Cradle on the Waves: Stigma, Mental Illness, and Education on Prince Edward Island and Beyond

by

Matthew Dixon

Department of Integrated Studies in Education
McGill University, Montreal

A thesis submitted to McGill University in partial fulfillment of the requirements of the degree of Master of Arts in Educational Studies, Education and Society

Table of Contents

Chapter 1: Introduction

Chapter 2: Connecting Mental Health and Stigma

Chapter 3: Rural Realities and the Case of Prince Edward Island

Chapter 4: Building Sustained Solutions

Abstract

In this thesis I will highlight the complexity of addressing issues around mental health in rural settings by using the case of Prince Edward Island. Mental health and stigma are vastly underrepresented issues in contemporary Canadian society. There is limited research that explicitly addresses mental health and stigma in formal educational contexts. The case of Prince Edward Island provides a unique perspective into how close-knit rural communities can perpetuate stigma and encourage discrimination. There is also a lack of consistency in information, attitudes, and proposed solutions. Together, these factors contribute to a climate of fear, secrecy, and silence which forces mental illness suffers to continue to suffer in silence.

Résumé

Dans cette thèse je vais souligner la complexité des problèmes de la santé mentale dans les cadres ruraux en utilisant le cas de l'île-du-Prince-Édouard. La santé mentale et la stigmatisation sont des probèmes insuffisamment représentées dans la société canadienne contemporaine. La recherche qui adresse explicitement la santé mentale et la stigmatisation dans les contextes éducatifs formels est limité. Le cas de l'île-du-Prince-Édouard fournit une perspective unique de comment les communautés rurales peuvent perpétuer le stigmatisation et encourager la discrimination. Il y a aussi un manque de constance dans les informations, les attitudes et les solutions proposées. Ensemble, ces facteurs contribuent à un climat de peur, le secret et le silence qui forcent les personnes qui souffrent des maladies mentales à continuer de souffrir en silence.

Acknowledgements

First and foremost, I owe a sincere thank you to my supervisor, Dr. Ronald Morris. I am appreciative for his enduring patience throughout this process. I remember one particular class where he became the first educator I encountered who explicitly and honestly addressed the issue of stigma and mental illness. For the moment of realization that lit the match for all that followed, I am truly thankful.

It is with humble respect and admiration that I thank the residents of the province of Prince Edward Island who contributed to shaping me into the man I am today. I can think of no better place to spend one’s formative years. I will forever call the Island my home.

To my mother, whose fierce independence and strength continues to inspire me. It is her conviction to confront what is not always easy, but necessary, that kept me grounded throughout this process.

Finally, this would not be possible without the undying support of my love, Brenna. For the late night conversations, venting sessions, tears, and endless encouragement, I am forever grateful.

Chapter 1: Introduction

1.1. Research Objectives

Mental health and stigma are vastly underrepresented issues in contemporary Canadian society. There is limited research that explicitly addresses mental health and stigma in formal educational contexts. The lack of attention mental health and stigma are given is baffling when one considers that the Canadian Mental Health Association explains that 20% of Canadians will personally experience a mental illness throughout their lives. There appears to be a lack of consistency in information, attitudes, and proposed solutions. Together, these factors may contribute to a climate of fear, secrecy, and silence that forces mental illness suffers to continue to suffer in silence.

My contribution to this research is two fold. First, the topic of stigma and mental illness within formal education is vastly under researched. By reviewing the available literature and linking it to formal education, my contributions will add a dimension that includes schools. Second, I will provide a unique context by focusing upon my home of Prince Edward Island. Mental health and stigma research is limited on Prince Edward Island. Moreover, research concerning mental health and stigma in formal education on Prince Edward Island does not exist. In this thesis I will highlight the complexity of addressing issues around mental health in rural settings by using the case of Prince Edward Island. In doing so, I hope to draw attention to an issue that is largely overlooked in education.

I will begin by situating myself in the research. This will help to identify my own bias as a researcher, and provide a better understanding of my experiences with mental illness and stigma. I will then explore the cultural landscape of mental illness and stigma within Canadian society. I will do this though a detailed literature review from the research as well as from mental health survivors. Once the larger context has been established, I will focus upon my home of Prince Edward Island. I will examine how this traditional society encourages stigma. Finally, I will propose a number of possible educational solutions to confront stigma and normalize mental illness. In many respects, stigma around mental health is the forgotten issue in education. Courses in ethics and social issues readily address controversial issues like capital punishment or euthanasia. Issues in mental health, however, rarely appear in classroom discussions.

1.2. My Interest in Mental Health and Stigma

The topic of this thesis has followed me throughout my life. There is a long history of mental illness within my family. It is a history that had gone largely unspoken until recent years. My father, grandfather, and aunt have all had unique experiences with mental illness throughout their lives. For most of my life, I refused to give this history the proper attention and respect that it deserved.

I believe my refusal to accept these experiences can be explained, in part, by stigma. My home province of Prince Edward Island is a very close-knit society. It is not without its benefits. Its residents are generally friendly and helpful. The crime rate is quite low compared to other maritime cities of Halifax, Nova Scotia and Moncton, New Brunswick. However, its small population and traditional values create a setting where privacy and anonymity are nearly impossible to maintain. If one finds oneself receiving a bad reputation, the stigma tends to follow the individual for a very long time. The result is a culture where individuals are hesitant to deviate from commonly accepted norms out of fear of being stigmatized.

This creates an atmosphere where controversial issues such as mental health tend to retract from public view. For example, advocacy for free and accessible abortions is a very new phenomenon on Prince Edward Island. The advocacy group, The Prince Edward Island Reproductive Rights Organization (PRRO) only formed as recently as 2011. Other similar advocacy groups such as the Ontario Coalition for Abortion Clinics (OCAC) and the National Abortion Federation (NAF) have existed since 1982 and earlier. This highlights the uphill battle and lag Prince Edward Island society experiences in respect to controversial social issues compared to other Canadian provinces.

In my second semester of graduate work at McGill University, I had the opportunity to study a course on values education. In this class, we examined a multitude of rarely discussed issues in education, such as religion, death, illness and disability narratives, and mental health and stigma. As we studied, analyzed, and reflected upon these issues in our course work, my response was almost a visceral one. I felt as if a weight had been lifted off of my chest.

I was not only free to pursue such themes, but actually encouraged to do so. It was an atmosphere where reflection and growth could occur and where no topic was off the table. To the latter point, it was one of the first times in my life where I had experienced this within the field of education. It encouraged me to reflect upon my own willing ignorance of my own history with mental health and stigma and motivated me to engage in this research.

1.3. Unsent Letters

The following are a series of letters I wish I could have sent to family members who experienced mental illness. My own fear of facing these issues prevented me from doing so previously. They are deeply personal and difficult to share, but I have come to realize that I must come to terms with my own fear of mental illness and stigma. It is an effort to situate myself within the research, both as a researcher and as a human being.

Dear Dad,

I know that it has been some time since we last talked. You may be wondering why I have decided to write you after all of these long years of silence. I wanted you to know that something has happened to me that is quite spectacular, and it has changed the way I feel about a lot of things between you and I. I'm a teacher now; in fact I am pursuing a Master's Degree at McGill University in Montreal. Can you believe it? A lot has changed since the last time I saw you when I was just nine years old. At the time, mom explained that you were sick and it was important for you to get a fresh start in British Columbia. Opportunities on Prince Edward Island had dried up for you. I never quite understood it, but I knew that it was a sensitive topic and didn't press her for more information.

Some of my fondest memories of you are when I would visit you at the Queen Elizabeth Hospital in Charlottetown. You were there quite often, though I never knew why. There was always a knowing silence between all of us. You never quite explained why you were in the hospital, and I never pushed to know the true reason. Perhaps it was out of my own fear and discomfort about the subject. I remember thinking to myself that you didn't look sick, apart from looking tired with the bags under your eyes, and your skin being pale. It was drained of its energy and warmth. But you looked good compared to the people I saw around the hospital: the elderly bounded to wheelchairs, those with casts on their arms, and the hairless heads. Perhaps that is one of the most difficult aspects of what you were going through, the invisibility and the silence of it all. I cannot imagine the pain you were going through. From the physical toll your condition was putting you through, to the emotional distress that simply living and *being* must have been for you. I did not recognize the severity of the situation, but maybe I was too young. Maybe I would have had more sympathy for you if you had a broken arm compared to having a manic-depressive condition. At least then I could have seen what was hurting you and where the pain was.

One of my classes this semester focused on issues of mental illness. The readings in that class humanized mental illness. We read a lot of good articles, firsthand accounts of what it is like to suffer from such a condition. One that made me think of you was by an author named Martha Manning. She spoke candidly about her experience with clinical depression and about the physical stress it put on her body. She spoke of the aches, the pains, and her inability to physically function. It was a profound moment for me as she deconstructed the myth that mental illness is not only a disease of the mind, but it affects all aspects of being (Manning, 1995).

Another author, Kay Redfield Jamison spoke of her experience of living with manic-depressive illness. In her book, Jamison speaks of the slow decent into the illness. It started with her inability to focus and concentrate. She can even pinpoint the moment when she realized she was insane (Jamison, 1995). I often think about your silent suffering and what it must have been like for you.

We never spoke about your childhood. I wish I could speak with you about growing up on that reserve in Flin Flon. I wish I could speak with you about having to grow up so fast and learning so many tough lessons along the way without the love and the support you deserved. I don't know how you survived it. I sometimes imagine myself in your shoes going through that hell. Whenever I am in trouble, I can always breathe easy knowing that I have a loving family who supports and looks out for me. I cannot imagine not having that safety net.

The world can be such a cold place sometimes, especially when it comes to people who exist outside of the norms of society. I'm so glad you found your way into treatment and into that hospital in Charlottetown. I wonder if you have kept up with your treatment since you moved to British Columbia. I wonder if you're taking care of yourself, and receiving the help you deserve. Sometimes my mind wanders to the worst places imaginable.

I'm writing you this letter, father, in the hope that it will somehow reach you, though I don't have an address to send it. I used to get letters in the mail from the government as a type of disability pension because of your condition. They only continued while I was studying in university, and after the age of twenty-five I was no longer eligible to receive them. I always looked forward to when those envelopes would arrive in the mail, not because of the money, but because it was a sign that you were alive. In a funny way, it was a small connection that I kept with you over the years. I have so many stories to tell you. I love you Dad, and I hope we can see each other again.

Love Always,

Your son

Dear Papa,

I will never forget the choice you made to move to Prince Edward Island in your final years of life and to stay with my mother and I. It was such a rewarding experience to get to know you again, and to have you so close to us. You lived so far away in British Columbia and Ontario for most of my life. I always looked forward to those trips to see you every second year. Having you stay with us during your final years could not be matched. Still, there were times where my confidence in myself wavered, especially near the end when we were so helpless.

In your final year you developed dementia and had to be relocated to a full-time care facility. I remember we always referred to it as “the lodge” in the hope that it would somehow lessen the blow. It’s funny how we do that; call things by other names when we all know the true reality of the situation. I remember visiting you almost daily, first in the hospital while you were waiting for a bed to become available. Then, after some months, the visits moved to “the lodge” itself.

We have been studying a lot of different topics this semester at McGill, and one of them was the culture of death and dying in our society. One author in particular, D.W. Moller made me think of all the pretenses we lived under when you became ill. He also speaks of the tension that exists between life and death, and how they are so strongly connected. Death is a prominent part of our existence, yet it is so often hidden. It is hidden even in hospitals where it is masked under clinical terms, professional dialogue, and special codes. This language rids us of our emotional attachment to it. It makes it routine (Moller, 2000).

I distinctly remember how the tone of our conversations changed after you became sick. I remember treading ever so softly, always concerned about how you were interpreting what I was saying. Dementia was rarely explicitly stated. Rather, I opted to lessen the blow by referring to it as “the new reality” or “the new situation.” It was too painful to confront at the time.

The years have slowly passed since your death. I find the atmosphere is returning to what it once had been. Time has restored me to the point where I can look back at things honestly. I can speak openly about how dementia changed you and changed me as well. I can appreciate the time spent with you. Being with you was what was important, whether sick or healthy. I love you Papa. I hope to see you again one day.

Love,

Your grandson

Dear Auntie,

When the news reached me that you were found at a bus station alone in the middle of the night in Toronto, a part of me had expected it. I understand that things have not been easy since my uncle’s stroke. I know what you did was an act of desperation and you knew my mother was in town and could help you. Even in your state, you knew that you just had to get to her. I remember when I would visit you when I was younger, I would think that something was different or abnormal about how you acted. I couldn’t put my finger on it, and I was always told that you were just unique. I didn’t know then that you had been diagnosed as clinically depressed since your teenage years, nor did I know that you had been prescribed Lithium to control your manic tendencies for the past forty years.

It makes me so angry to feel so helpless or to even understand what you are going through. My mother tells me that you now have complications because of the abundance of Lithium in your system for the better part of your life. I wonder if the doctors considered the consequences of such a heavy dosage for so long. But for me, the most troubling aspect of what happened was my reaction to it. As I said, I wasn't caught completely off guard. In fact, it was something that I partly expected to happen. I wonder then, how could I have gone for so many years pretending that everything was okay? How did I lie to myself and convince myself that things were fine? Why did I not reach out, speak up, or even attempt to look at the situation critically? Even after my uncle's stroke, when it was apparent that things were not going well, it did not strike me as something that warranted action.

I can try to hide behind excuses. I couldn't have done anything even if I wanted to. The geographical distance was too great to overcome. You were responsible for the situation. Ultimately, when I really look at those reasons I know they are hollow. There can be no justification for the blindness I chose to practice when it came to your dire situation. I felt powerless and unqualified to handle the situation. Yet, I could have done something, *anything.*

I'm so thankful that your act of desperation was one of seeking help, and not resorting to another more final solution. It's very telling of our society that we feel compelled to react to something rather than take the initiative and be proactive about such matters. I've learned so much from this event, and I cannot express my gratitude to you for helping open my eyes to my own hypocrisy. I'll try to keep my eyes open.

Love,

Your nephew

Chapter 2: Connecting Mental Health and Stigma

In the following chapter I will begin to examine the mental health landscape in Canada with respect to the issue of stigma. Mental health tends to be addressed in broad and clinical terms that fail to consider the human face of this issue. The following chapter contends that labeling individuals with poor mental health as “consumers,” and treating mental health as a clinical topic alone are ineffective strategies for understanding a complex and far-reaching phenomenon.

In this chapter I intend to give mental health a human face. This greatly differs from the very reality stigma produces. The United Nations Human Rights Council (2012) define stigma as “a process of dehumanizing, degrading, and devaluing people in certain population groups, often based on a feeling of disgust. Put differently, there is a perception that the person with the stigma is not quite human” (p. 4). I will begin by analyzing the feelings of vulnerability and fear that mental illness causes. I will rely on firsthand accounts from mental illness sufferers in an attempt to break down widespread misconceptions. I will also do this to illustrate the nature of the stigma they endure. In doing so, I will examine the challenges of speaking about one’s own experiences while also navigating the confusing bureaucracy of the mental health care system. These efforts will help to highlight the complexity of mental illness and stigma.

At the heart of the chapter is the notion that mental health and stigma affect everyone in society. In tackling this point, I will expand my analysis beyond the mental health sufferer and into families, peers, and society itself. I will critically analyze how families and peers tend to react to news of mental health problems and how this is detrimental to recovery. I will continue by looking at the Canadian mental health safety net and the lack of trust many victims of poor mental health have in the very system that is meant to support them. I will conclude the chapter by broaching the topic of language and how the words we use can encourage discrimination and stigma. By presenting mental health as something universal that impacts every human being in different ways, I hope to normalize it. At present, mental health is something that is hidden, secretive, and taboo. If that perception changes, the stigma attached to it may become less poignant and a better future may exist for everyone.

2.1. Understanding Stigma

Stigma invades all aspects of life. It can lead to loss of status, reduced career opportunities, and negative perceptions of self-worth. Quinn, Wilson, MacIntyr, and Tinklin (2009) note that stigma can indeed extend to feelings of weakness and inadequacy, which if left unaddressed, could potentially negatively affect future career opportunities (p. 406). These consequences were also observed by Corrigan (2005) in what he referred to as, “The loss of rightful life opportunity” (p. 18). This refers to the treatment mentally unwell individuals receive as a result of not being able to live independently, or find employment. Subsequently, the wider populace can treat them as social pariahs and criminals rather than victims of disease (p. 18).

2.2. Fear and Vulnerability: The Victim

Mental health and stigma are universal. Simmie and Nunes (2002) explain that mental health issues “can happen to anyone” (p. 1); we are all susceptible. According to The World Health Organization (2013), “there is no health without mental health” and “good mental health enables people to realize their potential, cope with the normal stresses of life, work productively, and contribute to their communities” (p. 5). The potency of stigma levied against those who suffer from mental illness stems from fear of vulnerability and the unknown.

We like to believe that we are in control of our lives. We plan our experiences, our families, our careers, and we aspire to live according to our interpretations of the good life. Losing control engenders a great deal of anxiety. When we lose control, we feel vulnerable. However, we often find ourselves in situations that are beyond our control. A common example of this is airplane travel. In these situations, we put our confidence in the pilots for the duration of the flight. The situation is out of our control. If something goes wrong during the flight, we hope that the pilot will be able to maintain control of the aircraft. Without this hope, the stress of flying would be unbearable. With mental illness, the loss of control can be devastating. There is rarely a pilot to heroically save the day. Instead, the crash is often followed by stigmatization, where insult adds to injury.

Vulnerability of the mind is much different. While certain individuals understand how to operate airplanes, no one fully understands the human brain. When the brain gets sick, our fears intensify because we may not know what is wrong, how to fix it, and we know that no one else has the answers either. Despite its long and documented history, mental health and mental disorders remain shrouded in mystery. We can clearly see this from the lack of consensus on its causes, contributing factors, and solutions. As a result, we find ourselves living in a climate of fear, which is a daunting challenge to overcome. This fear of mental illness does not subside like that of flying when we feel the wheels of the plane lightly touching down upon the runway. The threat of losing control of one’s life is very unsettling, and the fear of mental illness stays with us throughout our lives.

Our discomfort with mental health can be referred to as “mentalphobia” (Maté, 2012, p. 4). Like a bad habit, fear of the unknown and thoughts of one’s own mortality remind us that we do not have all the answers. This frightens us. However, fear is not always detrimental. For example, instinctive behaviours such as the fight or flight response is an effective defensive mechanism. Similarly, it’s possible to use fear as a unifying force. For example, cancer has been recognized as a threat and has motivated the public to seek a cure. Unfortunately, in terms of mental health, we instead tend to turn on each other by stigmatizing those who fall victim to it. This is important because it is at the core of why the stigma persists.

Corrigan (2005) argues that mental illness narratives can disrupt our outlook on life and the world. We would like to believe, Corrigan argues, that society is a generally good and just place. We believe that those who suffer from mental illness cannot be completely innocent and undeserving. Since the world is perceived to be a good and just place, it is the individual who is defective. Mental health sufferers are perceived to have somehow earned their disability (p. 25). This line of thinking acts as a blueprint for perceiving individuals as flawed, weak, and deserving of their condition.

Mentally ill individuals may also stigmatize themselves as well. This condition is commonly referred to as “self-stigma.” Vogel, Bitman, Hammer, and Wade (2013) define self-stigma as “the reduction in a person’s self-esteem or sense of self-worth due to the perception held by the individual that he or she is socially unacceptable” (p. 312). Moses (2010) builds upon this definition and attributes feelings of “shame, secrecy, fear, and anticipation of being rejected and discriminated against by others” (p. 782) as the main drivers of self-stigma. Stigma is complex; it takes on different forms and affects individuals in different ways.

Mental illness is perceived as weakness. This leads to the practice of under identifying mental health issues. This is particularly pervasive within institutions of higher learning where so-called “normal stress” of exams and workload are brushed aside as expected rites of passage. For Quinn et al. (2009) this inclines individuals not to report their symptoms and to suffer in silence, especially when the symptoms are not considered severe enough to warrant treatment. Untreated mental health conditions have the potential to become much more severe (p. 409).

Flett and Hewitt (2013) recognize this experience as “flying under the radar” (p. 12). This occurs when symptoms have not yet reached the threshold of diagnosis, but nevertheless cause the individual to suffer. This is problematic as much of the statistical data in respect to mental illness may be inaccurate as near-diagnosis cases tend to be omitted. Subsequently, while attention is being paid to severe conditions, many remain unnoticed, untreated, and can lead to full-blown disorders later in life (p. 16). This adds to the notion of fearing the unknown, as we do not recognize the full scope of these issues.

2.3. Fear and Vulnerability: A Common Experience

Feelings of fear and vulnerability are not limited to those who are afflicted with the feared condition. The experience of those who are close to the victim is also important. This extends to friends, co-workers, peers, community members, and even society as a whole (Corrigan, p. 11, 2005). We are all affected by mental health in varying degrees. It is universal, and so, we all feel some degree of vulnerability.

Corrigan (2005) posits that the idea that some individuals deal with life better than others reinforces the stereotype that developing a mental illness is a result of weakness of character (p. 25). Accordingly, individuals tend to shy away from both reporting warning signs if they, or people they know may be exhibiting symptoms. Moses (2010) observes the intensity of negative attention family members, and parents in particular endure as they are often blamed for their child's condition. The motivation to remain silent appears to come from both the desire to protect the victim and to protect those around them from further blame and embarrassment (p. 783).

Saks (2008) experienced mental illness throughout much of her life. She writes on the stages of the disease: the odd behaviour and the quirks such as ritually organizing bookshelves in a certain way every time. We also hear of the family that did not want to face the truth of what was happening around them (p. 10). Her parents avoided the topic through conservations brushed aside in lieu of other distractions and rationalizations such as, "Let's have a nice family weekend and then face this and discuss it when we all get back" (p. 24). Predictably, the conversations did not continue upon their return, and Saks was left to suffer in silence.

Scott Simmie is a prominent Canadian journalist who became mentally ill. He co-authored two books with his partner Julia Nunes: *The Last Taboo: A Survival Guide to Mental Health Care in Canada*, and the follow-up *Beyond Crazy: Journeys Through Mental Illness.* Simmie and Nunes explore these topics by drawing on the effective format of personal stories and essays. In doing so, the books act as more than just a toolbox of suggested advice and resources. Rather, these efforts tell the many untold stories that are often hidden behind statistics.

Drawing upon his personal experience, Simmie notes his observations of those around him. He witnessed how his friends would comment on his odd behaviour as he was descending into mania. They would note how full of energy he was, but when pressed, were resistant to having in-depth conversations about his health, despite the obvious showing of symptoms (Simmie & Nunes, 2002, p. 14).

Scott's partner, Julia, also shared her experience as well. Like Simmie, Nunes faced numerous challenges in respect to the disease. She spoke of her own self-doubt and her inability to look at the problem objectively. She found herself both rationalizing Scott's odd behaviour, while also losing patience with their inability to cope with the changes (Simmie & Nunes, 2002, p. 45). It was uncomfortable for them and they felt both unprepared and unsupported.

Fear of the unknown exists throughout society. I was struck by the recent rise of racism and discrimination targeting another vulnerable group: immigrants in the United Kingdom. This is evidenced by the rise in popularity of the far-right UK Independence Party (UKIP). In 2014, UKIP, with its staunch anti-immigration policies successfully won a seat in parliament in the constituency of Clacton, England.

Another example of fearing the unknown is the surge of Islamophobia, which has gripped much of the Western world since 2001. While Islamophobia is quite an old concept dating back centuries, its contemporary resurgence is quite pervasive. In the United States, it pins Muslims against non-Muslims as it "paints religious minorities as foreigners and pariahs who pose an internal threat to American values and society" (Ernst, 2013, p. 62). As a result, Muslims continue to be routinely and inaccurately associated with terrorism and extremism. This was evident in the 2010 British Social

Attitudes Survey that found “more than half [of those surveyed] would oppose the building of a large mosque at the end of their road as opposed to fifteen per cent who would object if it was a church” (Allen, 2010, p. 84).

Fear can relieve one of rational thought. It can pit individuals against each other; neighbour against neighbour and friend against friend. It is the driving force of our collective prejudice and subsequent discrimination against others. In the fourth chapter, I will examine how education can effectively challenge fear and stigma.

2.4. Understanding the Nature of Mental Illness

Mental illness and the resulting stigma are not linear. They cannot be remedied with a prescription alone. For the sufferer, they are present in every daily event and interaction. In effect, they become a part of the victim and remain with them throughout the rest of their lives. A defining characteristic of mental illness that sheds some light into why it is so frightening is the fact that mental illness may simply be impossible to fully conquer. Saks (2008) demonstrates this in her challenging and human account of her experiences with a lifelong condition of mental illness:

> Schizophrenia rolls in like a slow fog, becoming imperceptibly thicker as time goes on. At first, the day is bright enough, the sky is clear, the sunlight warms your shoulders. But soon, you notice a haze beginning to gather around you, and the air feels not quite so warm. After a while, the sun is a dim light bulb behind a heavy cloth. The horizon has vanished into a gray mist, and you feel a thick dampness in your lungs as you stand, cold and wet, in the afternoon dark. (p. 35)

This description is important as it explains that mental illness does not necessarily change a person quickly. It hits at the root of a fear many have about their own mortality.

A challenging reality of life is that it must eventually come to an end. Many of us would like to pass on in a peaceful manner, in our homes, in our sleep without any pain. The above description deviates from this reality. It illustrates the slow, insidious nature of mental illness and how it slowly unravels all that we've grown to know and love. With Saks (2008), we witness her slide into mania; the hallucinations, the paranoia, the disorganization, the struggle to decipher what is real and what is within the mind. "Consciousness gradually loses its coherence. One's center gives way. The center cannot hold" (p. 17).

2.5. The Digression Into Stigma

The Canadian Mental Heath Association (2008) states that stigma is "cross disciplinary and can be found in many places" (p. 2). The report of the association explains that stigma can affect anyone regardless of social status, wealth, or general happiness. In this respect, stigma does not discriminate. It potentially affects all classes, races, and cultures. Not unlike fear and vulnerability, stigma has permeated the human condition.

The contemporary pop culture landscape is laden with celebrities who have struggled with different forms of mental illness and the resulting stigma. These unlikely victims who have publically spoken about their struggles with mental health include Nicki Minaj, Ellen DeGeneres, Kanye West, Lady Gaga, Miley Cyrus, Jim Carrey, Brad Pitt, and Russell Brand, among others. These seemingly larger than life personalities were also victimized. Their vast wealth and the admiration of so many did not protect them. Celebrated musician and cultural icon Leonard Cohen explained in an interview that he felt as if he was "coming out of the closet" in discussing his own experiences with depression. He went on the state that “depression has certainly been an element that I’ve had to deal with all through my life” (Kingoffolk, 2009).

Fear and stigma are natural parts of being human. The challenge is not how we may eliminate them, but how we can manage to keep them in check by reducing them as much as humanly possible. This is not an easy task. I have found that identifying stigma and stigma-induced attitudes is complex. The first point to distinguish is the difference between stigma and discrimination. Stigma rests in the belief, while discrimination is the resulting action. It is easy to identify discriminatory behaviour, as it is observable. Stigma may be the root cause, but is as invisible as mental illness itself due to their internal nature. It is useful to identify and combat discriminatory behaviour, however it may be unwise to assume that correcting behaviour alone is the extent of the intervention needed.

Broaching this problem where the attitudes and beliefs originate could help us understand the full dimensions of stigma. Addressing fear and vulnerability requires more than a surface approach. Delving as deep as the source itself in order to effect true change may be a viable solution (Canadian Mental Health Association, 2008, p. 2). Prior to discussing solutions, it is useful to continue to examine the widespread nature and scope of stigma against mental heath sufferers.

2.6. The Mental Health Security Net

The mental health security net is failing. The Canadian Mental Health Association Prince Edward Island Division (2003) identifies “68% of the mentally ill or those with symptoms and feelings associated with mental illness will not seek professional help” (p. 3). Stigma continues to be a main barrier. A reoccurring theme introduced by Simmie and Nunes (2002) is the issue of barriers that have been erected to insulate society from unwanted deviations such as mental illness (p. vii). This insulation can take the form of the bureaucratic maze one is expected to navigate in finding appropriate treatment.

Gabor Maté's *Hidden Lives: Coming Out on Mental Illness* is a collection of essays that help to illustrate the vastness and complexity of mental health experiences. In the same vein as the works of Simmie and Nunes, those who have been directly affected by mental illness and stigma author these essays. This lends itself to a certain depth and authenticity which allows for the very human story to be shared.

One contributor notes, "I was calling for help along the way, but the system failed to recognize what was happening to me" (Maté, 2012, p. 96). Another stated, "Sometimes the nature of mental illness is that you're paranoid and that you can't seek help" (Canadian Mental Health Association Prince Edward Island Division, 2003, p. 4). The barrier of not knowing how to talk about these topics with professionals, and even loved ones is a major problem.

The inability to comfortably discuss mental health issues also includes parents and peers. DeSocio, Stember, and Schrinsky (2006) speak of the social stigma parents' feel and their resulting timidity in discussing these subjects with their children. This discomfort to discuss such topics leads many to turn to other sources of information such as television, movies, and sensationalist news stories (p. 81). Additionally, Chandra and Minkovitz (2007) recognize the impulse of families to keep the subject of mental health "within the family" and not wanting to disclose such problems to friends, peers, and professionals (p. 768). Also evident is the practice of stoicism, particularly in rural settings (Maté, 2012, p. 3). Relying on dubious informational sources provides a skewed understanding of mental health.

There appears to be a lack of appetite for problems that seemingly do not have clear solutions. There are enough challenges in life as it is, and we do not want to hear about mental health problems. Our inability to understand the issue, coupled with the absence of immediate solutions fuels stigma. Mukolo, Helfinger, and Wallson (2010) suggest that even if a condition is treated appropriately, stigma may remain (p. 94). It is extremely difficult to remove the stigma once someone has been labeled as mentally ill. And so, stigma, much like mental illness, is a lifelong condition.

2.7. Speaking Out and the Uphill Battle

Corrigan (2005) points out that society has not truly attempted to help individuals suffering from poor mental health as social structures have historically played a role in perpetuating the stigmatization of the mentally ill (p. 29). It takes courage to overcome illness and speak of one's experiences. The fact that speaking honestly about mental health is difficult is at the root of the problem. As a society, we have not yet reached the point where individuals feel welcome and safe to share their stories.

I am reminded of a story I previously heard on the CBC Radio One program *As It Happens* (2013). On the September 18th, 2013 episode, hosts Carol Off and Jeff Douglas heard from Jane Flaherty Lamb, a flight attendant for First Air. First Air is an airline that services remote Canadian communities in Nunavut and the Northwest Territories. Lamb explained that for the first time in the company's history, the flight crew was comprised entirely of members of the Inuit community. It was a heartwarming story of overcoming the immense societal barriers that exist against First Nations and Inuit people in Canada.

While it was an uplifting and inspiring story of personal drive and perseverance, it was also a tale of a society that is failing to address the important question of why these events are so rare. Like mental health survivors speaking openly of their experiences, I look forward to a day when an all-Inuit flight crew is simply the norm. It is at that point that a real shift will have occurred. An explanation for why neither of these realities have come to pass may be because we are overly reliant on exceptional individuals to bring change. Individual efforts are needed, but the system itself does not need to be a silent bystander; it can be an agent of change as well. An example of systemic support would be through Inuit-focused training and incentive programs. By encouraging and supporting such efforts, governments and the other apparatuses of the state could adopt a more active and central role.

Stigma smashing efforts could also be more effective and widespread if they enjoyed systemic support. Not only would the message reach more people, but it would also receive a level of legitimacy that it has not previously enjoyed. Non-governmental institutions like the Canadian Mental Health Association and The National Alliance on Mental Illness in the United States have advocated for change. However, they can be perceived as too close to the issue and their effectiveness limited without the support from other bodies outside of the mental health field. When issues of mental health and stigma are embraced as mainstream problems, efficient and concentrated change will follow. Until then, stigma and mental illness will continue to exist on the fringe and we will continue to talk of courage, isolated incidents, and small victories.

The power of sharing stories is noteworthy. It is important to feel free and encouraged to express yourself and to find an appropriate sounding board. To this point, Saks (2008) notes how having a mental illness can rob you of these conversations. It is difficult to fill in the gaps in timelines where individuals were sick and unable to function in society. The stigma is so great that one potential solution is to fabricate stories to fill in that missing time spent in hospital. This is problematic as it takes much effort to spin such a complex web of lies. It also lacks authenticity. Honesty and venting one's experiences is an advantage of sharing stories, and thus, if these stories are built on deception, one will not feel their potential healing effects (p. 288).

Simmie and Nunes (2002) also felt the sting of stigma when Simmie tried to share his story. The reactions and care he received differed greatly from person to person. He felt isolated and shamed because of the lack of empathy he received from his colleagues. "The rules changed" (p. 24) the moment his ailment was identified as mental rather than physical as "people didn't know how to react" (p. 24). The cycle of losing one's voice was evident in the shunning he received from his friends and peers. It became worse as he felt additional pain of watching the world go on around him, while no longer believing that he had a place in the world. He was isolated. The lack of people to talk to as a result of stigma fed his disease.

2.8. Falling Through the Cracks: Lack of Trust in the System

Treatment built on injustice is flawed. Uneven power relations jeopardize trust between mental health sufferers and the system itself. An individual likened their hospital experiences to that of getting food poisoning from a restaurant and not wanting to return (Maté, 2012, p. 62). For some, seeking help within the health care system leads to institutionalization and conforming to routines and behaviours. They lose their individuality and their freedom. Instead, being compliant, not asking questions, and not disturbing the status quo are rewarded (Maté, 2012, p. 177).

An individual whose mother had been admitted to hospital described this reality and the resulting change in his demeanour. He learned to speak in a soft voice despite the frustration he felt at the care his mother was receiving (Maté, 2012, p. 144). He was conditioned to talk to the doctors a certain way because of the power dynamics involved; they were his mother's gatekeepers, and he believed that he needed to treat them as such or face the consequences.

Encouraged by the success of their first book, Simmie and Nunes decided to broach the topic of mental health and stigma differently in their follow-up. In *Beyond Crazy: Journeys Through Mental Illness*, the authors encouraged submissions from readers. One contributor remarked, "Virtually every moment, I was reminded that some people have no control over their lives and that others have extraordinary power over mine" (Nunes & Simmie, 2004, p. 26). Another spoke of the mistreatment they received from nurses who would yell and belittle them. This made them wonder what would happen if the nurses did the same thing to patients who were suffering from physical injuries as opposed to mental ones (p. 32).

The difference between mental and physical injuries is significant. For example, insurance companies recognize the difference in terms of coverage. The onus tends to be on the victim to prove that their injuries are serious and debilitating. By their nature, physical injuries are easier to prove, as they tend to be observable. Doctors can examine patients and with some certainty, conclude whether or not they have a broken arm based on the resources available, such as the use of x-rays. The hidden nature of mental injuries makes receiving an accurate diagnosis problematic. The symptoms are internal, difficult to detect, and even harder to prove.

The same is true in terms of military recognition. In the United States, the Purple Heart is only awarded to soldiers with a visible physical injury. It ignores the many who sacrificed for their country and returned mentally wounded with post-traumatic stress and other psychological ailments. In 2009, the Pentagon considered the issue and ruled that the Purple Heart shall only be awarded for physical injuries. "At the heart of the disagreement are rival conceptions of moral character and military valor. Those who insist that only bleeding wounds should count believe that post-traumatic stress reflects a weakness of character unworthy of honor" (Sandel, 2009, p. 11).

Similarly, Canadian soldiers suffering from post-traumatic stress are often released from their positions and hence not eligible for a pension. Scott Costen is a veteran who was medically released from the Canadian Forces and suffers from post-traumatic stress disorder. He has been waiting for months for his pension and medical benefits to go into effect. While he continues to wait, he has been forced to dip into his savings and go into debt to cover his medical expenses. For their part, the government has been sluggish to respond to Costen's concerns (Foote, 2015).

Even those who find themselves with internal discomfort such as a headache exhibit visible signs such as a pained look. Mental illness stigma is so strong, that many who suffer do so under a veil of keeping up appearances and hiding perceived shortcomings at all costs. Flett and Hewitt (2013) describe this behaviour as "smiling depression" (p. 16). This, they argue comes from the desire to be socially accepted. It is particularly pertinent for young people who view their social standing as extremely important. The threat of being stigmatized and isolated is enough to pretend that everything is okay. Invisibly, and silently, sufferers of mental illness continue to do just that; suffer in silence.

Others can encourage silent suffering. This is true even for those who find the strength to vocalize their discomfort. Saks (2008) mentions an occasion where a fellow patient endured a broken back for weeks. The hospital staff dismissed his pain because they assumed it was a behaviour related to his condition. The reality that he may have been telling the truth did not appear to be seriously considered (p. 190).

These examples illustrate the malleability of the health care system in addressing mental illness. Diagnoses are not an exact science, despite the reliance on the *Diagnostic and Statistical Manual for Mental Disorders* (DSM). The DSM itself is problematic as it can be politically influenced and a reflection of societal norms. In the mid-twentieth century, homosexuality was included in the DSM and identified as a disorder. Years later, societal attitudes shifted and it was correctly removed.

In *They Say You're Crazy: How the World's Most Powerful Psychiatrists Decide Who's Normal*, author Paula Caplan is also critical of the ambiguous nature of diagnosing mental disorders. She explains, "The DSM is by no means the only worrying element of current mental health practice. It is simply one distillation of a long and widespread tradition in which prejudices come into play when those with the power to influence others make their decisions about who is and who is not normal" (Caplan, 1995, p. 31). It should then come as no surprise that our treatment of the mentally ill appears to lack a cohesive understanding and strategy.

Apart from misunderstanding, mental health and stigma also cannibalize society. Corrigan (2005) recognizes that "stigma also harms society and those in it" (p. 23). We are neglecting valuable resources by removing individuals from society. The World Health Organization (2013) estimates the worldwide lost economic output as a result of mental illness to be US$16.3 trillion between 2011 and 2030 (p. 8). Speaking strictly from an economic perspective, it may behoove society to solve this problem.

These facts are alarming because they identify mental health and stigma as major challenges facing society, but they may influence victims to hesitate in seeking help. Mukolo, Helfinger, and Wallston (2010) explain that the increasing rates of depression are, in part, not caused by a general lack of services, but by a lack of usage of those services (p. 93). Quinn et al. (2009) note that young people are quicker to turn to peers rather than trained specialists for help (p. 406). This leads me to believe that the problem is twofold: 1) Society does not recognize nor respect the complexity of mental illness. 2) Victims have lost faith in the system that is meant to support them. The end result is more individuals failing to receive the treatment they need.

2.9. The Power of Language

Language can help to reduce or to perpetuate stigma. It is important to consider the role language plays and the subtle messages words send. The health care community commonly refers to victims of poor mental health as "consumers." I find this terminology to be overly clinical and neglectful of the fact that these "consumers" are also human beings. By using such a clinical term, we risk diminishing individuality and likening victims to commodities. The word "consumers" evokes images of a consumer society and the person who is defined by his or her habits of consumption. It speaks more to an economic reality than to conditions of health and well-being. It also brings up images of the informed consumer, the person, for example, who consults consumer reports. Here, doing the right thing is primarily a matter of seeking information and making good decisions based upon that information. This works well for cars, but can it really apply to mental health, especially considering that the sufferer needs so much more than information? This language makes mental health sound like a market commodity. The human connection is absent.

Throughout this chapter, I have used a variety of terms to identify those who have experienced mental illness. I have opted to use terms such as “victim,” “sufferer,” and “survivor” to describe these individuals. These terms are not without problems as well. Any label that we attach to someone will bring with it its own set of stereotypes and preconceptions. However, I find the terms I have chosen to be less problematic as they include an element of empathy and emphasize the human side of this phenomenon.

We are conditioned to believe that mental illness is something that is supremely negative and dehumanizing. This begins in childhood with something as simple as hurling insults of being “crazy,” “coo-coo,” “nuts,” or “mental.” Our use of language teaches us that our social standing may be damaged if we are perceived to be mentally ill (Maté, 2012, p. 175). Tendencies to insult others based upon their mental health are noteworthy because they can influence how mental illness is perceived and how we behave. It is not usual for school age children to call each other “mental.” They know that this kind of insult will hurt.

The idea of being tainted or flawed is a powerful message. As I have previously discussed, those who fall victim to mental illness are often labeled as weak, irresponsible, and quitters. These descriptions carry weight for those who are attached to them. It is very illuminating that many who become mentally ill lose their support systems. A sibling of one particular victim spoke of this, noting that a family member was forced to suffer silently as they had no one to turn to. Yet, when he died, the funeral service was very well attended. All of those friends who had disappeared suddenly returned in droves (Nunes & Simmie, 2004, p. 40). It's regrettable that we tend to wait until someone dies before we feel comfortable enough to act.

Patricia Van Tighem, a contributor to *Beyond Crazy: Journeys Through Mental Illness* shared her brush with death as she encountered a bear in the Canadian wilderness. It was an episode that resulted in years of dealing with post-traumatic stress. Tighem spoke of feeling the immense power of the bear, and how small and insignificant she felt in its shadow (Nunes & Simmie, 2004, p. 28). I think of the bear as a metaphor for society's treatment of the mentally ill. I can imagine that mental health sufferers feel insignificant and powerless in the face of society's treatment of them. We have gotten quite good at holding funerals and remembering the dead, but could we not also try to pull those from the clutches of the bear?

Contrarily, the bear can also be considered to be those who suffer from mental illness. While bear attacks do happen, they are quite rare. Bears are not naturally hostile creatures. For the most part, they tend to keep to themselves unless driven out of their habitat, or if they feel threatened. Unfortunately, these details are often lost in the sensationalist headlines of news outlets, and gossip. The result is a public who learn to fear bears, rather than to seek to understand, protect, and appreciate them.

One of the most powerful comments I have encountered through researching this problem came from the thirteen-year-old sibling of one particular victim. Of her brother, she said, “If Doron’s body were hurting, people would send gifts, but because it’s his mind, they throw bricks” (Maté, 2012, p. 32). Again, lack of understanding, and perceived vulnerability can cause normally reasonable people to do very unreasonable things. Throughout this chapter I have made a point of emphasizing the importance of the human element; that a real human being is at the core of this phenomenon. It would thus be unwise to treat it as an abstract subject of study. Nunes and Simmie (2004) quite eloquently state, “Labels belong on soup cans, not people” (p. 5).

2.10. Conclusion

In this chapter I identified stigma as something that exists in all aspects of life. By doing this, I have shown that it is worthy of analysis beyond a strictly clinical perspective. I have demonstrated its universality by considering the experiences of family members, peers, and society itself. Fear of vulnerability and of that which we do not understand includes loss of control. In our society, we tend to think of the mind as something we can control through willpower. Many people seem to have difficulty accepting the fact that for some, this is not possible. Again, we are in a midst of a double standard. We do accept that the willpower alone will not fix a broken leg.

The fear of mental illness reminds us of own mortality. It’s confronting and uncomfortable. It motivates individuals to shame and stigmatize others. In effect, they no longer see the human being and only the illness that they fear and despise. The stigma leads to prejudice and discrimination that silences victims, and creates unhealthy power dynamics where victims feel the glare of judgment from those around them.

In the next chapter I will continue to explore stigma and mental health. The focus will shift to my home of Prince Edward Island, Canada. In doing this, I will consider the effects of mental health and stigma upon rural cultures while also tracing my own history. This will illuminate the distinctiveness of rural communities, how residents view mental health, and how traditional customs perpetuate stigma.

Chapter 3: Rural Realities and the Case of Prince Edward Island

In the following chapter, I explore the realities of rural life on Prince Edward Island, Canada in terms of the often-contentious relationship between its residents and the issue of mental health and stigma. I recount my personal experiences and feelings growing up on the Island in a series of anecdotes, while making the case for why the study of rural regions on a case-by-case basis is both worthwhile and needed. Additionally, I explore the key themes of fear and vulnerability, which, I argue, are the crucial barriers the education system and society at large face within this context.

This chapter proved to be more difficult to write than I first anticipated. The challenge came in the form of the very phenomenon that I decided to study: stigma. I often found myself reflecting on how my friends, family, peers, and other residents of Prince Edward Island would feel about reading the text. Would I be ostracized for sharing too much insider information on my beloved home? Throughout the chapter I struggle to provide a balanced examination of this particular context. In my view, there is a great deal of merit in a warts and all approach that is both honest, and frank. It is not my intention to embarrass, nor judge, but to examine and attempt to understand. Above all, this chapter is a love letter to the Island, my island, whom I love and respect.

3.1. Are You an Islander or Are You From Away?

Mental health cannot be addressed in isolation. It is helpful to first understand the context in which it exists. Prince Edward Island is a small, close-knit province that emphasizes the importance of family and tradition. However, to reside in Prince Edward Island, but to be originally from another province, greatly diminishes one’s social status. This is exemplified in a common question, “Are you an Islander or are you from away?”

My mother was born in North York, Toronto in 1950. Upon entering her twenties in the early 1970's, she decided to relocate to Canada's smallest province. While adjusting to life on the Island, she worked in the only hospital in the capital city of Charlottetown, while also working in a number of group homes and youth refuges. It was an adventure and a new beginning for the independent child of The Beatles and the Rolling Stones era. During those years spent on the Island, her life changed; she married, had a child, and for the next forty years, focused on making a life for herself. She was intent on being a productive member of society. In addition to raising her child, she was employed in the public school system, and she was elected twice as a Councillor in her new town.

Despite having lived and embracing "the Island way of life," however, she has never been able to overcome the stigma of "being from away." While my mother has called the Island home for the better part of her life, and while she has no intention of ever leaving the little rock for an extended period of time, let alone permanently, she will never truly be accepted as an authentic Islander. She is somehow seen as less-than in comparison to a born and bred Island resident.

I've observed that the stigma of being "from away" is perhaps at its most apparent when it comes to political affairs. It is the custom of Islanders to get to know their politicians very well. The reputation of one's family is just as important, if not more, than one's experience and one's potential as a viable candidate. This desire to know one's political representative on a personal level extends to the culture of door-to-door canvasing. To neglect this could very well mean losing the election.

I would accompany my mother many times on the campaign trail as she ran for the New Democratic Party at the provincial level, and later as a Councillor at the municipal level. I remember, consistently, the number one question she would hear from residents would be about her family history and her own history on the Island. Was she an Islander, or was she from away? It was a loaded question that carried great significance under the guise of a casual conversation starter. I believe that after my mother would tell them that she was indeed from away, and from Toronto no less, that the rest of the conversation: the ideas, the policies, the passion to better her community would ultimately fall on deaf ears.

It is important to emphasize that the residents of Prince Edward Island are not ignorant to the world around them. I can say this with some confidence having lived on the Island most of my life. The Islanders know that their way of life is unique. It is something of a point of pride, in our own little way, to go against the grain of the rest of the world. And so, it is reasonable to assume that fear of change, especially change from the outside is something to rally against. I've learned, by considering the case of my mother's political career that the uniqueness of the Island can divide and isolate. This is evident in the treatment of residents who were born off-Island. These individuals risk being ostracized by the community to varying degrees. This extends to mental illness sufferers and the subsequent stigma they face. Like the outsider, persons living with mental illness can be perceived as a threat to the community and its values.

Owens, Richerson, Murphy, Jageleweski, and Rossi (2008) conducted a study on mental health in a rural Appalachian American community. They focused on the barriers to participation in a behaviour parenting program. Additionally, they examined the perception of the program and its users. They found fear of being judged and mistrusted by those within higher positions in society, such as professionals, was a significant barrier to care (p. 179). The generalizability of the study was limited as it was based upon a single community, but other studies have found similar trends.

Smalley, Warren, and Rainer (2012) find social proximity to be a significant factor. They note that rural communities tend to be physically distant while being socially close. This closeness leads to mental health sufferers resisting care out of fear of falling victim to local gossip and other forms of discrimination within the community (p. 53). This leads me to believe that social connectedness is a powerful influencer on the decisions individuals make. Even if appropriate services are widely available, they will not be effective if they contradict the values within the social fabric of a community.

I can recall a particular staff meeting while I was teaching in a rural school in Prince Edward Island in which this general distrust of those within higher positions was particularly evident. The after-school meeting focused upon a number of proposed initiatives and best practices from the centrally located school board. While the information was quite useful, the tone of the meeting was combative and dismissive. It appeared that the major gripe of the staff was not in the ideas themselves, but in their origin; they seemed to deeply resent being told what to do by those who did not share their experience of living in a rural community and the challenges they faced. Again, lines were being drawn in the sand between “them” and “us” based upon difference.

This chapter emphasizes the role that geographically specific culture occupies within the spectrum of mental illness and stigma. I would be remised if I did not acknowledge that traditional barriers are present within these settings as well. As Curtis, Waters, and Brindis (2011) explain, these traditional barriers include issues of poverty, accessibility, and low educational achievement (p. 61). This is further confirmed by Simmie and Nunes (2002) who reference the Canadian Psychiatric Association's advice that maintaining a higher quality of life in categories such as income, nutrition, and opportunities leads to living a healthier life, both physically and mentally (p. 77).

Additionally, Speer, McFaul, and Mohatt (2009) identify financial stress as a key determinant in the mental health of university students. They identify university students as being a particularly vulnerable group that is susceptible to mental illness, in part, because many mental disorders become apparent in early adulthood, but also because of the climate of low job prospects after graduation coupled with the burden of immense student loan debt (p. 1). While this phenomenon is not exclusive to rural settings, the irony of the case of Prince Edward Island, when understood that financial stress is a contributor to overall mental health is not lost on me. The Island is a traditional "have-not" province economically that consistently relies on equalization payments from the federal government in order to remain afloat.

The World Health Organization (2013) observes that mental health of individuals should never be examined in isolation of social and economic conditions. The health of individuals will be affected by an environment that values conformity, fears the unknown, and ostracizes those who deviate from widely accepted norms. These are conditions that encourage and perpetuate stigma.

Deen, Bridges, McGahan, and Andrews (2012) add a cautionary note. They emphasize that it would be unwise to generalize findings and analyses to all rural settings (p. 149). In spite of experiencing shared histories and cultures, each individual, each history, and each culture is unique, distinct, and deserving of its own story. We should not compare rural Prince Edward Island with the rural American states, nor even other rural areas within Canada. Owens et al. (2008) argue that we should become culturally sensitive to the local values and beliefs of the communities around us and thus, adapt our treatment plans and programs accordingly (p. 192).

Ultimately, individuals learn to adapt to their settings. In her political career my mother learned very early on to tread carefully when it came to topics where she may be at a disadvantage. She learned to emphasize her positive contributions to Island life rather than her distant origins. She did this knowing that being "from away" would greatly damage her social capital, as well as her aspirations of holding public office. Instead, she chose to speak of the family she raised on Prince Edward Island. She spoke of her Island-born son who pursued higher education at the Island's only university, the University of Prince Edward Island. She also accentuated the fact that she had lived on the Island for the better part of her life, while in the same breath, smartly omitting to mention that she was born in another province.

The experience of adaptation in rural settings is vitally important for the topic of mental health and stigma. Murry, Helflinger, Suiter, and Brody (2011) observe that in the United States, rural African Americans typically have a higher level of poverty and mental illness than their urban counterparts. While this is in keeping with the general understanding of rural challenges, what is of interest to my topic is the argument that this inflated number is not only caused by a lack of resources, but also because of the experience of being stigmatized by the community (p. 1118).

Like so many Islanders who learn to remain silent about their true family origins, Murry et al. (2011) found that fear of marginalization from one's community is a significant threat which forces individuals to withdraw from society. Specifically, the fear of the "airing of dirty laundry" (p. 1125), and subsequently being labeled and judged by their families and peers are very real and grave concerns. Chandra and Minkovitz (2007) confirm this point in their examination of the factors that influence stigma among adolescents. They note that many parents feel the need to keep such matters "in the family" (p. 769). The topic of mental illness is avoided, even with the closest of friends, out of fear of being ostracized by the community (p. 773).

We can conclude that silence and inaction are perpetuated by various factors. Accessibility to services is a problem within rural settings. The perceived difficulty of accessing services inflates the problem. Loss of social standing is an additional threat that fuels this perception. Fears of being stigmatized and ostracized from one's community are also significant. It is perhaps Corrigan (2005) who put it best: "Stigma is a justification for a hostile response to mental illness from the community and the society at large" (p. 4). I will examine the veracity of this hostility in the following anecdote from my formative years as a young adult growing up in the fledgling underground punk community of Prince Edward Island.

3.2. A Trip to Unit 9: The Cost of Recognition

Unit 9 is known as the mental health ward at the Queen Elizabeth Hospital, the only general hospital in Charlottetown, Prince Edward Island. It services individuals who have endured mental breakdowns, suicide attempts, along with other rarely discussed mental traumas. The stigma of knowing someone or yourself being admitted to Unit 9 runs deep within the social fabric of Prince Edward Island.

In my teens and early twenties I was heavily involved in the underground punk community. It was a community based upon independent music, free ideas, community involvement, and friendship. I look back fondly on those times of inviting bands from all over North America to come and play in someone's living room or basement, to sleep on a sofa and to receive a hot meal as thanks. In short, it was a safe haven; a place where the rules and norms of the wider mainstream society didn't seem to infringe upon our lives. We were living the way we wanted, free from all of the perceived injustices around us. However, this was merely a façade that on one particular day came crashing down.

Word began to spread that a young man, someone who frequently participated in the scene had been admitted to Unit 9. While no one in my group of peers seemed to know the exact details, the worst was assumed and the stories spread like wildfire. Over the proceeding hours and days, the conversations quickly shifted from concern to ridicule and characterizations of the young man, our friend, as weak, flawed, deserving of his condition and responsible for what had happened.

In short order he simply disappeared from the community, our community, which we thought was so accepting. The mere mention of his name would evoke awkward smirks, avoiding looks, and forced segue ways to other topics. We rarely, if ever, asked if we could help in some way. It was an eye-opening experience, one that I will never forget. I am not especially proud of the fact that I never spoke up and that I never posed a helping gesture. I simply followed the very societal norms I thought I had been shielded against.

Lack of anonymity is a powerful barrier to care. In this case, the young man did not just lose his closest friends and acquaintances. He lost the entire community. In effect, he lost his past, present, and future as for as long as he called Prince Edward Island home, he would be tainted and known as “the kid who went to Unit 9.” We were all guilty of turning against him. Through this experience I learned that close-knit communities are not always as helpful and supportive as they purport to be. There is no place to hide for the individual who deviates from the commonly accepted norms for good mental health.

There are serious consequences to being labeled as deviant within a small community. The Department of Health and Wellness of Prince Edward Island consistently combines mental health and addictions together under one category. For example, in the Corpus Sanchez (2008) P.E.I. health system review report, one of the major findings was that “there are gaps in mental health and addiction services” (p. 21). I believe this is damaging, particularly on the Island as the term “addictions” can be considered a colloquialism for illegal drug use, essentially rendering the mentally ill as guilty by association. This is critically important because by combining mental health and addictions under one broad umbrella, the effect may be to present mental health as something similar to illegal drugs; harmful, deviant, and even criminal. The true danger lies in the possible alienation of the already vulnerable and misunderstood.

Anonymity can be both challenging and comforting. Living in an urban centre can encourage feelings of being lost in the crowd. In the crowd one does not stand out. We are less likely to be singled out, as is often the case in rural environments. Conversely, the feeling of being one amongst many, not unlike a single raindrop in a thunderstorm, can result in one feeling insignificant, even worthless.

I sometimes long for the times on the Island where I would leave my house to run errands downtown and almost certainly run into someone I know. At times, however, it was quite annoying: always having to look presentable, always smiling and appearing friendly. At the same time, it is somewhat of a relief to know that, in Montreal, I no longer need to worry that someone will recognize and possibly judge me. In both cases the experience is deeply paradoxical. The experience of the city is incredibly freeing, and yet, there certainly is a feeling of being lost in the crowd. In rural contexts, the experience of being recognized is incredibly affirming, and yet, there is no place to hide when experiencing psychological distress.

I wonder how the story of the young man in Unit 9 would have unfolded if he had had the option of anonymity. In big cities, one can choose to exist anonymously, but there are also opportunities to make the city appear smaller than it really is. Take for example the existence of school-based and community clubs; it is in these social circles that one can meet new people, forge friendships, and develop routines which lessen their anonymity. Routines can be another way to create a smaller community within a larger one. For example, if one shops on the same day at the same market on a weekly basis, it is possible to get to know the staff, and even other shoppers.

But what if our options are limited? We no longer have the choice to join one club or another, to shop at the store around the corner, or the one a little further away. Rather, we have no choices at all as there is only one club, only one store, only one choice, and only one chance to make a good impression. This describes the conditions of the individual in the example above.

Bunn et al. (2008) confirm this scenario. Their study specifically examined the importance of perceived identifiability for rural HIV/AIDS patients within their communities. They found that social pressure and lack of anonymity, which exists within rural settings, indeed has a major impact upon the stigmatized group (p. 286). Moreover, as the Prince Edward Island and Montreal comparison above described, it was also found that rural suffers perceived their stigma as greater than their urban counterparts (Bunn et al., 2008, p. 286).

At the heart of the matter is the culture itself. "Other barriers are more subtle and deeply ingrained in the norms and expectations of rural populations and the culture of rural life" (Zanjani & Rowles, 2012, p. 399). One's social standing matters immensely in rural communities. There are examples of this throughout rural societies, such as the annual Turkey Drive hosted by CBC Radio in Charlottetown. When one glances at this event on the surface, it appears to be quite positive and endearing: an entire community coming together to help needy families during the holiday season when money may be tight. It is not a new idea, but it's one that has taken on a unique dimension within Prince Edward Island.

During the annual Turkey Drive, which lasts for approximately two weeks every December, announcements of donations are broadcasted on a daily basis. It is important to note that these announcements do not only convey the quantity of food and the value of monetary donations received, but the names of the donors as well. In a society where one's family connections can mean a lot in terms of one's social standing, the Turkey

Drive has essentially morphed into a measuring stick of who is doing well, and who is in need. It is not uncommon for families to publically boast over the airwaves about bringing in three, four, or even five turkeys at once. The message is clear; my family is productive, caring, and financially secure.

At first glance the Turkey Drive appears to be a sustainable option to alleviate poverty. It has perverse effects, however, when it belittles individuals, when it fails to consider the needs and wants of those who receive the donation, and when it adds to the stigma of poverty. Poverty is not something that happens for only one week during a year. The danger of the Turkey Drive is that it can be ultimately hollow and self-serving, particularly if it serves to give good consciences and does very little to address the causes of poverty.

We can learn from the Turkey Drive and apply it to mental health. Mental health requires a different kind of recognition, a recognition that digs beneath the surface. People living with mental illness need to be recognized beyond the labels and stigma as fellow human beings who need and deserve sustained support. A supporting society is one that addresses the social and institutional barriers to good mental health.

3.3. The Mother and Her Child and the Moment of Realization

During the year prior to coming to McGill, I lived in the far western part of Prince Edward Island. I had relocated there a year previous for a teaching job at a nearby elementary school. As a “have-not province” with its aging population and outward migration, there were very few teaching positions available to newly qualified teachers like myself. Of the dozen French teachers who graduated from the Bachelor of Education program at the University of Prince Edward Island that year, I was the first to receive a posting. This was in large part due to my willingness to relocate to an isolated part of the Island. Beeson and Strange (2000) confirm that this is not an uncommon reality in their study of rural education trends, citing isolation as a key challenge to recruiting teachers for rural schools (p. 7).

The year I spent in Western P.E.I. was a deeply rewarding experience: wonderful families, caring teachers, and a real sense of community. However, within the isolated oasis, a specter was lurking around every bend in the road, past the abandoned motel, and under the breath of every person you spoke with. It was here where I received my final push to pursue this grossly underrepresented issue of mental health and stigma within the education system and beyond.

Shortly after receiving my official acceptance from McGill, an incident occurred less than a kilometer away from where I lived. Patricia Hennessey and her four-year-old son, Nash Campbell were found dead in their burned out vehicle on the 21st of June, 2013 on an isolated road in St. Felix, Prince Edward Island. Their deaths were originally treated as suspicious, and later ruled to be a murder-suicide carried out by Ms. Hennessey.

Their deaths led to a Coroner Inquest in March of 2015 that included three days of testimony. The Inquest returned with fifteen recommendations, most of which concerning domestic violence as it was learned that Hennessey had lost a custody battle with Campbell's father the day prior to the incident. Mental health was also addressed in the form of further education on filicide, workplace initiatives to support employees dealing with domestic violence and/or mental health concerns and the establishment of safety circles that families could turn to in times of need ("Patricia Hennessey, Nash Campbell Inquest", 2015).

At the time, I was not privy to all of the details of the case, but it did have an impact on me. It reminded me that in a place where seemingly everyone knows everyone else, there are still some realities that are too painful to bear. This incident served as a stark reminder that things are much more complex than we may think and that death can be considered more viable than reaching out for help.

There is clearly a culture of silence surrounding illness, particularly mental illness. One is expected to deal with one's problems privately. Stoicism and self-reliance are valued practices within rural societies. Speaking from my own experience, I am ashamed of the amount of times I have chosen not to go to the doctor over my lifetime. There are a multitude of reasons for this, but I do believe that is at least partly due to my rural upbringing and the value placed on personal strength. According to Zanjani and Rowles (2012) stigma is more rampant in rural areas in part because of the value placed on self-reliance and independence within these communities (p. 400). To be physically injured can be seen as an embarrassment. When it comes to being mentally injured, the embarrassment, secrecy, and lack of help seeking is only heightened. It can inevitably lead to tragedy.

In the Corpus Sanchez (2008) report, the authors note that not only do 28,000 of the approximately 130,000 Prince Edward Island residents require "some form of support for mental issues each year" (p. 40) but also that "mental health problems on Prince Edward Island are increasing" (p. 17). The report confirms that "the system is in need of some significant changes" (p. 102) and perhaps most damning, the authors admit that, "resistance to change in Prince Edward Island should be expected" (p. 87). What this report does not do is specify what these changes ought to look like, which is what I will explore in the next chapter. I will do this by examining the trend of awareness campaigns and the need for integration across sectors, while also exploring the role of the teacher and the education system within this context.

Chapter 4: Building Sustained Solutions

In this chapter I will examine mental illness and stigma from an education perspective. I will propose that a sustained and consistent approach is necessary to make substantial progress beyond stigma and discrimination. I will begin by grounding my analysis in a theoretical perspective. I will then discuss the current climate of awareness and casual activism. In doing so, I will discuss its merits and pitfalls.

The focus will then shift explicitly to education. I will begin by examining the current state of mental health and stigma in schools. I will argue that the initiatives, though well intentioned, are fragmented, isolated, and insufficient. I will identify the root cause of the problem as reliance on individual advocates instead of systemic support. I will illustrate this by discussing the inadequacy of teacher training programs and the role of teachers. Finally, I will note the power of school culture and collaboration as a way forward.

4.1. Labeling Theory

The theoretical framework in which I will base my analysis for the subsequent chapter is Labeling Theory. Labeling Theory examines the notion that the labeling of an individual may categorize them as being deviant, and thus vulnerable to discrimination, isolation, and further social violence. It was developed in the mid-twentieth century by sociologists such as Frank Tannenbaum, Edwin Lemert, Howard Becker, and Erving Goffman. It is a theory that is closely tied with issues of social justice as to be labeled and charged as deviant can also result in a loss of freedom. Loss of employment, loss of opportunities to gain employment, inability to live alone and independently, and the social pressure of being treated as an outsider all contribute to a lack of power, and loss of freedom (Corrigan, 2005).

4.2. The Double-Edged Sword of Awareness

Labeling Theory is rooted in how members of society perceive others. Awareness campaigns, for example, are usually labeled as worthwhile causes. By making mental health and stigma a legitimate cause, we can begin to change its deviant perception. As Labeling Theory argues, one is victimized by society if one does not ascribe to societal norms. Creating an awareness campaign based upon mental health and stigma can change its perception and begin to change the living conditions of those afflicted with the disease.

It would be irresponsible and inaccurate to argue that awareness campaigns are without merit. They expose people to ideas and perspectives they may not have previously considered. If nothing else, they raise the level of public consciousness concerning an issue. Zanjani and Rowles (2012) note that what is needed is "to overcome social stigma and reframe the topic of mental health in a more positive light" (p. 398). The reframing and normalizing of the topic could lessen the stigma. By emphasizing the universal nature of the phenomenon, a community-based approach may be more attainable than before (p. 402). The deviant label could be replaced with one that is more accepted.

Awareness campaigns, however, regardless of their perceived value are not always effective or sufficient. The problem lies in the fact that awareness campaigns rarely solve practical problems. For example, despite the large amount of money raised for cancer awareness, a cure has not been developed. Too often individuals believe that simply contributing to an awareness campaign is enough. In truth, important as they may be, awareness campaigns are only a first step. More work is required, and it can be detrimental to the cause to be satisfied with awareness alone.

In recent years there have been multiple high-profile awareness campaigns. From Breast Cancer Awareness Month, to Kony 2012, to the ALS Ice Bucket Challenge, this flurry of activity spurred on by social media is impossible to ignore. The explosion of social media teamed with the accessibility of the Internet has changed the global landscape in the twenty-first century. Even the rarely discussed topics of mental health and stigma have recently joined the limelight in the form of the Bell “Let’s Talk” campaign. And yet, how effective can awareness campaigns really be and what are the next steps that need to be taken when awareness has been achieved?

Breast Cancer Awareness Month is quite popular throughout North America, with giant corporations such as the National Football League (NFL) and World Wrestling Entertainment (WWE) involved each year for the month of October. For the four weeks the campaign spans, the NFL players and staff incorporate the colour pink into their uniforms and on the field. Likewise, the WWE changes their ring ropes to pink, while incorporating the colour scheme into the attire of some of their most popular stars.

However, after those four weeks, the campaign ends and the jerseys revert to their traditional team colours. The ring ropes are replaced with their traditional solid black, and the symbolic shades of pink retreat from view. It is at this point that breast cancer awareness risks returning to its compartment in the psyche of the general public until the following year. We can pat ourselves on the back for raising money, for having a conversation about the disease with a friend or loved one, or even for just thinking about it while we watch the programming. The danger here is that we lose sight of the fact that cancer exists year round. Those who have been touched by it know this reality all too well.

In 2012, an ambitious social media campaign was launched entitled Kony 2012 which aimed at highlighting the atrocities committed by Joseph Kony, leader of the Lords Resistance Army (LRA). The LRA has been active within central Africa for nearly two decades. The campaign was immensely popular as it was presented in a modern and attractive fashion, while documenting crimes against humanity including the recruitment of child soldiers. Despite the attention and support it received worldwide, in 2015 Joseph Kony remains at large, still commanding the LRA in central Africa and Kony 2012 is a distant memory. How could a social media campaign be so successful, gain such popularity and support, and yet be so ineffective on a practical solution-finding level?

More recently, we witnessed the ALS Ice Bucket Challenge, which also gained a popular following through social media. Men, women, and children of all ages and backgrounds were trumpeting the need to end this deadly disease, while donating money or humourously nominating someone to either donate or dump a bucket of ice water on their head. The entries varied depending on the individual; from heart felt memories of those who had been affected by the disease, to those simply stating how important the cause was.

As time wore on, videos began to appear featuring individuals who were apparently unaware of the connection between the act of dumping water on their head and the ALS campaign. From the ALS Ice Bucket Challenge, the title became known as the Ice Bucket Challenge; devoid of any mention of the disease itself. At the height of the phenomenon, American celebrity Martha Stewart appeared on a broadcast of *Good Morning America* to accept the challenge, pour water on her head, and nominate three other celebrities to do the same. In the clip, the four anchors, Stewart's assistant, and Stewart used the abbreviated ALS-free title, and they neglected to mention the reason for the act. In fact, during the clip, there was no mention of the ALS campaign at all (Padilla3048, 2014).

Whether these were isolated incidents, or part of a larger trend, I do not know, but it does serve to highlight, as do the cases outlined above, some of the potential limitations of awareness campaigns. They are effective to a certain point, particularly if they lose sight of their objectives. Talking about the issue is not, in and of itself, the solution. The key to creating real change may require a clear and practical plan of action. The Canadian Mental Health Association (2008) agrees, citing the need for educational initiatives based upon specific criteria as opposed to broad campaigns.

Consider the popular HIV/AIDS activism group Act Up. Their type of grassroots activism indeed had an aspect of awareness that was beneficial to their cause. It brought the plight of the queer community into the spotlight during a time in the United States when the general public exhibited apathy to the suffering of the queer community. This apathy was demonstrated by the fact that violence and assaults motivated by sexual orientation were not considered hate crimes during this era in the United States. It was only during this time of action and lobbying in the 1980's that these labels and perceptions began to be challenged (Meyer & Northridge, 2007, p. 197).

As Labeling Theory suggests, victims of HIV/AIDS were perceived as sexually promiscuous, primarily members of the queer community, and thus deviant and deserving of their treatment. Act Up sought to change that label to one of political and social crisis that demanded the attention of society. However, their activism did not stop at awareness alone; it evolved from demonstrations to grassroots political work including the formation of committees to tackle such issues as finance, outreach, and housing.

Corrigan (2005) notes that activism and protest can change behaviours. He cites the case of the television network ABC and the complaints they received over the depiction of the mentally ill in their series *Wonderland* (p. 282). In that case, direct action protest had an impact. It had a clear goal in mind. The campaign was not grounded in simply making the public aware of the depiction, but it included the prevision that once awareness was achieved, they would pressure the network to cancel the show. Awareness is what lit the match, but once it was lit, proponents of the reforms ran with it, grew, and expanded their capabilities.

4.3. The Pitfalls of Casual Activism

The apparent danger of awareness-only campaigns, as I have outlined above, is that they risk providing a false sense of achievement. When one of these campaigns comes to an end, there appears to be a communal sense of relief and satisfaction in respect to what has been accomplished. Sharing a link on social media, or using a hash tag, gives one a sense of having contributed to the solution. What we may see, however, is the rise of casual activism, where individuals support a cause for as long as it doesn’t trouble them. How much effort does it really take to “like” a post on Facebook or to “retweet” something on Twitter? How much can we truly accomplish if our interest and support for a cause only takes us as far as it inconveniences us, or until the next trendy fight comes along?

Flett and Hewitt (2013) build upon this, citing that social media contributes to projections of the good life, while remaining unconnected and detached (p. 17). This is an important point as the disconnected nature of social media itself may sway individuals to rally around a variety of causes without ever having to leave the comfort of their home. While this is not necessarily negative, it does provide a possible explanation for why causes seem to appear and disappear so routinely. Like someone browsing the Internet to kill time, once they lose interest, they simply move on to the next thing. An unfortunate consequence of this practice of casual activism may be that, while it has garnered increased attention for a limited timeframe, little practical progress has been made.

This brings me to the Bell “Let’s Talk” campaign to raise awareness about stigma and mental illness. Encouraging individuals to discuss a topic that has traditionally been hidden from public view is a positive first step, especially when the campaign calls upon the notoriety of an Olympic athlete like Clara Hughes. This, however, is only a first step. It may feel that much has been accomplished, but the question deserves to be asked; why do we need a national campaign to feel comfortable about discussing this topic? Why is it not common to talk about mental illness and stigma throughout the year? The answer lies in Labeling Theory and the belief, perpetuated by society around us, that these subjects remain taboo. As long as these questions are being asked, we can be assured that there is more work to be done.

4.4. Insufficient and Fragmented: Schools and Mental Health

Schools are not effectively addressing mental health and stigma. The current climate of interventions is limited in scope and duration. The Corpus Sanchez (2008) health system review for Prince Edward Island explains, “When available, [mental health] services are criticized as being segregated, isolating, fragmented, or incomplete" (p. 280). It is necessary to change the perceived value of mental health and stigma education and to do so consistently. This is particularly difficult as other aspects such as standardized tests and shrinking educational budgets currently dominate the education landscape.

Units that explicitly focus on stigma and mental health can be effective to a point. DeSocio et al. (2006) developed a six-class module for students aged ten to twelve to combat misinformation and stigma in respect to mental illness. The module incorporated a multi-disciplinary approach including discussions related to the origins and power of social stigma, the science behind mental illness, and activities involving the school nurse and counsellor. It even addressed common ailments such as daily stressors that many students face, as well as coping strategies.

The first class in the module involved situating oneself and confronting bias. Students were presented with subject specific vocabulary to help them articulate their thoughts clearly and respectfully. They were encouraged to share how they thought individuals with a mental illness would look and act. They were then presented with a number of successful famous people who suffered from mental illness and were surprised. "Often a child in the class would exclaim with delight and relief that he or she had the same disorder as Albert Einstein or Abraham Lincoln" (DeSocio et al., 2006, p. 83).

The second class of the module took a more scientific form. It described the link between the human brain, emotions, and behaviour. The third class involved stress, and coping. Students recalled times in their own lives when they felt stress. The fourth class focused on healthy practices and leading healthy lifestyles. The final two classes included information on common mental health problems in children. These classes were effective because they illustrated the common experiences individuals have with mental health.

The study found that after the module was completed, the students felt more informed and comfortable discussing the topics of mental illness and stigma (DeSocio et al., 2006, p. 86). The results are certainly promising, but I feel a sense of disappointment in knowing that the module only spanned six classes. With such positive results in only six classes, I wonder how much could be accomplished if a more long-term program was also in place.

I fear that a six-lesson unit without sufficient follow-up will not be enough. If addressed in isolation, mental illness and stigma risk remaining isolated and on the fringe. As I have established, awareness campaigns alone are not viable solutions because they exist in isolation and are short term in nature. Units in schools are ineffective for the same reason. Like awareness campaigns, they have merit, but they are only a small piece of a larger puzzle. They are not solutions in and of themselves. After the six lessons, the class would then move on to the next topic. This is insufficient because, much like breast cancer, mental health and stigma do not exist for only a short period of time. They are lifelong conditions, and thus, our response should be lifelong as well.

Mental health awareness weeks fall into the same category of beneficial, but insufficient. In 2013, the University of Prince Edward Island held their first Mental Health Awareness Week. It included workshops, a health fair, and puppy therapy. It was a positive step, but was once again only a piece of the puzzle. We should refrain from heralding them as the final solution. Again, mental illness and stigma are presented in fragments. A six-class module here, a week of activities there, but there is nothing which ties these efforts together on a consistent basis.

What is needed is a consistent approach which would keep such issues relevant and in the consciousness of the students. Building solutions into everyday routines, literature, and class material is a viable solution. As twenty-first century educators, we have been warned against teaching in isolation. Key words in teaching training programs continue to be “curriculum integration” and “authentic experiences.” Consider the massive shift that has taken place in math curricula in Prince Edward Island. No longer do we consider the learning of math in isolation as a viable and successful strategy. Rather, we attempt to make connections to the lives of the students and to the environment around us. The same can be done for mental health and confronting stigma. Just as we interact with math in our daily lives, we also interact with mental health and stigma.

Literature may provide the solution. One way in which we demonstrate the vastness of math is by illustrating it in books. Through literature, traditional word problems are given context and are built into the story. The same is true for same-sex marriage and sexual orientation. Little by little, literature within the classroom spanning all grade levels has begun to appear featuring same-sex couples, and children with two moms and two dads. It is an attempt to normalize the topic. The same could be, but is not currently being done, for stigma and mental illness. Perhaps books could be developed that feature children who suffer from self-esteem issues, depression, and other mental illnesses. They would not be presented only during designated health classes, but throughout the day in learning centres, read-alouds, and pair reading. This would be one way to keep these issues relevant. Once they become a normal part of the class they could be supplemented with explicit teaching modules, mental health weeks, and other interventions.

Some progress has been made to address mental illness and stigma in schools. The Canadian Mental Health Association has created a mental health curriculum guide for high schools across Canada. The guide is composed of best practices for teachers to follow. These include being informed, creating safe spaces, being flexible, and being committed throughout the school year. The guide also includes effective ways to accommodate students such as preferential seating, pre-arranged breaks, and assignment assistance. The problem is they will be ineffective if they are not ingrained into the school culture. Similarly, The Pan-Canadian Joint Consortium for School Health (2013) also advocates for the development of social and physical learning environments. These initiatives include strength-based perspectives, healthy school policies, acceptance and understanding, self-efficacy, social-emotional learning, and connectedness.

These efforts have the potential to improve the situation. Unfortunately, they also tend to exist to isolation. They are not yet normalized. Labeling Theory provides an explanation for this. It states that perceived deviant members of society face discrimination. This is also true of schools. Mental illness is perceived as deviant behaviour and thus does not enjoy the same level of legitimacy as other non-deviant activities such as athletics and academic achievement. Therefore, identifying and prioritizing it as both legitimate and worthwhile is an uphill battle. For example, providing extra study time for students to improve their grades, or fundraising for new soccer uniforms is relatively easy compared to creating a mental health action committee. Adding to the disjointed dilemma is the fact that the battle tends to be fought by a few social justice champions. What is needed is a community of advocates who are supported by the larger society.

4.5. Waiting for Champions

At present, the education system tends to rely on the individual, rather than the need for systemic change. Take for example, The Positive Mental Health Toolkit which has been used by the Prince Edward Island Department of Education from 2010 to 2015 which argues that the implementation of these concepts is the responsibility of individuals:

> Positive change begins with a single individual or small group of advocates within the school community and the development of an associated committee. This champion or group of champions can be any one of a number of people within the school community including administrators, teachers, students, parents, counsellors or support staff. (p. 34)

The problem with this approach is that it does not fully consider the power of the system itself. The departments of education and school boards in particular could play very important roles in changing mental health education. These changes are a paradigm shift. They are aimed at changing deep-rooted perceptions and ingrained understandings of mental health and stigma. It is an enormous task. “Cultural change must be a school-wide movement, not just an individual effort” (Gruenert & Whitaker, 2015, p. 127). Passing such an immense task onto individuals alone without proper support will, at best, result in inconsistent results, and at worst, ultimately fail. What is thus needed is a program where all partners play integral parts and share in the responsibility for its success.

From my experience as an educator, I would say that there were very few opportunities for "champions" to come forward. Teachers did not have the support they needed from other education partners, particularly those in higher positions of authority. These positions of higher power include departments of education, school boards, curriculum developers, and administrators. If these partners limit their involvement and put the onus on individual teachers to go above and beyond their already taxing responsibilities, the results will certainly be less impactful.

Let us consider the following scenario: School A has a very talented and passionate administrator who values the importance of school culture and considers the mental health of their students to be a high priority. Therefore, the administrator forms a school wellness committee with two other teachers who share her vision. They meet every second Tuesday to improve this issue within the school. The school counsellor also attends, but since resources are low and he is responsible for three other schools in the area, he only attends on a monthly basis.

School B also has a talented and passionate administrator who values community engagement and is concerned about the eating habits of his students. He has noticed that an alarming number of students arrive at school without a lunch, and he suspects that they haven't eaten breakfast either. So, his solution is to form a school wellness committee with a couple of other teachers who have also noticed this trend and feel passionately about it. Like School A, they also meet bi-weekly to discuss improvements that can be made. They also invite a community representative to attend the meetings and contribute their ideas in an attempt to bridge the gap between home and school.

Both School A and School B have dedicated individuals who champion issues that are important and relevant to themselves and to their schools. The problem is that "wellness" is a very subjective and broad term; it covers many areas, and without clear and explicit directives from above, they will remain undefined. Subsequently, important topics may be neglected, as physical ailments often receive the most attention.

Reinke, Stormont, Herman, Puri, and Goel (2011) provide evidence to support this view as they note that the main issues teachers tend to identify with their students are those that are the loudest and most visible. In their study, teachers identified Attention Deficit Hyperactivity Disorder (ADHD) as the biggest issue facing their students. In contrast, depression was identified as one of the least relevant issues (p. 6). Ultimately, the hidden issues of mental health and stigma are far too often put to the side, because, once again, the infrastructure is lacking and does not recognize the significance of the issue. It takes a "champion" to singlehandedly notice and bring these issues into the light.

A concrete illustration of this lack of infrastructure and systemic support can be found in the practice of embracing policy documents without also providing sufficient training and follow-up. While it may appear that efforts are being made, without support for its implementation, these policies risk being reduced to yet another document that frustrate educators. The frustration stems from its lack of apparent practical value and support. Such initiatives could perhaps be more effective if they were mandated by those in positions of authority, and circulated throughout the entire system. If that were the case, perhaps we would not find ourselves *waiting* for "champions" but *producing* them instead.

The lack of a clear and focused strategy is consistent with systemic violence. Epp and Watkinson (1997) explain:

> If institutionalized practices and procedures that adversely impact upon disadvantaged individuals constitute systemic violence, labels have the potential to be systemically violent. The direct impact of systemic violence results in frustration and powerlessness. These feelings are experienced by students, parents, teachers, and school administrators. (p. 124)

Labeling Theory is applicable as the term "champion" is also a very loaded label that brings with it certain expectations and behaviours. While this term is not consistent with the negative connotations typically associated with Labeling Theory, it is nevertheless relevant (Shulman, 2005, p. 427). A champion is someone who stands out, who fights for what they believe in, many times, against all odds. They are noble, brave, and selfless. Labeling those who advocate for the inclusion of mental health issues as champions rightfully acknowledges their efforts, but also diverts the attention away from the systemic problem itself. While we are heralding the accomplishments of the champion, we are not asking questions of why there is a need for a champion at all. If these behaviours were normalized, we wouldn't be considered champions doing extraordinary things, but simply human beings doing what is expected.

4.6. Effective Teacher Training

Teachers have a role to play. I am advocating for consistent and focused strategies to address mental illness and combat stigma. In respect to teacher training through higher education, there appears to be a lack of adequate preparation. Two prominent Atlantic Canadian universities who provide Bachelor of Education programs, The University of Prince Edward Island, and the University of New Brunswick, will, through the 2015/2016 academic year, combine to offer a total of two courses which may address the topic of mental illness, and stigma. In the case of UPEI, ED 415F *The Inclusive Classroom* (a class I took in my teacher education) is an ambitious attempt to cover the vast spectrum of topics related to inclusion, but falls well short of addressing that of mental illness stigma. At UNB, ED 5035 *Inclusionary Practices* appears to also incorporate a broad scope of the relevant topics. What is missing in both programs is specific and consistent information that could provide a foundation for teachers to draw upon in the future.

The unfortunate reality for these potential teachers is that many decide to attend institutions that subscribe to the increasingly popular calendar-year model. Under this program, students may become certified teachers within a single year. This is problematic as teachers may be less prepared than others who attend longer programs that have extended practice-teaching components. For example, McGill University offers four-year programs that include over seven hundred in-class hours for prospective teachers. They should be better prepared than students following a one-year degree because they have access to more resources, more time to grow and learn, and have more time to practice in authentic settings.

Mental health and stigma are vastly underrepresented in teacher education programs. Within a twelve-month program, it is very possible that potential teachers will only receive one single inclusionary course, much of which may not specifically address mental health and stigma. It is here where the survey nature of these courses is truly felt as instructors try their best to condense complex issues into a few classes; there simply is not enough time allotted to do them justice. Through casual conversations with my previous professors, many have expressed their inability to cover the subject matter. It tends to be an unwritten rule not to cover everything, but to cover what you can. Inevitably, things will be overlooked. Labeling Theory dictates that those topics that are not commonly accepted and valued will be the first to be omitted.

Once again, the system does not provide adequate support and it rests on the individual to seek out further information. This is dangerous because a single course could very well be the prospective teacher’s only experience with mental health and stigma before working with children who suffer from a mental illness in their future classrooms.

Even more, professional development offered by schools that specifically addresses this topic also appears to be severely lacking. Speaking from my own experience, professional development days within Prince Edward Island schools seemed to largely focus on hot topic issues such as low standardized test results and team building exercises. The grim reality is the possibility of noticing a student who is suffering from a mental illness and not knowing what to do. Moreover, instances of stigma may invade the classroom and teachers may once again feel unqualified to effectively stop it.

4.7. The Power of Collaboration

The discussion thus far has primarily been limited to the education system. However, it is also important to consider the need for collaboration that goes beyond the limits of individual sectors and disciplines. A cross-societal lens is deserving of attention as well. Zanjani and Rowles (2012) practiced this form of cooperation in their research by using a panel of experts from a variety of different fields. The act of including others, they argued, was to provide a better-rounded analysis of the issue (p. 401).

Collaboration can encourage a fusion of new ideas and solutions. Aoun and Johnson (2002) argue that collaboration is critical for capacity building. Their project, set in rural Western Australia, highlights the importance of regional allegiances, working for a common purpose, and collaborating with other bodies. These include The Western Australia Centre for Rural Health and Community Development, The South West Mental Health Service, and Rural Health Development. They note that these projects would not have been successful if undertaken separately (p. 44).

Building upon this, Azzi-Lessing (2010) highlights the lack of cooperation between government and community may be reduced. They note that success requires policy changes that promote uniform cooperation across governmental and community lines (p. 1). The World Health Organization (2013) concurs, citing one of their main objectives as enhancing integration between services, service providers and the community (p. 5), while also explicitly describing the education sector as a crucial actor in this process (p. 10).

The current perception of the education system as being disconnected from mental health is a problem. This is evident in the tendency for mental health sufferers to overlook seeking help within the education system. The Canadian Mental Health Association Prince Edward Island Division (2003) asked mental illness sufferers where they would go for help. Of the over one hundred options for care, which included community groups as well as governmental organizations, teachers and the school system were not mentioned once. The education sector, a crucial actor in integration, was not identified as a viable option (p. 8).

The casualties of limited cooperation include the mental illness sufferers themselves. As in the case of Saks (2008), each visit to a care facility meant having to deal with a different philosophy. This absence of cohesion was not only time-consuming and bothersome, but it interrupted, or even suspended her treatment: "The question of whether I was restrained or not had more to do with where I happened to be than how I behaved" (p. 174).

Even more, Saks (2008) cites the experience of attempting to contact her former psychoanalyst, and arguably the person who she achieved the most success with in the early years of her condition. The value placed by others on their continued relationship varied depending on where Saks found herself. One institution would encourage it, another would make it difficult, and another would outright refuse to allow it (p. 179). This is another brazen example that how we, as a society, treat mental illness is far from an exact science. It also demonstrates the confusing and debilitating effects lack of cooperation across institutions may cause.

This individualistic and splintered approach is far from acceptable when coupled with the fact that the World Health Organization (2011) notes that an officially approved mental health policy does not yet exist in Canada. The Mental Health Commission of Canada is currently developing a national mental health strategy, but this lack of official policy is indicative of the disjointed direction we can observe. In this context it is difficult to treat the system itself.

While we wait for government to act, others can benefit from collaboration. Perhaps the most powerful education-based example of collaboration is school climate. School climate and the environment in which students learn has been increasingly recognized as a contributing factor to the degree and richness of the learning that takes place. Indeed, school environments can play a positive and negative role in the acquisition of knowledge, depending on the openness, and general culture of the school (Flett & Hewitt, 2013, p. 21). This suggests that by being committed to open spaces, we can also embrace different ideas and perspectives that are not only tolerated, but encouraged as well. This would appear to provide an ideal setting for taboo topics such as mental illness and stigma to be explored in constructive and non-formal ways. It is important to note that like awareness campaigns, the existence of schools alone is not sufficient. The school climate must be receptive, encouraging, and fair. Once these conditions are met, real progress can be made.

4.8. Conclusion

In this chapter, I provided an overview of the current state of mental health and stigma in education. I began by analyzing the effectiveness of awareness campaigns. In doing so, I found that they are most effective when they have a clear focus and a mandate for action. In this regard, awareness campaigns alone are not sufficient, but can complement the cause. I also identified the rise of casual activism where individuals casually associate themselves with a cause for a short period of time. This is effective to a point in that it helps to raise awareness and garner attention, but it is ultimately short-term in nature and insufficient.

I explained the current climate of mental health and stigma in education as well as its areas of need. Presently, the education system is compartmentalized and relies on isolated units and annual mental health weeks to address these issues. These initiatives are problematic because they encourage the perception that mental illness is something that is “other.” By only addressing it at certain times throughout the year, it remains isolated and cannot enjoy the legitimacy of being normalized.

I concluded the chapter by demonstrating that educational initiatives could be successful, but they require certain specific conditions to be met. These conditions include a positive school culture, dedicated and consistent teaching, and systemic support. These conditions, along with a clear focus and consistency, are the keys to normalizing mental health and reducing stigma.

Conclusion

In this thesis I provided two important educational contributions. First, I drew attention to an issue that is largely neglected and even avoided in education. Research on mental health and stigma in education is practically non-existent. Secondly, the setting of Prince Edward Island provides unique insight into rural culture and its relationship with mental health and stigma. In my research for this thesis, I found that there is a dearth of scholarship on mental health and stigma specifically examining the case of Prince Edward Island.

Through my research, I found evidence that mental health is universal. It affects every single person in different ways. Family members, colleagues, friends, peers, and society itself also feel the impact of stigma. Universality along with our collective lack of understanding and fear fuel the stigma mental illness sufferers are forced to endure.

Secondly, I found that geographic location and one's culture could contribute to stigma. I found that the traditional close-knit culture of Prince Edward Island perpetuates the taboo label of mental illness. As a result of identifying mental illness as something that should be hidden, the society not only allows, but also encourages stigma to be levied against it.

Finally, I found there to be a lack of consistency and focus in addressing mental illness and stigma in schools. Teaching mental health and stigma in isolation and depending on individuals to champion these issues results in a fractured and uneven approach. I found that a clear focus, consistency, systemic support, and positive school culture are necessary to normalize mental illness and reduce stigma.

I was surprised by my own growth throughout the undertaking of this research. I previously had not felt comfortable enough to speak about mental illness and stigma openly. I have enjoyed very honest and inspiring conversations with family and loved ones for the first time as a result of this work. It was an incredibly freeing and uplifting experience to begin a dialogue both with the academic community and in my private life as well.

It is important to emphasize that my intention is not to provide generalizable findings. Generalizability would be difficult due to the specific context of Prince Edward Island. It would be unwise to suggest that my discussion of this case could extend to all rural and urban settings. Rather, my intention was to highlight the complexity of addressing issues around mental health in rural settings. As a next step, I could find myself conducting an onsite empirical study that examines the issues raised in the thesis. I am especially interested in looking at the issue of teacher training. I would like to specifically address how institutions of higher learning can effectively prepare teachers for the realities they will face in their future classrooms. Following the lessons learned from collaboration, I would like to work closely with both prospective teachers, and university faculty to uncover their needs, concerns, and paths forward.

Normalizing mental health and reducing stigma remain daunting challenges. “We cannot change this norm overnight, but we can make small changes within our schools to triumph over this self-defeating, learned behavior” (Gunzelmann, 2012, p. 38). Mental illness and stigma remain vast and largely undiscovered fields within education. I am eager to add my contributions to the growing community of voices that are pushing for greater understanding and social change. The future is bright.

References

Allen, C. (2010). *Islamophobia.* Farnham, Surrey: Ashgate.

Aoun, S., & Johnson, L. (2002). Capacity building in rural mental health in western Australia. *Australian Journal of Rural Health, 10*(1), 39-44.

Azzi-Lessing, L. (2010). Meeting the mental health needs of poor and vulnerable children in early care and education programs. *Early Childhood Research & Practice, 12*(1), 14.

Beeson, E., & Strange, M. (2000). *Why rural matters: The need for every state to take action on rural education.* US: Rural School and Community Trust.

Bunn, J. Y., Solomon, S. E., Varni, S. E., Miller, C. T., Forehand, R. L., & Ashikaga, T. (2008). Urban-rural differences in motivation to control prejudice toward people with HIV/AIDS: The impact of perceived identifiability in the community. *Journal of Rural Health, 24*(3), 285-291.

Canadian Mental Health Association. (2008). *Stigma and mental illness: A framework for action by the Canadian Mental Health Association.* Ottawa.

Canadian Mental Health Association Prince Edward Island Division. (2003). *Pain, perseverance & passion: A report on the support needs of individuals with severe and persistent mental illness on Prince Edward Island.* Prince Edward Island.

Caplan, P. J. (1995). *They say you're crazy: How the world's most powerful psychiatrists decide who is normal.* Reading, Mass: Addison-Wesley.

Chandra, A., & Minkovitz, C. (2007). Factors that influence mental health stigma among 8th grade adolescents. *Journal of Youth and Adolescence*, *36*(6), 763-774.

Corpus Sanchez. (2008). *An integrated health system review in PEI: A plan for change.* Prince Edward Island.

Corrigan, P. W. (Ed.). (2005). *On the stigma of mental illness: Practical strategies for research and social change.* Washington, DC: American Psychological Association.

Curtis, A. C., Waters, C. M., & Brindis, C. (2011). Rural adolescent health: The importance of prevention services in the rural community. *Journal of Rural Health, 27*(1), 60-71.

Deen, T. L., Bridges, A. J., McGahan, T. C., & Andrews, A. R. (2012). Cognitive appraisals of specialty mental health services and their relation to mental health service utilization in the rural population. *Journal of Rural Health, 28*(2), 142-151.

DeSocio, J., Stember, L., Schrinsky, J. (2006). Teaching children about mental health and illness: A school nurse health education program. *The Journal of School Nursing, 22*(2), 81-86.

Douglas, J., & Off, C. (Hosts). (2013, September 18). Saga Grouse, New Orleans New Trial, Whale Ear Wax [Radio program]. *As It Happens.* Toronto: CBC.

Epp, J. R., & Watkinson, A. M. (1997). *Systemic violence in education: Promise broken.* Albany: State University of New York Press.

Ernst, C. W. (Ed.). (2013). *Islamophobia in America: The anatomy of intolerance.* New York: Palgrave MacMillan.

Flett, G. L., & Hewitt, P. L. (2013). Disguised distress in children and adolescents “flying under the radar": Why psychological problems are underestimated and how schools must respond. *Canadian Journal of School Psychology, 28*(1), 12-27.

Foote, A. (2015, June 16). Retired veteran Scott Costen upset about wait for pension, benefits. *CBC News.* Retrieved from http://www.cbc.ca/news/canada/ottawa/retired-veteran-scott-costen-upset-about-wait-for-pension-benefits-1.3116051

Gruenert, S., & Whitaker, T. (2015). *School culture rewired: How to define, assess, and transform it*. Virginia: Association for Supervision & Curriculum Development.

Gunzelmann, B. (2012). *Hidden dangers: Subtle signs of failing schools.* Lanham, Md: Rowman & Littlefield Education.

Jamison, K. R. (1995). *An unquiet mind: A memoir of moods and madness.* New York: Vintage Books.

Joint Consortium For School Health. (2013) *Positive mental health toolkit.* Canada. Retrieved from http://www.jcshpositivementalhealthtoolkit.com

Kingoffolk. (2009, August 13). Leonard Cohen on depression and relationships [Video file]. Retrieved from https://www.youtube.com/watch?v=FAoHYBpj8vY

Manning, M. (1995). *Undercurrents: A life beneath the surface.* San Francisco: Harper & Row.

Maté, G. (2012). *Hidden lives: Coming out on mental illness.* L. Rowntree, & A. Boden (Eds.). Canada: Brindle and Glass.

Meyer, I. H., & Northridge, M. E. (2007) *The health of sexual minorities: Public health perspectives on lesbian, gay, bisexual, and transgender populations.* New York: Springer.

Moller, D. W. (2000). *Life's end: Technocratic dying in an age of spiritual yearning.* New York: Baywood Publishing.

Moses, T. (2010). Adolescent mental health consumers' self-stigma: Associations with parents' and adolescents' illness perceptions and parental stigma. *Journal of Community Psychology, 38*(6), 781-798.

Mukolo, A., Helfinger, C. A., & Wallston, K. A. (2010). The stigma of childhood mental disorders: A conceptual framework. *Journal of the American Academy of Child & Adolescent Psychiatry, 49*(2), 92-103.

Murry, V. M., Heflinger, C. A., Suiter, S. V., & Brody, G. H. (2011). Examining perceptions about mental health care and help-seeking among rural African American families of adolescents. *Journal of Youth and Adolescence, 40*(9), 1118-1131.

Nunes, J., & Simmie, S. (2004). *Beyond crazy: Journeys through mental illness.* Toronto: McClelland & Stewart.

Owens, J. S., Richerson, L., Murphy, C. E., Jageleweski, A., & Rossi, L. (2008). The parent perspective: Informing the cultural sensitivity of parenting programs in rural communities. *Child Youth Care Forum, 37*(57), 179-194.

Padilla3048. (2014, July 22). Martha Stewart takes on 'Ice Bucket Challenge' [Video file]. Retrieved from https://www.youtube.com/watch?v=hiiwzD54b6Y

Pan-Canadian Consortium for School Health. (2013). *Schools as a setting for promoting positive mental health: Better practices and perspectives.* Canada.

Patricia Hennessey, Nash Campbell inquest yields 15 recommendations (2015, March

30). *CBC News.* Retrieved from http://www.cbc.ca/news/canada/prince-edward-island/patricia-hennessey-nash-campbell-inquest-yields-15-recommendations-1.3015550

Quinn, N., Wilson, A., MacIntyr, G., & Tinklin, T. (2009). "People look at you differently": Students' experience of mental health support within higher education. *British Journal of Guidance & Counselling, 37*(4), 405-418.

Reinke, W. M., Stormont, M., Herman, K. C., Puri, R., & Goel, N. (2011). Supporting children's mental health in schools: Teacher perceptions of needs, roles, and barriers. *School Psychology Quarterly, 26*(1), 1-13.

Saks, E. R. (2008). *The center cannot hold: My journey through madness.* New York: Hyperion.

Sandel, M. J. (2009). *Justice: What's the right thing to do?.* New York: Farrar, Straus and Giroux.

Shulman, D. (2005). Labeling theory. In G. Ritzer (Ed.), *Encyclopedia of social theory.* (pp. 427-428). Thousand Oaks, CA: Sage Publications.

Simmie, S., & Nunes, J. (2002). *The last taboo: A survival guide to mental health care in Canada.* Toronto: McClelland & Stewart.

Smalley, K. B., Warren, J. C., & Rainer, J. P. (Eds.). (2012). *Rural mental health: Issues, policies, and best practices.* New York: Springer Publishing.

Speer, N., McFaul, M., & Mohatt, D. (2009). Nourishing students' mental health in a difficult economy. *Chronicle of Higher Education, 55*(36), 1.

United Nations Human Rights Council. (2012). *Report of the Special Rapporteur on the human right to safe drinking water and sanitation, Catarina de Albuquerque:*

Stigma and the realization of the human rights to water and sanitation (Publication No. A/HRC/21/42). Retrieved from: http://www.ohchr.org/Documents/HRBodies/HRCouncil/RegularSession/Session21/A-HRC-21-42_en.pdf

Vogel, D. L., Bitman, R. L., Hammer, J. H., & Wade, N. G. (2013). Is stigma internalized? The longitudinal impact of public stigma on self-stigma. *Journal of Counseling Psychology, 60*(2), 311-316.

World Health Organization. (2011). *Mental health atlas 2011: Canada.* Switzerland.

World Health Organization. (2013). *Mental health action plan 2013-2020.* Switzerland.

Zanjani, F., & Rowles, G. D. (2012). "We don't want to talk about that": Overcoming barriers to rural aging research and interventions on sensitive topics. *Journal of Rural Studies, 28*(4), 398-405.