LET'S TALK MADNESS: A CRITICAL DISCOURSE ANALYSIS OF PERSONAL

STORIES USED IN THE BELL LET'S TALK CAMPAIGN

by

Shailee Koranne

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Abstract

This study analyzes a sampling of the personal stories used in the Bell Let's Talk campaign, an annual mental health awareness campaign started in 2010 by Bell, a large Canadian telecommunications company. Using the method of critical discourse analysis, this paper discusses the ideologies regarding madness, race, and gender that inform the communications of the Bell Let's Talk campaign. This MRP aims to create an awareness of the limitations of such campaigns and the effects that these representations may have on the way we view madness and mad people.

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Introduction

Bell Let's Talk is an annual mental-health awareness campaign that was started in 2010 by Bell, a large Canadian telecommunications company. Every January, Bell donates 5 cents each time the hashtag "#BellLetsTalk" is shared on the social media networks Twitter, Facebook, Instagram, and Snapchat, on a day designated "Bell Let's Talk Day." The money raised each year is disbursed by Bell to Canadian mental-health organizations and initiatives; as of March 2020, Bell says it has partnered with over 1,000 organizations providing mental-health services ("Bell Let's Talk initiative extended to 2025," March 9, 2020). After its latest iteration on January 30, 2020, Bell announced that the campaign set "a new record" after over 150 million messages in "support of mental health" were shared ("Your actions counted!", January 30, 2020).

The Bell Let's Talk campaign consists primarily of personal storytelling and it is immediately evident that these stories adopt a universally positive tone towards people's experiences with madness, as might be expected of such a campaign. Bell Let's Talk claims that the campaign has created "unprecedented conversation" and has been "instrumental … in changing how Canadians view mental health" ("Bell Let's Talk initiative extended to 2025," March 9, 2020). A recent study of television coverage of mental health in Canada supports this claim: after studying television clips from 2013-2015, Whitley and Wang (2017) found a thirty percent increase in "positively oriented coverage" of people with mental illness, and attributed it to anti-stigma initiatives such as Bell Let's Talk (pp. 241-243).

Scholars in the fields of disability and mad studies, however, are unconvinced that institutional charity initiatives meaningfully change people's experiences with disabilities

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and madness. In particular, as will be shown below, many scholars have taken issue with representation in disability and mad charity in two respects: its tendency to individualize (rather than socially contextualize) issues with disability and madness, and a tendency toward whiteness in the range of experiences reported. Nevertheless, the subjects of Bell Let's Talk's narratives — to judge by the photographs available on their website, under the title "Mental health affects us all" — seem to display greater visible diversity relative to the selections made by other disability charities and initiatives. Bell Let's Talk's story subjects include visible religious minorities, racialized people from many backgrounds, and many women overall. Reducing stigma and creating more positive representations is the key mission of Bell Let's Talk, and this, alongside the campaign's apparent degree of influence on discourse about madness invites a closer investigation of the discourse created by and reinforced through Bell Let's Talk.

This major research paper (MRP) will analyze ten semi-randomly selected personal stories published by Bell Let's Talk, with the aim of identifying the campaign's underlying ideologies, and describing how those stories and ideologies may influence the perception and treatment of mad people. The study adopts the method of critical discourse analysis (CDA), focused primarily on a thematic analysis of experiential values implicit in the vocabulary used in the stories.

Literature Review

1. A Note on "Madness"

Wherever possible, this paper will use the terms "mad" or "madness" instead of "mentally ill", "mental illness", "mental disorder" or "mental-health issues". The term "mad" is not used universally because it historically indicates difference and invokes violence, but its ongoing reclamation is akin to that of the word "queer" among 2SLGBTQ+ communities.

The language used by mad people and activists is evolving, and in a few years, "mad" may not be the most accurate term for this paper's subject matter. This paper aims to imagine mad futures where minds and bodies are understood not through the medical/individual model — through which terms like "mental illness/disorder" were created and accepted— but through Mad Studies, a "meld of activism and intellectual activity" (Beresford, 2019, p. 1). Mad Studies is defined as "a field of scholarship, theory, and activism about the lived experiences, history, cultures, and politics about people who may identify as Mad, mentally ill, psychiatric survivors, consumers, service users, patients, neurodiverse, and disabled' (Castrodale, 2015, quoted in Beresford, 2019, p. 1). The term "mad" has been criticized for its seemingly inaccessible and elitist location in academia, but in essence, it is a social approach to understanding "how we can be made mad by society and our circumstances in it" (Beresford, 2019, p. 4).

2. The Charity Model and Medicalization

In contrast to the socially derived idea of madness, the charity model of disability is the framework for Bell Let's Talk and all other corporate disability charity initiatives.

Withers (2012) defines the disability charity model alongside the medical model of disability. The primary idea that the medical model posits is that disability is located in individuals' own bodies or minds, and should, if possible, be cured. Many charities are invested in reducing or eliminating disability and madness instead of focusing on systemic causes, such as socio-economic status, living conditions and homelessness, and oppression like racism, transphobia, etc. (Allen et al., 2014). Critics of the medical model are not opposed to disabled people receiving medical care. For example, Shakespeare (2017) writes that "rehabilitation interventions" such as wheelchairs, canes, and other mobile devices, speech and language therapy, and other kinds of healthcare enable disabled people to be included in society (p. 88). Indeed, it is not care itself, but the apparent motives and assumptions exhibited through medicalization that are problematized by scholars. The focus of the medical model is on the individual's failure to adapt to society rather than the failure of social environments to adjust to the needs of citizens (Evans, 1999). The medical model wants to eradicate disability by curing what it can and eliminating what it cannot (Clare, 2017).

Another central tenet of criticisms of the charity model takes issue with the fact that disability charities and corporations are seemingly motivated by their own goals. Corporations profit in tangible ways after donating to disability charities — their sales and market shares increase and they often receive free publicity (Withers, 2012). Waltz observes that advertisements about autism awareness prioritize charity brand awareness over sharing relevant and accurate information (Waltz, 2012). Corporations donating to disability charities may even be employing a marketing strategy to distract attention from

the corporations' own participation in the creation of social and political problems (Waltz, 2012; Withers, 2012).

Kamat (2004) adds that in the case of charities, leadership is often self-appointed or does not represent the interests of the group whom the organization aims to serve. Choudry and Shragge (2011) elaborate on this when they note that "low-profile, long-haul political education and community organizing work" is disregarded by many advocacy NGOs and campaigns, which instead choose to utilize academic and non-frontlines knowledge that does not disrupt their own practices and motivations (p. 513).

It is difficult to perceive giving to charity as a negative action because of how the act has been valorized across cultures and centuries as a virtuous act (Lloyd, 2018). However, Withers (2012) critically analyzes this valorization to argue that charities focus more on the able-bodied "giver" (p. 58). Drawing on past representations and understandings of difference — such as Christian formulations of disability in the Middle Ages — Withers (2012) traces disability charity's storied history of centering the nondisabled "good Samaritan," whether that is one person or a whole corporation (p. 58). Longmore (2015) supports this analysis and adds that during the Victorian period in Europe, the perception of disabled people was accompanied with "inspirational Christian stoicism" and sympathy (p. 86). Before long, stories of disability became stories of pity and "saintly compassion" (Longmore, 2015, p. 86).

3. Representation in Disability Charity

According to Bogdan et al. (2012) disability is not represented anywhere as much as it is represented in charity imagery. However, this representation is not necessarily

productive, for two reasons: a tendency toward narratives of "pity," and an orientation to the experiences of white men and of children.

Institutional charity advertising and large-scale initiatives like the March of Dimes have been known to create further stigma against disability and mental-health issues because of their use of passive and pity-laden representations (Bogdan et al., 2012; Costa et al., 2012; Longmore, 2015; Peters, 2017; Waltz, 2012; Withers, 2012). Pity sells, so charities tell disability stories that will emotionally persuade people to give money (Withers, 2012). After conducting a visual analysis of over 200 images of disability, Bogdan et al. (2012) wrote that pity is a "major draw" for charity campaigns (p. 43). Often, "new charity imagery" — which emerged after the 1930s — uses the popular portrayal of the "poster child" (Bogdan et al., 2012, p. 44). Children are often used in disability charity imagery because childhood represents innocence and vulnerability, eliciting a greater emotional reaction in the audience (Bernstein, 2011).

Longmore writes that pity and sympathy are not individual, personal reactions, but have roots in our "cultural values and social arrangements" (Longmore, 2015, p. 84). This is significant because these seemingly natural feelings are part of larger discourse and ideologies that "shape the social structure" (Clark quoted in Longmore, 2015, p. 84). Pity supports the charity and medical models of disability because of the opportunity it provides to blame disability on biological or natural phenomena, thereby absolving people and society of any "blame" or "guilt" associated with disability. Ultimately, representations in institutional disability charity only reinforce normative understandings of madness and disability (Peters, 2017).

Withers (2012) and Bogdan et al. (2012) describe disability charity representations as largely focused on white men and white children, especially when the goal of the imagery is to empathize with the disabled subject. Notwithstanding an overrepresentation of whiteness, disability and mad representation should not be studied without considering race because the construction of race as a social category is heavily imbued with ideas of disability (Kanani, 2011; Mollow, 2006). Furthermore, throughout history, pathologization has been used to further subjugate racialized people. For instance, colonial science "justified" slavery and racism because it found Black people to be "feeble-minded" and in need of subjugation for their own good (Baynton, 2001, pp. 38-39). The very idea of Black freedom became associated with madness through the invention of the disease drapetomania. A since "discarded diagnosis," drapetomania, was once the name given to the "mental disorder" of wanting to run away from slavery (Bynum, 2000, p. 1615).

Mollow (2006) suggests that looking at how madness and disability are, or are not, represented alongside both race and gender allows us to study the complexity of the stereotypical images of racialized mad and/or disabled women. Like Baynton and Bynum, Mollow connects these ideas to enslavement and anti-Blackness. Referring to the lack of representation of Black mad women, Mollow writes that Black women's "emotional suffering" is regarded as innate, citing historical constructions of Black womanhood during slavery (p. 292). For example, Mollow says the persisting image of the "strong Black woman" erases Black women's suffering, tracing the idea to the "mammy" stereotype, which required Black women to "deny their emotional and material needs" in order to be "faithful, obedient domestic servants" (p. 292). Mollow does not take issue with the representation of Black women as independent or self-sufficient, but rather with the

erasure of Black women's madness, and the notion that madness is somehow intrinsic to their experiences.

Historical ideas of mad racialized people continue to impact racialized people today. People of colour tend to experience more difficulty accessing and receiving consistent treatment (Chiu et al., 2018). Additionally, Kanani (2011) writes that constructions of race and disability/madness deeply impact the experiences of racialized people when navigating treatment because psychiatry's formation in the eras of colonialism and slavery has imbued racism into the discipline. Similarly, psychiatry fundamentally imagines Indigenous peoples as "primitive" and characterizes madness as a symbol of inherent weakness or "inability to cope" in Indigenous people, rather than as a result of the direct "cultural genocide" they continue to face (Kanani, 2011, pp. 6-7). This characterization of racialized mad people's experiences has formed lasting assumptions that blame internal aspects of their cultures and backgrounds for their conditions, thereby absolving the state and systemic factors of their role in creating madness.

4. Personal Storytelling (and its Limits) in Disability Charity

Bell Let's Talk represents the experiences of mad people through the use of personal stories. Its anti-stigma approach posits that sharing individual people's narratives related to madness can combat stigma; indeed, the campaign claims that discovering these representations is "an important first step towards lasting change" ("4 Pillars", Bell Let's Talk, n.d.). Many scholars and activists take issue with the way disability charities reappropriate personal stories in order to serve their own needs. Costa et al. (2012) write that mental-health organizations commonly seek personal stories to garner the momentum necessary to create a brand and receive grants, public attention, and the

support of authority figures like politicians and activists. Calling such stories "patient porn," they state that the consumption of personal stories about madness and disability can be exploitative (Costa et al., p. 93). They criticize how corporations capitalize on stories that serve their brands, ultimately using them in "sanitized" ways that are useful for them but do not disrupt the social systems that create disability and madness (Costa et al., 2012, p. 87). The stories are meant to be ones that the audience can identify with even if they do not share the experiences discussed.

Similarly, Razack (2007) refers to the consumption of such stories as "stealing the pain of others" (p. 375). Speaking specifically to grotesque and violent representations, and to the way society encourages a voyeuristic consumption of stories of the pain of people of colour, Razack calls empathy — when one begins to vicariously identify in another's suffering — a "double-edged sword" (p. 375). This protects the consumer of the story from being implicated in the system that harms the individual in the story.

Many scholars question the focus on representation of personal narratives as a solution, and the effectiveness of politics of recognition altogether (Costa et al., 2012; Coulthard, 2007; Choudry & Shragge, 2011; Harris, 2003; Kamat, 2004). As argued by Coulthard (2007), politics of recognition actually reproduce the power imbalances between the marginalized and a body of power because, for the powerful body to grant recognition, it writes its own terms in its own interests (p. 439). Where recognition is conceived as something granted by the dominant group to the subjugated group, politics of recognition fail to transcend power imbalances. If recognition is to be afforded by the group in power, it will only recognize what challenges it superficially.

5. Systemic Violence Against Mad People

Discussions continue to occur about the damage faced by mad people, especially mad people of colour, when their healthcare providers cannot recognize how racism and other types of violence are inherent in fields like psychiatry and social work (Kanani, 2011; Mollow, 2006). The deinstitutionalization movement, which began in the 1960s, saw psychiatric institutions begin to discharge patients *en masse* and then close altogether, without creating a reliable plan to integrate those patients back into the community (Hamden et al., 2011). Twenty-some years after deinstitutionalization began in Ontario and California, Dear and Wolch (1987) wrote extensively about how community mental-health networks, which were meant to absorb and better treat an influx of recently discharged patients, were underfunded. As state institutions and community programs did not fully coordinate upon deinstitutionalization, ex-patients found themselves housed in group homes and shelters, or wrongly assigned to nursing homes (Dear and Wolch, 1987). The lack of adequate community care also led to ex-patients being senselessly incarcerated for "crimes more indicative of their mental-health disabilities than criminal intent" (Dear and Wolch, 1987, p. 174).

Not only did the legacy of deinstitutionalization see a high number of mad people entered into prisons, incarceration has been recognized as creating madness. Solomon (2017) wrote about the "mental-health crisis" in Canadian prisons, detailing the inadequate mental-health training received by correctional officers and the lack of comprehensive statistics on self-harm, hospitalization, and suicides in prison. The Centre for Addiction and Mental Health (CAMH) says that people in Canadian prisons are "four to seven times more likely to experience mental illness" (Simpson, n.d.).

But madness and the justice system are linked even before incarceration occurs

for mad people, and especially for mad Black people, Indigenous people, and people of

colour. For example, Black Torontonians are twenty times more likely than white

Torontonians to be shot by police; experiencing this kind of racism-related stress has

been observed to increase rates of psychosis and depression in Toronto's Black

population by up to 200 to 300 per cent (McKenzie, 2020; Cecco, 2018). This stress is

not unfounded because there are frequent cases, historical and in the present, of police

across Canada killing mad people. 30-year-old Devon LaFleur, a white man from

Ottawa who lived with schizophrenia, was killed in March 2016 in Toronto after being

confronted by three officers (Fagan and Lofaro, 2017). In 2015, South-Sudanese

refugee Andrew Loku, who was suffering from post-traumatic stress disorder, was killed

by police in the hallway outside his apartment in Toronto (The Canadian Press, 2017).

Sammy Yatim, an 18-year-old Syrian immigrant, was killed in 2013 while behaving

erratically on a Toronto streetcar — his family said Yatim did not have a history of

madness or violence, and being perceived as mad was apparently dangerous enough.

James Forcillo was granted parole after serving two years in prison for killing Yatim

(Pagliaro, 2013). Since 1990, which marks the creation of the Special Investigations

Unit — the agency responsible for investigating police misconduct — only three Ontario

police officers have been convicted for involvement in on-duty deaths (Moore, 2013).

Furthermore, Abdirahman Abdi, a mad Somali-Canadian man, was violently

beaten by Ottawa police and later died from his injuries. Abdi's death ignited nationwide

protest, but the head of the Ottawa Police Association, Matt Skof, defended the police's

actions as a justifiable response to a "violent incident," adding that "suggestions racism

could have played a role are "inappropriate'" (Porter, 2016). As recently as May and June 2020, 29 year-old Regis Korchinski-Paquet, an Afro-Indigenous woman living in Toronto, died under questionable circumstances after her mother called 911 "pleading for her to be taken to a mental-health facility," and 26-year-old Chantel Moore, an Indigenous woman in New Brunswick, was shot by police who "responded to a mental-health call" (Cecco, 2020). I have noted only a handful of incidents here, but the over-policing of racialized mad people in Canada is relevant to this study because of the documented history of a connection between incarceration, racialization, and madness.

Research Questions

The literature on disability and mad charity leads one to expect that the charity discourse of Bell Let's Talk will tend to medicalize madness, create individualized representation rather than represent madness in the context of its social determinants, and neglect to discuss systemic violence. Furthermore, given that women of colour are sparsely represented in mad charity discourse despite race, gender, and madness closely intersecting, the depictions of racialized women in the Bell Let's Talk campaign should be studied in order to assess how such campaigns are starting to portray lesser-represented populations in charity discourse. Therefore, my study addresses the following three research questions:

RQ1: What ideas of medicalization and individualization, if any, are present in Bell Let's Talk discourse?

This research question reflects upon the themes of medicalization and individualization found to be prominent in corporate disability charity and considers their presence in Bell Let's Talk discourse. Answering this question serves as a starting point

and provides important introductory insight into Bell Let's Talk's approach to mad representations.

RQ2: To what extent does the discourse in Bell Let's Talk accommodate or reflect a socio-political understanding of madness?

This research question explores the converse to RQ1 because a politicized and social approach to madness, as established by mad scholars and activists, may be either an alternative to the medical model, or a positive response to the medicalization of mad people. Thus, addressing RQ2 in juxtaposition to RQ1 identifies the key parameters of Bell Let's Talk's approach to madness, and specifically the prominent ideologies that inform the discourse of the campaign.

RQ3: How does the discourse of Bell Let's Talk represent the experiences of mad racialized women, as compared with white men?

This research question will foster pointed findings pertaining to understanding the portrayals of mad racialized women in the Bell Let's Talk campaign and similar charity discourse. Exploring the stories of mad women of colour in Bell Let's Talk's stories responds to the concerns raised by many scholars regarding an overrepresentation of white men in charity discourse. Furthermore, as calls for diverse representation continue to be made across many forms of media, I aim to assess the ideologies behind the emerging stories and representations of women of colour.

Method

The scale, impact, and diversity of Bell Let's Talk make it an advantageous research site for exploring charity discourse and portrayals of madness. To answer my research questions, I conducted a critical discourse analysis (CDA).

1. CDA in the Study of Disability

According to Bryman (2012), CDA considers language, ideology, and social relations. Because discourse not only summarizes "what goes on in society" but also how meaning is created, a CDA prompts questions like "who uses this language? How, when, and why?" (Bryman, 2012, p. 538).

Grue (2011) writes that disability is a compelling topic to subject to CDA because the meaning of disability and disability studies models are shaped by discourse, especially that of race, gender, class, and public health. I found the work of scholars such as Longmore (2015), Bogdan et al. (2012), and Singh (2012) particularly useful in understanding how to investigate discursive constructions in chosen texts; in Longmore's case, the texts are charity telethons, Bogdan et al. analyzed historical photographs and posters representing disability charity, and Singh studied racism and orientalism in Canadian newspapers' coverage of the 2012 New Delhi gang rape. While Singh did not employ a thematic analysis in the context of disability and mad studies, it served as a useful reference for CDA methods applicable to Professional Communication major research papers.

These broad approaches to CDA leave room for varied procedures, so to work from an established frame for my analysis, I deferred to those adopted by Norman Fairclough. Fairclough's approach to CDA is concerned with "[increasing] consciousness of how language contributes to the domination of some people by others because consciousness is the first step for emancipation" (1989, p. 1). To Fairclough, discourse is comprised of three ingredients:

1) the texts, or the objects of textual analysis;

2) discursive practices, which involve the production, distribution, and consumption of texts, and;

3) the socio-cultural structures — ideology, hegemony, and power relations — that are challenged or reinforced by the texts (Simpson and Mayr, 2018, p. 53).

Fairclough believes that no language is neutral, and all language is grounded in ideology, and whether it occurs consciously or unconsciously, these ideologies are regarded as culturally accepted knowledge. Therefore, analyzing language can reveal the ideologies of the speaker or writer and the displays of power occurring through the texts. Furthermore, for Fairclough, a successful CDA also examines the institution through which the chosen texts are produced and considers its values when making connections between the texts and social/societal structures.

2. Understanding the Corpus and Choosing the Texts

The text I used for this analysis comes from the corpus of personal stories available on the Bell Let's Talk website under the section "Our Initiatives," subsection "Stories: Mental health affects us all." This section consists of 46 personal stories from Canadians with various backgrounds. All stories are presented with the subject's first name, and most provide both their first and last name. A photo of the subject is also available with all stories, and some are accompanied with videos. Stories are roughly 200 to 700 words long and written in the third person as having been summarized by the site's compilers. Aside from a handful of television personalities and professional athletes, most of the subjects of the stories are framed as people one might encounter in everyday life and are referred to as "spokespeople" for Bell Let's Talk. Since the stories were told to Bell Let's Talk and written according to the guidelines and motives

of the campaign, we do not have a complete understanding of what the subjects actually said— only how the campaign has written them. Therefore, I will analyze the discourse of the texts as reflecting the language and purposes of Bell Let's Talk, not of the individual subjects.

My analysis sought thematic commonalities in 10 of the stories — five stories randomly chosen from both the group of women of colour and the group of white men. This thematic analysis allowed for a study of how Bell Let's Talk represents the populations that disability and mad studies scholars have found to be both overrepresented and underrepresented in charity representations. Videos were not considered in my analysis because they are not available for each story and because a thorough visual/image analysis is not feasible within the scope of this research paper.

To allow spotlighting of references to particular socio-cultural structures, and specifically a comparison of representations of madness in racialized women to those in white men, as required by RQ3, I initially sorted the subjects by race and gender. This was based on pronouns or ethnic/racial signifiers where available in stories, and if unavailable, the subjects' appearances as racialized or white (pronouns were available in every story because they are provided in the third person). None of the stories identified their subjects with pronouns other than he/him/his and she/her/hers, and while no stories openly discuss transgender identity, this does not mean that there are no transgender subjects represented in the stories. I also do not aim to erase any subject's racial identities in my study — some subjects may identify as racialized but appear white passing.

Put simply, the corpus can be understood as representing: white men, white women, men of colour, and women of colour. There were 13 stories from women of colour and 15 stories from white men; to avoid personal bias in selecting particular stories from this group of 23 for analysis, I numbered them from 1 to 13 and 1 to 15, respectively. Next, I used the True Random Number Generator at www.random.org to generate five random numbers for each set. The stories that corresponded with these ten numbers made up my final set of texts, consisting of five stories each from white men and women of colour. Chris, David, Etienne, Kieran, and Michel made up the stories from white men; Denni, Queena, Shawntay Rose, Shreya, Souad were the subjects of the stories from women of colour. Finally, to create a snapshot in time of the selected corpus, I downloaded PDF copies of the stories' webpages from the Bell Let's Talk site, thus consistently ignoring any deletions or changes that might have occurred on the website during my research process. For ease of reference, all ten stories have been included in full in the appendix and will be cited in-text with the subject's first name.

3. Analytical Procedure

There is no "complete" set of devices or concepts with which one must conduct a critical discourse analysis of such stories; the concepts analyzed range from layout, word order, and metaphors to "hesitations, pauses, and laughter" (van Dijk, 1993 quoted in Mullet, 2018, p. 119). Mullet (2018) writes that chosen texts can be analyzed for their external and internal relations. External relations are analyzed to examine the social practices which "control the production of the text" and are in turn reified by the text (p.122). Internal relations are considered through the examination of things like tactical

structural organization and deliberate layout choices, highly frequent word usage, use of quotes, and more.

One concept that informed my thematic analysis was that of experiential values, which are part of the internal relations of the texts. Experiential values are choices made in the vocabulary of the texts which "reflect the knowledge and beliefs of the producer" (Fairclough, 2001, p. 95). Fairclough also suggests an analysis of relational and expressive values when examining the vocabulary of chosen texts, however, I focused solely on experiential values due to the length of the Bell Let's Talk stories and what was possible in the scope of this MRP. According to Fairclough, experiential values become evident in the choice of wording used by the producer of the text and suggest the ideological frameworks within which the text was created. A repetition of wording, or use of nearly synonymous words, is one way in which experiential values may be inferred. Thus, I conducted my critical discourse analysis through an informed examination of the vocabulary used in the Bell Let's Talk stories, and considered: what words or phrases appear repeatedly across the texts, and furthermore, what experiential values do they express? I inferred the presence of certain ideologies in the experiential values found in the texts by deferring to the critical analysis of scholars summarized in the literature review. I noted words that were commonly used to describe and represent madness and related parts of subjects' identities in the ten stories, such as "burden" and "overcome" and considered the ideological assumptions that might most likely be made evident by these common terms. Finally, I sorted my findings according to the three focal points expressed in my research questions: individualization, socio-political context, and representation.

Findings

A brief summary of the corpus of 10 analyzed stories will help set the stage for analysis directed in turn to each of my three research questions. In what follows, I will use bold face to highlight words and phrases that appeared repeatedly and/or indicate the experiential values of the Bell Let's Talk campaign. The stories discussed a variety of conditions and experiences including suicidal ideation, eating disorders, depression, post-traumatic stress disorder (PTSD), and Dissociative Identity Disorder (DID). All of the subjects are described as dealing with harm as it was caused to them (that is, none is portrayed as harming others). The women represented various religions and races. Some stories clearly focused on "catalysts,' or events that were pivotal in subjects' experiences with madness. For example, Chris experienced a devastating separation, David suffered multiple physical injuries that affected his emotional wellbeing, and Denni cited generational trauma. Two of the stories — from Kieran and Michel — were less specific diagnostically, with Kieran stating that he experienced symptoms of depression as early as 10 years old and Michel not naming any medical diagnoses, but referring to a **"weariness"** which enveloped him despite his life being "exciting."

Michel's story was unlike the others because it was much vaguer, remaining ambiguous about what it was that Michel experienced. In its tone, Michel's story stands out due to the lack of detail in it — for example, it mentions that he was able to get help after a **"pivotal encounter"** with "someone in the health field" but does not tell us the person's profession and why their meeting was so important in Michel's healing. Conversely, Chris, David, and Kieran's stories shared more intimate details and information about how they sought help and assistance towards recovery, with David

even naming the occupational therapist whom he credits as, again, "pivotal" in his **"remarkable improvement."**

Another outlier from the ten texts was the story from Etienne, a recognizable sports personality. Etienne's story in Bell's campaign is unlike the others because it does not include any mention of his experiences with mental-health issues. Instead, it reads like a celebrity biography, detailing his professional achievements such as multiple Grey Cup wins, published novels, and award nominations for his work in media. It is unclear why Etienne is a Bell Let's Talk ambassador beyond his popularity, because according to his story, he has not worked on mental-health initiatives prior to the campaign.

The stories also heavily imply a "giving back" message indicating subjects' involvement in the communities they are a part of based on their gender, race, age, and other identity factors. Community also comes up as a common theme, not only by way of playing a part in the recovery of some subjects, but usually also as one of the priorities in their advocacy and awareness efforts. Chris's story noted that he "strives to be a mental-health **ambassador**" and works to empower men with mental-health issues. Denni shared that she found a **"great sense of belonging and purpose"** after dedicating herself to servicing her Indigenous community. Kieran, one of the younger subjects, is involved in youth-focused mental-health advocacy. Shreya's story noted that she shares her story **"both in and outside her community"** to encourage people struggling with mental-health issues, but generally, her story is heavily focused on the South-Asian community.

1. Medicalization and Individualization

In this section, I consider RQ1, which asked: What ideas of medicalization and individualization, if any, are present in Bell Let's Talk discourse? I probed the texts for discursive indicators of experiential values that might, in turn, indicate the presence of ideologies researched and critiqued by disability and mad studies scholars.

Across both sets of stories, the first immediately clear ideology to emerge through frequent word usage was the ideology of madness as abnormal. The word "normal" was used specifically in David and Michel's stories to describe non-mad life.

"[Michel's] greatest wish was so simple: he **wanted to feel "normal" again.**"

"Though David **returned to normal life**, he carried a host of internal wounds that would scar the decade to come."

This idea was present in other stories, through the use of similar language which makes madness seem unfamiliar and unstable, like:

"Shreya **became herself** again."

"[Souad] **no longer recognized herself**" and'

"[Queena] **regained some form of inner stability.**"

Though the latter three stories did not explicitly use the word "normal," this language still implies that they felt like inferior versions of themselves while experiencing madness. Furthermore, the word "burden" was used in Chris and Shawntay Rose's accounts of their experiences:

"[Chris] felt **freed from the heavy burden** of his secret."

"[Shawntay Rose] was able to **shed the burden** she'd been carrying."

Language evoking a similar idea of madness as an unreasonable weight and stressor is seen in other stories. Michel's story refers to his experiences as **"a dark period"** in his life and Kieran's profile said that madness **"forced him to grow up quickly"** — this implies that Kieran did not experience a normal childhood.

These fearsome descriptions of madness may seem inconsistent with Bell Let's Talk's anti-stigma priorities, but are well in line with a medicalizing approach. In addition to madness being described as preventing subjects from experiencing a "normal" life, there are many instances displaying the narrative themes of "overcoming" or "cure."

For instance, Souad's story ended by noting that thanks to taking medication and feeling supported by her family, she was able to **"[move] forward"** and return to school. Chris said that opening up about his experiences in the oil and gas industry **"freed"** him and allowed him to engage in awareness work focused on empowering men to speak out about madness. Kieran's story ended by detailing the extent of his international advocacy work. David stated that he had "[devoted] himself to helping others in their own journeys". All the stories showcased the subjects as responsible people in Canadian society who now are either "cured" of their illnesses or have madness under their control.

All subjects described having personally reached out for help to cope with madness — no one mentioned being hospitalized or medicalized without their own express consent or experiencing any kind of interventionist approach as a first step. No stories clearly described what it is like to experience psychiatry and other medical treatment for madness — other than David, who briefly discussed his positive experience in a rehabilitation centre.

This near-universal focus in the analyzed texts on seeking individual cures for individual maladies is usually, but not always, related to solutions in institutional health-care settings. Exceptionally, while Shawntay Rose's story used the clearly individualized word "burden" when describing madness, we learn that a medical approach "did not have the desired effect" and that ultimately, **"alternative" methods** such as dance and painting helped her cope with suicidal thoughts. Denni described traveling, meditation, dance and performance, and serving her community, among the ways she became able to process her trauma. Queena also noted that in addition to psychiatry and medication, surrounding herself with non-judgmental and encouraging friends was helpful to control her stress. David, who suffered multiple debilitating physical injuries, credited the holistic approach of a rehabilitation program and the people he encountered in the program for helping him recover. Kieran, whose story said that madness forced him to grow up quickly, also stated that his experiences helped him develop qualities like empathy and compassion. Kieran's story also stated that **"his illness is a part of him"** — this echoed messages of many prominent disability justice advocates and academics, who suggest that trying to shed yourself of your experiences with disability and madness reproduce shame, and imply that one cannot live wholly or happily while being disabled or mad.

2. Socio-Political Context

I now turn to RQ2, concerning the representations of political and social understandings of madness in the ten stories. All of the stories end on an upbeat note, with no stories indicating that the person is still experiencing madness in a way that hinders them from working and participating in society in a "normal" way. As noted

earlier, most of the stories share details of catalysts or impelling events that were painted as responsible for the subjects' experiences with madness. The only exceptions are Etienne, whose story does not include any mention of madness; Kieran, whose account of experiencing madness, while detailed, does not discuss a "cause"; and Michel, whose story is also vague diagnostically. The seven remaining stories discuss a range of impetuses of which some reside in the domestic realm and others in a socio-political context, while some cross these divides. The catalysts include generational trauma; relationship issues including separation, familial issues, and emotionally taxing partnerships; stress related to immigrant status and unemployment; workplace conditions; physical injuries; witnessing violence, and more. Some stories note multiple catalysts.

The effects of negative physical environments and workplaces are described in some stories, with David making apparent that he experienced multiple life-threatening injuries in his work as a trucker, Chris stating that the oil and gas industry is alienating and **"highly demanding,"** and Queena describing her profession as being unwelcoming to public discussions of madness.

The stories also describe subjects leaving these dangerous and/or stressful environments: Chris expresses that "his mental-health issues were **incompatible with his work environment,**" and Queena said that she **"curates" her physical environment** to better deal with mental-health issues.

A story that stands out through discussing a catalyst as related to one's physical environment is Denni's, who described the lasting emotional toll felt by her community due to the violent and traumatic experiences of previous generations who were sent to

residential schools. This story is the only one that recognized systemic racism's role in fermenting madness. Notably, Denni's story expressed this thought in such careful terms as to require a reader to be sufficiently familiar with the idea of social determinants of health in order to grasp this message:

> Many generations of ʔaq'am children were forcibly sent to the St. Eugene Mission **residential school,** and these separations **affected the entire community** in profound ways that have yet to be healed. Emotional distress, loss of culture and different types of addiction have often been **a legacy that the community members cope with.**

While the story clearly discussed generational trauma, it was still largely apolitical in its tone and approach.

3. Racialized Women and White Men

While the five white men's stories did not include signifiers or details about their familial and cultural backgrounds, the stories from the five women of colour included much information of this kind. A theme to emerge clearly from the women's stories was that of cultural taboos. Four out of the five note cultural or intra-community disapproval as a barrier to opening up about madness. Souad, a Muslim woman who immigrated to Quebec from Algeria, stated that **"mental illness is taboo in her culture."** Denni, an Indigenous woman who grew up in a small community in Ktunaxa territory, stated that she **"refrained from talking about it,** telling herself that she needed to be strong in order to survive." Queena, who is Asian-Canadian, stated that she is **"from a culture … where mental illness is not often talked about publicly."** The first line in Shreya's story noted that **"in [her] South-Asian community, mental-health issues can be**

somewhat taboo." While Shawntay Rose's story did not explicitly note intra-cultural barriers, she stated that her mother initially dismissed her when she opened up about her mental health as a child and it was someone outside her family, the guidance counselor at school, who helped her.

This particular fixation regarding racially specific cultural barriers in the stories from women of colour corresponds with criticisms made by disability and mad studies scholars like Mollow (2006) and Kanani (2011), who found that racialized people's communities and practices are frequently characterized as innately causal of madness. Conversely, while a cultural commonality was present across some of the men's stories as well, there was a lack of information about each subject's background in the stories from white men. Chris' story places him in Alberta, but overall, the stories do not provide cultural details or make the men's heritage clear. Family was only discussed plainly in Kieran's story when he mentioned an early familiarity with madness due to his mother's own diagnosis of bipolar disorder. While the men's stories did not help us glean an understanding of the men's cultural backgrounds, the women's stories provided many details about their cultures and ethnic/racial backgrounds.

Nevertheless, a cultural commonality may be inferred from some of the men's stories; many male subjects shared that the pressures of masculinity kept them from seeking help or opening up about madness. Chris, who worked in the oil and gas sector, stated that the **"tough guy environment"** and "general mindset of the industry" discouraged workers from communicating with others about their health. This was a significant impediment for David as well, who was a rugby player and trucker, and noted that his peers **"never talked"** about the violent conditions of their sport or trade. Even

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after experiencing multiple brain injuries playing rugby and in his work, David felt the need to remain silent about his mental health. While not linking it to the pressures of masculinity, Kieran also stated that he initially "struggled more than he let people know."

As expressed in the stories, openly discussing the pressure men face to live up to the expectations of masculinity is indeed taboo, but it has not been explicitly located as a cultural issue for the white male subjects in the way that taboos were clearly culturally determined in the stories of racialized women.

Discussion

In this section, I will elaborate upon my findings and discuss the way Bell Let's Talk has characterized the subjects of the personal stories and the subjects' communities, suggest why the campaign may be interested in these depictions, and offer possible effects of texts of this kind on the broader context of Canadian society. My discussion is focused on cultural taboos, characterizations of subjects, and catalysts of madness.

1. Cultural Taboos

As described in the findings, the cultural and racial backgrounds of the women of colour were made very clear, while there was not a similar focus on the stories with white men subjects. Taboos in racialized communities were a significant focus in the stories from women of colour, with four out of five stories describing intra-community stigma as major barriers in their recovery. Stigma against mad people and discussions of madness certainly exists in racialized communities — for example, research indicates that South-Asian young adults' attitudes towards counselling and madness-related

issues are more negative than white young adults' (Loya et al., 2010; Mirza et al., 2019; Mokkarala et al., 2016). However, this research is often removed from the historical and social context in which South-Asians and other people of colour experience taboos and stigma around madness.

As Fairclough suggests, a critical discourse analysis requires explicitly and critically examining the socio-cultural structures that are challenged or reinforced by the texts. Thus, we must critique the way that cultural taboos are presented in the Bell Let's Talk personal stories. Stigma clearly also exists in broader Canadian society because the men describe experiencing it, but it is not characterized as culturally embedded. This contrast works to characterize racialized peoples' cultures as regressive and white society as relatively progressive.

I am not suggesting that the stories' compilers have purposely or maliciously characterized racialized communities as intolerant and white society as forward-looking. Depictions of this kind often occur unconsciously, because such ideology is considered as truth, and this only speaks to the pervasiveness of Orientalist attitudes in Canada and the West. Canada enjoys a reputation for tolerance, kindness, and diversity, while non-Western countries and communities are imagined as relatively ignorant, unwelcoming, and restrictive (Said, 1979). Yet, people of colour in Canada are poorer, hungrier, and sicker than their white counterparts, and when they encounter state systems like government, healthcare, and police, they are not always welcomed (Chiu et al., 2018; Kanani, 2011). By maintaining their focus on overcoming intra-community barriers, the stories overlooked the frequency with which people of colour who have

attempted to access healthcare but have not been cared for (Kanani, 2011; Mollow, 2006).

Furthermore, by characterizing cultural barriers as existing only within racialized communities, and without critiquing the documented misdiagnoses, ignorance, and abuse that racialized women can experience while accessing healthcare systems in the West, the stories painted an incomplete picture of what it means to live as mad (Kanani, 2011; Mollow, 2006). Focusing on encouraging people to speak up and get help — and doing so without adequately critiquing racial and gender-related biases present in systems such as medicalization — encourages a neoliberal understanding of madness, which only further reproduces the ideologies that "create" madness.

2. Orderly Characterizations

In the ten stories, madness was portrayed as happening to those who would be socially understood as "good" people. Again, we do not know what the subjects said — only what the compilers of the Bell Let's Talk stories chose to include. The necessary selectivity they would employ in this process to ensure that the stories support the campaign's mandates makes it unsurprising that none of the ten stories I analyzed described interactions with law enforcement or criminalization of any kind. There are also no mentions of homelessness, unemployment, food insecurity, or poverty. Indeed, each spokesperson was portrayed as a "responsible" and self-possessed member of Canadian society; any inability to work and other impediments were regarded as part of the subjects' pasts.

This could be for two reasons. First, the subjects must appear to be virtuous and moral people to avoid aligning Bell Let's Talk and its mission with anything that could be

perceived as "offensive" by a general audience. Second, for an anti-stigma approach to maintain a tone of optimism, the campaign needs to show some kind of positive advancement in subjects' lives; thus, the selected stories should be on track to happy endings, and selected people should largely exclude any who would describe themselves as *still* stigmatized.

With no mention of incarceration and criminalization, precarious housing, and financial insecurity, these ten Bell Let's Talk stories do not represent what research has shown — that criminalization, incarceration, and homelessness are frequent elements in the experiences of mad people. Furthermore, racialized people, particularly Black and Indigenous people, are criminalized and incarcerated at disproportionate rates as compared to white people in Canada, which highlights the importance of including the voices and perspectives of racialized people in describing the experiences of madness. A retelling of a racialized person's experiences with madness, including the social determinants of health which are disproportionately impacting racialized people — such as criminalization and incarceration, homelessness, poverty, and unemployment — would give voice to some of the most severely marginalized people in Canadian society. While glossing over more complex topics such as criminalization, homelessness, and poverty can be defended on a purely self-serving public relations-level, the omission of these issues only furthers misunderstandings about madness. This occurs through the spread of a neoliberal understanding of madness, which is evident through the idea that subjects can take it upon themselves to be cured and re-enter society as "better" or more capable versions of themselves.

Whether consciously or not, the Bell Let's Talk campaign and brand are highly

unlikely to have been constructed without an awareness of the corporate interests of

Bell, and those interests may very well conflict with representing the experiences of

incarcerated people. While Bell's charitable arm advocates for mental health, its

business managers maintain a "prohibitive and outdated system" that charges highly

unaffordable rates for phone calls to and from prisons in Canada (Canadaland, 2020).

Discussing madness as it relates to criminalization and incarceration could provide a

platform to people who might seek to do some awareness-raising of their own —

concerning the corporate funder's business practices. One woman living in a retirement

home was billed over $6,000 in a period of three months for speaking to her son

incarcerated in the Ottawa-Carleton Detention Centre (White, 2020).

Finally, while the idea of orderly characterizations includes representing people

who are "inoffensive" to a broader audience, as well as agreeable when considering

Bell's business dealings, the breadth of mad experiences and conditions in the Bell

Let's Talk stories is also rather controlled. With the exception of Keiran who shared that

he was diagnosed with Dissociative Identity Disorder (DID), the Bell Let's Talk stories

overwhelmingly focused on people who experienced anxiety, depression, post-traumatic

stress disorder, and suicidal ideation. Bipolar disorder and eating disorders are briefly

mentioned, but other conditions such as schizophrenia and borderline personality

disorder (BPD) are not. These conditions are more difficult to present to a wider

audience because they are much more stigmatized than anxiety, depression, etc., even

in the healthcare field. A survey conducted by Black et al. (2011) of 706 mental-health

clinicians found that most respondents thought BPD is a valid condition and diagnosis,

but nearly half of the respondents also reported that if they could, they would "prefer to avoid caring for a BPD patient" (p. 582). Black et al. wrote that "education about the nature and treatment of BPD can lead to more positive attitudes toward these patients and eventually serve to decrease stigma" (pp. 583-584). In the survey, the clinicians who cared for more BPD patients also had higher self-ratings of empathy and positive attitudes towards people with BPD.

Clearly, interacting with and knowing more about BPD reduces stigma in healthcare, so by representing more people living with borderline personality disorder in the campaign, Bell Let's Talk could also reduce stigma about the condition in Canadian society. However, as described by Costa et al. (2012) in their discussion of charities appropriating personal storytelling for personal gain, brands and companies will focus on using stories that audiences can largely identify with. The testimonies shared as part of the Bell Let's Talk campaign are supposed to feel recognizable, like "it can happen to you" (Costa et al., 2012, p. 89). Bell Let's Talk benefits from using widely understood and non-disruptive language that suggests madness can affect anyone, so it may be less concerned with representing people and stories that are more difficult to relate to and empathize with.

3. Catalysts of Madness

In some stories, it appears as though workplaces, social environments, and systemic mechanisms have clearly caused or exacerbated madness. For example, David suffered multiple work-related injuries as a truck driver, and Chris described the oil and gas industry as unreceptive to open communication. Souad described how difficult it was to be essentially a single parent and new immigrant in Canada, and Denni

discussed how systemic racism against her Indigenous community created lasting trauma that affected them for generations.

However, those workplaces, environments, and systemic factors were not discussed as needing to change — the onus was on subjects themselves to leave those environments or find a way to fit into them. Chris' story acknowledged the "work left to do" in the broader trades sector, but also described his own madness as "particularly incompatible with his work environment" and positioned his work in encouraging peers to speak up about madness as a solution. David suffered multiple life-threatening injuries and also expressed wanting to encourage other truck drivers to "take better care of their mental health and adopt a more positive outlook." Denni's story noted that she left her community to recover, and upon returning, put her time and energy into servicing the community. Souad met a social worker who helped her "find tools to cope" and no longer felt "defined by her illness."

In Chris's and David's cases, the key to coping with madness in their demanding and dangerous workplaces was described as opening up to peers. The stories employed a neutral approach focused on individual interactions. They did not question the structures of the work environments via mention of things such as unionization or higher standards of workplace safety and better pay, which would undoubtedly better protect workers' emotional, mental and physical health — their jobs are low-paying and some of the most dangerous professions in Canada (Barton, 2014). Likewise, Souad's story did not shed light on the rampant Islamophobia that Muslim immigrants living in Canada continue to experience on a daily basis (Abedi, 2020). Instead, the solutions to the problems and fear Souad faced as a new immigrant were described as being in her

own control. While Denni's story discussed intergenerational trauma, it did not critique

Canadian state systems and society for the ongoing discrimination levelled at

Indigenous populations, nor does it mention the closely linked histories of Indigenous

incarceration and psychiatry in Canada (Kanani, 2011; Lavallee and Poole, 2009;

LeFrancois, 2013). Denni was portrayed as succeeding despite the cards stacked

against her, then returning to her community members to do the work to uplift them.

The apolitical nature of these stories is, as suggested above, related to the

individualization of madness. As shown in the literature review, individualization is the

process by which disability and madness are constructed as existing within or because

of a person, not because of their physical and social environments; this is also the

mechanism in which cure-based and overcoming narratives exist. Individualization is

problematized by scholars and activists as part of the charity and medical models (also

referred to as the individual model) because of the disinterest in social environments

and overwhelming focus on "fixing" or "curing" people. To reiterate, critics of

individualization are not against people receiving care — they are against the motive

underlying the care, which is often to force people into systems that were not made for

them instead of imagining newer, braver, and more inclusive structures altogether.

Critiques of individualization position it within a neoliberal framework because it

allows systemic agents to separate themselves from their responsibility in creating and

exacerbating madness, especially in marginalized communities. This is evidenced by

the involvement in the Bell Let's Talk campaign of several Canadian politicians and

police departments with dubious records when it comes to engagement with the

experiences of mad and other people with disabilities. For example, on Bell Let's Talk

Day 2020, Ontario Premier Doug Ford tweeted in support of the campaign, but critics pointed out that one of the earliest actions his government took after Ford came into power was cutting $2.1 billion in planned mental-health funding (PressProgress, 2020). The Ford government also planned to cut $222 million from Ontario Disability Support Financial Assistance, a decision which service providers worried would worsen the issue of homelessness in Ontario (PressProgress, 2019).

In addition, the Liberal Party of Canada website shared a blog post dedicated to Bell Let's Talk. The post quotes several Liberal politicians including Prime Minister Justin Trudeau, who stated in an embedded tweet, "…there's still more work to do to end stigma & make sure Canadians can get the support they need. So let's keep talking, Canada!" ("Let's Talk," 2020). Some Twitter users responded to Trudeau's tweet in support of Bell Let's Talk by stating their frustrations that our national "universal" healthcare system, which Trudeau and the Liberal party currently oversee, does not adequately support mad people. "You have the power to do more," said user @BigredRyan01. Another user, @fitzy_fish, wrote "Respectfully sir, a lot can be done beyond "talking" about mental health. Your leadership has the means to influence, direct and support [mental-health] programs. If WE as a people need to do more, then our duly elected officials need to as well. #AwarenessIsntAction." Additionally, the user @Colleen37580212 said "I know that people are talking about mental health today, but [it] is so hard to try to find a good [psychiatrist], and the wait is so long." By suggesting that anyone can affect change by "talking," political leaders can easily redirect the issue of inadequate medical support in Canada to all of us rather than focusing on their

decision-making power, thereby creating an undue focus on the individual rather than the political.

As explained in the literature review with reference to Coulthard (2007), those in power will only allow for representation of stories that challenge it superficially. The Bell Let's Talk stories do not expressly mention governments, police, and other systemic parties, so their neutral nature allows for those parties to align with the campaign's messaging and display concern in a way that allows them to evade responsibility.

Conclusion

This paper analyzed ten of the stories told by Bell Let's Talk, a long-running and influential campaign concerned with decreasing stigma and creating more positive representations of mad people. Indeed, at first glance, these stories appear sanguine and progressive considering the diversity of spokespeople, as well as the surprising inclusion of some messaging aligned with the disability justice movement, like viewing disability as a part of one's identity, focusing on community care, and acknowledging the benefits of non-medical coping mechanisms. Based on the literature about the experiences of disabled and mad people, campaigns revolving around disability and mad charity, and the use of personal storytelling in such initiatives, I did not expect to find indication of ideas that are reflective of the language and demands of present-day disability justice advocates. However, while these messages are optimistic and forward-thinking in their own right, they were located within larger ideologies which encourage changing oneself instead of doing the initially messier but ultimately more valuable work of imagining and fighting for foundational change.

Following my critical discourse analysis of the Bell Let's Talk stories, I observed prominent messaging aligned with medicalization/individualization and apoliticization in all ten stories. In the five stories focused on women of colour, I found language that exhibited a racial bias and essentialist ideas of racialized communities. These discursive conceptualizations were not created solely by Bell Let's Talk, but reflect the power relations through which certain ideologies about madness and mad racialized women are formed and upheld.

There were some limitations to my study – for example, I worked with a small sample size of ten stories from forty-six overall due to what was manageable for the scope of this MRP. I did not study the accompanying videos or Bell Let's Talk's social media posts promoting these spokespeople's stories. I also lacked clarity on how these subjects were contacted and chosen to represent Bell Let's Talk, how the stories were obtained from them and what kinds of questions were asked of them, and who worked on transcribing and translating the stories from conversation to text for the Bell Let's Talk website. All this information would glean a fuller understanding of the ideologies underlying the Bell Let's Talk campaign. Further studies of Bell Let's Talk's personal storytelling mechanisms could include more or all stories as well as videos, search for the campaign's usage of these stories beyond the website and on social media, and attempt to obtain insight into the campaign's inner workings and the processes by which they sourced and made these stories public.

I trust that the subjects of the Bell Let's Talk stories engaged in difficult work to reach a place where they felt healthier and happier and capable of talking about their experiences for such a wide audience. I am not discrediting their personal efforts and

broader advocacy work as futile. However, the mere act of consuming mad people's stories may be mistakenly conflated with action and change. If engaging with such storytelling, we must challenge the idea that there can be an end to the discrimination faced by mad people on a societal level when using this medicalized/individual and apolitical approach. The ceaseless mental, physical, and emotional struggles felt by mad people inside our current systems is recognizable and urgent, and requires stories that speak unflinchingly to that urgency.

Appendix

1. Chris Johnson

When he started working in Alberta's oil and gas industry as a crane operator, Chris didn't think that his mood swings were a big deal, and the "tough guy" environment didn't allow for introspection either. Truth be told, he felt that the general mindset in the industry didn't encourage communication or concern for the mental health of the workers — it's a sector that is renowned for being highly demanding.

At age 22, Chris went through a separation that plunged him into a deep sadness. The weight of his pain affected him at work; he could spend days crying in the cab of his crane. He realized he couldn't keep going this way and went to the hospital. His ability to clearly express his emotions helped him and he quickly progressed through the steps leading to his diagnosis. Chris was diagnosed with bipolar disorder, and was offered the help he needed. The assistance program he then began enabled him to understand certain parts of his past. And while he was making progress, he found that his mental health issues were particularly incompatible with his work environment. So, out of fear of being judged, he didn't talk about them outside of his immediate circle.
It was a journalist friend who offered him the opportunity to take the big step and share his story publicly by talking about his mental illness and the stigmatization in his industry. With this opportunity, Chris openly talked about his past. The effects were immediate. He felt freed from the heavy burden of his secret and realized that he wasn't the only one dealing with these issues. He also recognizes that he is part of a growing conversation about mental health in the broader trades sector. However, the dialogue has to continue because there is a lot of work left to do…

That is how Chris's personal awareness campaign of empowering men with the courage to speak up about their mental health came to light. Whether in the public eye through media appearances, among fans of his band Form 10, through appearances in front of his peers in the heavy construction industry, or through work with various community organizations, Chris strives to be a mental health ambassador, tirelessly promoting the importance of taking care of both our bodies and minds, because "they simply go together".

2. David K. Henry

David's story is a study in resilience. A truck driver by profession, his life has been punctuated by far too many accidents that would have meant the end for many, but instead made him who he is today: a man with a mission to help others.

In his youth, David was an active, spirited young man well in control of his life. He was a rugby player and brushed off the frequent injuries that come hand in hand with the sport, refusing to show weakness of any sort. However, in 1986, he suffered a violent blow to the head that made a chink in the armour he had forged for himself. David's coach and peers never talked about brain injuries, and the impacts of such traumas were generally swept under the rug in his circle. So while he was compromised by the incident, David forged ahead without giving it much more thought. But in 1991, tragedy struck again when he fell victim to a terrible accident on a farm. Every effort was made to keep him alive and, after numerous surgeries and much medical care, he beat the odds. His body was in good hands—thanks to medicine, David, still a young man, was able to get back on his feet. However, the same couldn't be said for his mental health. Though David returned to normal life, he carried a host of internal wounds that would scar the decade to come. In silence, he noted that his memory was failing him. What's more, he was struggling with aggression. He knew that something about him had changed, but he lacked the words and understanding to pin down the source of his pain.

In 2001, while on the road in Florida, David was involved in a serious collision that changed the trucker's life forever. On the face of it, David didn't seem badly injured, but his head had taken yet another hit. It was too much for him. On the way back home, he suffered his first major panic attack and could no longer function. He knew that he needed help. With the support of his wife and family, he sought care to improve his psychological state. Heeding the advice of all his physical and mental health caregivers was no easy task. Still, though the results weren't perfect, David made progress. Feeling less alone, he opened up about some of his struggles and got involved in activities that were good for him. He started writing for a truck drivers' magazine, penning upbeat articles with an emphasis on finding solutions. He wanted to encourage his colleagues in the field to take better care of their mental health and adopt a more positive outlook. David worked hard to follow his own advice, even though he wasn't always successful.

In 2016, when he suffered yet another work-related injury, David couldn't take it anymore. He felt exhausted and fed up, and was assailed by suicidal thoughts. The blows that had accumulated over the years had finally caught up with him. This accident would be a turning point in David's life. To help him recover, his insurance provider offered him the chance to enter a multi-week rehabilitation program centred around a truly holistic approach. David could hardly believe it: a team would see to his entire well-being, taking care of his mind, body and soul. The care he received through the program and the people he met, particularly occupational therapist Sylvia Marusyk, would prove pivotal, and David made a remarkable improvement. David's life has been

marked by a great deal of suffering. During his rehabilitation, people told him that he had quite a story to share. Later, he would do just that, devoting himself to helping others in their own journeys.

Being there for those around us needn't require grand gestures. It can be as simple as treating others with kindness, saying thank you, paying a compliment, getting up to speak about your experience at a seminar or sharing something from your garden with a passerby. Actions like these have made a world of difference to David, just as they now brighten the lives of all those who cross his path.

3. Denni Clement

Denni is from ʔaq'am, a Ktunaxa community located in Ktunaxa territory in British Columbia. She grew up in this small Indigenous community, surrounded by a beautiful natural environment to which she is deeply connected. The mountains and rivers, the traditional practices, the culture of her nation are integral to her identity, as are the strong matriarchs who raised her and who continue to inspire her.

This community, which Denni carries in her heart, also experienced traumas. Many generations of ʔaq'am children were forcibly sent to the St. Eugene Mission residential school, and these separations affected the entire community in profound ways that have yet to be healed. Emotional distress, loss of culture and different types of addiction have often been a legacy that the community members cope with. When Denni was younger and struggled with anxiety, she refrained from talking about it, telling herself that she needed to be strong in order to survive.

One particular tragedy marked her life. Her uncle, barely older than she was, took his life. She was devastated. Denni did not know how to deal with his loss. She withdrew, lost interest in school, cut herself off from the world and no longer cared about life. In a moment of clarity, she realized that she needed help, and went looking for support—this enabled her not only to deal with her depression, but to gain the right tools for taking care of herself. After high school, she decided to discover another part of the world. During the seven months she spent in Southeast Asia, she got to know herself better. She also practised meditation, which proved beneficial for both her body and her mind.

When she returned to Canada, Denni began working for her community as a strategic planner. Through her role in service to her community, she discovered her strengths and abilities. She felt great sense of belonging and sense of purpose in serving her community. Denni lead ʔaq'am through a successful community engagement process that resulted in the community's first strategic plan. This plan provided the foundation for

many successful ventures for the community including a new school, power generation facility and new businesses. Denni moved from her community to pursue studies at the University of Victoria where she graduated with distinction in 2015. Since graduation, she has been working for the provincial and federal government on climate change and Indigenous community engagement.

Denni understands that mental health issues should not be trivialized. She knows how important it is for everyone in her community to feel comfortable to talk about mental health and to receive the help they need in order to heal. Denni has experienced trauma and time has enabled her to develop her own therapeutic mechanisms for maintaining her mental health. Through dance, choreography and performance, in particular, she is able to safely express herself and process her journey. This is Denni's way of celebrating her culture and helping others understand that Indigenous women are important, and Indigenous women have a right to be loved and heard. taxas ɫat ʔat ȼxanam- Let's talk.

4. Etienne Boulay

A popular sports personality recognized for his involvement with young people, Étienne Boulay made football his passion. The sport allowed him to reach great heights in professional sport and earn significant distinctions, including three Grey Cups in 2009, 2010, and 2012.

Étienne Boulay retired from football in June 2013 with the intention of launching a media career. It was a smart bet. Les Testeurs, a show he co-hosted for four years with Patrice Bélanger on VRAK, propelled him to stardom among young viewers and garnered him a Gala Artis award nomination in the "Meilleur animateur jeunesse" (best youth show host) category, as well as four Gémeaux award nominations in 2014. After working on several television projects, he made the leap to radio in 2017, participating regularly in "Véronique et les Fantastiques", a show on Rouge FM.

However, his career really took off in 2018, when it was announced that he would host a new show, Liens Rompus on MOI&CIE, as well as co-host Bootcamp: Le Parcours de l'Extrême a show on V. 2018 was also marked by the publication of his biography, "Le parcours d'un battant", and the release of a documentary by the same name. In 2019, he will host the show Naufragés de l'amour on Canal Vie for a second year in a row.

Since 2015, Étienne has published three novels for his youth series, Touchdown, in addition to managing popular Web platform Ma Famille Mon Chaos, a discussion, entertainment and information forum for parents.

A devoted father and an authentic, athletic and imperfect person, Étienne is omnipresent on his social media platforms, which he updates every morning and evening with a good dose of humour.

5. Kieran B. Drachenberg

Kieran's first signs of depression began when he was around ten years old. Already aware of certain mental health issues, his mother has bipolar disorder, he knew that it was not normal to feel tired and sad all the time or to have suicidal thoughts. But what he didn't know was how to talk about it. Over the years, depression would take a physical toll on Kieran and he began experiencing amnesia gaps and unusual behaviour, prompting him to make an appointment with his family doctor. After describing his migraine and joint pains, he used his time alone with his doctor as an opportunity to tell him about his dark thoughts. He was referred to a specialist, who diagnosed him with depression and generalized anxiety disorder. Just being able to put a name to his condition and symptoms was a relief, but Kieran still struggled more than he let people know. He was afraid of the "strange, weird and scary" symptoms, including the amnesia, which he felt he could not explain or talk about. Kieran still needed some time to get his head above water. To get there, he was able to count on the unconditional support of his family, his friends, his teachers and a trusted team of professionals.

Recently, Kieran struggled with psychosis where he was unable to differentiate between reality and the thoughts inside his mind. Having experienced psychosis in his younger years, Kieran knew his symptoms were unmanageable and he sought help, staying in hospital for several days. He was diagnosed with atypical eating disorder behaviours and Dissociative Identity Disorder (DID). These new diagnoses have changed Kieran's experience and he feels there is still a lot of internalized stigma with DID, which can impede people's ability to get help. He is not ashamed to talk about his conditions. He hopes that by sharing his story he can help create a world without stigma; where people can get immediate help and do not have to wait for a diagnosis.

Kieran is proud of how far he has come. Although he still has to deal with the effects of his illness every day, he can affirm that he is in a much better mental and physical state than before. Kieran sees his illness as a part of him. It has forced him to grow up quickly and develop human qualities such as compassion, empathy and a willingness to help others. His struggles have fueled his advocacy work, which today is his main focus. By taking tangible action, Kieran is working to help make the world a better place for people living with mental illness, while also supporting his own mental health and self-esteem.

In 2019, Kieran's advocacy work took him to Brisbane, Australia where he served as the Youth Co-Convenor of the International Association of Youth Mental Health Conference, attended by over 600 youth and adults. Through this work, his goal was to encourage the voices of Indigenous, LGBTQ, disabled people and those with highly stigmatized (more acute) disorders.

6. Michel

Michel counts himself lucky. He is surrounded by a loving family and old friends, and has a job which he is about passionate about that provides him a good living. He appreciates his stable and comfortable life every single day. He is far from the dark period he lived in his twenties.

In his early twenties, Michel was very industrious. He did well in school and was very involved in many extra-curricular activities. Life was full of excitement but insidiously, a weariness began to overcome him. Everyday moments which once had brought pleasure seemed to lose their meaning. Eventually even his mental and physical capacities began to fail. But, even while Michel was exhausted, enveloped by a profound sadness, a flicker of hope was still alive within him.

As chance would have it, he had a pivotal encounter. He came across someone in the health field who had the right combination of theoretical and practical wisdom. It made sense and he could trust what was being shared. His greatest wish was so simple: he wanted to feel "normal" again, to rediscover life's daily joys. He had to start by doing the basics: eating, sleeping, and moving. With some help, perseverance and a lot of patience, he also tried a variety of tools that had helped others in the past. He remained open-minded throughout; the recovery process is a long and very personal journey.

Through this long and arduous journey, Michel built his self-confidence back up and learned to accept that he no longer had to aim for perfection. To this day, he continues to savour this change in himself. By being less critical and demanding of himself, he is less stressed and even appreciates the value of his accomplishments. Thanks to this period of introspection, Michel came to understand what was good for him and his overall balance. He continues to savour the joy that the stability of his daily life brings him.

7. Queena Lau

Queena has always been high-functioning despite the various issues troubling her. Parts of her childhood were spent in foster care and she spent most of her adolescence avoiding any talks about her family and upbringing. As a teenager enrolled in a gifted program, Queena learned that it was easier to pretend to be what others assumed her to be. By the time she was in her third year of university, Queena had a drawer full of pills that she saw as an easy option and way out. She was going through a difficult period, but it was practically impossible for her family and friends to see that her mental health was deteriorating. She was the one to finally sound the alarm when her mental issues began to take a physical toll on her.

Through her time in university, she was able to obtain the help she sought. In therapy, Queena learned that she was suffering from an eating disorder, anxiety, and major depression. Medications and frequent sessions with a therapist eventually enabled her to regain some form of inner stability. She learned to be critical of her thinking process and to not always trust her inner voice, as it was frequently biased. She also learned to accept disability accommodations, which forced her to face and assess her new reality.

Queena notes that in her quest to maintain her mental health, she has focused primarily on curating the right kind of support system for herself. In addition to her medications and weekly sessions with her psychiatrist, she makes choices about her physical environment and the people she spends her time with. Since having been more active in talking about her mental struggles, Queena has been able to form friendships with people who she can freely open up to and talk about taboo subjects without judgement. Queena has also learned to listen to the wisdom her friends have earned from their own struggles. In order to help control different sources of stress, Queena has also largely dropped social media in order to develop more genuine and positive relationships.

Queena feels lucky to be able to speak freely about her issues and to have connected with others on the topic of mental health. As someone from a culture and profession where mental illness is not often talked about publicly, Queena ardently wants to raise awareness in these environments by sharing her story, opening up dialogue, and generating support for everyone experiencing mental health problems.

8. Shawntay Rose Dann

At 11 years old, Shawntay Rose felt different. She was bullied at school and faced suicidal thoughts, but when she talked about it with her mother, those around her thought that she was just trying to get attention. Yet Shawntay Rose had been living with these thoughts for a long time. She felt misunderstood and unheard. So she decided to discuss it with someone she trusted at school, her guidance counsellor.

Finally, Shawntay Rose felt she had someone she could confide in who had a sympathetic ear and, for the first time, she was able to shed the burden she'd been carrying.

Shawntay Rose got the support of a team of professionals who prescribed a medication to help manage her mental health issues. However, it did not have the desired effect. Determined, Shawntay Rose sought out alternative solutions that might help her feel better. She signed up for artistic activities and found great pleasure in painting and dance. Today, she has the support and ear of her mother, who has come to better understand the difficulties her daughter was experiencing. Shawntay Rose said it best herself, "No one is ever too young or too old to learn something new or change their perspective." With this in mind, she has since begun talking to students and teachers in schools, advocating awareness and education around mental health above all. Based on her experience, when these tools are implemented, people are more inclined to understand what others are going through. This is one of her greatest wishes, and she works tirelessly at it every day.

9. Shreya Patel

In Shreya's South-Asian community, mental health issues can be somewhat taboo. Consequently, far too many people hesitate to talk about it. They fear being judged, misunderstood or stigmatized. It is this situation that Shreya wants to change. She believes that the people of her community would better understand the importance of mental health if they were more informed on the subject. From experience, Shreya also believes that talking about and sharing what you're going through is a powerful healing tool.

Shreya was a witness to the 2019 Raptors Parade shooting and has suffered from PTSD since. In the past, Shreya was in an emotionally draining relationship followed by working in a workplace with a negative environment. She maintained her mental stability by dedicating herself to activities outside of her relationship and her work that she found personally stimulating. However, the daily tension finally got the better of her, to the point that she no longer took pleasure in any of her pastimes. Shreya was unable to identify her debilitating symptoms as anxiety. Ready to do anything to feel better, she decided to shed her community's taboo and talk about it. She would make her mental health a priority. Thanks to the support of her parents, Shreya became herself again. She called on her inner strength and started to show more compassion toward herself. Today, she continues to share her story in an effort to show others both in and outside her community that they are not alone and that they should always maintain hope.

10. Souad Saidj

In 2010, Souad arrived in Québec with her husband and two children. Shortly after their arrival, her husband returned to Algeria, leaving his family in their adoptive country. Without her bearings and without a job, Souad found herself alone with her children, eight and ten. She was afraid and didn't know what to do. She felt as though her hands were tied, which created a lot of stress and anxiety in her life. She no longer recognized herself. Three months went by, and Souad decided to see her doctor. She was diagnosed with depression. Although mental illness is taboo in her culture, she was relieved to be able to put a diagnosis to what she felt. The medication prescribed to Souad unfortunately didn't make her feel better, and she was crying a lot. Internet searches led her to a local community service centre, where she met a social worker who helped her understand her problems and find tools to cope. Knowing someone was listening was a good start for Souad's recovery. She wasn't in the best shape, but she felt that she had made some progress.

Souad's children felt guilty about her depression. Souad learned about a cross-cultural pediatric clinic, the Clinique pédiatrique transculturelle. Its mission is to give a voice to children from other countries and their families in the psychotherapy process. A multidisciplinary team meets with the mother and her children from time to time to better explain the illness and its effects. The family is relieved, and Souad now receives encouragement from her loved ones. She has participated in workshops, which help her be more active and prove to herself that she is not defined by her illness.

In 2014, Souad learned that she was expecting a third child, which brought her great happiness. The birth of her baby temporarily distracted her from her dark thoughts. With the invaluable support of her family, she felt better and better. Her medication also keeps her more balanced mentally. A while ago, Souad went back to school. She feels at peace with herself, she is moving forward, and she is happy.

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