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Exploring the Mental Health Experiences of African, Caribbean, and Black Youth in London, Ontario

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A thesis submitted in partial fulfillment of the requirements for the Master of Science degree in
Health and Rehabilitation Sciences

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Abstract

This qualitative study explores the mental health experiences of African, Caribbean, and Black (ACB) youth in London, Ontario, investigating how the factors of race, gender, culture, and place have shaped their perceptions and experiences of mental health. The data collection and analysis were conducted using a phenomenological approach and a critical lens informed by feminist, intersectionality, and critical race theories. These data illuminate the ways in which these young people's attitudes toward mental health and help-seeking strategies are impacted by broader social constructs and community expectations, which they navigate and often resist in their everyday lives. Their insights can provide assurance to ACB youth in other Canadian cities that they are not isolated in their experiences. These data also contribute new knowledge to the emerging literature on Black youth across the African and Caribbean diaspora and may be used to inform future mental health policies and programs in Canada.

Keywords

Mental health; youth; African; Caribbean; Black; Canada; qualitative; help-seeking.

Summary for Lay Audience

This thesis explores how the mental health of African, Caribbean, and Black (ACB) youth in London, Ontario has been understood and affected by their identities. Interviews were carried out with thirteen young women and two young men (n=15) between the ages of seventeen and twenty-one. Field notes were also recorded to capture additional data related to the participants' study experiences and personal reflections of the researcher as the project unfolded. The data reveal an array of meanings and experiences related to mental health in the lives of ACB youth. The participants spoke about feeling pressured to adhere to restrictive sociocultural norms regarding gender and health, the informal and formal strategies they used to seek help, and the barriers related to the uptake of mental health services. They expressed frustration with their own mental health experiences and the level of associated stigma in their communities and recommended increased representation of ACB counsellors, professionals, and resources. This study reveals how ACB youth navigate their racialized and gendered identities and understand mental health in a predominantly white, small-medium sized Canadian city. Given the little research available on the barriers and experiences faced by Black youth, the findings of this study will contribute to the literature, especially in a Canadian context and of youth in cities with smaller ACB populations. Their insights can provide a sense of assurance to ACB youth in London and other Canadian cities that there is potential in addressing the stigma, encouraging one another to seek help, and changing the cultural narrative of mental health in the younger generations of ACB people.

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Chapter 1

1 Introduction

As an integral component of wellness, mental health encompasses a series of complex issues that have a powerful impact on people's social, psychological, emotional, and spiritual well-being (World Health Organization, 2018). Mental health issues and disorders are a significant public health issue among youth aged 15 to 24, and approximately 20% of young Canadians experience a diagnosed mental disorder (Kessler et al., 2005). Mental health issues often begin before the age of 25 and ebb and flow, through remission and relapse, throughout an individual's life (2005). This early onset and pattern demonstrate the need to create accessible mental health intervention programs and services for this population. If youth mental health issues are not readily identified and understood, they can balloon and exacerbate the attendant suffering and morph into even more pressing conditions that can impair the trajectory of well-being across the lifespan (Aalto-Setälä et al., 2002; Fergusson & Woodward, 2002).

In the past 20 years, mental health issues have increased among youth globally (Berntsson and Köhler, 2001; Collishaw et al., 2004; Fombonne, 1998). In Canada 16.2% of the population belongs to a visible minority group, and 81% of them have experienced racial or ethnic discrimination (Across Boundaries, 2009; Arundel & Associates, 2009). The job insecurity, higher unemployment and underemployment rates, low educational attainment levels, and poverty as a result of racism in Canada contribute to poorer mental health among ethnic minorities, especially for immigrants (Beiser, 2005; De Maio & Kemp, 2010). The issues of lower access of mental health services disproportionately

affects racialized groups in Canada, and more specifically Black youth (Fante-Coleman & Jackson-Best, 2020).

Approximately four percent of Canada is comprised of Black Canadians, and this specific group is growing rapidly (Statistics Canada, 2019). Despite the small population, Black Canadians have a diverse history with significant contributions to the development of this country. The early settlement of enslaved Black people in Canada is connected to the American Revolution, the War of 1812 and the Underground Railway, with over 3000 Black people brought mostly to New Brunswick, Nova Scotia, Ontario, and Quebec (Fabbi & Jackson, n.d.). In 1924, the Canadian League for the Advancement of Coloured People began in London, Ontario, and was dedicated to improving the health, education, and social support of Black people in Canada (van Brenk, 2018). In the previous year, James F. Jenkins who was also a Londoner founded a national newspaper called *The Dawn of Tomorrow*, aimed at fighting workplace discrimination and advocating for other Black Canadians (2018).

In the mid 1960s, the movement of Black people into Canada predominantly came from Caribbean, arriving mostly in Toronto and Montreal in hopes for a better life away from unrest in their home countries (Fabbi & Jackson, n.d., Gooden & Rhonda Hackett, 2020). Many Black immigrants have maintained a connection to their countries of origin while contributing to the cultural, political, and socio-economic landscape of Canada (Gooden & Rhonda Hackett, 2020). In 1996, Nova Scotia became home to the first elementary school in the country to have an Afrocentric curriculum centered on Black studies (Fabbi & Jackson, n.d.). In present day Canada, the descendants of early Black immigrants – particularly of Caribbean descent – reside predominantly in the Greater Toronto Area

(Gooden & Rhonda Hackett, 2020). One of the most well known displays of Caribbean culture which is also specific to the Black Canadian experience in Toronto is Caribana; while this yearly event has drawn in millions of visitors and dollars for the nation's economy, it also highlights how this population makes their identities known in a country that prides itself on our multiculturalism (Gooden & Rhonda Hackett, 2020; The Caribana Success Story, 2010).

This qualitative study is designed to generate in-depth knowledge about the mental health experiences of ACB youth in a medium-sized, predominantly White Canadian city. Mental health research on Black populations is predominantly from the United States and the United Kingdom, leaving perspectives from other groups within the diaspora - particularly of Black Canadian youth - relatively unknown (Taylor & Richards, 2019). Lastly, very little is known about the experiences of youth in small-medium sized cities, in particular, because of their smaller population relative to ACB youth in larger metropolitan centres like Toronto.

Young Black Canadians face additional barriers of institutional racism and discrimination within a healthcare system that already fails youth (Arday, 2018; MacDonald et al., 2018). Therefore, this knowledge gap must be addressed to ensure the mental health needs of these young people are understood and provided in ways that align with their unique cultural, socio-economic, and geographic lived realities. In conjunction with these health determinants, the research project for this proposal aims to be attentive to the ways in which gender, race, age, and culture shape the mental health experiences of ACB youth, an issue that we currently know little about, especially in smaller centres like London, Ontario.

1.1 Terminology

It is important to provide clear definitions of some of the key terms related to this study, including race, gender, culture and cultural competency, anti-oppressive conceptual frameworks, and the ACB study population.

1.1.1 Race

Race refers to “conferred identities based on an imagined hierarchy of human value related to phenotypes, skin colour, and other supposed biological expressions of group inferiority” (Nestel, 2012, p. 5). Racism is defined as “an organized system premised on the categorization and ranking of social groups into races and devalues, disempowers, and differentially allocates desired societal opportunities and resources to racial groups regarded as inferior” (Williams & Mohammed, 2013, p. 1153).

For the purposes of this project, an African is defined as a person who was born in Africa, identifies as being of African descent, and/or whose family and ancestry originates from the African continent. A Caribbean or West Indian person is defined as someone who was born in the Caribbean, who identifies as being of Caribbean or West Indian descent, and/or whose family originates from the Caribbean. A Black person is someone whose family and ancestors come from the African diaspora. These operational definitions are necessary to establish the criteria for participation in the study; however, it is also important to be cognizant of the heterogeneity in the cultures, ethnic groups, and religious beliefs within the ACB population, which will be seen in the collected data.

In a racially structured society like that of North America, where White people, particularly men, possess significant structural power and privilege, disparities of all

kinds exist among those who fall outside of the dominant cultural population. This includes mental health issues, mental health service access, and interacting with providers for racialized people of colour. Racism directly impacts the mental health of people of colour, which can be expressed in feelings of hopelessness from witnessing acts of racial injustice or high levels of anxiety upon entering predominantly white spaces and not knowing how or if they will be safe. Service access is one piece of the mental health experience. Understanding how African, Caribbean, and Black youth, who have received very little attention in the mental health literature, especially in the Canadian context is imperative to better understand the barriers they face and how we can address them.

1.1.2 Gender

Gender has been theorized by Connell (2002) as socially and culturally constructed ways of being that tie into one's identity and social location in the world. While sex is often used to refer to biological differences, gender, especially through a socially constructed lens, refers to the socio-cultural and embodied practices people inhabit and perform to communicate who they are as women, men, trans, non-binary, and other identity categories among the gendered spectrum (Connell, 2002; Landstedt et al., 2009; West & Zimmerman, 1987). As a well-established social determinant of health, gender directly shapes the experiences of mental health, including help-seeking behaviours, service access utilization, and the types of mental health issues people experience (World Health Organization, 2002).

1.1.3 Culture, Cultural Competence and Cultural Safety

Culture is a multi-layered health determinant that refers to the produced material goods, norms, and values held by a group of people that are shaped by history, gender, class,

religion, politics and land borders (Tribe, 2005). Different cultures have different conceptions of and experiences with health and illness, healing practices, health behaviour and attitudes, and they also hold unique views about the healthcare system (Gopalkrishnan, 2014). Cultural competence is defined as an effective and respectful response from systems to people of all cultures, languages, classes, races, ethnic backgrounds, and religions in a way that recognizes, affirms, and values the worth of individuals, families, and communities (National Association of Social Workers, 2001). The cultural competence approach encouraged and used in social justice groups and fields such as social work, counseling psychology, nursing, and education to recognize the diverse needs of different groups of people. However, it can be used as a way of collapsing race and culture into one 'modal category' and ignoring the structural and systemic violence associated with racism among marginalized populations as well as the ethnic diversity that can exist among people within the same cultural group (Santiago-Irizarry, 1996).

Other approaches to consider which are not necessarily interchangeable with cultural competency are cultural sensitivity and cultural safety. Cultural sensitivity involves making an individual aware of differences through an understanding of cultural acceptance, respect, and how their life experiences can impact others (Darroch et al., 2017; Milne et al., 2016). Cultural safety has been defined as an active examination of the differences in power, politics, and social positions in healthcare and how they can contribute to the dehumanization, trauma, and institutional racism faced by vulnerable patients (Ramsden, 1993). Cultural safety in particular differs from cultural competence and sensitivity in its notion of power, which is informed by the differences in social

locations between patients and healthcare providers (Culley, 2006). Whiteness, for example, holds greater power as a social location, therefore White healthcare providers can practice cultural safety in their practice by understanding racism in order to identify it in the healthcare setting, and actively be anti-racist by confronting colleagues who are discriminating against patients (Mkandawire-Valhmu, 2018). This approach is further relevant in the context of ACB mental health; when providing care to Black populations, healthcare professionals should be aware of the community's experiences with the medical system and their cultural perceptions of mental health, understand the potential fears or mistrust of the system held by the patient, examine the potential biases they may hold towards their patients, and acknowledge the power imbalance between themselves and their patients (Curtis et al., 2019; Lavery et al., 2017). In short, cultural safety goes beyond concepts of cultural competence and sensitivity to hold healthcare providers responsible in recognizing and working to reduce health inequities, and focusing on the oppression faced by vulnerable patients and not solely their identities (Mkandawire-Valhmu, 2018).

1.1.4 Oppression, Anti-Oppression and Anti-Racism

Oppression is defined as “a system of domination that denies individuals dignity, human rights, social resources and power” (Dominelli, 2008, p. 10). An anti-oppression framework recognizes the importance of structural inequities and can be used to amend or diminish these imbalances (Harlow & Hearn, 1996; Dalrymple & Burke, 1995). This framework connects and helps to identify different dimensions of oppression by acknowledging the diversity of intersecting social identities, such as gender, race, and socioeconomic status, and how they construct individuals as either victims or perpetrators

of oppression (Sakamoto & Pitner, 2005). This helps to ensure that determinants such as class and gender can be addressed without ignoring the violence that has historically occurred for groups with intersecting marginalized identities and the ways that culture is often used to mask the structural injustices (Williams, 1999). Anti-racism strategies, which are included within the framework of anti-oppression, are used by researchers to target various forms of inequitable power and racialized privilege that are institutionally and socially ingrained (Bonnett, 1993; Dalal, 2008; Dei, 1996, 2000; Gould, 1994; Strawbridge, 1994).

Approaching mental health issues from these frameworks can raise tensions with normative discourse which is often centered on the biomedical model (Larson, 2008). This includes classifications of disorders by the Diagnostic and Statistical Manual, and interventions to eliminate issues which are deemed pathological (2008). While anti-oppressive perspectives can recognize the complexity of one's identity and how different forms of oppression against their identity can contribute to poor mental health, medically oriented approaches to care fail to acknowledge these factors and medicalize trauma which stems from challenges related to social exclusion, stigma, and more (2008). In this research project, the anti-oppression framework is critical to gain an enriched understanding of the ways that structural violence has impacted the mental health of ACB youth. As young Black people in a medium sized Canadian city, this framework can be used to analyze the complexity of multiple intersecting identities being oppressed conjunctively (Burke & Harrison, 2002).

1.2 Research Rationale, Aims and Questions

Community members and allied health researchers have expressed deep concerns for the mental health of ACB youth in literature and additional studies are critical to help address and improve their mental health literacy, service access, quality of care, and overall well-being (Etowa et al., 2007). In comparison to the United States, the service experiences of Black populations have been significantly neglected in Canadian mental health research, which can lead to inaccurate and inappropriate solutions for culturally competent mental health resources (Enang, 2002). While it is important to note the lack of Canadian-based research on ACB mental health in comparison to Black American populations, the reasons why systemic barriers and challenges for ACB Canadians are not well researched should be further investigated. As a student researcher in youth mental health who is also a member of this community, directly seeing the lack of Canadian-based research on ACB mental health in comparison to American literature has also encouraged further investigation in these systemic barriers and challenges for this population.

The objective of this research project is to explore the mental health experiences of ACB youth in London, Ontario to determine if there is a need for culturally competent and safe mental health services for this target population. The following research questions have been designed to facilitate the study aims:

1. What is the existing socio-cultural discourse about mental health among ACB youth?
2. Do gender, race, culture, place, and age shape the mental health experiences of ACB youth?

3. What do culturally competent or safe mental health services look like for ACB youth?

1.3 Chapter Overview

The existing research on gender and mental health shows a pattern among youth- young women generally report more mental health issues with symptoms of depression and anxiety twice as common to young men, who report higher self-esteem levels but have higher rates of death by suicide (Aalto-Setälä et al., 2002; Ge et al., 1994; Hankin et al., 1998; Landstedt et al., 2009; Tomori et al., 2000; Wannan & Fombonne, 1998). This area of research, however, is predominantly quantitative and focused on individual factors such as hormones, genetics, or psychological traits (Angold et al., 1998; Landstedt, Asplund, & Gillander Gådin, 2009; Nolen-Hoeksema et al., 1999; Piccinelli & Wilkinson, 2000). In my qualitative study, investigating how gender shapes the mental health experiences of youth and unpacking how structural patterns and inequities affect people differently across the spectrum will contribute a nuanced, in-depth perspective to the predominantly quantitative research that dominates this field.

Chapter 2

2 Literature Review

2.1 Introduction

This chapter covers the pertinent qualitative, phenomenological, and critically oriented literature on mental health experiences among ACB youth. The review process falls within a thematic approach and draws from multiple fields such as women's studies, sociology, psychology, and health sciences. Databases such as CINAHL, Google Scholar, PsycINFO, and Scopus were used to search to retrieve articles for my proposal and on-going research. Searches were limited to academic publications in the English language and the key terms included: mental health, mental health services, youth, adolescen*, young people, gender, gender roles, identity, femininity, masculinity, racialized, African, Caribbean, Black, ethnocultural, cultural competence, health promotion, anti-oppression, anti-oppressive practice, anti-racism, qualitative research, phenomenology, ethnographic, intersectionality, feminism, service access, service provision, structural violence, and stigma.

The key words were combined using the AND or OR Boolean operator. Due to the limited mental health research on young ACB populations, restrictions were not placed on the publication date of the articles. Based on these key words, 495 articles were found from the databases and the health research within Black populations was predominantly from the United States. The titles and the abstracts of these articles were screened based on the inclusion and exclusion criteria and their relevance to mental health discourse among ACB youth. Data based on the findings and limitations in racialized mental health research was included to be summarized for the review. The original literature review

was done prior to going into the field; since the collection and analysis of the data, but more literature has shaped the analysis of the data over the course of the study from articles, book chapters, government websites, and online mental health resources.

Articles were eligible for inclusion if they examined youth ideas about mental health and seeking help, racial and gendered differences in experiencing and understanding mental health, the role of mental health stigma in seeking treatment, cultural factors influencing health behaviour, anti-oppression and anti-racism in mental health services, how feminist and intersectional theories inform mental health research, mental health literacy or promotion, mental healthcare disparities, treatment barriers among marginalized youth, stigma reduction, or interventions geared to ACB populations. Articles were especially selected if they covered social support and perspectives on help-seeking within the ACB community. Articles were excluded if the main demographic studied was a population that was Caucasian, or racialized but not ACB. Articles were not included if the data was solely on the effects of specific variables such as substance abuse on mental health, if they covered immigrant or refugee populations that were not ACB, if they studied discrimination in contexts without looking at the impact on mental health, or if they focused on the mental health of racialized older adults. They also were not included if they studied aspects of health in a population such as physical activity or sexual health, but they excluded mental health.

2.2 Race

Racialized people can experience poor mental health due to the harmful societal effects of racial hierarchies. More specifically, racial discrimination in education, the workplace and throughout society has the power to produce mental health issues and emotional

distress (Brown, 2003). Comas-Diaz (2007) states, “constant exposure to racism increases behavioural exhaustion, psychological affliction, and physiological distress (p. 96). Racism can also lead to internalized oppression, which occurs marginalized people believe the negative emotional and social associations applied to them and doubt their own worth (Quinones Rosado & Barreto, 2002).

There are many barriers to accessing mental health services among racialized people, including a lack of information, affordability, cultural mistrust, and miscommunication (Beiser, 2005; Constantine, 2007; Fernando, 1988; Laroche, 2000). A qualitative study conducted by Whitley et al. (2006) with Afro Caribbean immigrants in Montreal revealed hesitation to use mental health services due to perceived overreliance of doctors on prescribing medication, and a preference for non-medicalized, spiritually informed healing practices. Race, ethnicity, and culture influence the meaning people give to their symptoms, their approaches to healing, and their accessibility to supportive networks, and when these are not considered by mental health services, they can lead to systematically inaccurate diagnoses and treatment of current and future racialized clients (Williams & Harris-Reid, 1999).

Men generally delay health help-seeking due to socialized masculinity norms such as avoiding vulnerability and portraying a sense of strength throughout any and all circumstances (Courtenay, 2000; Levant et al., 1992). However, the negative health outcomes that can result from delayed help-seeking are disproportionately higher for Black and African-American men who face racialized gender norms of being hypermasculine and too strong to admit to feeling low physically or mentally (Powell et al., 2016). For example, Scott et al. (2007) found that identifying mental health issues and

seeking help for these issues is a challenge for African American young men due to socialized norms of masculinity suggesting that showing emotion is a sign of weakness. This is significant to consider given that among African American adolescents, men make up more than eighty percent of the suicide rate (Joe, 2006).

The mental health experiences of many African-American women and girls are also shaped by an engrained sociocultural idea that they must remain strong in the face of adversity and accept their many struggles while struggling to just get by or even survive (Jones & Guy-Sheftall, 2015). Their resulting feelings of disappointment, frustration, and alienation are not always met with empathy among others in society and the social provision landscape, where they are often understood through the angry Black woman stereotype (Primm et al., 2019). These processes of social exclusion create further experiences of isolation and denigration which can lead to poor mental health, requiring services that are race and culture specific to these issues (Grote et al., 2007; Kwate et al., 2003; Thomas et al., 2008).

2.3 Culture

Regarding culture, much of the literature supports the idea of mental health institutions and providers taking the initiative to balance Western biomedical health practices while adapting to the culturally specific needs of their patients to improve their mental health (FECCA, 2011; Marsella, 2011). Culture significantly influences how health and illness are understood, and no single culture is the same, therefore there are differences across cultures in how they manage, view, and understand mental health (Kline & Huff, 2007). For example, cultures can differ in their beliefs of what cause mental illnesses, such as the 'evil eye', being spiritually possessed, or yin/yang imbalances (Ault & Brzuzy, 2009;

Helman, 2007). When service providers gain a deeper awareness of the various cultural perspectives, they can better understand how culturally contextualize their client's experience (Gopalkrishnan & Babacan, 2015).

Cultural biases, misconceptions, stereotypes, and service discrimination can negatively affect the mental health recovery process of racialized clients. When mental health professionals overlook or mishandle their appointments with these individuals because of their cultural or racial differences, the interventions and treatments they provide can be ineffective for the clients (Kline & Huff, 2007). Etowa et al. (2007) stated that insufficient and culturally insensitive mental health services could also be due to the fact that the health care system is structured to reflect the mental health experience of White middle-class men, as dominant cultural population. Othering the issues of people who fall outside of this group and come from communities where mental health is already stigmatized further complicates the task of providing culturally competent help and making it accessible to those who need it.

2.4 Gender

Differences in mental health experiences in gender across the lifespan emerged in the literature. Gender is a determinant of health that shapes and influences the mental health experiences of individuals. Regarding women, their gender-specific experiences such as caretaking and balancing work with family responsibilities can be accompanied with forms of sexism and misogyny (Jones & Guy-Sheftall, 2015). This can have a significant impact on the mental health of women, which can lead to issues related to confidence and a lack of self-worth. Depression commonly stems from feeling a loss of control or independence in one's life (World Health Organization, 2002). Examples of inequitable

gendered power dynamics women experience can range from not being allowed by her partner to make the financial decisions in a relationship, to not being able to access safe abortion clinics because of pro-life health policies supported by male politicians. The distress associated with not having personal autonomy in these cases along with factors such as forced marriage and being expected to be a nurturer, is associated with higher rates of depression along with other psychological issues (2002). For Black women and girls, the domestic, school, and work environments which are already made difficult by gender oppression are additionally affected by racism (Boyd-Franklin, 1991; Williams, 2005; Jones & Warner, 2011; Woods-Giscombé & Black, 2010). To cope with the challenges from inequity and violence within gender roles, women often seek out mental health services that are focused on empowerment, such as feminist therapy (Williams, 2005).

Few studies have been conducted to examine how gender impacts youth mental health. Chandra and Minkovitz (2006) found that boys experience more stigma in comparison to girls when it comes to utilizing mental health services, and as a result prefer to discuss their issues with family members. In a study conducted by Landstedt et al. (2009), they found that among 16- to 19-year-old students, they understood mental health as an emotional experience encompassing feelings related to confidence, embarrassment, stress, and self-esteem. Their perceptions of what is significant for mental health were organized into three categories of social processes: social interaction, performance, and responsibility (2009). Social interaction ranged from positive social relations and respect contributing to good health, to mistreatment and assault led to the opposite (2009).

Regarding performance, both the girls and boys in the study wanted respect and appreciation for their achievements and how they look and behave according to gender norms (2009). In terms of taking responsibility, a lower degree was associated with confidence, autonomy, and relaxation, correlating with positive mental health (2009). The participants argued that boys societally take on less responsibility and are generally more favoured, resulting in increased feelings of superiority and self-esteem (2009). The girls in this study identified feeling responsible for negotiating cultural norms of femininity and masculinity, which put them a higher risk for mental health issues (2009). Cuffe et al. (1995) found that among youth who seek help, young men access mental health services more in their early adolescent period, while young women access mental health services more in later adolescence.

2.5 Stigma

Stigma was one of the most significant themes that emerged from the search. Stigma is a common barrier that has been reported by young people to seeking help for their mental health needs (Gulliver et al., 2010). Walker et al. (2008) conducted a study on youth aged 8 to 18 years on perceptions of mental health stigma and found that compared to asthma, peers with depression were more stigmatized and were viewed as potentially dangerous. There is some literature on youth mental health stigma, but it is primarily based on adult perceptions of what stigma is like in younger populations (Pescosolido, 2007). This is a problem because the root issues preventing youth from seeking help for or having open discussions about mental health can not be addressed by people of a different age gap who are not living the lives of youth. In addition to being just as valuable as adults, the voices of young people hold power due to influencing future beliefs and attitudes of how

mental health should be discussed, promoted, and handled societally and structurally (Armstrong et al., 2000). This demonstrates a need for more work that privileges young people's experiences related to stigma (Pescosolido, 2007).

Armstrong et al. (2000) conducted a qualitative study exploring the attitudes and perceptions of 12-14 year old youth towards positive mental health and illness. Although mental health was associated with normality, there was no singular definition of what normality meant to the participants (2000). The young people from marginalized and rural neighbourhoods struggled to describe being "mentally healthy", focusing on the words separately and associated "mentally" with mental illness and "healthy" with diet and physical exercise (2000). Social support, personal achievements, a positive self concept and having people to talk to were identified by the participants as factors which influence mental health (2000). All the participants viewed adults as having a key role in helping maintain and promote good mental health by making young people feel safe and cared for (2000). With respect to negative feelings, the participants processed their anger or frustration through fights with other young people or with inanimate objects (2000).

Across cultures, stigma is a complex and important factor in how they navigate and understand mental health and illness. Generalized forms of stigma can occur within people struggling with their mental health, whereas double stigma is what prevents members of the community to seek out mental health services for themselves (Gary, 2005). Various factors like the insider or outsider relationship of the researcher to the community, the views of mental health held by the community leaders and gatekeepers, and different perspectives about mental health by gender, age, and generation within the community impact what can be researched. These issues have been central to the

formation of this project and to ensuring that community concerns, specifically those of youth who are often denied an equal voice compared to adults, are addressed in a way that align with anti-oppression and anti-racism frameworks.

The few studies that have been conducted on African-American youth revealed more negative stereotypes of mental illness and disorders, which were often influenced by the views of their parents and relatives (Kranke et al., 2012). In a study conducted by Lindsey et al. (2006), African American young men who did not seek treatment for their mental health issues stated that cultural stigma, embarrassment, potential exclusion, and shame were the most significant barriers to receiving help. Among the boys who did seek treatment, they faced cultural barriers from their Caucasian therapists who did not understand their background (2006). To reduce the stigma that prevents racialized youth from seeking help, Miranda et al. (2015) recommend an increase in the representation and visibility of racialized mental health professionals and educators, in order for them to see that people they racially or ethnically identify with are in these spaces.

2.6 Service Utilization

The factors influencing youth service utilization of health services were also a prominent theme in much of the related literature. Youth tend to be reluctant to seek help due to the vulnerability associated with talking about mental health issues and illness symptoms (Collins et al., 2004; Slade et al., 2009; Zachrisson et al., 2006). However, young people who look for treatment prefer to get their peers involved in the help-seeking process instead of their parents or family doctor (Rickwood et al., 2007). Studies on young people's attitudes towards mental health and their willingness to seek help have produced various findings. Sheffield et al. (2004) found that the attitudes of youth toward mental

illness do not predict their willingness to seek treatment for themselves. In a study by Yap et al. (2011), young people who viewed individuals with mental health issues as having a weakness rather than sickness were less likely to seek help. They also found that youth who believed in the potential danger and unpredictability of individuals with mental illness were more likely to seek help if they were to develop mental health issues (2011).

Chapter 3

3 Methods

3.1 Introduction

This chapter provides a discussion of the research methods used in the design of this research project. I begin with a description of the theoretical framework and epistemological paradigm employed, followed by the recruitment criteria and the selected participants who took part in the study. Next, I detail procedures used for data collection, management, and analysis. The chapter concludes with a discussion of researcher reflexivity and the ethical considerations employed during the study.

3.2 Theoretical Framework

A theoretical framework informed by feminist, intersectional, and critical race theory was used to capture and interpret the ways in which key socio-cultural factors, including gender, race, and structural inequity, shape how participants experience mental health, help-seeking behaviours, and service access. This paradigm is often used in studies with historically marginalized individuals and groups who struggle to negotiate and find safe spaces to express their ideas about the adversity and power imbalances they go through on a regular basis (Fay, 1987; Morrow & Brown, 1994). A qualitative phenomenological approach was employed in the creation of the research questions that guided this study. Qualitative research is defined by Hammersley (2013) as “a form of social inquiry that tends to adopt a flexible and data-driven research design, to use relatively unstructured data, to emphasize the essential role of subjectivity in the research process, to study a small number of naturally occurring cases in detail, and to use verbal rather than statistical forms of analysis” (p. 12). Phenomenology is a type of methodology that aims

to understand how people embody and assign meaning to their everyday lived experiences (Palinkas, 2014). Taken together, these paradigms align well with my study's focus on understanding how ACB youth in London, whose lives are directly shaped by gender, race, and social marginalization, both construct and experience different aspects of mental health in London, Ontario.

Although the theories employed in this study framework coalesce, they each contribute something unique. Feminist theories can be used to explore gender inequalities in aspects of life such as culture, education, social interactions, and the healthcare system (Lorber, 2005). Intersectionality, a term coined by Kimberlé Crenshaw, addresses the issue of discrimination often being approached along a single axis of identity which “erases Black women in the conceptualization, identification and remediation of race and sex discrimination by limiting inquiry to the experiences of otherwise privileged members of the group” (Crenshaw, 1989: p. 140; Hopkins, 2019). It challenges the idea of universal gendered experiences and mutually exclusive categories of identity; other scholars in this field argue that the experiences of Black women, in particular, are affected by racism and classism concurrently (Collins, 1990; Crenshaw, 1989; Davis, 1981).

This conceptual tool was initially meant to research the experiences of Black women in the workplace however, is also used as social justice, political, epistemological, and ontological frameworks (Hancock, 2016; May, 2015). Critical race theory positions and privileges racialized perspectives while acknowledging that race is a social construct and calling for the elimination of racial subjugation (Parker & Lynn, 2002). These all align

with my research objective, which is to investigate the experiences of ACB youth understanding mental health issues or navigating systems of care.

3.3 Participants and Recruitment

Through this critically oriented qualitative project, qualitative data was collected from the several subpopulations of young men and women in London, Ontario who identify as African, Caribbean, or Black. Fifteen participants (n=15) were interviewed, including thirteen young women and two young men. Purposive sampling was used to target populations anticipated to have important insights similar to the research objectives, leading to trustworthy and rigorous data (Campbell et al., 2020). This method of sampling was also done to specifically select the participants who meet the inclusion criteria: youth who self-identify as ACB, who are between the ages of 16-20, who speak English, and live in London.

Participants were included if they self-identified as ACB, were between the ages of 16-20, if they spoke English, and grew up or lived in London at the time of the study. One exception to this criteria was made. A participant who was twenty-one years old volunteered to participate and I decided to proceed with their inclusion, given that they were only one year beyond the limit and they had valuable insight to share.

The participants were recruited through study information posters that were posted at and sent to various cultural, community, and youth-centered agencies, clubs and organizations on and off campus to be disseminated within their networks. Prior to submitting these posters, I contacted the executive members of these organizations via email, phone, or in person and introduced myself and the study I was conducting. If they

were receptive to the idea of sharing information about the study, I provided them with my contact information and a copy of the poster. Depending on the communication with the staff or organizational leads, I was asked to give either my poster, a paragraph to share through their social media platforms, or both. One student association at Western University invited me to speak about my study to their members at their general meeting. This method was the most effective, as the majority of my emails I received from potential participants were in the week following my presentation.

Overall, I received sixteen email responses to the Recruitment Poster and Online Ad from young people who expressed an interest in participating (Appendix A and B). All participants self-reported meeting the inclusion when they initially contacted me. To ensure that they met the study criteria, I asked participants to confirm their age and cultural identity during the preliminary questions stage of the interview. As noted above, one participant that fell outside the age criteria for inclusion was ultimately included. Another volunteer was excluded from the study after stating they met the inclusion criteria in her email, but then admitting to not being of ACB descent in the preliminary stage of the interview.

3.4 Data Collection

Study data were collected through individual semi-structured interviews with participants about the roles of gender, race, culture, place, and age in their mental health experiences as ACB youth. Semi-structured interviews are a useful method to obtain qualitative data on the behaviours, beliefs, and perspectives of individuals, and consists of generating questions or probes for the researcher to cover and ask the participant in a conversational manner (Harrell & Bradley, 2009). This method of interviewing offers several

advantages, such as a reciprocal dynamic between the interviewer and participant, providing the interviewer with the opportunity to create follow-up questions to participant's answers, and allowing exploration beyond what is asked in the interview guide (Hardon et al., 2004; H. Rubin & I. Rubin, 2005; Polit & Beck, 2010; Kallio et al., 2016). The shortest interview with one of the participants was just under 10 minutes, and the longest was approximately 70 minutes. After requesting and obtaining consent from the participants to record them for data collection and analysis, I began their interviews with a set of preliminary questions about who they are and how they identify.

Throughout the interviews, I took note of the observations I made of the participants; for example, one young woman seemed to smirk or force a smile when she talked about the ways her cultural community hinders open communication about mental health, and one young man looked down while covering his mouth throughout his entire interview. I ended the demographic portion of questions asking the participants what their reasons were for participating in my study. Asking this question provided me with a better understanding of what they may expect to be asked and how they want their lived experiences to contribute to this field of research. To help facilitate trust in myself and the study, the participants selected the interview location, which included private, safe spaces at Western University or the downtown public library.

Participants asked to meet outside the designated space or walk to the interview room on their own. When they arrived, I greeted them, introduced myself, and thanked them for meeting with me. I engaged in informal, everyday conversation, asking them questions like: "how are things going?", "did you have any classes today?", and "what program are you in?" while answering any questions they had about myself. After this initial dialogue,

I explained the research topic of my study. I asked them to read the Letter of Information and Consent (Appendix C), while expanding on its contents such as the purpose, risks, and benefits of participating. Each participant was made aware of: the debriefing process that would be conducted throughout and after the interview; the voluntary nature of their participation; and the right to withdraw at any time and still receive the entire honorarium of twenty-five dollars provided for participating. Participants were asked if their interview could be audio-recorded in order to be transcribed and quoted with pseudonyms for data analysis. They provided their consent; however, they had the right to refuse both and still participate in the study. All participants agreed to an audio-recording and/or the use of unidentified interview quotes being used in reports or publications.

As stated earlier, the interview began with a set of preliminary questions prior to asking the core questions of my study to gain a better understanding of what motivated the participants to contact me (Appendix D). This was important to get a sense of what each participant would likely have more insight to share with me regarding mental health, as well as to confirm that their participation was out of genuine interest and consent in the study. This included asking if they were from London, how long they have lived in London, if they like living here, their age, their gender and cultural identity, and why they were interested in participating.

An informal debriefing process (Appendix E) was done throughout each interview to assess where participants were at emotionally and help ensure that they were not triggered by a question asked or any information shared. In addition to the \$25 honorarium, participants were given detailed information about the location and hours of

operation for mental health resources, and I also provided my contact information should they wish to discuss any issues related to the interview.

3.5 Data Analysis

Qualitative analysis is an inductive process designed to develop a ‘thick description’ of the phenomena being investigated, which is achieved by deep immersion in the data over time in order to assess its rich context and meaning (Denzin, 1978; Dey, 1993; Geertz, 1973). Prior to beginning my first coding cycle, I read through each transcript multiple times to try to glean from the participants’ mental health experiences relative to the issues of gender, race, and also place. In addition, I wrote down memos along the transcript margins and in my notebook of field notes to document my thoughts and reflections and how emerging findings aligned with my theoretical framework.

I then manually coded each transcript line by line to generate initial codes, which were words or phrases that described a section of data, like ‘religious beliefs’ or ‘cultural shame’. The codes that were conceptually similar were combined into a category, of which there were in my data set. The most prominent categories were determined by being the most common and representative of the participant data, and were frequently intertwined with one another. They included: perceptions of mental health, help-seeking behaviours, gender, stigma, mental health service barriers, sociocultural influences, and representation (Appendix F).

When each interview was completed, I listened to and transcribed the audio recordings on Microsoft Word. The audio recordings amounted to 215 pages of transcribed typed data that were analyzed by hand. Any information identifying the participants such as personal

names were excluded in the transcribed interviews to be replaced with pseudonyms. The audio recordings and transcribed Word documents were uploaded onto a pin-protected personal computer, and the password protected files were stored in a Dropbox File.

Once the categories were finalized, they underwent further analysis to produce substantive study themes. The initial codes and categories written along the margins of the interview transcripts were then organized and mapped under their appropriate themes. Arrows were used to connect any ideas or categories that overlapped across different themes. The data went through multiple cycles of inductive coding, with special attention paid to data that aligned with my initial research questions. My first cycle of coding resulted in a set of codes such as religion and faith, cultural misconceptions, mental health services, and coping strategies, and race which needed to be further refined. This iterative process was necessary to interpret the experiences and perceptions of mental health from participants of themselves and others in their lives.

3.6 Reflexivity and Positionality

Reflexivity is a crucial process in creating qualitative research that has rigor and is trustworthy (Teh & Lek, 2018). On the importance of reflexivity, Berger (2015) states that “researchers need to increasingly focus on self-knowledge and sensitivity; better understand the role of the self in the creation of knowledge; carefully self-monitor the impact of their biases, beliefs, and personal experiences on their research; and maintain the balance between the personal and the universal” (p. 220). Positionality, on the other hand, is “determined by where one stands in relation to ‘the other’” (Merriam, Johnson-Bailey, Lee, Lee, Ntseane, & Muhamad, 2001, p. 411). Positionality is important to include in qualitative research in order to contextualize the researcher and demonstrate

why the research produced may have differed if the data was interpreted by someone else (Jafar, 2018). Throughout the data collection and analysis process, I recorded field notes of my observations, thoughts, answers that stood out from the participants, and the participants' body language. When conducting research on sensitive, culturally charged issues like mental health, it can be advantageous for the researcher to share certain experiences or characteristics with the study population.

It is significant for the researcher in their reflexive to develop an understanding of their similarities and differences with the participants, to determine their role as either an outsider or insider (Berger, 2015; Teh & Lek, 2018). A study of this nature conducted through the lens of a researcher with a similar background is an important contribution to the literature gap on mental health in ACB youth for several reasons. Accessibility to the study population and data that is rich with information may be easier to obtain if the participants believe the researcher may have more sympathy to their experiences or will provide more specific and appropriate resources (Berger, 2015; De Tona, 2006).

My insider-outsider role fostered critical self-examination from myself throughout this study. Like my participants, I identify as a Black woman who is a member of the ACB community in London. However, while they were all high school or undergraduate students, I was a graduate student in addition to a peer support volunteer, and a member of a youth mental health and addictions council in London who is familiar with the local discourse about mental health and ideas of stigma among individual members, aligned agencies and researchers. As an insider, I have a close understanding of common cultural ideas about mental health in ACB communities, and participants were likely more comfortable to share their experiences with someone they can identify with, which could

be a factor in the strength of the data. However, being a researcher of a similar background from the same city, I was also aware that this could complicate the study, in that participants may feel less able to be truthful or vulnerable in their interviews if they fear their identity could become known to others.

In the positions I held which differed from my participants, I examined how they informed what I knew and believed regarding mental health and illness. I incorporate biomedical and holistic knowledge in my approach to mental health issues due to my academic background in health studies, my upbringing in an East African, Christian household, and the medical, intersectional, and social perspectives towards mental health which I observed in the spaces I occupied at school, at work, and in my volunteer roles. I examined my own privilege of having a positive service experience with counsellors who did not discredit the intersectional context of some of my personal issues and the difference in my challenges with poor mental health compared to the participants who had no experience seeking help, or had family members who were insensitive to their struggles. When I conducted and analyzed my interviews, I used my positionality to flesh out concepts within my questions which were unfamiliar or difficult to understand, I refrained from imposing any opinions which were strongly in favour of or against seeking help because of my positive experience, and I added gendered and cultural context to perceptions of mental health which may not have been easily gleaned by other researchers.

3.7 Ethical Considerations

Prior to collecting the data for this project, an application was submitted to and approved by the Non-Medical Research Ethics Delegated Review Board at Western University.

Exploring complex, stigmatized issues in local ACB communities is challenging, particularly in a medium-sized city where the ACB population is relatively small. It is especially challenging to work with youth, whose perspectives are often superseded by the concerns or voices of their parents or community elders. According to the Health Sciences Research Ethics Board under Research Western (2016), parental consent is required for all children younger than 18. However, in this study, I proposed a waive of parental consent to ensure full respect for and autonomy of the youth participants, many of whom likely live with their parents and/or who may be unduly influenced by the adults in their community. It is imperative to view this population as people who are their own beings and are capable to make decisions about their participation in studies.

An additional rationale for waiving the parental consent is the fact that some youth come from families or cultural backgrounds where mental health is stigmatized. For these participants, there is a real risk of their experiences being suppressed by elders, which can be circumvented by relying upon the individual's consent only. The controversial nature of the research topic, fear of the participants being stigmatized if knowledge of their involvement in the project is known, and unfamiliarity with the researcher could have prevented guardians from providing consent for their children to be in the study (Maiter et al., 2008). These complicated issues were acknowledged carefully through the ethics proposal and data collection. It was also reiterated to the participants that their identities would be kept anonymized and confidential through the use of pseudonyms, not including identifying information that can be associated with participants in the thesis and subsequent publications, and safely storing the data in private places accessible only to the lead researcher. It is imperative to develop trust and acknowledge issues related to

trust in communities that have had negative experiences with mental health or research, and to allow participants to define mental illness in a way that is most appropriate to them and/or their community (2008).

During the research interactions, participants provide private and sensitive information and some may view these experiences as an opportunity to receive guidance from someone they perceive as a professional who can offer help (Duncan et al., 2009). This is particularly true with marginalized groups, including racialized youth. Their vulnerability and complex motivations for participating in the study should be acknowledged. To further prevent any misunderstandings, answers from participants were clarified by asking them to explain anything that seemed confusing, repeating what they said to get confirmation, or formulating questions to unpack what was, to me, an unclear answer. Although the participants shared stories and examples which may have been painful to recall, none of them expressed discomfort or requested to discontinue the interview.

An anti-oppressive or anti-racist framework is also significant for using particular language to alleviate issues of power with youth to prevent further stigma or forms of structural violence from being reproduced (Hopton, 1997; Larson, 2008). These frameworks are used to advocate for an egalitarian relationship between clients and mental health professional by negotiating with the use of titles, ranks, or positions which can cause power dynamics that possibly create distance between youth and their service provider (Larson, 2008). Anti-racist and anti-oppression advocates support language that is sensitive, focusing on the background, perspectives, and strengths of clients rather than their diagnoses (Arredondo & Rosen, 2007; Fernando, 1988; Larson, 2008).

3.8 Conclusion

This chapter opens with a discussion about the study's theoretical framework, provides a description of the backgrounds of the fifteen participants recruited, explains the data collection and analysis processes, unpacks the insider-outsider tensions within my reflexivity, and concludes with an explanation of the ethical procedures required for this study. This information helps the reader as well as other mental health researchers grasp the diversity of Black people who do not identify as African American and have received little attention in previous studies. The youth interviewed in this study included 13 young women and 2 young men. Various methods of recruitment were used to find young ACB individuals to participate in this study, ranging from poster dissemination to in-person presentations.

This was followed by a breakdown of the questions asked in the semi-structured interviews, which covered areas regarding their reasons for participating, their definitions of mental health, how their age has impacted their experiences seeking help, and more which explored their raced and gendered experiences, in addition to their cultural background and location. These questions produced data, which, when coded, produced various categories demonstrating the raced and gendered mental health experiences of the participants - particularly of the ACB women in this study - and the issues they experience as an outcome of how they are socialized, the tropes they internalize, and the institutional oppression they experience.

The methods and subsequent results also display the efficacy of a phenomenological approach for this study. The purposive sampling and semi-structured interview methods support investigating the subjectivity of how a particular phenomenon is experienced

through an open-ended thorough exploration of how individuals understand the world, themselves, and one another based on their own informed experiences and identities. The following two chapters provide an in-depth overview of the findings produced from the data analysis.

Chapter 4

4 Findings: Mental Health Worldview, Gendered Emotions, Race & Cultural Barriers to Talking about Mental Health

4.1 Introduction

This chapter explores the study participants' worldviews about mental health, gendered emotions relative to mental health experiences, race, and cultural barriers to talking about mental health. Prior to addressing the themes within the data, I will be describing the demographics of the study sample.

The participants' worldviews reflect their foundational beliefs and ideas about mental health and provide rich contextual understanding for many of the other issues they raised during the interviews. Under the theme of gendered emotions and mental health experiences, the interpretations of how gender, primarily in terms of social roles and expectations, affect what the young women and men in this study experience and observe relative to mental health. The next section about race and mental health examines how their experiences of discrimination, racialized stereotypes (projected and internalized), and different aspects of representation have impacted their mental health. The final theme, cultural barriers to talking about mental health, displays the ways that the participants' respective ACB cultural communities have been limited from moving forward with open dialogue and treatment of mental health issues.

The findings are analyzed using an intersectional theoretical approach, previously explained in the Methods chapter. Applying this framework to the data highlights the ways in which the culture, race, and gender overlap, often in complex and shifting ways,

in participants' lived experiences. Lived experience, particularly in phenomenology, can be defined as "our situated, immediate, activities and encounters in everyday experience, prereflexively taken for granted as reality rather than as something perceived or represented" (Oxford Reference, 2020). These data reveal new insights about how mental health is constructed and negotiated among ACB youth in smaller communities that are unique, and provide significant value to the current health literature, which tends to address these issues among young ACB people living in metropolitan locales such as Toronto or Montreal. These include participants wanting to reduce the cultural stigmas associated with mental health, which are profoundly shaped by gender and often leaves young women feeling additional pressure to manage their issues on their own while upholding social roles and expectations that sometimes exacerbated their emotional struggles. Their insights also reflect current social discourse among Black youth about the tensions between wanting to see themselves represented in more meaningful ways in mental health promotion and the tendency to silence mental health issues within local cultural communities.

4.2 Sociodemographic Profile of Participants

With regards to age, the youngest participant in this study was seventeen, the average age of my participants was nineteen, and approximately half of my participants were twenty years old. Those who talked about religion identified as Christian or Muslim, and in terms of race and ethnicity, the participants identified as Black, African, Caribbean-Canadian, Nigerian, Jamaican, Ghanaian, Kenyan, Eritrean, Zimbabwean, and Somali.

Most participants were from London or the Greater Toronto Area, two were born in British Columbia, one was an out-of-province student from Alberta, and two were

international students from African countries. From the twelve participants who identified as African, four were born in the continent and either immigrated to Canada when they were younger or came to Canada to attend Western as an International Student. Of the fifteen participants, twelve were students at Western University, 2 were students in London high schools, and 1 was did not disclose their level of education. Two of the participants were siblings and at the time of the study, one of the participants was homeless. I selected and used pseudonyms for the participants to keep their identity confidential.

4.3 Theme 1: Mental Health Worldview – Conceptualizations and Definitive Experiences

4.3.1 Worldview

The term “worldview” has been used in anthropology to refer to belief systems along with their social importance; worldviews shape cultural beliefs, the people who are born into a specific cultural environment, their behaviour, and their understanding of reality (Mussell et al., 2004; Kearney, 1984). They include, but are not limited to political views, participation in society, and cultural ideologies related to psychological well-being or management (Mussell et al., 2004). The worldview concept is a useful approach to mapping and making sense of how the participants in this study define mental health, how it is recognized in their everyday lives, and how it both connects and separates them from their cultural upbringings as ACB youth. The key attributes associated with mental health worldviews in this context included notions of wellness and holism, difficult mental health experiences, and the influence of the media on perceptions of mental health.

4.3.2 Wellness and Holism

When asked what comes to mind when they hear the words “mental health”, many participants spoke of wellness and different aspects of self-care. When asked to elaborate on what they meant by wellness, participants cited feeling secure with their own thoughts and themselves: “Um, feeling secure, in my own, like with myself, and, um, positive thoughts...” (Olivia). Holism also came through in many of their discussions about mental health, as in the case of Trevor: “Mentally, physically, spiritually and emotionally, mentally takes...a really good chunk of me that I need to always keep good and on the go and ready and safe.”

Similarly, Fatima said: “The way you are physically and spiritually and all that kind of stuff definitely has an effect on the way you are existing in this world...whenever I do go through something mentally, it can affect my everyday life, it affects me in so many different ways.” For Folade, wellness is also perceived as something unique to each person: “I feel like there’s not just one way to define it. To me personally...are you able to function in a capacity similar to – I don’t want to say that of others, because there’s no normal, but to like, the societal norm.”

Some participants flagged the issue of illness when discussing what the term mental health means, which was often unpacked through reference to depression, schizophrenia, and other mental health disorders they deemed to be “negative.” In these instances, the difference between mental health and mental illness was raised: “Mental health is something that everybody has...I know people usually get mental health/mental illness confused...[it’s] just the way you are in your mind.” (Fatima). This distinction in the minds of participants is important, as it shows their understanding of mental health as one

dimension of an individual's overall wellbeing with varying degrees along a continuum. This knowledge can better help the participants identify when changes in their mental health are minor difficulties to overcome through effective coping strategies, or are severe enough to rely on help from a healthcare provider.

4.3.3 Difficult Mental Health Experiences

When talking about challenging mental health experiences, for certain participants, the idea that mental health issues can be discernable or separated from other feelings was discussed. Folade, for instance, relayed that she did not consider these things when she was younger and sometimes wonders if her mental health issues are “just” sadness or something more: “Is this just sadness or could it be something more?...like when I panic in certain situations...is it something deeper?...[in] high school, I didn't even think about it at all, but coming to university, it's definitely been something that's more on my radar.” Several participants alluded to the difficulty they faced in even figuring out for themselves whether their own mental state merited being identified as healthy or unhealthy. Yemi, for example, described tensions between her ideas about health and herself: “Even if I'm stressed...am I happy? Like, am I in a stable state of mind? Even if I'm stressed, like, I'm still good, I can still laugh.” Simone described feelings of helplessness associated with different mental health experiences and the lack of supports, which can be a self-perpetuating cycle:

“I think of like, depression, feeling lonely, anxiety...like there's no one there to help you during problems...keeping everything contained which...prevents you from getting the help you need... something's happening in my life and I just don't want to tell anybody about it but then deep down it's hurting me.”

Ami spoke about how she manages and aims to reduce stress through peer support: “Um, mental health to me is just trying to keep, like, stress free, and, having people to talk to if I’m ever feeling not myself.” Similarly, Helen talked about the peer-related benefits of the mindfulness strategies she practices: “Practicing mindfulness...keeping yourself...balanced...and I think the best way to tackle that is, um, honestly having peers and other people around you just to discuss whatever those thoughts are.”

The stigma surrounding mental health and illness within their respective cultures was the most common reason raised by participants for wanting to speak to me about the experiences of themselves and other Black people in their lives, as explained by Fatima:

“Mental health in our communities...it’s not really discussed, it’s kind of like taboo if you do have mental illness or have some struggle with mental health in general...I feel like this population is very uh, needs a lot of work in that regard, in terms of support, in terms of knowledge and research.”

In a similar vein, Simone specifically talked about the assumed “strength” of people in ACB communities which can prevent them from seeking out the help they need: “Black people don’t really go to the student services and ask like, ‘I have a mental health problem’...even if we have a problem we’re unable to like, go and talk to someone about it...we’re supposed to be this strong figure.”

A common thread I noticed early on in the data analysis about mental health stigma was a lack of discussion about it. As Olivia said: “I think really strongly about mental health within the African community due to the fact that it’s something that ISN’T talked about, and, when I saw this, I wanted to get in on it...especially due to the fact that it’s not

really expressed.” Oyin also said “Mental health is important to me personally, and, I feel like it’s not talked about enough in our community, and people are really suffering.” As a result of the silence, which Folade has also witnessed and experienced, participating in this study was a way to be given the space to speak about mental health and be involved in helping reduce the stigma: “It’s time for me to like, not just like, be sitting here at the back and letting people talk, but also participate and find out myself what can I bring to the table.”

The issue of resisting performative positivity, which has a detrimental impact on her well-being was raised by Fatima:

“Just being like, happy all the time is like the goal...which is very exhausting...the only times I feel like, these people actually care about me, is when we can sit down and actually just cry together. But when you’re just saying ‘life is fine’...it just feels performative.”

As she explained further, the negative effects of performative positivity go beyond the strain of not being her most authentic self. This performance can also lead to the denial and invalidation of her own feelings and experiences, thereby worsening one’s overall mental health.

Lulu discussed the issue of possibly seeking therapy as a preventative measure, despite considering herself healthy: “Anyone who goes to a therapist isn’t crazy...I might actually start...just go see a therapist *in case*, because you never know what could be wrong.” Although not a predominant opinion among all participants, Lulu’s insights shed additional light on the presence of ACB youth who are aware that therapy should not

only be sought by individuals who feel like they are struggling. Promoting this view could encourage more young people to talk to someone about their mental and emotional health.

At the outset of the interviews, participants were asked how they felt about the overall interview experience, and what they would like to see accomplished with the findings of this study. A few participants stated that they were impressed by how the questions made them reflect on their life. The participants' answers to this last question were categorized into two themes: to increase representation of ACB leadership in the mental health field, and to reduce the stigma of mental health in ACB communities. Jasmine connected her need for representation in mental health research to the lack of visibility in a local context: "For youth like me, and finding their identity [in] social like groups, ethnically...it's very hard finding someone that looks like me."

Similarly, Ami said "...what drew my attention was that it was directed towards Black students, like I said before, because I've never seen a study like that, so yeah that drew my attention." The participants expressed wanting to see more people who had similar identities not only in the studies they read about regarding mental health, but also in positions of power advocating for stigma reduction and working as health professionals to better serve our populations.

Fatima spoke about the importance of creating research that focuses on the effects of structural oppression on the mental health of young Black people:

"Racism, White supremacy are big ideas, big ideologies that kind of run our society, and that really does shape the way Black youth exist in this world, and

even like historical things like colonialism and slavery, intergenerational trauma is a really big thing that's not really researched on or talked about."

4.3.4 The Media's Influence on Perceptions of Mental Health

One participant, Yemi mentioned the perceptions of mental health impacted by the representation of mental health issues in the media, particularly of celebrities who are in the public eye:

"What comes to mind? First of all is Kanye West. *laughs*...my parents...don't really know anyone that has mental health problems...it's not something that's written on your face...But um, yeah, it's definitely in reference to the media."

Kanye West is a Black American artist, known over the last two decades for being one of the most controversial public figures in the world with his polarizing music, and critiques of other prominent figures (Birchmeier, 2007; Caramanica, 2013). He is remembered for stating former president George W. Bush does not care about Black people, and interrupting Taylor Swift's acceptance speech at the 2009 MTV Video Music Awards to argue that Beyoncé had one of the best videos of all time (Byrne, 2005; de Moraes, 2005; Kreps, 2020; Respers, 2009; Vozick, 2009).

He continued to disappoint and divide the general public - especially his former fans - after expressing support for Bill Cosby amid his sexual assault allegations, arguing that slavery was a choice on TMZ, and calling his bipolar disorder a superpower (Lee & Beaumont-Thomas, 2018; Trepany, 2019). Given how Kanye and his behaviour is viewed – especially after disclosing his bipolar disorder diagnosis - and celebrities in general when they are seen as “spiraling”, this could contribute to a negative image of

what mental illness is, especially among people who do not know someone who is struggling with mental health issues.

4.4 Theme 2: Gendered Health Experiences

4.4.1 Introduction

To get a sense of the gendered mental health experiences of the participants in this study, inquiry was made regarding how their mental health experiences have been shaped by their identity as young men or young women. While some of the participants initially indicated that there is no difference, they would often provide numerous examples to explain why they think gender has an influence on mental health. Their insights in this regard included the issues of gendered differences in biology and behaviour, women's experiences of cultural and mental health invalidation, and the difficulties men face regarding mental health.

4.4.2 Gendered Biology and Behaviour

The biological difference between men and women, as well as understandings of gender as something that is socially constructed, was a key topic raised in the interviews. Mary, for instance, made a distinction about the differences between women and men: "Um, I think we're both different biologically and psychologically, we don't have the same burdens of life and the same experiences." Another participant, Helen, shared insights that reflect how these fundamental ideas about gender carry over into perceptions of mental health among women and men: "Women are much more likely to be, like, in tune with their emotions...they tend to be represented as on the more emotional side of things,

but men tend not to accept or be honest with what they're going through, and they tend to brush it off.”

Among the participants, both genders made associations between gender, biology, and mental health which did not always align in ways that would be considered ‘politically correct’. This was the case with Marlon’s conflation of gender and women’s genetic predisposition for bipolar disorder:

“One minute they’re [women] happy, one minute they’re sad...the reason why is because like, our genes...men should like act rough, tough...I’m not offending any lady or anything but like, they’re soft, they show more emotion...a pet dies, they’ll cry, but men won’t.”

This transparency in his perspective, despite being a generalization, is significant as it may reflect dominant gendered norms about emotions that, despite being outdated, are reproduced across generations, especially within families and communities where these traditional mores are widely supported.

4.4.3 Women’s Experiences of Cultural and Mental Health Invalidation

Several female participants discussed the gendered familial and community standards they are expected to meet which were often framed relative to what is expected of or provided to young men. Ami spoke about the pressure that has been placed on men in her family to succeed through professional achievements: “My dad has a lot more expectations for [my brother], like with school and career...I feel like now he’s feeling the disappointment since he’s done school but he’s not where he is yet.” In her

experience, Ami spells out a sense that she was not expected by her father to fulfill these traditional markers of success due to being a woman. In a similar vein, Oyin spoke about the early pressures girls face versus the patience and time afforded to young men as they grow into adulthood:

“[Yoruba] culture is very like, heavy on like, marriage, have a family...for girls, it's more of like, 'no, you need to do this, you need to do this'...they have the patience [for men]... to like, heal or be better...I don't get that same benefit... 'no, it can be any day now...you could find someone any day.'”

Another young woman named Olivia talked about the multiple layers of pressure she has faced as a result of being the oldest daughter with no brothers, and first young person in her hometown's Nigerian community to go to university: “We have to be really good in what we do because we're like, representing...our family...so everyone looks up to me...you're always thinking about it in the back of your head.” The layered stressors experienced by many of the participants are important to consider in the lived experiences of ACB youth to pinpoint the array of issues at play in their mental health experiences, including being the children of immigrants and achieving educational success, which is a common stressor as it often symbolizes that the sacrifices their families made were worth it. When these pressures are higher due to intersecting with factors such as gender roles, culture, and family structure, they can stifle young people like Olivia from attempting to achieve their goals, which can negatively impact their mental health.

When discussing invalidation within the context of mental health, several participants talked about their concerns not being met, despite being proactive in taking care of their wellbeing. Jasmine discussed the extensive labour involved in finding a good physician or service provider, which is one who will take her symptoms as a woman seriously: “Going to certain doctors and certain people, they have...[ideas] about women, they don’t take physical symptoms seriously...you have to keep trying until you find the *right* doctor, the *right* psychologist, the *right* person.” Similarly, Folade provided an example of being dismissed by a doctor when she went to see him for a sore throat, which could be linked with any number of minor or serious conditions: “I had gone to the doctor, I *told* him I have a sore throat...and then he’s like ‘go to Tim Hortons, get a cold smoothie’...this is why I don’t come to the hospital...I’m gonna have to really PUSH to get what I’m saying across.”

The same participant shared another story of her breakdown after a stressful incident to explain how the invalidation of women’s feelings have affected the way she processes her emotions:

“I feel like it was symptoms of a panic attack...I was able to call my roommate, and she was like, ‘it’s okay. You’re going to be okay’...there’s been so many situations where I should have spoken out...as a woman...if I asked for help, then they’d say, ‘ugh, that’s why, a woman can’t’...my mental health has been affected because I’ve taken a lot of things on my shoulders.”

These feelings of being dismissed, at a systematic and interpersonal level, within the healthcare setting is something many of the young women in this study are familiar with.

This invalidation does not end in the doctor's office; shrinking women's realities denies them the ability of being fully understood not only by service providers, but themselves as well.

4.4.4 The Challenges Men Face Regarding Mental Health

In addition to the invalidation they have experienced, many of the female participants also spoke about the community and societal norms that prevent the men in their lives from being able to discuss their mental and emotional health with others. They were aware of the differences in what they were free to express in comparison to their male peers as a result of hegemonic gender norms of how men and women can and should portray themselves. Along with the young women, the two male participants discussed how these standards have played out among themselves and the men in their own families.

Simone talks about the performance of masculine toughness men are expected to meet, unlike women who are given the space to express their emotions about how they truly feel: “[Men] have to be hard, ‘my emotions don’t really matter’...females [can say]...I’m feeling this way...even though it hurts [guys] they won’t say it.” The ability for women to express their emotions more than men stems from the idea that women are inherently more emotional, which Lulu touches on: “I feel like for men, it’s harder to show emotion just because society tells them they shouldn’t be, and for women...we just do it all the time.”

Similarly, Iman has witnessed situations within her family regarding who can and cannot express their feelings, which reflecting how toxic masculinity confines and hinders men

from experiencing fulfilling emotional wellness: “I see it most with my brother because he has a lot of problems but he just doesn’t *talk* about it, he doesn’t feel like he should, or he’s not allowed.” Fatima expands on how men are hindered from being anything other than stoic compared to women: “Men are not allowed to express *any* emotion *period*...they’re not even allowed to be fully happy...at least women can have that.”

While there may be greater acceptance for women to be vulnerable, it can engender negative associations as well. For instance, Folade said: “While women face a lot of, oh you’re supposed to be weak, but they *don’t* want to be seen as weak...they’re both fighting against, like, what they’re being held towards.”

Trevor confirmed these perceptions in the experience he shared of the gendered double standards imposed by his grandmother: “She would expect my sister to be upset about things and cry more about them...with me, she’d expect me to, just...keep it together and keep going.” The same participant used the word “careful” when explaining how he polices himself to maintain his masculine image and lament the inequities built into gendered double standards he has experienced: “You’re not supposed to cry...if you’re not careful about how you choose to show your mental health...you’re going to be considered an emotional boy...in reality you could just be more in touch with your feelings...I wish it wasn’t like that, it *is* like that.” For Marlon, his father provides very little support beyond stereotypical ‘be a man’: “He’s always like ‘you should man up! This is life!’” However, he does receive emotional support from the matriarchs in his family, saying: “I mainly talk to my mom abroad and she will give me advice and say ‘you should talk to your step-mom about it.’”

4.5 Theme 3: Race and Mental Health

4.5.1 Introduction

At the structural level, racism is the discriminatory ideas used to distribute power inequitably along different racial and cultural identities that are based on deeply problematic, hierarchical ideologies (Gee & Ford, 2011; Geronimus & Thompson, 2004; Jones, 2000; Powell, 2008). Acts of racism such as discrimination are just as critical as factors like social support and early childhood development, which have been identified as a critical social determinant of mental health. Research demonstrates correlations between perceived discrimination and mental health issues (Krieger 1999, 2014). The data reported herein likewise reflect the ways in which the participants' racialized identity impacted on how they navigate the worlds they inhabit, and how their encounters with the systems in power work to strengthen or lessen their perceived social value. The key insights that emerged included the impact of internalized and projected stereotypes, overt and covert forms of discrimination, and the belief held by some participants that mental health issues only affect White populations.

4.5.2 Racial Stereotypes

Helen opened up about her experience as a young Black woman receiving different treatment and support from her non-Black female counterparts in school and in the workplace:

“A co-worker of mine can come late...do a mistake...it's easily handled, but then me being the only Black woman at the clinic...the youngest...sometimes I just feel like...it could be a factor...there are [non-Black] girls [in high school...going

through a break-up...but when a Black girl goes through that, they're like, 'oh, well, you'll be fine, girl' ...the reality is, is we're all women...we do need, like, that similar support.”

The response that Helen has received from her peers may not be intentional. However, it can be attributed to the “superwoman” or “Johnetta Henry” trope that has historically been placed on Black women to put their health on the line in order to excel in life (Primm et al., 2019). This role socializes Black women from an early age by various influences such as their families and the media to exhibit both masculine and feminine traits simultaneously, thus being strong and resilient while nurturing others (Hamin, 2008; Kerrigan et al., 2007; Nelson et al., 2016; Stanton et al., 2017; Watson & Hunter, 2016). When Black women are expected to constantly meet adversity with strength and little external support, it leaves little room for them to be fragile and express vulnerability.

Folade has had difficulty allowing herself to express vulnerability while wanting to maintain a sense of independence, due to racialized expectations associated with ‘strong Black women.’ She said: “If I reach out for help...‘are you sure? You’re a Black woman, come on, you guys can handle anything’ ...there’s that block...stopping people from really getting what I’m trying to say.” She speaks further about the inner work she does to decipher the image others have of her in comparison to her perception of this image: “It *does* affect the way I *feel* people react to me, but it also affects the way people [actually] react to me...it is a barrier [to] myself...people are just going to see me as this, why bother.”

Self-imposed barriers as a result of internalizing projected superwoman tropes were also a real consequence for Simone. She too explained the similar reasoning behind her hesitation to access mental health services and assumptions of being viewed as too strong to receive treatment: “I’m probably just going to get over it, I have this stronger, like, fabric on me *laughs*...I just feel like if I was to get help I’ll just be dismissed *quicker*.”

Viewing Black women as inherently angrier than their non-Black peers, even in situations where their outrage is justified, can be ascribed to the Sapphire stereotype. This historically embedded trope was popularized by a character on the Amos ‘n Andy show, who is portrayed as a bossy and aggressive Black woman (Primm et al., 2019). This is seen in Yemi’s quote: “Let’s say a Black person is screaming to a White person now, but the White person’s in the wrong, everyone’s going to think, like, oh wow...the stereotypical angry Black woman.” Applying these negative and violent traits towards Black women can often result in their normal emotions being vilified (2019). Similar to the superwoman trope, withdrawing the space to feel vulnerable enough to express the emotional spectrum in a healthy manner can worsen the mental health of Black women.

Olivia spoke about the hyperawareness – and sense of responsibility- associated with being a member of a racial group that is pathologized and viewed in monolithic ways: “You always have this feeling...to act in a certain way because you’re like representing a wide group of people...even to go to the school counsellor...I just kept thinking...they’re going to think that every Black person wants [help].”

4.5.3 Overt and Covert Experiences of Racial Discrimination

In addition to stereotypes, Yemi elaborated on the ways that racial discrimination has increased her hypervigilance and impacted her mental health while looking for employment:

“If you’re constantly striving...and the system is pushing you back...your mental health can deteriorate...why am I not progressing as far as I want to?...for example, you’re applying for a job...I have a name that’s obviously not a Caucasian name...you might even think that the employer will...discriminate...[so] I changed it to the short form.”

Trevor gave another example of discrimination through racial profiling in law enforcement: “If I were to get pulled over...because I’m Black and I suspiciously was up to something, when in reality I was on my way home...as long as I am aware that I’m not the only one going through it, it’s okay but it’s not okay.” While this is not a pleasant experience, it was bittersweet for Trevor to know that he can relate to other Black people who unfortunately are too familiar with this form of prejudice.

4.5.4 That’s a White Issue

Another common reason given by participants as to why mental health issues were not seen as significant in their families and cultures was the belief that mental health issues are a “Western” and/or “White” problem. Jasmine, who is of Caribbean descent, brought up her brother-in-law as an example of someone who sees life in Canada as a contributor to poor mental health: “...he’s Rastafarian, so he refuses to go to like doctors and stuff like that, and tells everyone...’if you go back to the islands, we’ll be more happier.’”

Fatima, whose Somali Muslim community also tends to detach themselves from the reality of being affected by mental health issues, said: “[we are] very dismissive of...going to therapy, getting medication...depression and anxiety and eating disorders...are considered a White person thing.” It does not help that depictions in the media of who is the typical service user or provider enforce these beliefs, and can lead to Black youth feeling a lower sense of belonging, which is explained by Iman: “Because [mental health is] always represented by, um, mostly like White people, I wouldn’t believe that a Black person would be involved in this...I’m not supposed to be placed here.”

4.6 Theme 4: Cultural Barriers to Talking About Mental Health

4.6.1 Introduction

Participants highlighted the barriers to talking about mental health that they have observed from family members and folks of a similar background, often stemming from the beliefs upheld about mental health rooted in their culture. Culture is analogous to a script for an actor; it consists of structures and patterns a group of people are meant to follow and learn in their way of living to operate in their environment (Kraft, 1979;1996). There are various levels of culture, with the largest and most diverse being the multinational level, such as “African” or “Caribbean” culture with each having specific national cultures (1979;1996). Across the various national cultures of the ACB participants, the most prominent barriers to mental health awareness and treatment were silence, fear of being gossiped, and religion prioritized as the solution to all problems.

4.6.2 “They’re Not Against It, They Just Don’t Talk About It”

Two participants spoke about the ways their family members avoided talking about mental health, beginning with Ami: “When we’re feeling down...we don’t really talk about it...and if my dad notices...he just tells us to forget about it.” In Helen’s life, her family does not necessarily dismiss mental health, but rather places more importance on physical health: “[When we] talk about cases where students deal with rape...mental health does play a part...[but my] parents [give more consideration to] the physical part of the situation.” The narrow parameters of what is discussed regarding health can be for different reasons, such as the lack of comfort due to stigma attached to an illness, or only recognizing illnesses that present visible symptoms. However, physical and mental health are inextricably linked; in the example raised by Helen, minimizing the mental effects of a traumatic event can further hinder a person’s ability to move forward or let physical issues linger on, thus leaving the person untreated.

Olivia expressed her frustrations regarding why there is a lack of dialogue: “From some of the Nigerians that I’ve met...people my parents’ age...fob’s (fresh off the boat) ...[they] need to understand that it’s not that just because they come from Africa and things like this don’t happen there.” Similar to Olivia, Folade expressed the importance of new immigrants opening up to mental health discussion to prevent carrying on the cultural taboo: “As um, more, um, new Canadians come into the country...they also need to be included in the conversation. As we evolve, we need to evolve the conversation as well.”

Many ACB youth in the diaspora have parents who are immigrants; Oyin, who immigrated to Canada with her family, spoke about the guilt she feels experiencing

hardships when she thinks of her own privilege living in the West: “Not everybody has the opportunities that I have...I’m like ‘suck it up, there’s somebody else that has it worse than you where you’re from...’...being able to go to university...I shouldn’t feel sad.” Lulu pointed out that unlike other Africans, the silence within her family fortunately does not stem from having a negative view towards mental health: “My mom’s never told me ‘go see a therapist or a psychologist’...there’s this stereotype in Africa that people who go to the therapist are crazy, yeah, but [my parents are] not against it, they just don’t talk about it.”

Yemi, who like Lulu was also from a Nigerian family, talked about the gradual change in the perspective about mental illness she has seen within modern Yoruba culture: “In the past...they would think, like, ‘ah, this one, this is mad’...in the present day, people are more aware of what mental health is...that it’s okay to admit you need help.” Although there may be a cultural shift in overtly negative opinions on mental health, the silence that persists around mental illness still speaks to ongoing judgment and limitations on admitting and seeking help. The fear of being seen as “crazy” still stigmatizes and prevents conversations about mental health for many Black youth, often leaving them to either self-medicate, seek help by themselves, or delay the process of finding care (Anucha et al., 2017; Ferrari et al., 2015; Lovell & Shahsiah, 2006; McMurty & Curling, 2008).

4.6.3 Fear of Community Judgment

Another cultural barrier raised by participants preventing their family members to seek help is the idea that mental health struggles should be kept private due to fear of their issues spreading within their cultural community: “In [my] family, my sister like really

supports [reaching out]...other people are kind of like ‘...it’s family business, if you have a problem talk to us.’” (Jasmine). Fears of being seen as different from your own community were pointed out by Yemi as a factor in preventing her family from being open to one another about their problems: “[Nigerian] parents are so concerned about what other people think about them...to conform [with] other people.” Simone also pointed out the fear of being a topic of gossip that is present within her cultural community, hindering them from sharing their issues to one another: “If you have a problem, keep it to yourself...they’d rather go to a White [doctor]...because Ghanaians talk a lot...a White person will keep your business private.”

Their fears of being judged are confirmed through experience; Simone provided an example of the judgmental things she has heard said about people in her community struggling with their mental health: “There was someone that my dad worked with [who] was also Ghanaian and [when] he committed suicide...everyone was like...that was just a stupid way to die.” This quote is significant in not only revealing that the co-worker may not have received community support for his issues when he was alive, but in highlighting why this perspective can limit others within that community from vocalizing what they may be struggling with as well.

4.6.4 Religious Beliefs, Shame, and Solutions Toward Mental Health Issues

Although religion was an effective coping method through challenging times for several participants, it was also a harmful source of judgment in the families and communities of many. Simone shared: “There’s a lot of Ghanaians that are like, Christian, and it’s like, [suicide] is against like the whole biblical thing...you’re not going to go to heaven.”

Fatima unpacked the dangers of simplifying mental health issues in her Somali community as something that only requires faith to be rehabilitated: “People often say ‘well you just need God in your life and you’ll be cured’...it’s neurological, it could be environmental, hormonal...God can do so much but you also have an effect on your life and how you want to live it.”

It was also common within families and communities to use religion - particularly the encouragement of prayer - to dismiss mental health concerns raised by participants, like Mary: “I told my mom like I had depression...[she] was like...‘you can work on it, you can pray about it, it’s not a big deal, you can overcome it.’” While prayer and belief in God can be a powerful coping method for some, this mentality can hinder being open to other options for treatment if it has been normalized within a culture, which Folade’s mother understands: “[If] someone is depressed...‘You’ll be fine. By the grace of God, all is well.’...my mom always says, ‘you can’t give what you don’t have’...if you don’t have that [mental health] knowledge...then you can’t give it to your kids.”

Along with the idea of not following religious practices, Folade often heard of mental health issues being blamed on punishments through the use of dark arts in Nigeria:

“My mom’s a very religious person...‘let’s pray about it. Don’t prophecy there’s power in the tongue.’...I’d be like ‘mommy I’m sick’, she’d be like ‘you’re not sick, your enemy is sick...there’s a lot of...deflecting, of ‘it’s not on you, it’s something else unexplainable.’”

Fortunately for Helen, she has seen progress in mental health dialogue in the church she attends: “I um, take care of Bible study [at my church]...we’ve been pushing the idea of

like, mindfulness, and that does really apply to mental health.” It remains to be seen, given the deeply entrenched reliance on spiritual and religious practices which have demonstrated benefits and hindrances for many within ACB communities.

4.7 Conclusion

This chapter presented a description of the worldviews, gendered mental health experiences, racial experiences, and cultural barriers to discussing mental health in the lives of the fifteen participants in this study. Providing their nuanced and personalized insight into their experiences enforces the idea that mental health should be viewed and treated with a holistic, oppression-focused approach in order to address the needs of the person – particularly marginalized populations -, instead of just the illness. Several prominent themes emerged from the participants’ answers regarding the roles of gender and race in relation to their mental health, such as the complex and interwoven forms of barriers they face personally and within their communities, the stereotypes that arise in their daily interactions, and pressures to perform what is socially acceptable of a young ACB man or woman.

While religion was commonly referred to as an alternative to mental health treatment, and to dismiss the issues participants attempted to bring up to family members, it was often a coping strategy and source of strength in their darkest times. It was also important to note the feelings of guilt shared by participants who were children of immigrants or newcomers themselves contributing to their personal shame and preventing them from reaching out for support. This chapter sheds light on the unique lived experiences of ACB youth in a small-medium sized city to provide context for the following chapter which

takes a more in-depth look at the challenges presented to these youth regarding place and existing mental health services.

Chapter 5

5 Findings: Mental Health Services, Help Seeking Behaviours, Systemic Barriers to Services & Place

5.1 Introduction

This chapter explores the study participants' perspectives of mental health services, help-seeking behaviours, systemic barriers to services, and how place shapes their mental health experiences. The young ACB people express what they believe is missing and needs to be improved before their voices are heard within the realm of mental health service provision and making that step of getting meaningful help. With respect to the theme of help-seeking behaviours, participants shared their reasons for not reaching out to mental health services, and how they coped with challenges on their own or with the help of their community. They also raised critical points about the minimal effort in service promotion they have witnessed, especially on campus. The theme of systemic barriers to services shed light on cultural differences and ageism. With respect to the role of place in shaping their mental health experiences, participants identified several factors that differentiate small-medium sized cities from greater metropolitan areas such as size, safety, and the mentality of residents originally from London.

5.2 Theme 1: Mental Health Services

5.2.1 Introduction

Mental health services are meant to provide various supports to individuals and/or groups of people experiencing mental health issues. Some of these include, inpatient hospitalization, group therapy, one-on-one counselling, and psychiatric medication. Canada's healthcare system is largely funded by the public, however, the majority of

mental health outpatient services are considered private and require out-of-pocket funding in order to be accessed (Grant, 2017; Martin et al., 2018). For marginalized populations who experience exclusion or discrimination when accessing health care, especially mental health services, obtaining the services they need is very difficult. In many instances, they do not or are unable to access these services, which is a painful reminder of the health disparities generated by a system which is not so “universal”. When talking about mental health services, the issues of access and service promotion, particularly critiques of current approaches, were raised most often.

5.2.2 Service Access

Some participants were in close proximity to mental health resources as a result of being a student at Western University, which houses an array of on-campus services including Student Health Services, the Peer Support Centre, and Psychological Services. At Student Health Services located in the University Community Centre (UCC) at Western University, a team of psychotherapists, psychiatrists, and social workers provide counselling for mental health and addictions issues. The Peer Support Centre, also located in the UCC, offers a confidential and judgment free space for students to receive support from their peers. Western’s Psychological Services, which are located in the Student Services Building in an open space, provide safe and confidential methods of help for the concerns of students, such as single sessions, drop-ins for international students, and group lecture programs.

In terms of off-campus services, some participants were aware of mobile service for people who are experiencing a crisis or require information about mental health supports. As Fatima said: “I think there’s a couple like Kids Help Phone...my sister goes to a high

school in London so they definitely do talk about a lot of resources that they can have access to.” Another participant, Marlon, accessed off-campus mental health services when he felt overwhelmed after using cannabis: “I would say like, Victoria hospital, is it like Section A?... one time I went there...you know when you first like, consume like, weed...wondering what happened to you.”

Jasmine also had knowledge about and experience with off-campus mental health services specifically the Canadian Mental Health Association (CMHA) and Youth Opportunities Unlimited (YOU). Her experiences were unique among my sample because she was homeless at the time of our interview, the only participant to be in this difficult situation. She shared her insights about trying to find supportive housing, which often involves long waitlists and feeling like she has to “take what she can get.” As she said: “With CMHA [in London], there’s like transitional case management, and you do that for 6 months...I’m homeless, so um, I’m like put on a lot of wait lists for housing...I have to take everything like, anything that I can get.” Trevor pointed out the benefits of seeking advice and making sense of their challenges with others. For him it was about, “Seeing it through another perspective and getting another answer can help...the more answers, the more I understand, the more better I feel, and the better I become.”

5.2.3 Mental Health Service Promotion

Participants had several critiques about the way mental health services are promoted on and off the campus of Western University. Ami expressed disappointment about the trend that Western adopts of delivering mass emails about certain mental health information, saying: “The only time [we hear about services] is when something bad happens...one of the [Western] students committed suicide and that’s when we really heard...’oh you can

come talk to us here.” In a similar vein, Helen highlighted the limited reach of other dominant approaches to mental health promotion on campus: “Advertisements are put out...through my health sci classes or through campus, but...I don’t feel like it’s being reached out to the youth as much as it should be.” Oyin drew attention to the inappropriate ‘fit’ between dominant mental health ideologies and over-information, which can make navigating the available resources feel overwhelming:

“[Mental health] still seems like...a hippie movement...not really accepted yet...in the university space, sometimes it can seem like we’re saturated with like, oh, deal with your emotions and exercise...but...[we] don’t really know how to like, access [services].”

Folade provided suggestions for ways to improve the promotion of campus services, drawing attention to the role of mental health professionals as well as faculty members:

“Increase in social media [promotion] and like in forms we know youth are going to use will help them...or if professors spend 10 minutes before class talking about it.”

Participants’ suggestions also included the power of social media in service promotion and awareness, as Yemi said: “Social media’s probably your best tool...you never know when someone’s actually going through something...if they see it...they can make the conscious decision to go.” Trevor drew attention to the lack of effective social media applications related to mental health: “[There are] very few ads I’ll actually see of helping hotlines, and services to help people who are in a bad situation...if there is a chance to promote more, I think they should take that chance.”

5.3 Theme 2: Help-Seeking Behaviours

5.3.1 Introduction

In the context of health, help-seeking originates from “illness behaviour” in medical sociology, which is a study of the ways people make sense of their symptoms, communication of their symptoms to health care providers or a lack thereof, or measures of prevention or treatment (Mechanic, 1982; Rickwood & Thomas, 2012). The participants engaged in several kinds of help-seeking behaviours. Their insights and practices in this regard were drawn from the positive and negative experiences related to the receipt of mental health supports, along with their ideas about why they avoided help in some situations and the coping strategies they adopted to help deal with mental health issues. Olivia explained the role that a teacher played in helping her take the steps to receiving help: “My teacher said that there are things offered if you ever want to talk to anyone...and I just decided I was going to go one day...and I really enjoyed it.” When asked how she knew that she needed to reach out for help, Jasmine stated: “Just having the same sadness and anger and not feeling like things are moving along...people not understanding me or taking me seriously.”

The primary reasons study participants raised when discussing why they have not sought services is a fear of being misunderstood, not knowing where to go, or believing they can overcome their struggles independently. Iman mentioned her trepidation about speaking about their sensitive issues with a stranger: “I felt like I couldn’t talk to anyone...I needed to talk to someone that I didn’t want to know...instead of um, feeling trapped.” Fatima brought up her fears about receiving bad news regarding her mental health without an adequate safety net: “What if I do find out something that I just wasn’t ready

to learn about myself, and then I won't have the resources to go with the next steps, because my family isn't super supportive." Helen was another participant who was unsure about where or maybe also how to access supportive services following a traumatic shooting incident. Here she talks about wishing she had known more information in this regard: "We were witnesses of a shooting...my emotions weren't properly put out...I should have maybe [sought] some form of service then, but I didn't know where to go."

Trevor's ability to overcome his struggles independently was through positive self-talk: "I always tell myself, you know, you'll get through this. You're gonna be okay...I'm normally the type of person to have a leveled head and be like 'it's cool.'" When discussing different aspects of help-seeking behaviours, Oyin suggested an approach that could particularly work well with ACB youth, perhaps especially those who are children of immigrants: "Peer mentorship [from ACB people] in Canada longer...they understand like, mental health and they're also African...they can understand why my parents say the things that they say, because they once said or believed those things."

5.3.2 Mental Health Coping Strategies

In the context of mental health and illness, coping can be understood as "constantly changing cognitive and behavioral efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person" (Lazarus & Folkman, 1984, p.141). Coping strategies can include things like meditating, spending time with friends, denial, or asking your doctor for a specialized referral. According to the literature on African American's experiences with mental health treatment, this diverse population tends to prefer informal coping strategies, such as handling their

mental health themselves by self-medicating or continuing to persevere despite their issues, being social within their community, or going to church over more professional sources of support (Conner et al., 2010).

The young men and women in this study discussed relying on informal- often individual- coping strategies, such as physical activity, journaling, and watching TV to cope with their issues. For Jasmine, self-care means: “Taking a bath...having time to myself...colouring, going to the gym, doing healthy things.” Ami shared that when she is feeling low, she distracts herself by watching a movie or going to sleep. In addition to self-talk, Trevor’s coping strategies included dancing, basketball, and making music. In light of the absence of anyone else to talk to, Fatima engaged in self-care to cope with her trying week: “Last week was a very heavy week for me, so I did a lot of like, self-reflection...I try to talk to somebody...if people in my life are busy...I often times just go through it with myself.”

Folade spoke about how cathartic it is when she lets herself process her emotional challenges physically, especially after bottling up her feelings: “I have a very bad habit of bottling it in...[but] I end up crying and then, in the midst of crying there’s... kind of release [of] a little bit of the stress.” Marlon shared a uniquely youth-oriented approach to managing his mental health issues: YouTube! As he said: “If I’m going through, like...depression or something...I go on YouTube, I just type in what is depression, how to get rid of depression and stuff.”

Several participants, including Grace, stated that practicing their faith was fundamental to finding strength in adversity, whether it be through prayer, attending church services or

listening to gospel music: “This weekend...I [missed] home...so I just went to church...spoke to my friends, and that kind of like brought my spirits up.” Oyin found humor in her spiritual outlook during her dark times: “Gospel music...gets me out of feeling the way I feel, even though sometimes I’m like, oh, God, like why *laughs* why am I feeling all this?...it gets worse, but then, it’s okay.” Trevor talked about finding comfort in venting to a higher power or coping through releasing energy into various activities or good deeds: “Sometimes I’ll take the time out of my day to just, you know, talk to God...instead of just suppressing it...dancing or playing basketball or making music, or helping someone else.”

5.4 Theme 3: Systemic Barriers to Services – Cultural Differences and Ageism

5.4.1 Introduction

The most common systemic barriers participants identified as compromising their access to mental health services were cultural differences and ageism. These issues reflect the interplay between individual, social, and systemic barriers to mental health care among this population. While systemic barriers within the mental healthcare system affect Canadians of all races, the challenges faced specifically by Black populations are particularly alarming, and reveal the further neglect in services for marginalized communities (Fante-Coleman & Jackson-Best, 2020). These include Black-Caribbean patients waiting twice as long for care, with an average of 16 months in comparison to 7 months among their White counterparts, only 35% of this population having access to a family physician in contrast to 62% of white patients, and a lack of service availability

for low-income communities (Anderson et al., 2015; F.A.C.E.S. of Peel Collaborative, 2015).

5.4.2 Cultural Differences

Folade's observations of service and treatment promotion explain why people, especially from marginalized groups, may also expect more diverse cultural representation among service providers: "There is a lot of, it seems movement towards inclusivity of, 'we want you to come talk to us, it doesn't matter where you're from, who you are, like, come talk to us.'" The lack of cultural diversity among service providers was an issue that discouraged Olivia from talking to a professional: "I was 1 of 5 Black students in my high school...it's so hard to find like, resources...literally everyone is either White or Filipino." From the perspectives of the participants, including Fatima, this lack of representation translates into feeling like her experience will not receive empathy and validation:

"I have not reached out to anybody simply because I have not found a place that could talk to me in a way that I would understand, in a way that I would feel respected and listened to...a lot of the practitioners in London are White women, and their experience is valid obviously, but not nearly the same as mine or other Black youth in London, so I feel like if London does revamp their mental health supports they'd be really beneficial."

Helen shared an experience that her friend had when trying to access mental health services which was directly related to cultural differences between her friend and the provider on staff: "I had a friend...she's Middle Eastern, and he's, not, he's White...it

gradually got to the point where they *COULD* understand each other, but...it took *TIME*.” Oyin, also in reference to a friend, explains the downside of having a counsellor from a different culture, namely the need to spend a lot of time explaining her background than getting to the roots of her issues: “The person that [my friend is] seeing...asks her like awkward questions...[worsening] her mental health...[the sessions are] like a history lesson...you have to correct them when they say wrong things.”

Just as the participants did not think their cultural identities were adequately acknowledged, they did not see any professionals they felt they could identify with: “I’m not saying I don’t feel comfortable around white people, but sometimes you want to be around someone..like you *laughs*” (Ami). This issue of a lack of diversity among providers has also caused Fatima to lose interest in making an effort to seek counselling: “Um, a lot of the practitioners in London are White women, and their experience is valid obviously, but not nearly the same as mine or other Black youth...there’s only so much you can learn from a textbook.”

5.4.3 Ageism Within the Provision Landscape

Barriers based on age were raised by a few participants, which included being excluded from formal services because they were not of age as well as feeling like their youth worked against them in terms of being taken seriously. As Fatima shared: “When I was younger...I did feel like I can’t really go talk to anybody...they’d have to refer back to my parents...once I turned 18 I felt a little more like independent...I’d be treated as an adult and not as a kid.” When Iman said “I wanted to reach out but I’m thinking I should wait until I’m 18 so I don’t get like, parents involved or anything”, it reflected the difficulty participants may face when seeking autonomy as young people who are not

children but are not adults either. Olivia mentioned the relationship between transportation and age as a factor that impacted her attempt to seek help: “Before I was 16 I wasn’t able to drive, so I couldn’t go anywhere I wanted to go...[when] I was able to drive, it was easier to access different mental resources.”

5.5 Theme 4: Place

5.5.1 Introduction

The place where someone lives influences their well-being, including that which is related to mental health. For example, epidemiological research has found benefits in the mental health of individuals residing in greener urban spaces compared to the least green areas, and even show significant improvement in the first few years after moving to a green space (Alcock et al., 2013; de Vries et al., 2003; van den Berg et al., 2010). A more recent study conducted by Wood et al. (2017) showed the importance of parks in close proximity to neighbourhoods for positive mental health effects. The key themes identified in this study regarding the impact of place on participants’ mental health experiences included perceptions of the city’s people and environment, the types of and availability to services, international students’ perceptions of mental health services abroad, living in proximity to campus services as a post-secondary student, and connections with other ACB people in the community.

5.5.2 London: Perceptions of The City and Its Population

Trevor who, prior to moving to London with his family, lived in the Greater Toronto Area (GTA) for the majority of his life. He shared what he’s observed about the

differences between Torontonians and Londoners in terms of an authentic sense of identity, as well as views about what is and is not socially acceptable:

“There’s a lot of people who portray to be who they aren’t in London, um, versus people who genuinely live and go through that struggle and hustle in Toronto...if you just acted like it and you weren’t really who you are, that could get you in trouble...there’s a lot of...freedom here...in Toronto, if you do something that gets out of hand, there’s going to be someone to put you in your place.”

Trevor also expressed a link he believed to connect the behaviours of London youth to what may be passed down generationally within families in the small city: “You think about the way their parents are teaching them is the way they were raised as well...it’s just a cycle...in Toronto...[you would] be told ‘yo what are you doing? That’s weird’ or ‘that’s rude’...in London, I don’t see that.”

Additional benefits of space/place on the wellbeing of individuals include cleanliness and a feeling of safety, which Trevor pointed out about London in contrast to his hometown: “There’s a lot of things *I DON’T* miss...it’s a lot more clean...You turn on the news, CP24 in Toronto...someone either got kidnapped, or murdered, or there’s a case.”

London’s safety was also mentioned by Fatima when asked if she liked living in London, saying: “I like it a lot, um, like I did all my schooling here, um, so, like I’m really used to [London]...it is a pretty safe, nice city.”

5.5.3 Availability, Accessibility, and Types of Services

When asked if the size or make-up of a city impacts the kinds of mental health services available, the participants had mixed opinions. For some, the limitations they perceived

for ACB youth in a smaller city such as London had to do with cultural homogeneity: “When you have a small population...predominantly White...resources will also be kind of small...if the services are limited, the first come would be the...White, um, male, you know, middle class.” (Folade). Fatima also considered the differences in access for people of colour to enter mental health professions in a city where they are more visible: “[Toronto has] way more resources...and there’s like so many more opportunities for practitioners of colour with different life experiences to go into that field because the population is much more diverse.”

Jasmine, a young woman with extensive service experience in both London and Toronto pointed out the issue of wait times, which she believed were more pronounced in a smaller city: “In Toronto, I had more connections to places, so that helped me get into like a lot of things easier...with CMHA [in London], there’s like transitional case management...5 of the 6 months that I was here, I was playing phone tag with a worker.”

Helen had a different outlook towards London and its issues to resolve in service accessibility: “[London is] not overpopulated...it is very much big in land size...it has a lot to work in terms of mental health institutes because it only comes through campus or certain facilities...[there should be] walk-in clinics [across] the city.”

This same participant had another interesting point about the relationship between city size and the proximity that immigrants have to others of the same cultural group, which can be more difficult to develop with a smaller population of a specific community:

“I see, like, a lot of Eritrean people...on an event basis...because you’re only seeing them [at events], you don’t feel close enough to tell them what you’re

dealing with...[in] Toronto...you see an Eritrean person [everywhere]...it's much more easier to [talk] and [get help] seeking services.”

ACB people face significant adjustments to their lives when they are displaced or immigrate to nations where their collectivist cultures are not the norm, which can further affect their wellbeing when they live in areas with little to no interactions with others of their background. It is important to consider how this isolation, in addition to being unfamiliar with what is available due to various barriers such as language, can prevent them from knowing where to go and potentially worsen their mental health outcomes.

Yemi had a different outlook on place, population size and service provision based on her perspectives about remote areas: “Rural communities are pretty close...do I know my neighbour in Brampton? No...[they] have a stronger sense of community...if it's a smaller city...you don't really need that many [services].” Trevor has associated London with medicalization in comparison to Toronto, where he believes there are more services and different treatment options:

“[In London] There's a lot of people professionally...[who] will quickly label you as depressed and suicidal and give you pills...I have a lot of friends who do struggle and look for help, and when they come back to me, they get prescribed with medication...in Toronto, they...not only [suggest] just medication but programs and services you could go to...then again, that's all *I've* seen.”

Although Trevor was aware of potential obstacles to finding services in London, he believed that facing multiple barriers could build a sense of determination to get help: “I do feel like it's difficult to reach out [here] and because of that...I personally feel like it

will push me to keep fighting...there's gotta be one of these services that can help me, one of these programs that can help me do what I gotta do to get better.”

A few of the participants were unsure if their input on service availability and city size were more about Western, rather than the London area. Mary states: “I think it's easy...Western's pretty like – it's mostly students, so they offer a lot of services for students, so I think it's a strength.” Simone is slightly more city-specific, but still aligns the quality of services to what is provided by the university: “London...would be easier to get help or support...you know student support services...in Brampton it's mentioned, but it's like, you have to do your own research to find it, whereas here, you know it's in the school.”

Grace acknowledged the privilege of slightly better access to and awareness of mental health services when they became students at Western: “There's so many like, resources...there's like an open, like, place where you can talk about it on campus, so I think, like as Western students we're quite fortunate.” For Folade, the privilege of being a university student came in the form of seeing messages about mental health which previously were non-existent: “Prior to coming to university...I never really seen, like, um, an outward display of like, mental health services...because I'm mostly immersed in student areas and there's a lot of...suicides that have occurred...and stress that students report.”

5.5.4 International Students' Experiences in/from African Metropolitan Cities

A few youth who participated in this study were international students from different African countries. As a young woman who identifies as Black and African and was born

and raised in Canada, I was curious to understand what mental health services are like for young people in the African continent and if there is a difference living in a place where you are not the minority. Some of the participants who grew up in Canada expressed the idea that people in the continent have archaic and stigmatizing views about mental health, therefore I was interested to learn how these insights aligned (or did not) with what their peers who have recently arrived in this country expressed. Two young women in the study went to high school in Nairobi, Kenya but had different systems of support in their academic environments. Grace mentions that there was a mental health professional present in her school: “[Counselling] wasn’t as big as it is here, they would just be like, ‘oh yeah there’s a therapist [and nurse] if you need anything’...some people still think it’s just like, oh spiritual, you don’t need to worry.” Mary’s school experience in Nairobi was not really any better, however, she provided a positive update on the conditions of student mental health in her hometown:

“My [high] school [in Nairobi]...didn’t have counsellors or somebody you could speak to...[mental health is] becoming like a big deal [in Kenya], and the government is trying to actually implement [solutions] because many [young] people are committing suicide...it’s becoming serious.”

Both young women had similar school experiences in Kenya, but what makes Grace unique is the difference in her family’s perspective on mental health. She explains the impact of having an older sibling who attended a Canadian university and how this helped raised awareness of student mental health issues within her familial setting prior to her entrance at Western:

“My sister went to the University of Waterloo and there were many, like, suicides there...before...my mom would just say ‘oh let’s pray’, but then now, it’s like, ‘oh if you need to actually see someone, go see someone, you need to exercise, talk to someone’ now she’s taking it a bit more seriously, because she knows there’s more to it.”

5.5.5 Community Connections

Participants stated that they felt some level of connection to their socio-cultural and youth communities in London. Folade, like some of the participants, emphasized the cultural clubs and associations they are members of with other young ACB students: “The African Students Association, as well as the Black Students Association, [are] the primary source of interaction with people from my culture.” Grace’s means of connecting with other ACB students also shows how international students are able to build their own sense of community: “Through [African Students Association] and stuff like that, that really helps...some of [my friends] are international as well so that kind of are my connections.”

Oyin spoke about the struggle of balancing these cultural connections with her White peers and with friends who are from the diaspora: “Sometimes...I want to fit in with like, my White friends, because like, there’s a lot of White people here.” Marlon, who was a recent immigrant felt connected to his community through a local organization dedicated to supporting newcomers: “I mainly, like, go there to like, catch up and stuff...go camping...see what’s in the neighbourhood, in the city that can offer us good benefits.”

In contrast, two participants spoke about the lack of connections with other ACB people due to London's demographics, beginning with Fatima and her own cultural community:

“There isn't as many [Somalis] as there is in Toronto...I feel like I'm [in Somalia] whenever I go to Toronto even though I'm from London.” Additionally, Trevor

mentioned the lack of ACB peers in his life being a result of geographic location:

“There's not really a lot of Black people in the city, and um, *laughs* uh, those who are, always live on the ends, if it's East end, or Kipps lane, or Westmount, uh, so, I kind of majority of the time keep to myself.”

Although some participants who grew up in London did not feel a sense of home in the city they call home, Jasmine's experience shows bigger cities considered more diverse do not always translate to stronger cultural ties: “I grew up in midtown Toronto which is mainly a White area and had Filipino like, uh, friends growing up, so I grew up knowing everyone else's culture, now I'm learning mine.” It is reassuring to know that this did not prevent her from building a connection to her culture, especially after moving to a smaller and whiter area. This can also have a positive effect on her mental wellbeing in the long run.

5.6 Conclusion

This chapter explores the insights and experiences of the ACB youth in this study related to mental health services, help seeking behaviours, systemic barriers to services, and place. Their perspectives illuminate their perceptions of the world and how their cultural identities position them and shape their experiences in different spaces. Most of the participants did not have firsthand knowledge of mental health services because they have not yet reached out for help, stemming from the factors discussed above: therapists

who do not understand their experience because they have not lived it and locating their mental health strain as an individual issue versus being linked with the structural violence they are faced with on a daily basis.

The participants spoke in depth about their lives and perspectives on how mental health is approached within their families and cultural communities. The systemic barriers of exclusionary provision, age, and wait times involved challenges such as a lack of diversity in service spaces, the uncomfortable power dynamics between themselves and a much older health professional, and the assumption that these professionals are in their position because they are mentally healthy. The participants who were Western students and sought out help accessed the psychological services on campus, and did not feel the need to search what was offered in the London area. Some of their reasons included not wanting to leave the Western bubble, and viewing London as a city they are only here for to go to school and go back to their hometowns when they graduate.

The participants with little experience accessing services expressed that they do not always want to be instructed on what to do on their own to relieve stress and anxiety levels when they are at their peak, such as mindful breathing or journaling, and would prefer guidance from a peer supporter or professional who shows they are invested in the betterment of their mental health. The findings in this chapter reveal the lived experiences of some of the city's most marginalized youth related to mental health. This is important to better understand young people who are left in the cracks because of systems of power, and not because of who they are. As the data demonstrate, it is not the race, gender, culture, and age of these youth that are barriers to optimal mental health, but rather racist,

sexist, ageist, and classist forms of oppression which are the obstacles to an improved wellbeing.

Chapter 6

6 Discussion

6.1 Introduction

The primary focus of this chapter is to analyze and situate the project findings in relationship to the existing research on mental health among ACB youth, in particular African diaspora youth who are often excluded from the literature. Study limitations, recommendations, and potential directions for future research related to this topic are also discussed. The objective of this qualitative study was to explore the mental health experiences of youth who identify as African, Caribbean, and/or Black in London, Ontario, and more specifically, how factors such as race, place, culture, gender, and age have shaped and informed their experiences. Using a critically oriented framework, semi-structured interviews were conducted with fifteen ACB youth (thirteen women and two men), which were designed to answer the following research questions:

1. What is the existing socio-cultural discourse about mental health among ACB youth?
2. Do gender, race, culture, and place shape the mental health experiences of ACB youth?
3. What do culturally competent or safe mental health services look like for ACB youth?

6.2 Overview of Study Findings and Current Literature

The results of this study revealed that the youth themselves did not have extensive personal histories of accessing professional services or local resources related to mental health. More often than not, they relied on their own strength to cope through challenging periods in their life or on the trust in their religious faith. None of them were diagnosed with a mental disorder or prescribed medication, yet they had extensive insights about the issues under investigation based on their observations of family, peers, and socio-cultural discourse more broadly.

The descriptions of mental health provided by the participants reflect the important fact that the ACB community is not culturally monolithic. This assumption might be made of this population by certain professionals, which is harmful if it leads to preconceived notions or providing a ‘one size fits all’ approach to treatment for every ACB service user. Because this was displayed through their vast knowledge, different outlooks, various levels of self-awareness and critical thought of how they, along with their families and communities approach it. In addition, their answers often revealed how various aspects of their identity (i.e., gender, cultural heritage) were intertwined and mediated their understandings of mental health, which highlights the intersectional nature of their lived experiences and the ways in which they articulated them.

There was a significant gender gap in the study, which was overwhelmingly dominated by women participants. This trend is also reflected in the literature; men are often socialized to suppress their own emotions and rely on their own strength in comparison to women, which in turn can lead to not seeking help for their concerns (Galdas et al., 2005; Pattyn et al., 2015). Due to gender roles and the need to perform strength, seeking

professional help for mental health issues can be stigmatizing for men, as they may feel like a failure by appearing weak (Good et al., 2005; Jorm & Griffiths, 2008).

In their understandings of mental health as something holistic, the participants explained that it is not independent from other components of their health, and even described it as the foundation that drives their overall wellbeing and ability to go about their day to day life. To some, this meant living a meaningful life with or without stress, being happy, and practicing mindfulness. This was similar to the findings of Brooks & Moore's (2016) qualitative investigation of the perceptions of health and wellness among African American young adults. In their findings, participants included physical, mental, and spiritual health in their ideas of what it meant to be healthy, such as happiness, no stress, and practicing yoga or meditation (Brooks & Moore, 2016). Also both studies focused on the perceptions of young adults solely within different Black populations. This is of particular importance, as it fills a gap in mental health research where studies tend to compare the outcomes of participants across different racial categories, or have a small fraction of racialized individuals in comparison to their white counterparts.

Arboleda-Flórez's (2003) work stated that mental illness is most often witnessed by society through film or media representation, and tends to perpetuate negative stereotypes of individuals with these illnesses such as being erratic or a risk to the safety of others. One participant associated the words "mental health" with Kanye West - an artist who gained more media attention centered on his behaviour that was often associated to his mental illness. The negative attention he received could explain how he would be the main point of reference, albeit harmful, for someone like her parents who may not personally know anyone dealing with mental health challenges. This has also been

echoed in earlier literature on depictions of mentally ill people in the media primarily being dangerous, unpredictable, or incompetent (Diefenbach, 1997; Signorielli, 1989; Stout & Villegas, 2000; Wahl, 1997).

A few of the participants shared their insight on what constitutes “normal” with regards to mental health, with one stating that it does not exist regardless of what may be accepted societally, and another who had a destigmatized approach to treatment which normalized therapy. Varying thoughts on normality in relation to mental health also arose from young people in Armstrong et al. (2000) research, such as “normal” not being real given the flawed nature of humans, and normality not having an effect on one’s ability to have emotions.

In a set of criteria described by Cutrona (2002) about assessing social supports, three of the six identified were receiving affirmation of your value to strengthen your confidence, guaranteeing that people can trust they will be supported, and getting help from someone in a position of power or authority, like a counselor. These were also identified by my study participants when discussing what support looked like to them, which included agency workers, friends and loved ones they can rely on for help.

A considerable portion of the data were generated by participants’ responses to the second research question: Do gender, race, culture, and place shape the mental health of ACB youth? This confirms the importance of gender, race, culture, and place in shaping the mental health of ACB youth in London. Some of the beliefs held by participants about the gendered differences in emotional and mental health can be connected to cultural and gendered norms (Spence & Helmreich, 1978). These norms are what impact

a man's ability to seek help and explain that delays in comparison to women are social, and not biological (Addis & Mahalik, 2003; Fish et al., 2015; Galdas et al., 2005; Powell et al., 2016).

Masculinity norms can also influence men to avert help, cope on their own, and be stoic during times of hardship (Powell et al., 2016). This was confirmed by women who participated in the study, and by one of the male participants who said he has not accessed any mental health services because "I always tell myself, you know, you'll get through this. You're gonna be okay...I'm normally the type of person to have a leveled head and be like 'it's cool.'"

In a phenomenological study conducted by Thomas et al. (2011) about gendered racial identity, young African American young women were asked what it means to be a woman, and their responses were predominantly centered on the problematic outcomes of sexist and racist stereotypes. These issues were also discussed among the young women in this study, who referred to various forms of dismissal they have faced in professional settings, their families, and their communities because of gendered and racist stereotypes (i.e. Sapphire, etc.). The ways in which their gendered experiences are intertwined with race reflects the intersectionality of mental health experiences, and the research that might best align with their needs and those of other marginalized youth.

Discrimination is defined as ". . . actions carried out by members of dominant groups, or their representatives, that have a differential and harmful impact on members of subordinate groups" (Feagin & Feagin, 1999, p.21). Both the young men and women in this study shared insights the various forms of discrimination that has impacted their

lives, as well as the preferential treatment they have witnessed given to others due to race. From watching their White female counterparts receive more support and tenderness from their peers when they dealt with heartbreak, to facing different levels of prejudice in the workplace, the young women recalled several examples of discrimination in their lives. One young woman stated that her fear of potential discrimination while applying for jobs led her to shorten her name on her resume – a barrier that exists for many people with non-Western names before they even step foot into the workplace. The issue of name changing to fit in appears in other research with young women of colour, including that which highlights the role of daily and systemic racial violence in their lives (Jiwani et al., 2006).

In *Girlhood: Redefining the limits*, Jiwani et al. (2006) state “balancing and negotiating competing demands is a hallmark of contemporary girlhood” (p. xiii). This was borne out in my study as well, especially when the women participants discussed balancing the gendered role expectations of them as women to be passive, submissive, and nurturing of others (Buckley & Carter, 2005), with their own ideas about who they are as women. These normative expectations were most expressed and felt with the most severity within the context of their families and cultures. Two participants who were Nigerian, and ethnically Yoruba, spoke about the pressures they face as daughters and of feeling like they were the socio-moral representatives of the family who have been raised to aspire to be the perfect wife, mother, and caretaker. This aligns with the notion of cultural purity, as they bear the weight of reproducing newer generations of their culture and must not steer away from what is expected of them and considered “good” (Jiwani et al., 2006).

When participants talked about the influence of gender, norms and roles continued to permeate into the different types of stigma the participants experienced regarding what they believed they were or were not allowed to perform in front of others. One of the male participants unpacked how he is cautious of his behaviour due to the possibility of being seen as weak or inferior if he acts outside of gendered expectations. This self-surveillance is described by Foucault as a gaze powerful enough to be internalized by an individual to oversee and inspect themselves (Jiwani et al., 2006; Foucault, 1980). The internalization in the participant's actions can be viewed as an effort to appease the socio-cultural, medical, political, and racial forces that exert the pressure on them to conform in the first place.

Fear of being judged and ostracized by others in their community was also raised by participants as a reason to keep their mental health issues or concerns hidden from family members, especially when there are powerful cultural beliefs about the importance of presenting idealized, proud images of the familial unit. These findings are consistent with reports of the value of privacy among African-American families and the attendant ideas about mental illness being viewed as unacceptable by family and friends (Boyd-Franklin, 1987; Cooper-Patrick et al., 1999; Lindsey et al., 2006). Adolescents in these studies are often cited as worrying about being rejected if their peers know they use mental health services. Research has also revealed a greater influence of peers in seeking help among Caucasian youth than African-American youth (Munsch & Wampler, 1993; Timlin-Scalera et al., 2003). Aside from one of the young women who shared that her white female friend influenced her decision to speak to her school counsellor, it is difficult to determine if this finding is similar to my participants in this study.

One of the Nigerian young women who pointed out the tendency for the religious deflection - by family and community members of physical or mental health issues, an issue that is presented in divergent ways in the literature about the influence of spiritualism on mental health stigma. Some studies show that it absolves someone of their illness, while others demonstrate that individuals who are religious may blame the person's illness on being punished for their sins or poor morals (Abdullah & Brown, 2011; Griffith & Baker, 1993; Mishra et al., 2009). From the accounts of the participants, the deflection they witnessed leaned more towards the latter. Fatima, for example, stated: "in my [Muslim] community, people often say 'well you just need God in your life and you'll be cured' ...it's a little more complicated than that...God can do so much but you also have an effect on your life." When asked about her family's views on mental health issues, Iman said: "they just use an excuse and say it's caused by not being as close to God." Given this, a dominant trend in the cultural settings of several participants who have been deemed to be being sinful or punished by God is encouraging them to engage in more spiritual practices, which in turn would prevent them from seeking formal mental health services.

The participants sharing their religious coping strategies of prayer, listening to gospel music, bible study, and attending congregation services with their church friends contributed to the emergence in literature on the religious participation of ACB youth, specifically adolescents. This was also reflected in another study which found twenty five percent of African American youth participants who coped through prayer and their own relationships with God (Samuel, 2015). The participants in this study demonstrated their understanding of what it means to live in a raced and gendered world and insightful about

the different forms of discrimination they have faced as a result of patriarchy and anti-Black racism. Thomas et al. (2011) also found that African American high school and college aged girls and women had a strong sense of their identity.

6.3 Limitations

This study explored the mental health experiences of young people who identify as African, Caribbean, and/or Black in London, Ontario and how race, gender, culture, place, and age has influenced their experiences. The participants included 13 young women and 2 young men, and thus was not sufficient in terms of gender distribution to generate a fulsome comparative gendered analysis. Given the disparity of men in seeking help and readiness to talk about mental health, these experiences would have been beneficial to investigate among a larger group of young ACB men. Future studies should consider conducting a similar qualitative study which strictly focuses on this demographic.

Additionally, there was no representation of ACB youth who identified as trans, non-binary or gender nonconforming. Information gathered from a larger spectrum of gender identity along with the experience of being Black would have allowed for more of an analysis about how these particular youth navigate the often traditional gendered expectations in their culture, especially if they do not fit their standards of masculinity or femininity.

In regards to culture, the participants were predominantly from African countries, and only three of the fifteen were of Caribbean descent, including the two men who both identified as Jamaican. Similar to the African-Canadian population, Caribbean-Canadians

originate from many countries with various cultures other than Jamaica which also deserve recognition in mental health research. Two of the fifteen participants who identified as Muslim were siblings. In addition to being little representation in comparison to the majority of the participants who identified as Christian, their lived experiences likely could have been more similar than to other Muslim ACB youth in London of a different gender or cultural background.

Some participants spoke about receiving mental health support in the form of a counsellor or care team, but the data collected and analyzed for this study was predominantly with ACB youth who did not seek or use mental health services or have an official diagnosis. As a result, the responses from the participants were mostly perceptions of what the systems of care are like for young ACB people in London, as well as from discourse within their families and communities. These included observations of shame-centered discussions after the passing of someone due to suicide, cultural beliefs of religious faith being a stronger solution than medical treatment, and broader social dialogue regarding disappointment in the healthcare system failing ACB populations. Interviews with ACB youth at Western was also a limitation, due to a lack of data from students who went to Fanshawe or other small colleges in London, or were Londoners enrolled in post-secondary schools outside of the city.

6.4 Recommendations

There are several evidence-based and promising new practices which align with this study's findings to address issues for this sub-population. When concluding the interviews, inquiries were made with each participant to determine potential recommendations as well as the best approach to support knowledge mobilization. The

most prominent recommendation from the participants about how mental health services should be adapted to align with their racial and cultural identity was for more ACB people employed in counselling, psychologist, and psychiatrist positions. Increased efforts in the delivery of culturally competent care have been suggested in the literature as a way to reduce service barriers, especially practitioner discrimination and Eurocentric forms of treatment which lack understanding of Black lives (Fante-Coleman & Jackson-Best, 2020; Shahsiah & Ying Yee, 2006).

The need to see representation in their mental health services also comes from the belief that a similar racial and gender identity between client and provider could translate into more empathetic service and a better understanding of their challenges. For non-Black mental health professionals, it would even be beneficial to practice cultural humility and refrain from passing judgment on unfamiliar beliefs as it would be perceived as a more genuine effort in supporting ACB youth. In Ontario, the Black Youth Action Plan was launched, aiming to work toward “eliminating systemic, race-based disparities by increasing opportunities for Black children, youth and families across the province” (Ontario Ministry of Children, Community and Social Services, 2020). The plan’s initiatives include culturally relevant and preventative measures, such as “Innovative Supports for Black Parents” to improve the overall wellbeing of Black families, and an “Enhanced Youth Outreach Program” for Black youth and their caregivers to be connected by clinical workers to nearby resources (2020). These initiatives could provide the specific support and prioritization needed not only by the participants, but other ACB youth in Ontario who are looking for help suited to their unique lived experiences.

In addition to cultural and gender representation, participants wanted to see issues resolved in wait lists and service access for ACB youth who are homeless, street involved, and who do not have adequate support workers in their school settings. Participants also recommended support that is unique for the newcomer experience, such as acknowledging language barriers and cultural customs, the moving process, and possible sociopolitical issues in their country of origin. To effectively improve access to care for ACB populations, anti-racist and culturally sensitive approaches should be incorporated into patient prioritization and triage screening.

Patient prioritization is “the process of ranking referrals in a certain order based on various criteria with the aim of improving fairness and equity in the delivery of care” (Déry et al., 2019, p. 1). The literature on triage assessments has shown disparities in priority for racialized patients, particularly through less urgent emergency severity index scores, longer wait times, and lower prescriptions of opioids and analgesics than their White counterparts (Epps et al., 2008; Heins et al., 2006; Okunseri et al., 2013; Saha et al., Schrader & Lewis, 2013; Todd et al., 1993; Todd et al., 2000; Vigil et al., 2015). In the context of mental health care for ACB youth, researchers suggest conducting more studies to find effective interventions, culturally adapting evidence-based interventions, and seeking the input of youth who receive this treatment (Black Health Alliance, 2015; F.A.C.E.S. of Peel Collaborative, 2015; Fante-Coleman & Jackson-Best, 2020). It would be beneficial for mental health professionals to incorporate treatment which considers the lived experiences of ACB youth in Canada. In addition to racism and systemic barriers to care, youth who are refugees living with trauma would benefit from narrative exposure therapy, cognitive behavioural therapy and eye movement desensitization (Crumlish &

O'Rourke, 2010; Gwozdziewicz & Mehl-Madrona, 2013; Murray et al., 2010; Williams & Thompson, 2011).

Although representation was a significant recommendation, some participants questioned the efficacy of cultural competence training sessions in mental health services when the professionals receiving this training have not experienced living in a Black body.

Addressing mental health disparities through a health-equity lens would go beyond cultural competence in striving for actions aligned with anti-racist praxis. In the context of health, equity is “responding differently according to different needs in order to reduce or compensate for unequal barriers...to support the attainment of equal outcomes among different population groups” (Patychuk, 2011, p. 8). In order to address the forms of systemic discrimination which drive health inequities, mental health services should incorporate strategies such as upstream advocacy to eliminate discriminatory policies, governance structures which give decision making power to racialized communities, commitment to anti-oppressive organizational changes at all levels, identifying and challenging systemic racism, and efficiently engaging minority populations (Association of Ontario Health Centres, 2006; OCASI, 2005b; Patychuk, 2011). The mental health of individuals is influenced by and interconnected with various social determinants of health; therefore, another anti-oppressive strategy would be to increase equity at the public policy level in employment, income and housing (Canadian Mental Health Association, 2002; Heart and Stroke Foundation, 2010; Ontario Chronic Diseases Prevention Alliance, 2009).

Participants mentioned how they, along with members of their communities should hold themselves accountable. There will not be a change in mental health services if cultural

stigma continues to persist and prevent future generations from exploring these professions. This change can start small by encouraging young ACB people to volunteer in mental health organizations, search for the availability of peer support programs if therapy or counselling is not accessible, listen to podcasts centered on mental health, or even create blogs and other social media pages to discuss with others. On the community level, participants also suggested culturally specific social media campaigns similar to Bell Let's Talk for ACB people to engage in critical dialogue about mental health.

Additionally, participants suggested that teachers, professors, adults and community elders could read this study to understand the experiences of youth and why certain perspectives on mental health and illness should no longer be normalized. To change the narrative, one participant specifically touched on sex education that is in the school curriculum and suggested incorporating more mental health literacy classes. In this education, it is recommended to increase awareness of the different methods of help-seeking and treatment for young ACB people who may have misinformed ideas of what therapy is. To further reduce the stigma of mental health within our communities, it would also be beneficial to see representation of ACB people across different age groups who have successfully sought out mental health support and could share their stories of seeking help.

6.5 Implications for Future Research

The implications of this study are significant to ACB youth across Canada who have wanted to read a research paper where they saw themselves in the participants speaking about mental health in a critical, honest, and vulnerable way. Each participant in this study was interviewed once, and the data collection occurred at the beginning of the

school year, when students are typically experiencing low levels of stress. A few of the participants were open to seeking some type of mental health resource after the interviews, due to the sharing of their experiences being meaningful and easier than they expected.

Future studies should continue investigating the experiences of ACB youth through qualitative approaches in different methodological processes, and in other small or rural towns where they may face greater service disparities due to assumptions that they may not be located there. Future studies on ACB youth mental health should aim to interview participants multiple times over a greater length of time to track changes in stigmatizing attitudes, confirm whether or not they followed through with their decision to seek help, if they disclosed their decision to friends and family members, and if this disclosure resulted in negative changes in their relationships. Given that the interviews were conducted early in the school year, it would be valuable to further explore the experiences of ACB students throughout both course terms. This data would further contribute to research on stigma reduction by revealing more misconceptions related to service use or acknowledgment of mental health issues. This could also be incorporated into mental health workshops geared to ACB students, associations, or communities where stigma is more prevalent, with the hope that individuals who were judged for disclosing can now receive acceptance and support from their peers and loved ones.

The majority of the young women in this study used prayer and church services as a way to cope. In contrast, only one of two male identified participants stated that they were religious. In addition to recruiting more men for a balanced analysis, future mental health research on ACB youth should explore potential differences in religious or spiritual

beliefs and practices across gender identity. This would be important to have a more accurate picture of how significant the role of religion is in the lives of ACB men, to learn of the different healthy or unhealthy ways people cope if they do not rely on religion, and why they choose their preferred coping methods. Studies could also be conducted in church settings where initiatives are being made to discuss and destigmatize mental illness and service use within their congregation, and how they go about educating one another while still prioritizing their faith.

Racism and sexism in the lives of young African American women and girls have been referred to as the “double jeopardy” status by theorists, who recommend this group make sense of their gendered racial identity in an oppressive society (Shorter-Gooden & Washington, 1996). These experiences are not one-time incidents for many ACB youth, therefore, future studies should continue the work of investigating the long term effects of racial and gender-based discrimination, both visible and invisible, on the health of this population. More importantly, future research should be centered on the experiences of ACB youth in Canada, as their stories debunk the idea of this nation as a safe haven where everybody is considered “Canadian”, nobody is othered, and thus do not experience violence because of who they are.

The findings from this study have demonstrated the significance of employing qualitative methods in health research to investigate the lived mental health experience of underrepresented ACB youth. Through the racially and culturally specific stories shared by ACB people, there is light shed on the different stigmas and obstacles faced from within and outside our communities, which policy makers, service providers, program

implementers, and evaluators must incorporate for mental health care to truly be for everyone in Canada.

6.6 Conclusion

The findings from this project illuminate the effects of various intersecting structural inequities in the lives of ACB youth, regarding mental health services, sociocultural discourse of mental health, the effects of cultural expectations throughout the lifespan on the mental health of ACB youth particularly as they relate to gender, and the overall mental health experiences of being an ACB youth in a predominantly White, small Canadian city. All of the participants expressed positive feelings about the interview experience, and thanked the interviewer for providing them with the space to express their ideas and experiences about topics that are special to them, topics they have had few, if any, previous opportunities to talk about in a supported, meaningful way.

Educational, programmatic, and policy recommendations will be provided to local and national organizations, in the hopes of informing the design of anti-racist, and anti-oppressive mental health programs which promote cultural humility.

Findings reported herein will be presented to local and national conferences, stakeholders, social media pages centered on mental health, and ACB associations in the London area. Manuscripts from this study will be produced to contribute to the dearth of peer-reviewed research and scholarship on Black youth mental health. A policy paper may also be developed from the findings in order for concrete steps toward cultural safety and service funding to be implemented, especially at the national level. Journals of interest for publications will center equity in health, mental health in Canada, racial and ethnic disparities, and the health of youth and adolescents. The goal is for the results to be

strong enough to inform mental illness symptom identification, stigma reduction, trauma informed care from the impact of structural violence on mental health, and formal and informal help-seeking in ACB communities. While there are barriers in our population that must be addressed, it is also critical that ACB people are not pathologized or viewed as a group of people living in constant suffering that requires saving. This population is not defined by the various forms of violence and oppression they have historically worked to resist and be resilient against through their pride in who they are.

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Appendix A: Recruitment Poster



PARTICIPANTS NEEDED FOR RESEARCH ABOUT MENTAL HEALTH EXPERIENCES AMONG RACIALIZED YOUTH

Would you like to take part in a study about how gender, race, culture, and place influence the mental health experiences of African, Caribbean, and Black youth in London, Ontario?

Do you meet the following criteria?:

African, Caribbean, or Black youth between the ages of 16-20 living in London who has experience with or interest in mental health issues

If you are interested in participating, you will take part in one individual semi-structured interview of around 60-90 minutes in length. In appreciation for your time, you will receive an honorarium of \$25.

Your insights are very important, and I look forward to speaking with you.

Masters Student Investigator: Lily Yosieph

Principal Investigator: Dr. Treena Orchard, PhD

Appendix B: Online Ad

PARTICIPANTS NEEDED FOR RESEARCH ABOUT MENTAL HEALTH EXPERIENCES AMONG RACIALIZED YOUTH:

Would you like to take part in a study about how gender, race, culture, and place influence the mental health experiences of African, Caribbean, and Black youth in London, Ontario?

Do you meet the following criteria?:

- African, Caribbean, or Black youth between the ages of 16-20 living in London who has experience with or interest in mental health issues

If you are interested in participating, you will take part in one individual semi-structured interview of around 60-90 minutes in length. In appreciation of your time, you will receive an honorarium of \$25.

Your insights are very important, and I look forward to speaking with you.

Masters Student Investigator: Lily Yosieph

Principal Investigator: Dr. Treena Orchard, PhD

Appendix C: Letter of Information and Consent



Letter of Information and Consent

Project Title: Exploring the Mental Health Experiences of African, Caribbean, and Black (ACB) Youth in London, Ontario

Document Title: Letter of Information and Consent – Youth Participant

Principal Investigator:

Dr. Treena Orchard, Ph.D.

Masters Student Investigator:

Lily Yosieph, MSc Candidate

1. Invitation to Participate

You are being invited to participate in this research study about race, gender, place, culture, and their influence on the mental health experiences of ACB youth in London, Ontario because you have direct and important insights in these areas as a member of the study's population of interest.

2. Why is this study being done?

ACB youth are often underrepresented within local and national mental health conversations and initiatives. This has led to negative and inaccurate ideas about mental health not being an area of concern for ACB youth who may be hesitant to seek help due to the stigma attached to mental health and illness, which further marginalizes this population. Very little is known about the experiences of ACB youth in small-medium sized cities, and this knowledge gap must be addressed to ensure the mental health needs of these young people are

understood and met by mental health services. Your perspectives are worthy of being listened to, and that is why you are being invited to take part in this study.

The purpose of this study is to explore the mental health experiences of ACB youth in to find if there is a need for culturally competent mental health services for this population in London, Ontario. The objectives for this study are:

4. What is the existing socio-cultural discourse about mental health among ACB youth?
5. Do gender, race, culture, and place shape the mental health experiences of ACB youth?
6. What do culturally competent or safe mental health services look like for ACB youth?

3. How long will you be in this study?

It is expected that there will be 1 study visit during your participation in this study and each visit will take approximately 60-90 minutes.

4. What are the study procedures?

You will be interviewed on a one-to-one basis to gain a thorough understanding of your experiences with mental health, stigma, service access, and mental health literacy. Asking questions about these topics will help understand how mental health is experienced among ACB youth and what perceptions, behaviours, and challenges can be a risk to the mental health of ACB which can be solved through culturally competent support and accessible education. The interviews will be done in a quiet, private space in a library or community centre chosen by the participant. The interviews will be recorded on an audio recorder and will be typed out word for word on a computer by the student investigator to have an accurate record of what was stated. If you consent to the study, the interview will be audio recorded, but you are still allowed to participate if you do not consent to be audio recorded. The principal and student investigators are the only individuals who will have access to this information. Your identity will be kept confidential to the researchers, and all data will be labeled by your age, gender, and pseudonym (fake name) in reports and publications of this study. The electronic data will be stored on a password protected laptop at the student's private residence and any paper copies of the interview data will be in a locked filing cabinet at her home. After a period of seven years both sets of data will be destroyed. There is no plan of secondary use of the recorded or transcribed interview data.

5. What are the risks and harms of participating in this study?

There are possible risks and harms to you in this study. Some of the interview questions may trigger emotional, negative, or uncomfortable feelings and reactions such as fear or anxiety, particularly if they have not been able to openly discuss mental health with their families or peers. If a participant is experiencing distress during their interview session, they will be allowed to take their time to pause from continuing the interview or express any thoughts or feelings they may be experiencing as part of the informal debriefing process.

6. What are the benefits of participating in this study?

The possible benefits to you may be an improvement in your mood and attitude as a result of being open to talk about mental health in a safe space. The possible benefits to society may be improving mental health policies and services for ACB youth with the findings of the study presented in a report. Another benefit would be adding to the Canadian research on mental health in ACB populations in smaller cities.

7. Can participants choose to leave the study?

If you want to withdraw from the study at any time, you have the write to request (written, calling, etc.) withdrawal of data collected about you. If you want your data removed please let the researcher know and it will all be destroyed from our records. However, once the study has been published, your information will not be able to be withdrawn.

8. How will participants' information be kept confidential?

Anonymity and confidentiality of the information that you disclose is respected and protected. I will not report any information that identifies you and all information obtained will be made and kept confidential. This includes any personal names you may share during the interviews which will be changed when your data is analyzed into reports, presentations, or publications. Personal quotes however will be used within the publication of this study. You will be asked to read this information and sign the consent form, and after that a pseudonym will be given to you instead of using your real name during the study. By doing this, the information gathered will contain pseudonyms and not names, which means that no one will be able to identify you. Only the masters student investigator interviewing you and the principal investigator will have access to the information from the study. Representatives of Western University's Health Sciences Research Ethics Board may require access to your study-related records to monitor the conduct of the research. The principal investigator and

masters student investigator will keep any personal information about you in a secure and confidential information for 7 years. A list linking your pseudonym with your name will be kept in a locked secure cabinet only accessible by the student and principle investigators separate from your study file. While we do our best to protect your information there is no guarantee that we will be able to do so. If data is collected during the project which may be required to report by law we have a duty to report.

9. Are participants compensated to be in this study?

You will be compensated \$25 for your participation in this study. If you begin but do not complete the interview you will still receive the entire \$25 compensation.

10. What are the rights of participants?

Your participation in this study is voluntary. You may decide not to be in this study. Even if you consent to participate you have the right to not answer individual questions or to withdraw from the study at any time. If you choose not to participate or to leave the study at any time it will have no effect on your health care and social services you access. You do not waive any legal right by consenting to this study. In order to ensure that you fully understand the nature of your participation we encourage you to read through the letter of information and ask us any questions you may have, which will be answered immediately. Only your consent is required, but if you would like to tell your parents about this study, you have the right to do so.

11. Whom do participants contact for questions?

If you have questions about this research study please contact:

Principal Investigator + Contact:

Dr. Treena Orchard, Ph.D.

Masters Student Investigator + Contact:

Lily Yosieph

This letter is yours to keep for future reference.

12. Consent



Project Title: Exploring the Mental Health Experiences of African, Caribbean, and Black (ACB) Youth in London, Ontario

Principal Investigator + Contact:

Dr. Treena Orchard, Ph.D.

Masters Student Investigator + Contact:

Lily Yosieph, MSc Candidate

I have read the Letter of Information, have had the nature of the study explained to me and I agree to participate. All questions have been answered to my satisfaction.

I agree to be audio recorded in this research

YES NO

I consent to the use of unidentified quotes obtained during the study in the dissemination of this research

YES NO

Print Name of Participant

Signature

Date (DD-MMM-YYYY)

My signature means that I have explained the study to the participant named above. I have answered all questions.

Print Name of Person
Obtaining Consent

Signature

Date (DD-*MMM*-
YYYY)

Appendix D: Interview Guide

Interview Questions for ACB Youth Participants

Preliminary questions: Are you from London?; If not, how long have you lived here and what brought you here?; How do you like living in the city?; How old are you and how do you identify culturally or ethnically? Would you say you feel connected to your socio-cultural and/or youth communities?; Can you say a little bit about why you are interested in the study?

Mental Health: When I say ‘mental health’, what comes to mind? What does mental health mean or represent to you?; How is mental health viewed and discussed amongst your family members or ethnic community?; Have you ever had to seek mental health services about your emotions or thoughts? If so, how did you know that you needed to reach out for help?; When you are not able to talk to someone, what do you do to improve your thoughts or emotions?

Youth/Age: Are you aware of mental health services in the community that are geared towards youth?; If so, have you accessed any of these services? If not, do you think there should be better representation or discussion about these services in places where youth spend time, maybe more social-media platforms?; Have you ever had an experience where your age impacted your ability to access mental health services?; Why do you think this occurred?

Gender and Place: Do you think that your mental health experiences have been shaped by your identity as a young man or as a young woman? Are men and women’s experiences in this aspect of life different? If so, how? Do family or community members respond differently when discussing or intervening in mental health matters among young women and men? If so, how and why do you think this is? How about the community you come from, how does the size or make-up of a city impact the kinds of mental health services available?; Do you think the smaller size of the city is a strength or hindrance related to finding and accessing mental health services that reflect your cultural, gendered, and/or age needs?

Race and Culture: Do you think your racial or cultural identity has played a role in responses from family, community, or services when reaching out for help?; If so, how?; In your experience, do you find that the mental health services are culturally competent or reflect your lived realities? If so, can you explain?; If not, how should the services be adapted to align better with your cultural identity?

Research Experience and Knowledge Translation: How did you find the interview experience?; Did anything come up that you weren't anticipating or were surprised at?; Are you feeling okay after the experience?; Who do you think needs to learn about or hear the results from the study?

Appendix E: Debriefing Process Script

Debriefing Process Script

An informal debriefing process will be done throughout each interview to assess where you are at emotionally. This is to ensure that you have not been emotionally triggered or upset by the process, or if you have that adequate supports are provided to ensure you can access the requisite services needed to address any discomfort you may feel. I will provide brochures that detail the location and hours of operation for local mental health resources and allied professionals. I am aware that triggers or emotional disruptions stemming from research participation can emerge days or even weeks after the interview, and I will discuss this possibility with you at the end of the study. I will provide not only the mental health resource information but also my personal contact information, should you wish to contact me directly to discuss any issues that may have arisen after the completion of the interview.

Examples of Debriefing Questions:

How do you find this interview so far?

Are you experiencing any discomfort or negative feelings from this interview? If so, would you like to unpack these thoughts or emotions?

Are you comfortable with continuing this interview?

Are there any questions or areas about gender, race, culture, place, age, and mental health I did not cover in this interview that you would like to speak about?

How are you feeling after this interview? Would you want my contact information or local mental health resources to talk to?

What is next on your agenda for the day after this interview?

Local Mental Health Resources:

Canadian Mental Health Association Walk-In Crisis Centre

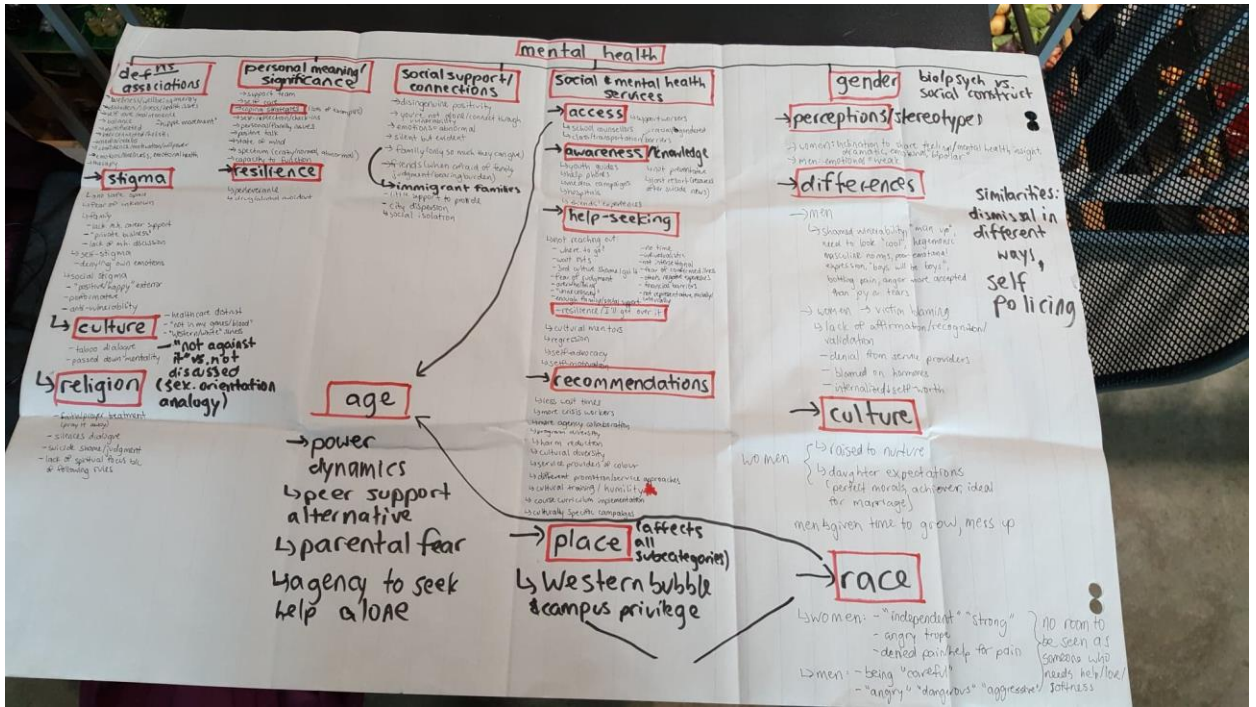
London InterCommunity Health Centre

Cornerstone Counselling

Reach Out

Family Services Thames Valley

Appendix F: Data Analysis Chart



Curriculum Vitae

Name: Lily Yosieph

Post-secondary Education and Degrees: The University of Western Ontario
London, Ontario, Canada
2011-2016 B.HSc.

The University of Western Ontario
London, Ontario, Canada
2017-present M.Sc.

Related Work Experience Research Assistant
Parkwood Institute Mental Health Care Building
2019-present

Teaching Assistant
Western University
2017-2019