relies on an individualistic approach that it is “regarded as a pathological condition rooted in deficiencies pertaining to the individual mother while negates “looking at broader social, political, economic, and structural contexts and the ways in which they intersect with individual women's circumstances” (p. 145).

Mauthner (1999) argues that “postpartum depression occurs when women are unable to experience, express, and validate their feelings and needs within supportive, accepting, and non-judgmental interpersonal relationships and cultural contexts” (p. 143). Patrizia Romito (1989) aligns with Mauthner in contesting medical science’s pathologization of women’s typical experience of motherhood, arguing postpartum depression should not be understood as an exceptional pathological response, but should be seen as mothers’ reaction to their social, economic, and political circumstances. Romito argues that women often feel overwhelmed after childbirth as they generally do more of the household work and family care, and also suffer from a gendered labour market that inadequately accommodates them. For Romito, the greater they suffer from these inequalities, the greater they are likely to be labeled as depressed.

Echoing the above research, Amelin described an absence of social and family support during her pregnancy, childbirth, and while rearing her child, and she felt this absence deeply.

She also described how her job in a sexist and racist office amplified her stress of adjusting to work outside the home while caring for her young child. Her physician's diagnosis of postpartum depression did not involve serious exploration of these issues, and her experiences support feminist scholars' contentions that psychiatric practices are gendered, focusing on women's bodies as the reason for their distress while delimiting the unequal and gendered culture that impacts women's lives (Caplan & Cosgrove, 2004; Cosgrove & Riddle, 2004; Lester, 2013; Linder, 2004; Potter, 2009; Ussher, 2010).

Amelin's physician's prescription of antidepressants further illustrates that Amelin's body was seen as the basis of her distress. Amelin complied with medical knowledge by disciplining her mind to achieve perceived social normalcy. Amelin said when she lost her 'normal' social and family life due to her difficulties of sleeping, anger, and depression, on the advice of her physician, she took the antidepressant Effexor for eight months. As she noted, Effexor helped her to improve her life by reaching a functional 'norm' as a wife, a mother, a worker, and a social person saying: "You do not know how depression impacted me, even my sex life was gone. It became okay after taking Effexor. The medicine helped me to reduce my anger, sleep better, and to be social."

After eight months, Amelin stopped taking the drug because she felt she no longer needed it and because she was gaining "too much weight." She perceived her weight gain as the result of her hormones changes affected by the drug, saying "the medicine was affecting my hormones that I gained 20 pounds within eight months." However, Amelin experienced severe side effects from withdrawal after only two days. As she explained: "my body was shaking, and I was like I am dying." Amelin immediately went to her physician, who said the drug must be stopped gradually and only after consulting with a physician. Later, Amelin discontinued the drug gradually by reducing the dosages. Amelin's stories suggest that medicalization was not a straightforward process in her case. She tried to employ her own approach to the use of medication, but finally relinquished to expert knowledge. Amelin found that the medical intervention was beneficial for her self-improvement and empowerment.

Jenifer also explained that her whole diagnosis process was very quick, but that her physician's prescription medication helped with her sleeping difficulties and anxiety stemmed from her failure to satisfy her thesis committee. Jenifer described how one day she felt overwhelmed and so sick that she went to the ER and was admitted immediately as she was "looking very pitiable." On that day, a physician first saw her, and she was then sent to a mental health specialist. The doctor asked her "more somatic problems, like [her] stomach pain, sleeping trouble, and then the mental health specialist had a brief talk on subjective emotional tick marks." As Jenifer noted, based on their brief appraisals of her experiences, her doctor and the "mental health specialist explained it was depression and anxiety."

Jenifer was prescribed two kinds of antidepressants: one was for daily use, which she took over the course of six months for her sleep, to calm her mind, and to better focus on her studies. The other medication was for her feelings of restlessness, which she took for few days and discontinued as it made her feel sleepy and nauseous. Besides her drug therapy, she was also referred for psychotherapy, but Jenifer only took the drugs as she wanted a quick remedy to discipline her mind to achieve high productivity to cope with the demands of her graduate school. She said taking an antidepressant required little effort to calm her mind, compared to going to a therapist which she viewed as time consuming, and she was not comfortable or ready to share her stories with a therapist.

Jenifer's stories point to scholars' assertion that, today, people are increasingly relying on antidepressants to resolve their unpleasant experiences, such as sleepless nights, exam nerves, or general sadness, as quickly as they can to achieve productivity and wellness (Ruddick, 2008). Within the neoliberal culture and the expansion of biomedicines and biotechnologies, seeking these services has been framed as a personal and moral responsibility—that is, seeking services to achieve health in order to be a good and productive citizen (Ecks, 2005; Rose & Novas, 2004).

Jenifer's stories could be read as her compliance to neoliberal philosophy, as she used antidepressants to achieve her high productivity; however, her compliance to physicians' advice was strategic because she did not used all treatments she was advised to undergo, but rather only ones she felt best alleviated her pain. For example, although her physician prescribed her two antidepressants, she only continued use of the one that she felt suited her, and she did not seek prescribed psychotherapy, as earlier discussed.

Similar to Amelin and Jenifer, Jisa shared with me an account of being swiftly dispensed a label and medication by her physician. Nonetheless, unlike Amelin and Jenifer, Jisa expressed her frustration with her quick diagnosis and her prescription antidepressant medications. Jisa described how in the summer of 2016, one night she was feeling "very sick, sad, and anxious" and called the helpline, who suggested she "[go] to the emergency room." The next day, Jisa's father took her to a doctor, who saw her "for five minutes and he was just like, here are some pills." Jisa was diagnosed with depression and anxiety disorders, without an explanation. Jisa then went to a pharmacy with her father, but the pharmacist was hiding information from her:

> …the pharmacist took the doctor's note and he was like "please do not read this, just take them." I was really confused about it and my dad was like "do not read them." I asked the pharmacist if he could read the prescription so that I can know

> what's going on and what I will be taking. I was 18 or 19 and started taking antidepressant, Prozac.

As the excerpt illustrates, Jisa was infantilized by the physician and by her family. She clearly wanted more control over her own care. Jisa said that she began taking Prozac without knowing that she was given an antidepressant at an earlier age. Although Jisa was confused about the medication, she took Prozac because she was desperate to get over her pain.

However, Jisa later changed doctors in an effort to gain a better sense of what she was experiencing. She describes her experience with her second doctor as better; however, he also diagnosed Jisa "with clinical depression" after she relayed her anxiousness and sadness. Nonetheless, her new doctor acknowledged that Jisa should have not been prescribed Prozac without an examination, but suggested she continue to take the medication as an immediate discontinuation might amplify her anxiousness. Jisa complied with this doctor's recommendations and took Prozac daily for a year and a half, after which she stopped due to her doctor's warning that "taking Prozac for a long time is harmful."

When Jisa stopped the Prozac, her anxiousness was magnified. Jisa was then prescribed a birth control pill to govern her "mood changes," which she said helped her with her anxieties during her menstruation, but not in other times. At this point in time Jisa does not feel that she has recovered from her sadness and anxiety. Jisa again went to her physician and informed him of her reoccurring feelings of sadness and anxiousness, and she was told that "her brain gets used to being sad" and experiencing "Post-Traumatic Stress Disorder" (PTSD).

Despite the hopelessness this information conveyed in terms of recovery, Jisa appears to have absorbed her physician's explanation about her sadness and anxiousness. Jisa entirely complied with her diagnosis and treatments, unlike the people in her community, who generally relied on praying to relieve their mental pain. They typically do not see such suffering as a medical issue. Jisa said she benefitted from the medicine and psychotherapy to docile her continuous emotion of sadness. This insight reflects the Foucauldian notion of health professionals' power by enabling patients to take care of their mind and body.

Lamia, on the other hand, researched material on the Internet to help her understand ways to deal with her suffering before seeking mental health assistance. As she explained:

> I was struggling with some mental health issues. So, I got information from the Internet and I sorted that my main problem was depression, loneliness, lack of concentration but my one did not last, it just had phases. So, it will be triggered by a few things – homesickness, craving home foods, feeling overwhelmed and stressed by the pressure of the university and financial worries. So, that just broke me down, sometimes it would be okay, other times, it will hit and I just go into a slump.

Lamia arguably took up common discourses about depression as a legitimate explanation for suffering deriving from her vulnerabilities as an international student. Nevertheless, she also expressed her confusion about it:

> I was not doing the stuff that I enjoy. I noticed my grade was going down. I did not want to have much fun to be around. So, I did not want to call it depression, oh I just tell me: "oh this week, I am just going to be sad." That's what I think, or my period is coming. I have hormones, that's what I used to think. Then, I was reading materials and I thought, "Oh, I might have depression." I used to be confused about it, like once in every three months, "That's what I am, depressed." I was like oh I am stressed from school. That's what happening. One time it got so

> bad. I just go to school and go home. That's what I did, like two months straight, people like "are you alive" but I did not know if I was depressed, or I was missing home.

However, Lamia's stories suggest that she was not fully rendered docile by such medical discourses of depression but was instead troubled as to whether her distress could be called depression or not, even though she was diagnosed with "mild depression" by her physician. For her, social problems of isolation, and pressure to perform competed at times with biomedical explanations for her feelings. Lamia's stories speak to Jene Ussher's (2010) assertion that psychiatry's mass-circulated information packages, such as medical journals, self-help books, drug company literature, and health policies discursively construct the biomedical model of depression, and position women's distress as an illness. Her stories also align with scholars' assertions about the ways that online tools encourage people to screen their distress through the psychiatric lens, which further widens the reach of psychiatric categories and medical intervention into social distress (Marecek, 2006; Ussher, 2010; Vaswani Bye, 2020).

Although Lamia was confused about labelling her suffering as depression, she did affirm biomedical explanations about her premenstrual changes, identifying the experience as biologically and naturally negative and debilitating for women. Lamia's stories call to mind the work of scholars who explore how medical science pathologizes women's premenstrual changes as Premenstrual Dysphoric Disorder (PMDD) (Fullagar, 2009; Ussher, 2010). Feminist scholars note that the biomedical discursive construction of premenstrual changes as illness encourages women to take up the subject position of 'premenstrual stress sufferer', through a process of subjectification (Ussher, 2010, p. 14). In this way, Lamia's story illuminates the multiple tensions between lived experiences, lay interpretations, and western medical and psychiatric discourse about women’s bodies and emotions.

Borderline Personality Disorder: Natasha’s Stories

Natasha was identified with Borderline Personality Disorder (BPD)[16] along with depression and anxiety disorders; however, her physician identified BPD as her main mental health problem. Natasha said as a result of her tumultuous childhood, she began suffering from anxiousness and sleeping and eating difficulties nine years ago when she was 17 years old. One of her high school teachers interpreted these concerns as emotional disabilities and referred her to a high school counselor.

Natasha then underwent a wide array of medical and mental health investigations and treatments to identify the “root causes” of her pain. Natasha was upset because she suffered from the same problems for a long time, which was exacerbated in 2018 after fleeing to Lethbridge from her home city. While Natasha moved to end the repetitive domestic and sexual violence she faced at home, she began experiencing more racism and other difficulties as a racialized woman in white-settler-dominant Lethbridge. In the city, Natasha found a lack of cultural services, which left her feeling lonely and excluded, while at her shared residence she experienced insults and racism from white roommates.

In 2018, she recalls having a severe panic attack, and was hospitalized for the first time in Lethbridge:

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[16] The Diagnostic and Statistical Manual of Mental Disorders (DSM-5) defines BPD as “instability of self-image, personal goals, interpersonal relationships, and affects, accompanied by impulsivity, risk taking, and/or hostility” (American Psychiatric Association, 2013).

> On that night, I was breathing very really fast; my heart was strange, and I started to lose all of my feeling like from my legs, my arms and my head too, my teeth which was really strange feeling, then I could not text or anything or even grab the phone. So, I asked google to call 911 for me. Then, the ambulance came, and they gave me all the anxiety medication to help and they diagnosed me with the heart condition and then sent me up to the mental health ward crisis bed here in Lethbridge to stay.

Natasha remained in the mental health ward for few days and was counselled because of her suicide-attempts and self-harm history. Later, she was given Eye Movement Desensitization and Reprocessing psychotherapy — focused on post-traumatic stress. Natasha continued to rely on psychiatric treatments and switched between five psychiatrists with the hope of recovering, but doctors could not definitively explain the basis of her pain:

> I went to five different psychiatrists; Dr. [X] referred me to Dr. [Y]; he is a psychiatrist, who referred me to an internist in downtown who referred me to a specialist who referred me to the last guy, and I was like, "Can you just figure this out," and he was like, "Yeah, you have a borderline personality disorder." The whole time I had borderline personality disorder, and anxiety and depression are just symptoms of it. Borderline personality disorder is a type of disorder, you don't really know who you are. It's like a specific set of characteristics in a person that makes them very hard to make friends with and very like dysfunctional and yeah, it's very complicated and I was just diagnosed with it.

Here, Natasha has drawn heavily upon expert knowledge, and begun to see her personality as problematic. She further expressed her frustration that because she has BPD, she finds herself unable to create meaningful relationships with friends or a man she dated, and does not feel ‘stable’—finding herself extremely happy one day and awfully miserable in the next, to the point where she has attempted suicide and self-harmed several times. She went on to describe herself as a risk-taker, recalling a time when she impulsively left home for three weeks to meet her online boyfriend in the United States, as well as when she abruptly moved to Lethbridge in an attempt to escape sexual and domestic violence. Natasha says her parents wanted her to be a tough person and have a successful career as a doctor, but she did not succeed academically. Natasha eventually went to school for a nursing degree but left as this was not the career she wanted. Through an anti-psychiatry feminist lens (Berger, 2014; Bjorklund, 2006; Chesler, 2018; Shaw & Proctor, 2005), it can be read that Natasha’s personality has been pathologized because she engaged in many risky behaviours, such as self-harming and attempting suicide, which are seen as ‘unwomanly’ behaviours in patriarchal culture, where passive and loyal womanhood to their violence is encouraged.

Some feminists contend that it is in fact, because of its ‘symptoms’ sui generis a gendered problem for women. In other words, these symptoms are seen as pathological only when the patient is a woman, as risk-taking, aggression, impulsivity are seen as pathological, while these same traits are often normative for men. The diagnosis places women’s response to their oppression as their individual pathology without understanding women’s responses to their violence within the social context of sexual violence and gender power relations (Shaw & Proctor, 2005, p.483). Thereby, the categorization needs to be understood within the psychiatric power that has been informed by a highly gendered culture. BPD is typically applied to women rather than men because of this interrelationship. For Natasha, gender along with racial power relations are significant issues to understand her damage.

The following excerpt further illustrates Natasha's internalization of the problematic discourses of BPD that she began seeing, in which deficiency is a fundamental attribute of people with BPD:

> I have met one close classmate friend because he had borderline personality too. I did not know that but we both started to be alone and nobody in the class would talk to us, nobody. We were like why; we do not know. Then we started taking with each other and we got along perfectly. And he was like, "Do you have borderline?" I am like, "Yeah, that's why no one coming to us."

Natasha's stories open up Foucauldian scholars' claims about the ways psychiatric categorization divides and dispositions people in society, leading them to internalize and govern their lives through this categorization and encouraging individuals to work within it to achieve normalcy (Castel et al., 1982; Malacrida, 2015; Thoits, 2010).

Natasha wanted to achieve balance with the help of biomedical treatments. She said after undergoing a range of treatments and medications, she found an antidepressant drug helpful:

> Without medication, I am like a blob, just stay in the bed, I do not come to class, I do not eat and sleep; then, I start medication and then get off and do things….You know medicine does not always work. So, you just keep switching between medicines because different medicines have different effects on different people. Mainly, I started, when I came here, I got a good doctor, who first prescribed me Venlafaxine, but that one the wrong one that made me really evil, one of the murderer people, very violent because psychiatric medicine can change your brain and it can change lot of things. I was just fighting with big men.

Natasha said that she had been using antidepressants for the past two years. During this time, even though she experienced side effects of antidepressants and withdrawal symptoms, she trusted her physician's knowledge profoundly and constituted herself as an active subject pursuing treatment pathways toward a stabilized recovery. She expressed her reliance on psychiatric knowledge this way:

> Doctors give drugs because it helps to change your brain, it stimulates different parts of the brain, but it teaches your brain to do it itself, so, like, there is high chance that I do not have to be on medication forever, it's just like for now. And if my brain never learns to be happy on its own, that's fine, I will just keep taking medications.

In Natasha's life, antidepressant therapy has operated as a form of biopower by encouraging her to govern her psyche to align with a neoliberal happy self-hood in Canada, and through her active desire and participation to achieve these goals. Her stories align with scholars' assertions that the philosophy of antidepressants has been influenced by neoliberal principles; individuals are given medications to alleviate negative emotions as they are seen as barriers to happiness and productivity (Fullagar, 2009). Although sadness and happiness can coexist and are normative reactions to an individuals' life events, the emotion of sadness has been pathologized within neoliberal contexts that insist upon individuals' high productivity; psychiatry assists in pathologizing sadness (Cvetkovich, 2012; Fullagar, 2009). Natasha's categorization thus illustrates her diagnosis has been influenced by gendered cultural expectations (Berger, 2014; Chesler, 1972; Marecek, 2006; Ussher, 2010), as well as neoliberalist notions that highlight individuals' need to maintain stability (Bradley & Westen, 2005; Berger, 2014).

However, as Natasha noted, she was actually helped through these interventions, similar to some other women in this study. Thus, findings from this research suggest women's use of mental health services changed them in such a way that, at least for some of these women, some things, such as tradition, connection, values are lost, while other things like life satisfaction and feeling of wellness are gained. Thereby, women's experiences also indicate the beneficial aspects of medical care, but that it's complicated, and particularly so when those interventions are not helpful and too contradictory to these women's traditional notion of mental wellbeing. In the following section, Nila's stories explore the complicatedness of these interventions.

Multiple Diagnoses: Nila's Stories

Similar to Natasha, Nila also underwent a wide array of psychiatric treatments. Nila said she was diagnosed with diverse mental illnesses including "autism, generalized anxiety disorders, depression disorder with bipolar, attention deficit disorder with obsessive compulsive disorder." Nila described how she was taken to the psychiatrist when she was six-years old in her home country, as she was friendless, lonely, and different from her peers— and her mother perceived such concerns as an indication that Nila needed medical attention:

> I was taken to a psychiatrist when I was six years old. Part of that because I was a weird kid with no friends, and I was sad all the time and that was bad. Instead of helping me to be more social and find me crowd and my mom was like "take her to the psychiatrist, I am sure they will fix it." And it did not because the problem was largely social. I was somewhat isolated and lonely, and it got fixed when I had a couple of friends. Then I came here; so, I did not have many friends again and I started being depressed again.

In certain psychological discourses, it is recognized that when a person experiences extended periods of loneliness there is a risk of developing biological dysfunctions, psychological distress, and behavioural problems, which need proper diagnosis, care, and management. This may be termed as ‘pathological loneliness’ (Hawkley & Cacioppo, 2003; Tiwari, 2013, p. 322).

Further, in the West, childhood differences that may not necessarily be deemed problematic and/or pathological in other contexts and regions of the world are labelled as such, because a far broader range of behaviors are identified or perceived pathological due to psychiatric professional infrastructure development in the West (Malacrida, 2003, p.18). Nila’s mother arguably reflected such ideals associated with her social differences and inability to make friends, believing even before her daughter had seen a mental health professional in their home country that there was a medical solution to her challenges. Nila’s stories speak to scholars’ claim that psychiatrization has increasingly become a global phenomenon (Ecks, 2005; Khan, 2017). In fact, Nila’s mother took psychiatric discourses to understand Nila’s friendliness and loneliness.

While Nila was critical about her mother’s decision to take her to a psychiatrist, she appeared to categorize her friendlessness and loneliness as pathological and a result of her autism. Nila told me that she was diagnosed with autism[17], as she could not make a proper connection with people or convey her emotions, and because of this she does not have friends. Nila said that people think she is “disorganized, hostile, angry, and intimidating,” even though

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[17] American Psychiatric Association (2013) defines autism as “[d]eficits in social-emotional reciprocity, ranging, for example, from abnormal social approach and failure of normal back-and-forth conversation; to reduced sharing of interests, emotions, or affect; to failure to initiate or respond to social interactions and so on”

she feels she is none of these things. She describes trying “not to be intimidating and to be approachable”; however, “for some reasons, I just [come] across as cold and emotionless.” She discussed how she often monitors her expressions and behaviours, as she thinks that because she is autistic, she cannot communicate ‘appropriately’:

> It may also be the way I present myself, you know; one time, I was having a weird pain and I was talking to someone about it and it turned out that seeing a photo of me, my face does not look that I am in pain. And so yeah, may be the way I expressed my actual face, the emotions I feel, it seems muted to people somehow. I try not to. You might have noticed during our conversation shifting my pitch a lot and that’s another thing that I try to modulate my speech so that people think of me as less robotic, but it stills tend to be happen and people stills tend to be intimidating by me.

As the vignette represents, Nila internalized the normalized discourses around communication to such an extent that she monitors her facial and other expression to fit into society, which she said costs her emotionally. She often feels isolated from others and fears that she could not convey the appropriate message to people around her.

Nila’s stories further could be read in the context of Chloe Silverman’s (2007) argument that normative social expectations are problematically related to labelling some children as autistic. Silverman notes that the construction of autism as a pathology rather than a human difference is linked with the normative notion of “whole personhood,” in which a person cannot be a “whole person” without having an ability to communicate ‘appropriately’ (p.7).

Additionally, Silverman argues that, similar to other disorders, autism has become a site for experimentation in post-industrial modernity, where a range of techniques and specializations have developed to define ‘normal’ human lives. In other words, it is an inseparable part of a larger story about biomedicine, and the dominance of biomedical models in psychiatry that relies on the perception of mental illnesses as a result of neurochemical imbalance (Malacrida, 2003; Rose, 2003; Silverman, 2007). The American pharmaceutical industry, brain imaging, and other computer-based techniques have reinforced the idea that autism is something that is firmly lodged in brain structure and function (Silverman, 2007). These technologies produce specific types of knowledge about human bodies, placing individuals under biomedical surveillance. Such categorization is problematic, as it leads individuals to self-surveil their behaviour; we see this in Nila, who continuously scrutinizes her behaviours and life, and sees herself as lacking.

Nila noted that she was also diagnosed with Obsessive Compulsion Disorder (OCD)[18] and anxiety when she told to her physician that she overthinks her identity, behaviour, and beauty.

> You know how people watch soccer and hockey games. [My country people] watch beauty queens. And so, from childhood, I have been fed this notion that you have to be 90 60 90 measurements. And I have like 115 85 110; you know that’s my measurements. So, that’s a lot more than ninety sixty ninety. I do not think that I look particularly bad but because of the bullshit beauty culture that’s been embedded into my psyche, I am fairly insecure about my appearance. I know it is

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[18] According to DSM, “OCD is characterized by the presence of obsessions and/or compulsions. Obsessions are recurrent and persistent thoughts, urges, or images that are experienced as intrusive and unwanted, whereas compulsions are repetitive behaviors or mental acts that an individual feels driven to perform in response to an obsession or according to rules that must be applied rigidly” (American Psychiatric Association, 2013).

> stupid, it is a terrible cultural package. The problem is that it still affects my psyche.

Nila's overthinking is certainly related to heteropatriarchal culture, where women are largely judged and valued based on their appearance. In everyday life, women are continuously encouraged by the media to work on their bodies and wear makeup to 'empower' themselves, which becomes the 'feminine ideal'. Women increasingly focus on this ideal in order to feel included within the regimes of patriarchal structures (Bartky, 2015; Bordo, 1990).

Further, Nila's anxieties around her appearance arguably arise from her culture, which is obsessed with women's beauty, as Nila said. In her home country, breast augmentation surgery is prevalent; her aunt had the surgery, and her stepmother is very concerned about women's beauty. Surrounded by such people, Nila noted, she developed insecurities about her appearance and confessed that sometimes her lack of dedication to achieve 'feminine ideals' and her ongoing anxieties around her body, speaking, and expressions contribute to her overthinking. While Nila outlined how patriarchal and neoliberal cultures have impacted her life, she mostly used expert knowledge to explain her suffering, enacting self-governance to align with the diagnoses she was dispensed. However, it is also important to note how Nila contested medical treatments and biomedicines. The following section reflects on Nila and other women's resistance of psychiatric treatments.

Refusing Psychiatrization and Medicalization

To many postcolonial scholars, the West is everywhere in mind and in structure; as a system of knowledge, the West has produced itself as superior while naturalizing its colonial power as beneficial for colonized people, leading them to alter their cognitive thinking and their ways of living to match Western norms and structures (Khan, 2017; Lock & Nguyen, 2010; Mills, 2017; Nandy, 1983; Scheper-Hughes, 1987; Spivak, 1988). Although people increasingly question the presence and legitimacy of colonial power, it holds firm (Lock & Nguyen, 2010) and today in Western society, the mass of racism is perpetuated through its legal systems and other institutions (Gillborn, 2018) and the "majority of racism remains hidden beneath a veneer of normality and it is only the more crude and obvious forms of racism that are seen as problematic by most people" (Gillborn, 2018, p. 339).

Within this systemically racist structure, it is hard to resist colonial power, particularly when it is presented in the form of social good, saving and protecting human lives and health, such as in the case of medical and psychiatric knowledge. Most of the women in this study moved to Canada based on the belief that the West is a better place to live. However, the majority also suffered in their post-immigration surroundings, often as a result of being excluded and feeling as though they were treated as others, in addition to the domestic violence some faced in their relationships. Certainly, these women had limited power to overthrow the discriminatory structure and norms that contributed to their stress thus complicating Foucauldian notion of "power as circulating and available to all subjects" (Malacrida, 2003, p. 241).

Yet, remarkably, several women in this study did resist psychiatric knowledge, their diagnoses, and their treatments, along with some patriarchal and colonial norms that they were not comfortable adopting or recognized to be hindering their lives. Many women accepted the patriarchal and colonial norms only as long as they felt was necessary to survive or succeed in Canada, as discussed in Chapter Three, actively selecting the norms they would conform to or reject, which could be read these women's agency. This is a clear demonstration of Butler's (2004) notion of resistance, in which individuals are active in conforming and nonconforming to norms/power. However, the resistance of these women was more significantly motivated by the need to create a space to live within neoliberal/colonial and patriarchal power relations, and thus could also be read as exemplifying Abu-Lughod's (1990) and Malacrida's (2003) visions of daily forms of resistance that the women enmeshed with the diverse power relations they engaged with.

The following section will reflect on the women's stories of refusing medical diagnoses and treatments, demonstrating their enactments of agency. In terms of a response to biomedical interventions, it emerges that for many women, their resistance to psychiatric treatments largely occurred because of their dissatisfaction with the services and biomedicines being offered. However, some women declined treatments because of their reliance on cultural ways of healing their pain.

One example is found in Jillian's story, as her refusal of psychiatric diagnosis and treatment was directly tied to her reliance on cultural ways of seeing and healing her suffering. Jillian moved to Canada in 2013, when she was 15 years-old, from South-East Asia with her father and siblings. They also joined her mother, who migrated to Canada as a worker in 2007. Jillian explained that when she moved from a large city in Canada where her family lives to attend her first year in an undergraduate program in Lethbridge, she was living by herself and was not motivated to go to the university. She was not doing homework or going out to meet people and was staying bed most of the time.

Jillian did not identify any of these behaviours as symptoms of depression, because in her community and family, such life states are simply perceived as laziness, and those experiencing these feelings are advised to "just get up and start working and to pray to the God." Although Jillian noted that "here in Canada people may call it depression and they would go for help," she did not seek mental health services because, influenced by the perceptions of her community, she saw these states neither as psychiatric issues nor urgent things that needed professional help.

Nevertheless, in her second year, having been exposed to the discursive construction of mental illness in Canada, Jillian did seek out counselling services at her university. However, she stopped after only a single use of the service, as she ultimately felt that psychiatric knowledge and treatments were too contradictory to her cultural and family definition of mental illness and her healing practices. Following this experience, Jillian began praying and relying on God, along with strengthening her community connections to improve her wellbeing. By so doing, she took a step to resist colonizing her life according to Western individualistic culture and treatment. Jillian explained her defiance of medical knowledge and the prescription of antidepressants by saying:

> I have doubts about the existence of mental illness, and I think it is a Western thing… I have doubts about it. For some people it is real, for some, it is not. My brother told me mental illness is not real and antidepressants are a placebo. When patients take pills, they report that they get better, it's not the antidepressant that helping them, like you know chemically it is fake, but they think as they are taking antidepressants, they are getting better.

Sasha, who moved to Canada as an international undergraduate student from southern Africa, also mentioned similar dynamics in her stories of refusing psychiatric diagnosis and treatments. However, unlike Jillian, she was strategic in her compliance and resistance of biomedical treatment; while Jillian completely rejected the biomedical notion of mental illness after only a single use of psychotherapy, Sasha engaged with psychotherapy for a significant amount of time before rejecting the service.

In her first four years, Sasha underwent family crises, financial precarity, and study difficulties that led her to seek help from physicians and four psychotherapists over several years. Though she had hoped to see benefits from this process, she eventually stopped using both services as they ultimately were not helpful for her. She was particularly skeptical of medical interventions, saying:

> I was feeling tired all the time, but the doctor said I have depression and prescribed me an antidepressant. She even told me about birth control pills, just giving different options… These are the reasons I stopped going to the medical treatments because I felt like it kept going one issue to another.

Sasha did not accept her physician's categorization or take antidepressants because her family members generally avoid biomedical treatments. As Sasha noted: "My parents do not like medical treatments, even when I went to a doctor for my eyes and my parents said that I am not drinking water that's why my eyes are dry."

When Sasha went to a nutritionist, her aunt, who lives in Canada, saw it as stupid and unnecessary; when she used psychotherapy, she was criticized by her family and by her community peers in Lethbridge because "the service is not advocated" in Sasha's community. Instead, it is more common for individuals to share their distress "with their close friends and family members who they can trust."

Sasha further described that her refusal became more solidified when she was able to relieve her distress by practicing her culture and religion noting: "I always depend on Allah and I pray even when I used psychotherapy, but from 2019, I have been relying on Allah fully and becoming closer to Allah and that reduced my stress level." In addition, Sasha also said she began to take more breaks from her work to spend time with her community friends:

> I work and give my time to my friends because I knew working all the time is not good. So, I cook for my friends. I make people happy. That makes me happy. It's a kind of achievement … If I am with my friends, I can manage stress because we have common things to discuss and we are in a same situation. We remember each other when we apply for an extension of a study permit and renew our passports, which strengthens our bonding and gives us a sense of belonging and security…

As discussed in Chapter Three, Sasha was raised in a family where women's caring is valued. After first moving to Canada, Sasha had been attempting to please her aunt by sacrificing her own needs, but she was stressed. Later, Sasha wanted to embrace Western culture by being an individualistic and independent woman, focusing solely on her own well-being. However, she ultimately returned to her culture and religion to get what she feels is meaningful relief. In her stories, we can see she actively reflected on two sets of knowledge (medical and cultural healings) and subjectivities (original cultural and neoliberal), and complied with, resisted, and combined two sets of knowledge and subjectivities (praying and psychotherapy) to achieve meaningful relief, which could be read her enactment of agency.

Lamia's stories also represent her strategic compliance and resistance to biomedical mental health treatments. Similar to Sasha, Lamia also avoided biomedicine based on her family's beliefs, but used psychotherapy. However, she later rejected psychotherapy because the advice she was given placed responsibility for finding solutions to wellness on Lamia herself, whereas she wanted a collaborative process of support to ease her pain. Consequently, she focused on strengthening her community connection as therapy: "I realize that if I am by myself for too long, I will be slipping into depression. If there is not social interaction, I start thinking and anxiety comes in. I start overthinking; that's why you are getting overwhelmed." Lamia further explained her non-compliance to biomedicine by saying:

> I know medication is not bad, but the way I was raised we don't do the medication like that. Like when it comes to medication, the basic medication is for stomach or headache, but if I need pills to boost my mood every single day that does not go very well with my family. If I tell my friends, "Hey, I am on antidepressants for new two years of my life, they will not take this seriously." I try to avoid it as much as I can.

Scholars note that Western biomedicine is one of the most powerful tools of colonizing processes; by replacing and/or reformulating traditional healing systems with biomedical discourse and practice, colonial empires assert authority and power over the colonized body (Lock & Nguyen, 2010; Arnold, 1993). In this research, Sasha, Lamia, Jillian, and by extension, their families and communities defied Western biomedical colonization and normalizing discourses of biomedicines as necessary to healing mental distress.

Not all resistance in this study came as a result of family and cultural beliefs. For example, Nila's refusal was driven by her dissatisfaction with the diagnostic process and her experiences of severe side-effects with antidepressants. Nila sought psychiatric and medical assistance for the past ten years; yet, she did not get relief from her pain. Nila explained her frustration with this process by saying:

> I think psychiatry is bullshit because I have all of these diagnoses, but 95% is based on like a little questionnaire that changes from time to time and the answer can change by the mood of a person….And most of the time, at least for me,

> diagnosis does not seem to be very useful because they kind of throw drugs on me that do not work.

In this excerpt, aligning with some scholars, Nila defied the taken-for-granted assumption that psychiatric categorizations and treatments are scientific and enduring (Lock & Nguyen, 2010, p.59) and allied with some scholars' contention that psychiatric diagnosis are subjective, depending upon how patients describe their problems and how the health professionals interpret their stories (Berger, 2014). Nonetheless, psychiatry is increasingly expanding throughout the world by claiming its knowledge to be neutral and following a scientifically-based taxonomy of symptoms to diagnose patients (Berger, 2014; Kleinman, 2008; Ussher, 2010).

Nila's resistance was further bolstered by her severe experience of side-effects of anti-depressants:

> I used many antidepressants, but I stopped when I had fluoxetine attack. I have taken Zoloft, Cipralex, Effexor and there is a couple more I forgot. I tried Effexor first that did not work; then, I tried Cipralex and that worked for a while then it stopped working. Then, I tried Fluoxetine in the last Spring that ruined my life. I took 5mg of three days in a row. Of note, this is 10mg pills. So, this is half dosage and I was suicidal for basically for all of that week and I could not do anything for most of the next week and my life was collapsing. So, because of that I stopped taking the drugs.

Antidepressants have even created some permanent discomfort for Nila:

> One thing Effexor did to me permanently is that I can feel my pulses in my hands, like right now I can feel my pulses. Can you feel your pulses? I can feel it in my

> fingertips, like I am feeling my blood is pumping in my vein. I did not use to have that and now I do, and this is weird. So, if it is quiet and I am alone I will be noticing this, and it is like, "What the fuck?" It started with the Effexor and it did not stop. Then, another thing started, migraines happened. I did not have it until I took Effexor, even after stopping taking it I have it. Now I am having migraines on and off, basically every day for two weeks. It used to be once every few months and before that, I never have them.

Nila's experiences reflect the anti-psychiatry literature that argues psychiatric drugs are more threatening than they are made to seem (Currie, 2005; Fabris & Aubrecht, 2014; Farber, 1992; Gardiner, 1995; Read et al., 2014), as these medicines can have severe and undesirable side-effects including suicidal tendencies, biochemical imbalance, anger, weight gain, death, and numbness (Currie, 2005; Fabris & Aubrecht, 2014; Farber, 1992; Gardiner, 1995). Many survivors who were given psychiatric medication experienced negative side-effects and later resisted not only the medications but also the notion of mental illness, as the labelling process assisted in the coercive psychiatric treatments (Fabris & Aubrecht, 2014, p.185).

Additionally, feminist scholars contend that women generally experience higher rates of the most harmful side effects of SSRIs[19], as a result of patriarchal cultural structures that make women more likely to be categorized as mentally ill (Currie, 2005; Hamilton et al., 1996). Echoing the above research, Nila describes how she was diagnosed with OCD, anxiety disorders,

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[19] It is important to note that Selective Serotonin Reuptake Inhibitors
(SSRIs) are widely used in the treatment of depressive disorders and anxiety disorders (Renoir, 2013). The medical science's explanation is that SSRIs increase serotonin of brain and helps people to feel better (Renoir, 2013).

and depression and prescribed antidepressants because of her overthinking of 'feminine ideals' and her other attributes.

Mary also challenged physicians' unnecessary prescription of antidepressants in her home country saying: "I could not make sense of why the doctor gave me the Selective Serotonin Reuptake Inhibitor when I was grieving over my grandmother death." Mary explained that:

> I was sad, and the doctor probably thought I am depressed. I have used the medication for three weeks, but not for my mental health in that sense, but the doctor suggested. They did not help me. They only made me sick. I was super dizzy all the time. I even could not get out of bed. I was so weak that even I could not go to work. I was like, what the hell, I never had like this before.

Mary said that she did not use any antidepressants after having such severe side effects. Yet, it is worth noting that she is a regular user of psychotherapy and found it very beneficial for her survival, self-improvement, and empowerment in a structurally different country, as discussed in Chapter Four.

For Mary, mental health discourses were enabling, and her compliance with mental health services could be seen as her strategy to resist her race and gender based social subordination and suffering that she experienced in Canada and for what she sought mental health services. Mary also noted that she used her traditional culture to relieve her stress and enhance her mental wellbeing, such as maintaining good family, social and community connections. Here, we can see how Mary used various elements creatively for her wellness, an example of the strategic compliance that she exercised through active reflection on the diverse treatment approaches, and through her compliance with psychotherapy and rejection of biomedicines. There is no dichotomy between resistance and compliance in her stories because

Mary complied with psychotherapy to resist her racial and gender-based discrimination and subordination in Canada.

Natasha's stories also represent her strategic compliance and resistance to biomedicines, although she drew heavily on biomedical discourses of mental health in labelling her suffering and also for her cure, as discussed earlier in this chapter. The following narratives explain Natasha's agency in resisting biomedical knowledge:

> They thought I was being moody because I was a girl. They prescribed me the birth control pills before giving me the antidepressants ... the doctor was a man, he automatically assumed that it is your period because you are a girl and emotional.

Natasha resisted her physician's misogynist interpretations of her emotions and the prescription birth control pills. More resistance can be found in Natasha's stories when we look at her experiences of using psychotherapy, discussed in Chapter Four; here, she discusses how she switched between several therapists, as she did not like their therapy generally focusing on building a rational mind as a cure for sadness and suffering.

Several other women's responses to and pursuit of psychiatric and medical knowledge cannot be understood by utilizing simplistic resistance/compliance debates. Their stories indicate that this is a far more complex process, whereby women complied with, rejected, or combined psychiatric and traditional knowledge sets. In summary, in this research, the resistance of several women to biomedical mental health services mostly ensued due to their dissatisfaction with mental health services, and their reliance on cultural ways of relieving suffering.

Conclusions

In this chapter, I explored each woman's diagnosis and treatment focusing specifically on their compliance and resistance to medical power. In doing so, I illustrated the ways in which biomedical, neoliberal, colonial, and patriarchal power uphold one another and work together. This is demonstrated by the fact that women sought mental health services due to suffering that I argue occurred within gender, patriarchal, and colonial discourses and power relations. However, the treatments prescribed by their physicians operated to further urge the women to adapt to these misogynist and imperial structures by neoliberalizing their minds.

Findings from my research suggest that women suffered from diverse webs of power relations. Non-conformity to feminine ideals and gender norms, and sexual and intimate partner violence, damaged several women emotionally. For some women, alienation resulted from not sharing and fitting into the mainstream neoliberal culture and subjectivities in Canada, such that they sought mental health services because of it. Some other women's pain resulted from racialization and racism in the home, at the workplace, in public space. Women's emotional damage contributed to their anger, deep sadness, as well as difficulties in sleep and low appetite and energy and some other health complications.

By being exposed to the psychiatric discourses of mental illness, most women viewed these distresses as indicators of psychiatric pathology, and therefore sought mental health services. The majority were diagnosed with depression or anxiety disorders by their physicians. These diagnoses were often combined with one or more of the mental illnesses including BPD, PTSD, ADHD, OCD, PPD and Autism. Few women even took up lay psychiatric discourses and self-categorized their pain. A biological explanation of the women's distress was given to most of the women by their physicians, who suggested biomedicines as the most potent remedy to take control of their own bodies and minds and engage in self-discipline to be a good/productive citizen, wife, worker. This explanation does not consider the effects of social context and diverse power relations on women's distress.

In these women's lives, this categorization fostered social control through the insistence that they take control of their own bodies and minds and engage in self-discipline, as well as by dividing and segregating them from the society. Some of these women drew heavily upon perceived expert knowledge about their categorization, coming to the understanding that they have ontological issues and must govern their minds by taking antidepressants. Several women explained that medical interventions and treatment was beneficial and enabling for them to achieve wellness and self-improvement. However, some other women's experiences were complicated when the intervention was not helpful for them.

It appears that these women actively reflected on these discourses and the power operating within them. Several women took some biomedical health treatment and resisted other treatments in finding their mental wellness and sometimes combined two sets of healing practices to relieve their pain. Some other women completely resisted medical treatment, in particular biomedicine, at various points as a result of the embodied suffering they faced while taking their prescribed treatments. Importantly, some women rejected and stopped using any sort of biomedical mental health care because they found them to be too contradictory to their cultural and family definition of mental illness and their healing practices. These women relied on praying and on God, along with strengthening their community connections to improve their wellbeing. By so doing, they took a stride to resist colonizing their life according to Western individualistic culture and treatment.

Chapter 6: Women's Suffering and Mental Health Services: Specificity to Lethbridge Context

Introduction

My focus on racialized immigrant women's experiences with using mental health services from the context of a small Albertan city did not principally aim to search for a better mental health approach, as most mental health studies tend to attempt. Rather, the women's narratives in this study have been, in part, a response to scholars' claims about the ways in which normative suffering has been constructed as mental illness, the ways that psychiatric knowledge is gendered (Caplan & Cosgrove, 2004; Chesler, 1972; Ussher, 2010) and imperialist (Fanon, 1961/2007; Fernando, 1988; Khan, 2017; Keller, 2001), and the perpetuation of truth claims regarding the 'scientific' ability to help people with their suffering (Waldron, 2002).

I believe that asking the women to speak for themselves about why they sought mental health services in Lethbridge provided rich views about the complexities of the many intersections of subordination they experienced in the small city, in particular those which damaged and made them doubt themselves, their abilities, and their chances at a better life. The women's experiences interacting with Canadian mental health professionals, and their compliance with and resistance to the diagnoses and treatments, also uncovers a thread linking the medical, neoliberal, patriarchal, and other power relations operating in their lives.

In this concluding chapter, by bringing together the main findings from the previous chapters, I offer a rethinking of the biomedical model of mental illnesses and its conceptualization of mental illness as a naturally and universally occurring pathology that exists within sufferers. Ultimately, I argue that current framings of mental illness obscure or render invisible the structural, cultural, and professional power relations that operate both to the benefit and detriment of clients. Further, these power relations are often seemingly invisible to service providers, as demonstrated by the experiences these women shared. The women's stories show us how well-intended professionals can unintentionally inflict violence, or normative notions about the ideal citizen, the good patient, or the well person upon women. Further, these ideas and discursive practices can find their way into many of the women's ways of seeing and knowing their worlds and themselves – not always to good effect.

Suffering

As we saw in Chapter Three, while most of these women believed moving to Lethbridge would be an uplifting experience, they were confronted with the new culture, structure, education, and environment of Lethbridge. Most of the women did not receive culturally appropriate accommodation or support for their integration into this new world; rather, they were required to assimilate to a new system that jeopardized most of their 'original' cultural practices, previous knowledge and ways of living, in ways that ultimately impacted their sense of self, identity, and well-being.

The women in this study often lacked a sense of belonging due to their different identity, culture, and interests, which did not conform to mainstream social 'ideals'. Because of these differences, most of the women self-isolated from the dominant group in Lethbridge. Some of them developed a form of double-consciousness due to their frequent experiences of racism and discrimination against their skin colour, identity, culture, and language, in which they began seeing the world through two lenses, with both the perspective of their 'original' culture, and that of mainstream Canadian culture. This process was alienating for them, as they came to view their identity as problematic and lacking, and their self-confidence was compromised by the emotional damage this caused.

In addition to these experiences of racism and ethnocentrism, various combinations of intersecting identities including gender, class, immigration status, age, and other minority statuses exacerbated the women's distress while living in Lethbridge and other Canadian cities. Noncompliance to gendered norms and feminine ideals, along with other forms of violence, contributed to Nila, Mary, Moumi's distress. Jisa, who did not receive any accommodation support because she migrated to the small town of Lethbridge, further experienced pain related to the intersections of her class, age, and ethnic background. Financial precarity, immigration status, gender, race, domestic violence, new education, and cultural differences contributed to Sasha's "numbness". Lamia, Jillian, Sasha, Jasmine, Jenifer, and Lotus's pain was exacerbated by the high demands placed upon international students, related to differences in language, cultural, and educational systems. Mary, Sasha, Natasha, and Moumi experienced domestic violence at home, and Arvin, Sasha, and Natasha suffered from sexual violence along with other distresses.

Because some of these women (Moumi, Sasha, Natasha) were unfamiliar with the new culture and laws in Canada or dependent on their family members they could not seek social and legal support to flee abusive relationships or environments. These women often felt helpless, as they lacked the kind of community connection and support that they relied on before coming to Canada. Additionally, these women faced a double bind within their communities; if they disclosed violence or left abusive situations, they risked losing what community support they had because they would be going against gendered cultural norms held by their cultural groups both at home and in Canada.

The women’s stories reveal suffering from a range of intersecting subordinations, contributing to sleeping and eating difficulties, low energy, iron deficiency, lack of focus, headaches, dizziness, and other physical discomforts which led them to seek medical health assistance. While the suffering and sickness these women experienced could be seen as an appropriate response to their life situations, without an explanatory framework about those situations, lacking adequate local cultural, social and economic supports, and finding themselves situated in a society where the psychologization of suffering is normative, they instead went to physicians or psychotherapists seeking solutions, drawing upon on western psychiatric discourses of suffering and mental illness. Nevertheless, a few women, including Lotus, Lamia, Jisa, and Jillian, were reluctant to seek mental health services initially, either because they did not know what the services entailed, or because they were dependent on cultural ways of interpreting psychological pain and distress, which is far more diversified as compared to biomedical mental health and treatments.

The women’s narratives thus represent how the normative power of western medical knowledge operated in these women’s lives, leading them to believe the circulating psychiatric ‘truth’ that medication and psychotherapy could ease or cure their distress over their cultural ways of healing, even though some women later resisted services and biomedical notions of mental illness. As such, the normative power of medical discourse and knowledge has also been offset by the women demonstrating that they were not always rendered docile by medical knowledge. The following two sections will tell us more on this.

Psychotherapy

In Chapter Four, we saw that several of the women in this study did not initially consider seeking out mental health services when they started to feel lost, mainly due to the divergent knowledge and practices about mental health in their culture. Indeed, in most of the women's cultures, the prominent perception of mental illness is that it is not real, and is instead seen as a result of sin, or the effects of spirits that require the intervention of traditional healers, priests, religious leaders and prayers.

However, traditional ideas of mental illness have increasingly been changing in many of these cultures, due to the expansion of western medical knowledge systems and treatments. Thus, perceptions of mental illness are diversified within any culture, depending on the degree to which people take up medical and psychiatric discourses of mental illness. Class, age, religion, education, and geographical location affect how and to what extent biomedical notions of mental illness have been taken up and internalized within most of these women's cultures. In this study, women who came from the upper class, whose family members possessed higher education credentials, and those living in the urban areas of their country described being more familiar with psychiatric and medical discourses. This reflects a common presumption that globally people's use of and reliance upon Western medical treatment is characterized as evidence of their progress, while a belief in traditional notions of mental illness is seen as indicative of people's backwardness. These perceptions were amply illustrated in some of the women's stories.

Most of the women were aware of biomedical, westernized mental health discourses before their immigration to Canada, and four of them had in fact used psychiatric treatments in their home countries. However, these women explained that the notion of mental health is given far more importance in Canada than in their home countries. Several of them did not see mental health professionals initially when they felt distressed but sought their services after coming across the prominent mental health awareness campaigns and circulating discourses on the importance of mental health in their workplaces and schools once in Canada. These women also felt comfortable seeking counselling services because of their changing subjectivities about using mental health services once they lived in Canada, and they came to see counseling as a necessary service for their survival in the new social structure and culture of Canada.

Twelve women out of the thirteen sought psychotherapy. Of those, the women who used private psychotherapy noted their satisfaction, as they were able to get appointments when they needed, and they found the therapists to be caring. Nevertheless, the majority (nine) of the women used public mental health services because they could not afford private psychotherapy, and most of these women were unhappy because of several interrelated issues they experienced in psychotherapy. These women were disappointed in not being able to get an appointment when they needed one—the delay in their appointments sometimes left them feeling they needed to cope on their own, and in some cases, as though they no longer needed to speak to someone once their appointments arrived. Rules requiring the use of a certain, limited number of counselling sessions and the inability to see the same and preferred counselor in all sessions hindered the establishment of trusting relationships between the women and their counselors, despite that all the women perceived this connection to be essential for them to open up and share their intimate stories with their therapists. Most of the women also described their counselors' lack of empathy, unwillingness to listen, and insufficient knowledge regarding the struggles these women had experienced as racialized persons, immigrants, and international students as key issues in finding and feeling helped by a service provider.

Some women, including Sasha, Nila, Natasha, Jasmine, and Lamia, expressed their frustration at finding therapy to be too mechanical, noting that most of the time their therapists focused on preplanned and one-size-fits-all approaches, which most of the women in this study did not find appropriate or beneficial. Sasha, Nila, Natasha, Lamia, Jisa, Jasmine, and Arvin explained psychotherapies were individualising, as they were encouraged to work on their inner selves and to find and implement their own cures, rather than acknowledging the structural pressures the women faced and offering meaningful suggestions for improving those. Further, these individualized approaches were difficult for these women to manage or embrace, since prior to coming to Canada, they had used a more collaborative approach to reducing stress and pain. Thus, it is apparent that psychotherapies enacted cultural imperialism by privileging western ways of knowing and constructing independent and instrumental subjectivities over other possibilities.

Because of a pressing need to survive in Canada, Amelin, Mary, Jisa, Lotus, Moumi, Jasmine, and Jenifer chose to follow these more Western, individualist, logical-rational ways of managing feelings and reactions, and they embraced learning to work on themselves. In a sense, they took up and internalized core concepts of wellness that dominate Canadian culture—which focus on motivated, independent, self-governed, and self-fulling personalities as healthy—demonstrating their assimilation to neoliberal notions of subjectivity. These women stories reflect Nikolas Rose’s (1999) contention that psychotherapy fuses western and neoliberal forms of “technology of the self” to recruit people to be willing agents in governing their thoughts with notions of ‘rationality’ and autonomy. However, these women were definitely strategic and active in materializing Western culture and also psychotherapy.

Diagnosis, Compliance, and Resistance

Most of the women in this study were diagnosed with mental illness by their physicians, though a few self-diagnosed, drawing upon lay discourses on the medicalization of mental distress, and illustrating their compliance with psychiatric conceptualizations of their problems as pathological, rather than in terms of their traditional cultural ways of seeing and labelling human misery. It is also clear that the philosophical underpinnings of the women's diagnoses were informed by biomedical, neoliberal, colonial, and patriarchal power, and they illustrate the ways in which these forms of power uphold one another.

While most of these women sought mental health services due to pain that I suggest is itself a product of neoliberal/colonial and patriarchal culture, the psychiatric treatments prescribed by their physicians functioned to further encourage several women to assimilate to these misogynist and imperial structures in order to function 'better' as workers, students, mothers, and social beings. For example, Amelin's stories reveal how she sought psychotherapy because she suffered from a racialized and gender-hostile office environment, along with the stress of raising her son with minimal family support. Her therapist suggested Amelin assimilate to 'Canadian culture', which she described as beneficial. Further, she was given an antidepressant to help with her sleep difficulties, anxiousness, and anger. These interventions were helpful in getting back her social, conjugal, and family life, she explained. Jenifer's narratives outline how she relied on antidepressants to resolve her unpleasant experiences, such as sleepless nights and anxieties, as quickly as possible, in order to focus on her studies and be productive.

In this respect, several women's stories support feminist and Foucauldian scholars' assertions that psychiatric interventions work on peoples' lives through the truth claim of its ability to train people to fit into the very society that created their suffering (Berger, 2014; Bjorklund, 2006; Bondi, 2005; Chesler, 1972; Chesler, 2018; Foucault, 1965; Shaw & Proctor, 2005; Thoits, 2010). The narratives demonstrate how this approach negates understanding the effects of culture and structure on an individual's life, leaving them to blame and attempt to fix their suffering themselves, with the help of medical treatments.

It is evident that normative orders of western subjectivity were established within the women's lives through their mental illness categorizations, and as they internalized problematic discourses of mental illness that suggested to them that they were deficient and lacking. These understandings, for most, only further contributed to their pain. Many of these women's stories suggest that although they tended to prefer biomedical mental health services in seeking solutions for their pain and suffering, they did not solely depend on these approaches. These women also actively reflected on their original cultural and psychiatric perceptions of mental health and illness, and critically interpreted these two sets of knowledge to define their own solutions and healing systems.

In a sense, for these women, the process of westernization in terms of personal responsibility and individualization was incomplete. For example, some women underwent biomedical treatments and concurrently (or later) turned to other practices to feel better, including prayer and spending time with people in their communities. Thus, these women actively reflected on both biomedical and traditional cultural discourses of mental illness, as a way of resisting western medical knowledge. This resistance for a few took place even while taking their prescribed biomedical or westernized treatments. Notably, for a small number of these women, it was the relief they found through a reliance on family, community, and cultural beliefs and healing systems that led them to refuse biomedical treatments.

Methodological and Theoretical Contributions

In my research, I have been influenced by the Foucauldian idea of mental illness as a constructed truth (Foucault, 1965). Although I acknowledge subjects as produced by discourses, I intended to explore the material effects of those psychiatric discourses and practices in a small group of racialized immigrant women's lives by using a feminist standpoint approach. I set out an argument in Chapter Two that humans not only reiterate the knowledge through which they are produced but are active subjects who also interpret knowledge, comply, and resist. By asking women to speak to their experiences of expert psychiatric and psychological support, I was able to explore those interpretations, compliances and resistances, and also to understand how those discourses unfold in the helping encounter for some immigrant, racialized, and hence, marginalized women.

These women's stories provided rich perspectives, relating the material effects of biomedical mental health knowledge in which their misery—which I argue is largely the product of structural forces, such as racism, poverty, western ethnocentrism, and the stressors of culture shock— has been psychiatrized, pathologized, and medicalized by both them and their physicians. However, medicalization was not a simple process. For many of the women, other ways of knowing mental illness and navigating daily life initially made it troubling for them to label their distress as a medical problem and seek mental health services.

Nonetheless, several of them later regularly defined, understood, and treated their pain as illness and depended upon biomedicines, antidepressants, and psychotherapy to construct themselves as 'patients', aligning themselves with medical and psychiatric treatments prevalent in Canada. These women found medical intervention to be helpful in relieving the pain that had resulted from intersectional social subordinations. However, some of them entirely rejected biomedical mental health services after initially turning to them for assistance, relying instead on their cultural ways of seeing and healing distress. This demonstrates that these women not only reiterated the knowledge through which they were being produced, but were also active subjects who interpreted different sets of knowledge and utilized both compliance and resistance, often simultaneously and in synergistic and adaptive ways.

While Foucault (1965; 1972) can help us to understand in part the encounter between these women and western psy sector discursive practices, this is only a partial theory to explain the subjectivities these women brought to their encounters. Rather, in addition to the Foucauldian notion of a subject shaped through discourses and practices of self-work and knowledge internalization, there were other, more violent and repressive forces at work that engendered these women's pain, and this is where post-colonial and feminist theory can help. Thereby, combining the critical theories of Foucauldian, anti-psychiatry feminist, postcolonial, and postcolonial feminist approaches (which are too infrequently adopted in mental health studies) has provided the foundation for my comprehensive reading of their stories.

In this study, Foucauldian literature (Bondi, 2005; Marecek, 2006; Poole, 2011; Rose, 1990; Rose, 1992; Teghtsoonian, 2009; Ussher, 2010) has been particularly useful in understanding the power of psychiatric discourses on women's lives, and the ways in which neoliberal governmentality has impacted them. The women I spoke with each came from a different society with diverse notions of subjectivities, mental health, and wellbeing, but they each reflected medical truths about illness, normalcy, and how one comes to be 'fit' or 'unfit' in Canada, and used medical treatments to cure their problems. Several women categorized their personality as problematic if they could not follow the 'ideal' notion of neoliberal subjectivity focusing on being independent, goal-oriented, and highly productive, even though in their 'original' culture this would not be seen as a problem or mental illness. On the other hand, to several women, the neoliberal notions of subjectivities that were preferred in Canada and in psychotherapy complicated their experiences of living and healing.

While Foucauldian literature was constructive to unpack the elements of power linking biomedical and neoliberal discourses, postcolonial literature became important in analyzing how psychotherapy encouraging the racialized immigrant women to assimilate to the neoliberal forms of subjectivities is both imperialist and racist. Even though most of the women explained that because they were from a collective society they needed a collaborative approach for their mental wellbeing, they were prescribed solutions to adopt individualizing techniques to relieve their distress. This focus in the 'helping' services not only imposed Western values, beliefs, and healing practices upon the women, but also produced their notions of subjectivities, ways of living, and traditional methods of healing psychological pain as awkward. This scholarship was therefore useful to unpack the detrimental impacts of systemic racism and structural discrimination on the women, and to reflect upon the ways colonialism and racism first led them to seek mental health services, then categorized their experiences as a mental health or individual issues.

Unfortunately, most mental health research, even that using a postcolonial approach, misses addressing the subtle colonial aspects of neoliberal governmentality in racialized people's lives in Canada. Instead, studies mainly focus on the barriers racialized individuals encounter in psychotherapy and often views mental health services as empowering and beneficial, missing the colonial undertones of mental health services in Canada.

Beyond racialization, most of the women in this study suffered immensely because of their gender. Their non-compliance with gender norms and experiences of gender-based violence, including sexual, physical, and emotional abuse, contributed to their suffering. Wherein postcolonial and Foucauldian scholarships alone were not adequate in reflecting upon the women's narratives, anti-psychiatry feminist analysis was helpful to interpret how the women suffered within heteropatriarchal culture and unpack how their responses to discriminatory patriarchal culture was labelled as a 'troubled personality'.

Anti-psychiatry feminist visions also provided the foundation to analyze how some women in this study absorbed medical discourses about normative life states, including premenstrual and post-birth suffering, as illnesses. As some women even interpreted their pain from diverse social subordination as the result of their hormonal changes due to menstruation/childbirth/age, utilizing an anti-psychiatry feminist perspective was crucial to fully reflecting upon their experiences (Berger, 2014; Caplan & Cosgrove, 2004; Chesler, 1972; Johnson, 2005; Linder, 2004; Marecek, 2006; Poland, & Caplan, 2004; Ussher, 2010).

Postcolonial feminist scholarship was particularly helpful in highlighting the intersectional forms of suffering across gender, class, ethnicity, immigration status, race, age, and other categories that traversed the women's pain. This lens was essential to understand how the women were subjects of both culture and structure; both 'original' and 'Canadian', the women suffered from non-compliance to their 'original' cultural feminine ideals and also from neoliberal ways of living. Several women said they learned how to sacrifice their lives for the benefit of their family, but in Canada, when reflecting on the mainstream culture that requires self-improvement and empowerment, the women engaged in their self-improvement and prioritised their needs, which added to or complicated their pain. In a sense, they had to balance both cultures for their survival in their community and mainstream society.

These four critical approaches undoubtedly ensured a more engaged reading of the experiences of racialized immigrant women and the use of mental health services in Canada. There exists a significant body of research on immigrant women's mental health, but studies that consider the diverse intersecting power relations that complicate such women's lives are notably absent. Thereby, analyzing these women's experiences using an intersectional lens was imperative, and facilitated the identification of a broader background of literature to be considered when studying racialized immigrant women's mental health.

Additionally, this research focuses on the women's experiences in a small urban centre where research from these intersectional lenses is absent. The women's experiences provided rich views on how living in a white-settler dominant small city as an immigrant and racialized woman is more challenging compared to the bigger cities in Canada. While larger urban centres offer the possibility of celebrating one's culture by fostering a sense of belonging and feeling of home, in Lethbridge culturally-diversified services are lacking, which several women found isolating and excluding. Further, the women reported experiences of racialization and ethnicization to be more common in Lethbridge than compared to other cities in Canada.

Because it is white-settler dominant, finding a job and getting a promotion in Lethbridge was also difficult for several of the women I spoke with, as they reported fewer job opportunities and privileging of white employees. In the workplace, some of the women's knowledge and skills were denounced, even though they worked hard and were appropriately skilled. This attitude was hurtful, and the women described feeling rejected, which contributed to self-doubt and pain, one of the reasons for seeking psychotherapy. By exploring these women's tensions in a small urban centre this study contributes to knowledge gaps of the extant research.

With that said, in this research, I have only explored some racialized immigrant women's stories of using mental health services and the forms of power they encountered in Lethbridge. During my research participant search, I also learned about some racialized immigrant men's use of mental health services in Lethbridge. Examining racialized immigrant men's experiences in seeking mental health services would have provided further insights about the impact of colonization and migration on colonized peoples' lives, and how men's experiences may be different from or similar to those of racialized immigrant women.

While I suggest that this would be a fruitful project for future exploration, I assert here that examining racialized immigrant women's use of mental health services in Canada has been the most urgent point of dispersion for exploring gender issues, colonization, power relations, the pathologizing of misery, and the medicalization and psychiatrization of women's bodies and emotions. Nevertheless, I also acknowledge the need for further studies on racialized immigrant men's use of mental health services to examine the pain and suffering that may lead them to use mental health services.

In this research, I also aimed to explore racialized refugee women's experiences of using mental health services to learn their diverse displacements and marginalization stories, but unfortunately, I failed to include any of these women's perspectives. I suggest future research solely focusing on this group of women could be a very productive area for exploration. I also think it might have been interesting to speak with some women who are bi/lesbian/queer, which is another intersection that matters. Additionally, from my research findings, it is apparent that the impacts of migration and racialization are much more damaging to the lives of children than adults—particularly for those who migrated between the ages of 9 to 14. Thus, the experiences of racialized immigrant children using mental health services could provide important insight into their perceptions of mental health and illness, as well as their suffering and the power relations they experience in a new country.

Further, my study solely depended on women's narratives to understand the material effects of psychiatric discourses in their lives. Future research could combine methods of discourse analysis to examine the truth construction of psychiatry by selecting psychiatric promotional materials with a feminist standpoint approach to explore the effects of these particular representations on women. An examination of women's use of mental health services in the Global South would further be informative in understanding the expansion of western psychiatric knowledge in the Global South, and to add an international perspective in mental health scholarships.

That being said, as the analysis for this study drew to a close, I became convinced that exploring 13 racialized immigrant women's narratives through an analysis of their use of mental health services has been the best way to understand the tensions, struggles, and suffering of racialized immigrant women in a new country, particularly in a small city, and elucidate the damaging effects of racialization, gendered culture, class-based discrimination, ethnicization, and other related social subordinations. Further, the narratives assisted in unpacking the ways medical and psychiatric knowledge is ultimately gendered and imperialist.

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Appendix A: Call for Participants

Are You a Racialized Immigrant Woman and Used Mental Health Services in Lethbridge?

If you have used mental health services in Lethbridge after 2007, I would love to hear your stories.

I am Shahina Parvin, and this call for participants is for my Ph.D. research project at the University of Lethbridge.

Your participation is voluntary and confidential.

The conversation will be approximately 1-2 hours in length.

To show my appreciation a $30 gift card will be offered to the research participants.

If you are interested in sharing your stories of using mental health resources, please contact me at 587 257 0564 or s.parvin@uleth.ca

Appendix A: Call for Participants

Are You a Racialized Refugee Woman and Used Mental Health Services in Lethbridge?

If you have used mental health services in Lethbridge after 2007, I would love to hear your stories.

I am Shahina Parvin, and this call for participants is for my Ph.D. research project at the University of Lethbridge.

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Appendix B: Fact Sheet

Name: ___________________________________ Age: ______________

Religion: ____________________ Nationality/Ethnicity

____

Personal Information:

Marital Status______________ _____________________

Education_________________ Job ________________________________

Family Information

Please provide a description of your family members currently

Relationship with the Respondent	Gender	Age	Education	Marital Status	Occupation

Appendix C: Consent Form for the Women

Dear Participant,

I would like to invite you for an interview for my Ph.D. research project. I am interested in hearing the stories of some immigrant women of colour who have used mental health services in Lethbridge. This is a consent form for you to let you know about my research. Please feel free to ask if you have any questions about my research. The project is not funded by any agency. A mutually convenient time and place will be chosen for the interview. It will take one to two hours. You could stop the interview at anytime if you feel uncomfortable.

I am asking for your permission to record the interview. The recorder is password protected. You can ask to pause the recorder whenever you want. I will destroy the recording and notes of your interview if you want me to. The conversation will be downloaded to a password protected folder on my password protected computer. Then I will delete the recording. A backup copy of the recording will be stored in a separate encrypted drive. I will type the interview up on my computer, and I will keep it in a password protected folder on my password protected computer. I will also store a backup copy of the written text of the interview on a separate encrypted backup drive.

I will change all the biographical details about you and others in the written copy of your interview. My thesis supervisor will have access to the written copy of your interview, but she will not know your name. I will also change the biographical details when I use your short narratives and quotations in the research report and articles, which will be publicly available. If you have any preference for the use of a different name in the research report and articles, please let me know. I will change all the biographical details of you and others to mask your identities.

If you would like to see a written copy of your interview, please sign below. A protected electronic copy will be sent to you. You can ask for corrections if you have any. Please note that you will have one month to reply to me by email with any changes. I will keep your interview information for five years after I graduate. It will be destroyed after that time.

The confidentiality of your information will be protected. You will not be at any risk by telling your stories with me. You may get some relief by sharing your views. However, I may have to report information to the appropriate authorities to protect you if you disclose that you are at risk to self-harm or suicide. You will be given a $30 gift card for giving your valuable time to me.

If you have any questions about my study, please feel free to call me or send me an email at any time. My mobile number is 587-257-0564 and my email address is s.parvin@uleth.ca. You could also address your questions concerning your rights as a participant in my research to the Office of Research Ethics, University of Lethbridge via the phone no 403-329-2747 or Email address research.services@uleth.ca.

Sincerely,

Shahina Parvin

Ph.D. Candidate in Cultural, Social, and Political Thought
University of Lethbridge, Lethbridge, AB

I have read this letter and I have understood what the researcher said to me, and I agree to participate in this research.

______________________________ ______________________________
Participant Signature and Date Name (please print)

______________________________ Shahina Parvin
Researcher's Signature and Date Name (please print)

I would like to know about my interview transcript. Please send me the transcript of my interview (Might take 12 months).
Yes/ No________________
If yes, please write your email account_______________________