FROM OBSCURITY TO VISIBILITY:
A PHENOMENOLOGICAL STUDY ON THE MENTAL HEALTH EXPERIENCES OF YOUNG BLACK WOMEN IN THE GREATER TORONTO AREA

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ABSTRACT

This qualitative study explores the mental health experiences of young Black women, aged 18–25, residing in the Greater Toronto Area. Informed by critical race theory (CRT), critical disability studies (CDS), and the concept of anti-Black racism (ABR), the study interrogates how systems of oppression including racism, sexism, and anti-Blackness shape young Black women's mental health and help-seeking behaviours. Drawing on van Manen's (1990, 1997) approach to hermeneutic phenomenology, along with McCracken's (1988) long interview method (LIM), the study sought to answer the following overarching question: How do young Black women in the GTA experience mental health, and how do these experiences shape their help-seeking behaviours? Supporting sub-questions included the following: 1) How do young Black women become aware of and manage their mental health concerns? 2) How do the intersections of race and gender influence young Black women's mental health experiences? 3) What role does mental health stigma play in young Black women's experiences of service utilization for their mental health concerns?

Data was gathered from in-depth, semi-structured interviews with 14 young, Black, women-identified participants. One of the key findings from these interviews was that young Black women experience mental health concerns at the intersection of systems of oppression and domination, including racism, sexism, and anti-Blackness. Each participant spoke to the ways that young Black women learn about themselves and mental health (Theme 1), including how they came to know about their mental health concerns (Subtheme 1), of which a significant part was navigating the conversation of mental health in the Black community (Subtheme 2). In addition, participants shared insights on the assumptions about young Black women (Theme 2), including the expectation for young Black women to be strong and pull through (Subtheme 3),

while also navigating the ways their various emotions are reduced to anger (Subtheme 4). As a result of these pressures, participants often felt that acknowledging their mental health concerns enabled others to perceive them as weak or deficient (Subtheme 5). Further, participants spoke to the barriers and facilitators to help-seeking and what effective mental healthcare looks like (Theme 3), discussing their experiences in accessing mental health supports (Subtheme 6) with many choosing to find ways to manage their distress outside of formal means (Subtheme 7). They also spoke to what they need for mental health care to be meaningful and effective for them (Subtheme 8).

The study underscores the urgent need for transformative and integrative approaches to mental health care that validate young Black women's experiences and account for intersecting systems of oppression. Implications extend to mental health practice, disaggregated data collection, and social work education, calling for frameworks that embrace race, gender, and systemic inequities to foster environments where young Black women can not only survive but thrive.

DEDICATION

This dissertation is dedicated to my two incredible daughters. Raqi and Cece, for whom my love is timeless and boundless. Raqi, I know that you are still here with me in spirit, directing every step of the way, and I thank you. Cece, thank you for walking this journey with me, I could not have done this without you.

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LIST OF ACRONYMS

ABR	Anti-Black Racism
CAMH	Centre for Addiction and Mental Health
CRT	Critical Race Theory
CDS	Critical Disability Studies
LIM	Long Interview Method
MHCC	Mental Health Commission of Canada
MHRC	Mental Health Research Canada
PHAC	Public Health Agency of Canada
WHO	World Health Organization
YBW	Young Black Women
YouthREX	Youth Research & Evaluation Exchange

CHAPTER 1: INTRODUCTION

"*Black women have, on one hand, always been highly visible, and so, on the other hand, have been rendered invisible through the depersonalization of racism.*"
(Audre Lorde, 2007, p. 42)

Young Black adults in Canada face unique challenges in terms of their mental health and well-being, shaped by their complex and intersecting social locations. Indeed, mental health remains a critical concern among young adult populations in Canada (Khenti, 2013; McKenzie, 2017). However, there has been relatively little research into the mental health experiences and the influence of systemic racism and mental health stigma among young Black adults. Recently, youth-serving agencies and advocates—such as AMANI Mental Health & Substance Use Program for Black Youth, offered through the Centre for Addiction and Mental Health (CAMH) (formerly known as the Substance Abuse Program for African, Canadian and Caribbean Youth, or SAPACCY)—have become more vocal about the mental health needs of Black youth. For example, at the Black Health Experience Symposium (2017) and the Sound Mind Forums (2015, 2016, 2020), mental health providers and professionals reiterated that Black communities lack data on the prevalence of mental illness and addiction among African Canadians (African Canadian Mental Health Working Group, 2017), as well as targeted research that focuses on system reform and better treatment outcomes (Black Health Alliance, 2017; Salami et al., 2023).

After participating in these mental health forums in Toronto in recent years, as well as my work in community and private practice, I became more critically aware of the extent of this issue among the young Black population in the Greater Toronto Area (GTA) in Ontario, Canada. The twin pandemic of COVID-19 and racial uprisings that ensued further illuminated not only the reality of health and mental health disparities faced by Black people in Canada, but also the

critical need for disaggregated data on Black youth mental health (Taylor & Richards, 2019; Waldron et al., 2024).

These impacts are felt even more acutely among young Black women (YBW) between the ages of 18 and 25 years living in the GTA, as they are an often under-researched and underserved part of the Black community in relation to their mental health needs. Much of the research in the Canadian context focuses on young Black women's sexual health (Darko et al., 2024), young parents (Goddard-Durant et al., 2024), or other deficit-focused contexts. There is a dearth of literature on how young Black women understand their experiences with mental health concerns and the extent to which mental health stigma impacts these experiences and their decisions around help-seeking. With this research, I seek to fill this gap in knowledge and to inform the design of more effective mental health support programs for young Black women living with mental health challenges in Ontario.

In this study, I examined the lived mental health experiences of young Black women (YBW) 18-25 years of age living in the GTA, including those identified as being from African and Caribbean heritage and those who are Black Canadian-born. I sought to understand how they conceptualize and navigate their mental health concerns, the messages they receive from their communities and society at large, and the factors that influence their decisions (or not) to seek support. As the experiences of young Black women are situated at the convergence of race, gender, ability, and other aspects of their identities, I sought to contextualize these intersectional understandings, looking for the ways in which racism, sexism, ableism, classism, and other forces compound and complicate these experiences. In doing so, I hope to amplify the often-silenced voices of young Black women, contribute to empirical literature that provides evidence of their needs, and add to the calls for changes that will enable young Black women to thrive.

Purpose of the Study

The main goal of my research was to develop a deeper understanding of the experiences of YBW living with mental health concerns in the GTA, in order to provide more effective and meaningful service provision to/with YBW. The findings of this study contribute to social work scholarship that can enhance service providers' and policymakers' knowledge of YBW's mental health needs. The findings contribute to improved outcomes for YBW dealing with mental health challenges, encouraging shifts to service and healthcare providers to accurately meet this group's needs in service.

In my study, I explored the extent to which participants experience discrimination and racism, as well as the effects of these dynamics on their mental health and help-seeking. My findings challenge the hegemony of social, economic, medical, and political structures in society that shape assumptions and practices regarding the mental health concerns of YBW. I used critical race theory (CRT), critical disability studies (CDS), and anti-Black racism (ABR) to illuminate how dominant ideologies silence the voices and realities of those living on the margins of society. Through utilizing these critical paradigms, I sought to deconstruct knowledge, power, and privilege to enact alternate ways of understanding YBW's lived experiences of mental health concerns.

Statement of the Problem

While there is mandated race-based data collection in the fields of justice, education, and child welfare (Government of Ontario, 2017), there is currently no coordinated approach for gaining data on racial inequities in health and mental health outcomes in Ontario (Royson, 2020; The Black Experience Project, 2017). There have been urgent calls (Black Health Alliance 2016, 2017; Black Health Experience in Health Care, 2016) to address the mental health of Black

Canadian youth. In a report in 2017 by the Office of the High Commissioner of the United Nations for Human Rights Council (UNHRC, 2017), Black Canadians were found to "experience a higher and disproportionate level of chronic health conditions such as… mental health problems," and that "there is a lack of race-based data and research that could inform prevention, intervention and strategies" to mitigate these disparities (p. 14, 16). These disparities are the result of the entrenchment of Anti-Black racism in Canadian institutions and policies that are born from Canada's history of enslavement, racial segregation, and marginalization that have had a deleterious impact on Black people (UNHRC, 2017). At the Black Government Leader's Summit (2017) in Ottawa, the previous Minister of Youth and Community Services for Ontario acknowledged that there was "is a crisis that looms within the Black communities, particularly as it relates to young Black people's mental health and that aggregated data is needed to action any remedy necessary" (Ontario Government Update, 2017, p. 4).

In the Canadian context, there is little known about how mental health stigma converges with race, gender, ability, and other social categories to influence help-seeking behaviour among Black youth, and especially young Black women, with mental health concerns. The limited research on young Black women within the Canadian context tends to focus on specialized populations, such as Black young mothers and those living with HIV, IPV, educational systems, or those with substance use challenges. Existing research tends to focus on specialized issues related to YBW, such as young Caribbean-Canadian mothers (Durant et al., 2023), sexual health (Darko et al., 2024), or YBW and educational systems (George, 2020). Findings from this research are instrumental in bridging the research gap, specifically regarding Black youth mental health; however, a specific focus on the complex and intersectional experiences of YBWs with mental health concerns is warranted.

Additionally, as I present in the literature review (Chapter 2), almost all research that examines young Black people's experiences with mental health concerns defaults to stigma as a construct that exacerbates mental distress as well as hinders seeking and maintaining mental health supports. However, this study holds that to gain deeper insights into mental health experiences of young people, research should go beyond an analysis of stigma at the individual level. An analysis of racism, discrimination, and systems of power nested within stigma must be employed due to the unique systemic racism and intersectional oppression that YBW experiences daily in society at large. This is even more critical, as findings from recent research conducted with Black populations in Ottawa indicate that the prevalence of depression among Black Canadians is 65.87%, which is six times the annual rate of the general population, and that Black women are most affected (Cénat et al., 2021).

Rationale for the Study

This research is motivated by my professional experience as a social worker, with more than 15 years of working with young Black adults across various contexts, including frontline counselling and private practice. I am concerned for the well-being of young Black adults, particularly young Black women who are living with mental health concerns. In my previous professional roles working with racialized youth and young Black adults, I became aware of how Black youth mental distress is often ignored or minimized by service providers and health practitioners, and thereby often becomes internalized by the young adults. I have observed the inadequacies of the health care and mental healthcare systems and how institutions compound the intersectional oppression that YBW with mental health concerns experience. I am also aware of the multiple and complex challenges that young Black women face systemically based on their gender, race, and mental health. Additionally, as a past member of the African Canadian

Mental Health Working Group (2017) in Toronto, I have noted that stigma reduction and appropriate mental health interventions are imperative to the well-being of this population.

In recent years, I have witnessed young Black adults dying by suicide or presenting with suicide ideation. In the cases I have observed, these young adults were not engaged with mental health support, nor were they acknowledged as living with mental health distress. Though some have tried to engage with support, they reported that their concerns were dismissed by support systems. I have also witnessed situations in which some young Black women were referred for mental health supports and were misdiagnosed or dismissed as having emotional responses to hormone problems or stress in general that practitioners thought did not require interventions. While suicide is the second leading cause of death among young adults 15–34 years old in Canada, young Black adults are historically perceived not to be at-risk (Darius et al., 2024; Mental Health Commission of Canada, 2024; Wong, 2024). Waldron and colleagues (2024) contended that stigma and cultural beliefs present the largest obstacle to young Black people gaining access to and utilizing mental health supports and that Black youth mental health is a public health crisis in Canada.

Additionally, this research will address the substantial gap in race-based data regarding Black youth and young adults' mental health by disaggregating data by both race and gender. As of the time of this writing in 2024 and 2025, there is only one known GTA study, detailed in Chapter 2, that specifically investigated the health and mental health experiences of young Black women in 2003. This is problematic as more than half of Canada's Black population (52.4%) resides in Ontario, with the majority (36.9%) residing in the GTA (Statistics Canada, 2021). Studies in recent years with Black youth living with mental health in the Canadian contexts indicate that young Black people's mental health is exacerbated by systemic anti-Black racism

and other oppressive forces that often stymy the pathways to mental health supports (Cénat et al, 2023; Fante-Coleman et al., 2023). The situation is even more dire for young Black women, who must navigate complicated intersectional identities on a daily basis (Goddard-Durant et al., 2023).

Research Questions

To guide the exploration of young Black women's experiences with mental health concerns, I utilized the following research questions to guide the study: How do Young Black Women (18-25) in the Greater Toronto Area (GTA) experience mental health, and how do their experiences shape their help-seeking behaviours? In order to support this overarching question, I explored the following three sub-questions:

1. How do YBW become aware of and manage their mental health concerns?
2. How do the intersections of race and gender influence YBW's mental health experiences?
3. What role does mental health stigma play in YBW's experiences of service utilization for their mental health concerns?

Context of the Study: Young Adults and Mental Health in Canada

Though I present a deeper analysis of the existing literature in the next chapter, here I provide an overview of the state of Black youth mental health in Canada to underscore the importance of this study and its findings.

Young Adults and Mental Health in Canada

The World Health Organization (WHO, 2023) reported that mental health conditions are among the leading causes of illness and disability among young people. According to Neal and colleagues (2011), "one in five people in developed countries such as Canada and Australia will experience mental illness during their life span" (p. 491). Few studies on youth mental health

focus on the Canadian experience. Marcus and Westra's (2012) study, the first of its kind conducted in the Canadian context, examined the mental health literacy of young people aged 18–24 compared with older adults aged 25–64. The young adults in the study had unique views and needs with respect to the management of mental health problems. The Canadian Mental Health Association (CMHA, 2014) reported that 28% of individuals aged 20–29 years experience mental illness in any given year, and that suicide accounts for 24% of all deaths among 15–24-year-olds and 16% among 25–44-year-olds.

The first comprehensive national report released by Mental Health Research Canada (Cooper et al., 2024) stated that "66%–75% of mental health challenges in Canadian youth are first manifested before age 24, with the second leading cause of death among young adults 18 years of age and above identified as suicide" (p. 5). Malla and colleagues (2018) reported that "most (75%) of mental health challenges have their first onset before age 25" (p. 217). Similarly, the Canadian Health Survey (2023) reported self-reported declines in youth and young adults' mental health between 2019 and 2023; women aged 16-21 reported a 33% decline, compared to young men of the same age, who reported a 19% decline. They attributed this decline to the transition from adolescence to young adulthood, compounded by the restrictions and stress brought on by the COVID-19 pandemic. The Canadian Institute of Health Information (CIHI, 2025) further reported that women aged 15–24 years were represented in 58% of all hospitalizations for mental health distress. The report also indicated that young women experience higher rates of mood and anxiety disorders than men, which aligns with WHO (2023) research showing young women demonstrate more mental health indicators compared to young men.

The History of Black Communities in Canada

Black people have been in Canada since the 1600s, and Mathieu De Coste was the first recorded Black person to arrive in Nova Scotia in 1608 (Beau et al., 2012; Sadlier, 2010). Contrary to the myth that Canada did not participate in slavery, all Black people who came to Canada after DeCoste came as slaves. The first recorded slave to arrive in New France in 1628 was Olivier Le Jeune, who was only six years old. Slavery gained its "legal foundation in New France between 1689 and 1709" (Wamsley et al., 2021, as cited in Mullings et al., 2021, p. 46). The enslavement of Black people took place throughout various parts of Canada, including Nova Scotia, New Brunswick, Newfoundland, Quebec, and Ontario (Winks, 1971, 1997). The Slavery Abolition Act of 1834 in the British colonies and the Fugitive Act of 1850 in the United States (US) led to the Underground Railroad to Canada, which saw an influx of free Black slaves from the US who were fleeing racial oppression (Maynard, 2017).

The Black population of Canada consists of people who trace their ancestry to Africa and self-identify as Black (Boatswain & Lalonde, 2000). Today, these communities are heterogeneous, comprising people who speak various languages, represent different social classes, have diverse sexual orientations, and hold varying political, social, historical, economic, spiritual, and cultural affiliations. It is "uncontested that the struggle for a Black identity in a White-settled colonial country such as Canada is complex" (Massaquoi & Wane, 2007, p. 155).

In 1971, the Black population in Canada accounted for only 0.2% of the total population, rising to 3.5% in 2016. According to the Canadian 2021 census, the Black population constituted 4.3% of the Canadian population, making Black people the third largest (16.1%) racialized group in Canada, preceded by South Asians at 7.1% and East Asians at 4.8% (Statistics Canada, 2021).

According to the 2021 Canada Census, almost half (52.4%) of all Black people in Canada reside in Ontario, and 36.9% live in the Greater Toronto Area. Black people also comprise the second largest Canadian-born population among visible minority groups (41.0%). The Black population is expected to increase to 3 million by 2041 (Statistics Canada, 2024). The National Household Survey (2024) found that, with a median age of 30.2 years, Blacks were the youngest visible minority group, accounting for 41.2% of the general population in Canada. Findings from the Black Experience Project (BEP, 2017) conducted with youth through Ontario found that while Black people 55 years and over prefer to identify by an ethnic-specific group based on their place or origin, younger Black Canadians, 34 years of age and under, prefer to be labelled as Black. The Black youth population constitutes 19.4% of all racialized youth in Canada, with 72.8% of the total Black population under the age of 45 (Statistics Canada, 2022). Finally, it must also be acknowledged that the label of "Black" is often contested, with different terms accepted within different communities, such as those who are Canadian-born compared to those who have immigrated to Canada.

Given the history of Black populations in Canada—enslavement, forced migration, segregation, and marginalization—it is no wonder that Black people continue to experience racial prejudice, discrimination, and inhumane treatment across all institutions. The "historical and collective experiences of enslaved and displaced Black communities have produced and perpetuated intergenerational trauma," leaving ongoing detrimental health and mental health impacts on Black people (Adu et al., 2025, p. 1; Dixon et al., 2023; Maynard, 2017).

Young Black Adults and Mental Health

Young Black people in Canada face a myriad of social inequities that negatively impact their mental health and well-being (Anucha et al., 2018; Fante-Coleman et al., 2023; Salami,

2023). Research suggests that factors such as racial discrimination, systemic racism, chronic trauma, and lack of culturally competent mental health professionals contribute to increased levels of mental health conditions, such as anxiety and major depression, among Black youth (Bowden, 2023; Kalambay, 2023; Salami et al., 2022). Black youth tend to deny the existence of mental health distress and avoid accessing services (Fante-Coleman & Jackson-Best, 2020; Patel, 2015; Taylor & Richards, 2019). Different cultural beliefs and traditions among Black people influence their attitudes to mental health concerns and help-seeking practices (Jones & Guy-Sheftall, 2015; McCann et al., 2016; Nadeem et al., 2007; Shefer et al., 2012). Mental health stigma within Black Canadian communities is at a crisis level (Benjamin, 2003; Khenti, 2013). This reality calls for new approaches to early identification of mental health concerns and the delivery of social services that are culturally and linguistically responsive to YBW.

Mental Health Research Canada (Cooper et al., 2024) stated that Black Canadians are "300% more likely not to access services when needed in the past year compared to non-black Canadians" (p. 9). The report also found that Black youth and young adults face many barriers to service access for mental health distress, particularly racism and discrimination (Cooper et al., 2024). Similarly, the BEP, while not a health-specific study, examined the lived experiences of Black people living in the GTA and found that the health and well-being of young Black adults aged 16–24 is a significant concern; one in two participants in this age group named racism as the most significant challenge they faced (BEP, 2017). While racism and discrimination greatly impact the mental health and mental health outcomes of young Black people, mental health stigma is also a main factor that impacts mental health.

Mental health stigma has been deemed a crisis in Black communities (Fante-Coleman & Jackson-Best, 2020; Khenti, 2013; McKenzie, 2020; Taylor & Richards, 2019). Youth-serving

agencies and other advocates have become increasingly vocal about mental health stigma and the inadequate response to the needs of Black youth. Dr. Kwame McKenzie (2020), a psychiatrist at the Centre for Addiction and Mental Health in Toronto, argued that mental health concerns constitute a crisis in the Black community in Canada. The issue of mental health stigma within African, Caribbean, and Black Canadian communities is widely known and discussed at public forums on mental health (Orridge et al., 2020; Black Health Alliance, 2016, 2017). At the Black Health Experience Symposium in 2017 and the Sound Mind Forums in 2015 and 2016, mental health providers and professionals frequently reiterated that the Black community lacks data on the prevalence of mental health challenges and addiction amongst African Canadians (African Canadian Mental Health Working Group, 2017), as well as targeted research that focuses on systemic reform, and better evidence-based treatments (Black Health Alliance, 2016).

Studies on mental health stigma rarely capture the unique interplay of race, gender, ability, and other social categories with mental health issues (Beauboeuf-Lafontant, 2007; Etowa et al., 2007; Jones & Guy-Sheftall, 2015; Okeke, 2013). While several research studies (Alvidrez et al., 2008; Shefer et al., 2012; Thornicroft, 2008; Williams & Williams-Morris, 2000) have identified stigma as a barrier to youth access to mental health services and/or support in the United States, there is a paucity of research that focuses on how the stigma of mental illness affects young Black women's access to mental health services and/or support. The findings from this study will thus provide much-needed data on this issue by focusing on both the Canadian context and the specific experiences of young Black women.

Language

Terms in social justice research take on different nuances depending on the context or discipline in which they are used; for the purpose of this study, it is key to conceptualize these

terms as I understand and use them here. These definitions are influenced by the chosen theoretical frameworks, including critical race theory, critical disability theory, and anti-Black racism, that guide this work, providing context and orientation to the discussion present throughout the research process as well as this dissertation.

Gender

Gender refers to the socially constructed roles, behaviours, expressions, and identities of girls, women, boys, men, and gender-diverse people, as well as distinctions between "masculine" and "feminine" (Kaufman et al., 2023). The concept of gender influences how people perceive themselves and each other, how they act and interact, and their position in the distribution of power in society. In the Euro-Western tradition, gender has been interpreted as binary, with distinct, dichotomous categories of women and men. However, there is considerable diversity in how we understand, experience, and express gender, including transgender and Two-Spirit people. Gender is seen as "performatively enacted" according to social norms (Butler, 1990).

Women are more likely than men to experience and be treated for mental health concerns, which has led to interrogations of the gendered facets of mental distress. Particular attention in this area has been given to historical conceptions of women as irrational and biologically predisposed to mental health problems, such as depression and anxiety (Busfield, 1996).

Lived Experiences

Encounters in everyday situations include personal thoughts, feelings, and physical and mental well-being. My phenomenological methodology approaches the lived experiences of Black women living with mental health concerns as valid knowledge about the world in a context where their experiences have often been dismissed, devalued, and silenced. As Scott

(1991) notes, experience is not neutral, but is "the process by which, for all social beings, subjectivity is constructed" (p. 782).

Mental Health

Traditionally, mental health and well-being have been defined in the literature as the absence of mental illness (Ryan & Deci, 2001; Wells et al., 2003). In recent times, however, mental health has been distinguished from the mere absence of mental illness, but rather as an integral facet of overall health and well-being (Keys, 2002, 2006; MHCC, 2012). Mental health is defined by the World Health Organization (WHO, 2010) as "a state of well-being in which every individual realizes her or his own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community" (p. 10). Adopting a more holistic perspective, the Public Health Agency of Canada (PHAC, 2006) asserted that mental health is the capacity for each and all of us to

> feel, think, and act in ways that enhance our ability to enjoy life and work through challenges we face. It is also seen as a positive sense of emotional and spiritual well-being that respects the importance of culture, equity, social justice, interconnections and personal dignity. (as cited in CIHI, 2009, p. 3)

This latter conceptualization of mental health will inform this dissertation as it presents a more encompassing approach.

Mental Health Stigma

Goffman (1963) defined stigma as an "attribute that is deeply discrediting," and argued that "stigma reduces a whole and usual person to a tainted discounted one" (p. 3). According to Goffman (1963), the stigmatized individual is a person who possesses an "undesirable difference." However, others have contested Goffman's view of stigma as too vague and

individually focused (Hatzenbuehler, 2013; Link & Phelan, 2001), arguing that Goffman's emphasis encourages viewing stigma as a highly individual issue, instead of a contextual, structural, and social process. Link and Phelan (2001) argued that Goffman's definition implies that stigma is something in the person rather than a designation that others have attached to the individual.

Today, stigma is often conceptualized as the "co-occurrence of its components—labelling, stereotyping, separation, status loss, and discrimination—and for stigmatization to occur, power must be exercised" (Link & Phelan, 2001, p. 363). Stigma is a social construct comprising social rejection, devaluation, and discrimination (Crocker et al., 1998; Goffman 1963; Jones et al., 1984). Stigma has also been conceptualized as a "mark" of "social disgrace, arising within social relations and disqualifying those who bear it from full social acceptance" (Howarth, 2012, p. 442).

Recently, stigma research has explored different sites and intersections of stigma ("intersectional stigma"), acknowledging the dynamic and complex nature of stigma. Stigma theory explores double stigma, which refers to members who identify as part of an already stigmatized group, such as a racialized group and then risk the added label of "mental illness" to their existing stigmatized identity (Gary, 2005). Stigmatization is multifaceted so it can have dramatic effects on the distribution of life chances in areas such as earnings, housing, criminality, health, mental health, and life itself (Link & Phelan, 2001).

Mental Illness

To understand the experiences of individuals living with mental illness, it is necessary to explore how mental illness as a disability is understood and perceived. Mental illnesses are characterized by alterations in thinking, mood, or behaviour—or some combination thereof—

associated with significant distress and impaired functioning. Granello and Granello (2001) argued that the definition of mental "varies and mostly depends on the standards in the community within which one resides" (p. 102). The very ways in which mental illness is constructed and understood by individuals can contribute further to the stigma that serves as a barrier to service-seeking (Watkins & Neighbors, 2007; Williams & Williams, 2000). In this study, I was intentional in using the terms mental health concerns and mental distress interchangeably as in my experiences working with racialized and Black young adults, the term "mental illness" was perceived and talked about in a negative and fearful manner. Being cognizant of the connotation of mental illness as aligned with the medical model, I knew that this language would not be favourable to the participants.

Race and Racism

Traditionally, "'race' was constructed in relation to biological origin and physical appearance" (Reimer-Kirkham & Anderson, 2002, p. 4). Race is often used to refer to a biological or genetic trait. Studies have, however, demonstrated that "race" is a socially constructed concept with shifting meanings across space and time (Omi & Winant, 1994; Williams et al., 1994). Race and racialization lend legitimacy to the actions of the dominant class who control "other" racial groups (Fernando, 2017). Race, then, becomes a societal norm associated with privilege or lack thereof. Racism, on the other hand, is a "way of thinking that places a superior people in position of power over peoples of various other races, mainly based on perceived skin colour, Black, red, yellow and so on" (Fernando, 2017, p. 1).

Young Black Women

The definition of youth changes depending on location and sector. According to the Society for Adolescent Health and Medicine, more than 10 countries use the designation *youth*

and *young adult* interchangeably and sometimes extend the category to include those 15–30 or even 40 years old (Walker-Harding et al., 2017). Statistics Canada (2021) defined young adults as those between ages 15–34, while the Ontario Ministry of Labour (2018) defines young workers as those under age 25 years. This suggests that no universal guidelines define *youth* or *young adults*, but rather that they shift and change over time, sometimes amidst controversy. For the purposes of this study, young women are defined as women-identified individuals 18–25 years old.

Help-Seeking

Help-seeking for mental health distress can take multiple forms and mean different things in different contexts. For the purposes of this paper, help-seeking is conceptualized as a request to obtain assistance through either/a combination of informal supports or formalized services for the purpose of resolving emotional, behavioural, or mental health issues (Rickwood et al., 2012). While formal supports often take the form of mental health care through a primary care provider, psychologist/psychiatrist, social worker, or therapist, informal supports can include peer groups, cultural or religious supports, or other community members. What are considered to be informal or formal supports varies across demographic, spatial, ethno-cultural and temporal contexts.

Summary and Organization of the Dissertation

This seven-chapter dissertation focuses on the lived experiences of young Black women ages 18–25 in the GTA, living with mental health concerns. The first chapter, the introduction, identifies the problem at the center of this study, providing details about this dissertation's purpose, rationale, and context. Research questions are highlighted, as well as key terms that orient readers to the study. Finally, this chapter concludes by providing the organization of the dissertation. Chapter 2 provides an extensive review of the literature related to my study. More

specifically, this chapter focuses on racism, mental health, models of mental health, and inequities in access to mental health support. Chapter 3 describes the theoretical frameworks that guide the study, including critical race theory (CRT), anti-Black racism (ABR), and critical disability studies (CDS). Each theory is presented with key concepts and understandings, as well as their relevance to the study and the ways in which they complement each other to deepen the theoretical foundations of this work. In Chapter 4, I present the study's methodology and research methods, beginning with a thorough review of hermeneutic phenomenology and the rationale for its utilization in the study. I also provide an extensive review of McCracken's (1988) Long Interview Method (LIM), establishing important links between methodology and method and illustrating how this design is meaningful for the topic at hand. Chapter 5 presents the findings of the study, gathered from 14 young Black women participants who chose to share their experiences. Chapter 6 discusses the study's major themes through the lens of CRT, CDS and ABR, with connections to existing literature. Finally, Chapter 7 concludes the study by addressing its contributions and implications for social work theory, policy, and practice. Delimitations of the study and recommendations for future research are also addressed.

CHAPTER 2: LITERATURE REVIEW

In order to effectively explore the mental health experiences of young Black women (18–25 years) in this study, I had to begin with what had already been published about this topic and population. Accordingly, I critically reviewed a mix of empirical, theoretical, and grey literature to identify gaps and existing knowledge on young Black adults and mental health. This extensive literature was collected through a review of journals and publications from disciplines such as social work, education, sociology, mental and physical health care, psychiatry and psychology, and others. In addition, I reviewed blog posts, news articles, and publications by scholars and community members speaking on this issue in the community. All literature was gathered using a combination of the following key search terms: "young Black adults", "young Black women and mental* (health/illness/ill health/distress)", "Black women and mental*", "Black youth and mental*", "mental illness, stigma and help-seeking", "Black youth and mental health care", "research and young Black women," "young Black women and rac* (race/racism/racialization)", and "young Black women and discrimination". As I show in this chapter, this literature review reveals a significant paucity of research that explore the mental health experiences of young Black women in the GTA. Relevant literature fell under one or more of the following themes: (a) mental health stigma in Black communities; (b) young Black women, mental health, and stigma; (c) racism and mental health in Canada; (d) racism and models of mental health; and (e) access and utilization of mental health services and other help-seeking measures.

Understandings and perspectives of mental health, the negative impacts of stigma, racism and the barriers and complexities of mental health care are well-documented in literature in the US and the UK (Ayodeji et al. 2021; Bakare, 2024; Edge, 2013; Jones et al., 2021; Modeste-James et al., 2024; Ncube et al., 2022; Stoll et al., 2022). However, there is limited research that

speaks to this issue within the Canadian context, particularly the relationship between mental health stigma and anti-Blackness, and young Black women lived experiences with mental health concerns and navigating mental health supports. In this chapter, I review the literature on mental health, including conceptualizations and understandings, stigma, barriers to support, and interactions with racism, particularly through the lens of young Black women and the ways they navigate their world. Due to the paucity of research on Black young adults and mental health in Canada, the findings and insights presented here are supplemented by research conducted in the US and UK, with relevant inferences explored.

Mental Health Stigma in Black Canadian Communities

Mental health stigma has been deemed to be a crisis in African Canadian communities (Fante-Coleman & Jackson-Best, 2020; Khenti, 2013; McKenzie, 2020; Taylor & Richards, 2019), yet there has been relatively little research into the effects of mental health stigma among Black populations in Canada. Canada's Chief Public Health Officer, Dr. Theresa Tam, has described stigma as the primary driver of health inequities, noting that experiencing stigma is closely associated with poor physical and mental health outcomes (Public Health Canada Report, 2019). Dr. Tam, Canada's former Chief Public Health Officer further noted that stigma at the individual level is a significant barrier to healthcare and leads people to avoid or delay seeking care and disclosing health conditions (Public Health Canada Report, 2019).

Some youth-serving agencies and many advocates within Black communities have become increasingly vocal about mental health stigma and the lacklustre governmental response to the needs of Black youth. For example, the AMANI Mental Health & Substance Use Program (formerly known as the Substance Abuse Program for African, Canadian, and Caribbean Youth, or SAPACCY) offered through the Centre for Addiction and Mental Health (CAMH), is

landmark programming offering culturally responsive and collective care for Black youth living with mental health and substance use challenges. However, the program had not received an increase in funding since the mid-1990s until 2021, during the height of the COVID-19 pandemic and racial uprisings due to George Floyd's murder.

In addition to the issues associated with the mental health crisis in Black communities, multiple sites of stigma co-exist. For example, the individual feelings and fear of the stigma in relation to mental health challenges are directly linked to one's community and the larger external dominant community. As a result, this interplay of different levels of stigma negatively impacts the mental health and well-being of Black people in general, as well as the under-theorized category of young Black women in particular. Individual or internalized stigma is a direct result of how one's community and the outside world perceive the mental health challenges of those affected. It is well-established that Black mental health challenges are largely pathologized and rooted in old, racist tropes of Black male criminality and danger and Black women's anger, hypersexuality, and strength. These stereotypes inform both how Black people view themselves, through the internalization of these false narratives and how the larger dominant White community, among others, views Blackness through a negative lens in general. The existing literature on internal and external stigma largely centres on how multiple sites of stigma coexist. For example, Murney and colleagues (2020) examined how health providers understand the stigma associated with mental health and substance use and ways to address stigma and its concomitant of discrimination in Ontario, Canada. The authors used a phenomenological approach, whereby they conducted twenty-three interviews with staff, peer workers, and three focus groups of front-line mental health providers. Through thematic analysis, they found that multiple forms of stigma intersect, such as mental health, substance use, race,

gender, and age converge to create significant barriers to care (Murney et al., 2020). These barriers can only be mitigated through appropriate staff training and similar interventions. There is no doubt that this is important work; however, it misses the crucial aspect of how and why internal stigma exists.

At the individual level, the internalization of the ways that the Black community and society at large understand and perceive mental health and wellness intersect to produce fear and reluctance to seek help. This is largely a result of how white society has historically and contemporarily framed Black people as different, inferior, and a danger to society at large. The internalization of the negativity and fear of these tropes filters into one's knowledge and belief of how family, community, and society will understand mental health challenges. Ostensibly, this phenomenon is at the centre of the reluctance to seek help, thereby creating a vicious circle (Keating & Robertson, 2004).

This notion of a vicious circle is articulated in Keating and Robertson's (2004) study, where they argue that members of the Black community in the United States do not receive the mental health services that they need, particularly Black men. The authors employed a purposive sampling method to generate in-depth insights into the disparity in mental health diagnoses and treatment. Their findings indicate that the reasons for these disparities are two-fold, the first centres on the reluctance of Black people to engage mental health services, and the second is the racial bias of service workers. This constellation produces what the authors referred to as circles of fear, resulting in substandard and inappropriate levels of care and punitive interventions. They further argued that this cycle can only be broken through systematic change. This study is helpful insofar as it identifies how the connection and interaction between internal and external stigma, and how racial bias informs the ways that Black men are treated.

Similarly, in an effort to understand the underlying factors of mental health disparities of different racial ethnic groups in the US, Misra and colleagues (2021) conducted a systematic review that focused on the cultural aspects of stigma relating to mental illness through the lens of the society, structural conditions, community, and self within the ethnic groups of Asian, Black, and Latinx Americans. Their findings demonstrate that there is a greater level of both internal and external stigma for these groups than for American White groups. The lack of service barriers in combination with the fear of familial shame and burden, a lack of knowledge about available services, and internalized stigma played a significant role in determining whether one will engage in seeking help or not.

Understanding the root causes of stigma is central to preventing its harms. In an effort to generate understandings of the root causes of stigma, Sotero (2006) used historical trauma theory in an effort to understand the ways in which populations suffer from long-term intergenerational trauma as a result of colonialism, slavery, war, and genocide. The author argued that how we understand the various impacts of historical trauma can help us determine the best way to serve impacted communities today. This is an important contribution to the literature because it demonstrates how history informs the present and allows us to get at the root causes of internal and external stigma. Such an approach is particularly salient in Black communities as the harms resulting from slavery, segregation, and scientific racism continue to live in the present and are visited upon Black bodies on a day-to-day basis.

The interlocking factors of the social construction of Blackness are central to the reaction of Black people and their choice to either not seek help or take a significant risk to seek help that can have significantly negative consequences for oneself, their family, and their community. Addressing the differing levels of stigma and breaking down their constituent parts is central to

being able to address the racial, gendered, and class-based inequities that exist within mental health discourses, practice, and education. My study is an important intervention in this literature, as my focus on the experiences of YBW is often overlooked by researchers, who either examine the Black community as a homogenous whole or racialized people as a single unit. My research, focusing on the ways in which the mental health experiences of YBW in the GTA shape their help-seeking behaviours, generates significant insights into how we understand the intersectionality of race, gender, and mental health within the Canadian context.

Young Black Women, Mental Health, and Stigma

While several research studies (Alvidrez et al., 2008; Shefer et al., 2012; Thornicroft, 2008; Williams & Williams-Morris, 2000) have identified stigma as a barrier to youth access to mental health services and/or support in the United States, there is a paucity of research that examines how mental health stigma affects young Black men and women. Studies on mental health stigma rarely capture the unique interplay of race, gender, ability, and other social categories with mental health issues (Beauboeuf-Lafontant, 2007; Etowa et al., 2007; Jones & Guy-Sheftall, 2015; Okeke, 2013). While young Black men have received some attention in the literature for the adversities they face, such as involvement with the criminal justice system, low educational attainment, and mental health challenges (Crichlow & Lauricella, 2018; James et al., 2010), young Black women (aged 18–25) are rarely discussed.

My research directly addresses this significant gap in the literature by contributing much-needed data on the specific experiences of young Black women within the Canadian context. More specifically, I examine how the gendered and racialized identities of young Black women influence their experience with mental distress and mental health stigma. Such a question provides us with clear elucidation of how a young Black woman's sense of self not only induces

or contributes to her mental distress, but also influences her reaction to the situation, including her willingness to seek help. Black women are often made to feel invisible by dominant societal discourses that do not recognize the complexities of walking through the world as Black and as a woman (Benn-John, 2016; Billups et al., 2022; Mowatt et al., 2013; Neeganagwedgin, 2013; Showunmi, 2023). Accordingly, their experiences, particularly as they relate to mental health concerns, are often minimized or conflated with those of Black men or White women, even though their experiences, needs, and barriers are unique.

In her book *Ain't I a Woman*, hooks (1989) called attention to the invisibility of Black women and the exclusion of Black women from Women's Studies, as well as the sexism and racism to which they are relegated. More recent research has confirmed this reality in multiple contexts, such as higher education (Chapdelaine et al., 2023; West et al., 2021), employment (Cooke & Hastings, 2024; Hall et al., 2012; Williams, 2023), maternal health care (Cotton, 2022; Matthews et al., 2021; Taylor, 2020), and many others. For example, a research study conducted with Black women college students attending a historically White university found that these Black women experienced both hypervisibility and invisibility (Newton, 2023). Through qualitative interviews conducted with 25 undergraduate Black women using an intersectional lens, findings revealed that they experienced invisibility through microaggression from White students in all areas of the campus and hypervisibility based on patriarchal norms in the classrooms by White instructors. Microaggressions in the classroom depicted controlling images such as the angry Black woman and the strong Black woman tropes (Newton, 2023).

There are a few studies that focus on young Black women's health in the Canadian context, but none specifically explore their experiences with mental health and stigma. Community-based research conducted by the Toronto-based Women's Health in Women's Hands

Community Health Centre (2003) explored racial discrimination as a health risk for young women of colour aged 16–22 using a focus group of 15 young, racialized women. Anti-racist practitioners were also recruited to participate in a focus group to talk about working with young, racialized women. The researchers found that 42% of participants reported experiences of racism in both the health care system and in society more broadly, which was detrimental to their psychological well-being. The authors also found that approximately 20% of the young women in the study experienced racism within the health care system in the form of dismissal, cultural insensitivity, and substandard care. The authors concluded that gender, race, and class affect the experiences of young, racialized women in all sectors. They generated policies and strategies to develop anti-racist modes of practice suitable for caring for young, racialized women in Ontario. Both the methods of this research and its findings provide valuable background for my study, as it explored the experiences of young Black women with health care in general.

Other than the Women's Health in Women's Hands (2003) study, most of the literature on this issue focuses on Black women in the US. Thomas and colleagues (2011) used focus groups with 17 African American women aged 15–22 years to explore the meaning and salience of gendered racial identity. Participants were asked a number of questions about their racialized and gendered identities, such as, "What does it mean to be an African American, and what does it mean to be a woman?" (Thomas et al., 2011, p. 532). Their results indicated that race and gender simultaneously influenced the participants' perceptions of themselves, and that, importantly, the young women's experiences reflected a greater salience of gendered race than race and gender as individual and separate constructs.

Further, Shorter-Gooden and Washington (1996) examined the experiences of 17 Black women college students aged 18–22 years at a community college in the American South

regarding identity formation. Semi-structured interviews were used to determine the relative salience of identity domains, including race, gender, sexual orientation, relationships, career, and religious and political beliefs. Results indicated that racial identity had the greatest significance for identity formation, followed by gender. The notion of strength also emerged as an important aspect of the young women's identities. Shorter-Gooden and Washington (1996) concluded that the young women developed a sense of strength in reaction to struggling with race and gender, two ascribed devalued identities, and that this strength might be protective against the negative psychological effects of racism and sexism. While this study cannot be generalized to all young Black women, it sheds light on the impact that one's self-perception can have on mental health and responses to mental distress.

Using data from the National Survey of American Life, Seaton and colleagues (2010) employed an intersectional approach to examine psychological well-being and perceived discrimination among 810 African American and 360 Caribbean American Black youth aged 13–17 years living in the US. The results of this study indicated a link between perceived discrimination and depressive symptoms, low self-esteem, and low life satisfaction, while also finding that positive race group identity was correlated with good mental health among Black youth in the US. Furthermore, the researchers suggested that "Black Caribbean young women may experience more psychological distress than other Black youth due to cultural and economic expectations placed on them" (Seaton et al., 2010, p. 1374). They also noted that age is a factor, as older adolescents in the study reported higher levels of discrimination and lower life satisfaction than younger participants (Seaton et al., 2010). These findings are relevant to my study: the Black population is not homogeneous, and differences in experience across subgroups of young Black women should be considered.

To generate insights into the challenge of stigma within Black communities, Craddock and colleagues (2023) examined how community perceptions of mental health impact young Black women's perceptions of mental health and thereby inform help-seeking behaviour. The authors conducted 48 semi-structured interviews with YBW aged 18-24 in Los Angeles, California. From their analysis, three themes emerged: 1) a lack of discussion, 2) conversations being had, and 3) the expectations of Black women. The findings from their study underscore the need for mental health researchers and service providers to engage with community-based organizations to provide safe spaces where concerns can be discussed.

In an effort to disaggregate the concept of the Black community as a homogenous whole, Richards and colleagues (2018) sought to elucidate the impacts of intersectional trauma experienced by Black, lesbian, bisexual, and queer young women. This study demonstrates that the intersections of race and sexuality produce significant levels of discrimination in society in general, but also within the LGBTQ community. The rejection that Black LGBTQ people face from the LGBTQ community, coupled with the pressure to remain closeted within their own communities, causes them significant harm. Such an intervention is important for disaggregating data on Black communities into the complex identities and people who comprise them.

Adding to this literature, my study of young Black women aged 18–25 years takes into account the discrimination this population faces, which may, in turn, influence the impact of stigma on their mental health and subsequent help-seeking. There are several studies that speak to how stereotypes affect Black women's well-being. For example, Jerald and colleagues (2017) explored the mental and physical health consequences of racial and gender stereotypes on 609 Black women college participants and whether these were moderated by racial identity. A structural equation model was used to test the direct and indirect associations between meta-

stereotype awareness (or being aware that others hold negative stereotypes of one's group), mental health, self-care, and drug and alcohol use. The results indicated an indirect association between meta-stereotype awareness and increased substance use and lower levels of self-care. The authors also found that the impact of meta-stereotype awareness on well-being was greater for women whose racial identity was more central to their sense of self (Jerald et al., 2017).

While this study highlights the detrimental effects that stereotyping can have on the mental health of Black women, Jerald and colleagues (2017) noted that their model did not account for stereotypes such as the Jezebel, Sapphire, and Strong Black woman phenomena. Black women face unique forms of discrimination based on their race and gender (Collins, 2000; Crenshaw, 1989), manifesting in common conceptualizations of Black womanhood as fitting into the hyper-sexual Jezebel, the caring and nurturing yet stoic Mammy, the verbally and physically aggressive Sapphire, and/or the resilient and emotionally strong Black woman (Harris-Perry, 2013; Massaquoi & Wane, 2007; Parks, 2010; Waldron, 2019). Collins (2000) has described these and other stereotypes as the controlling images of Black women; images that have been used to position Black women beyond the scope of humanity, to pathologize Blackness, and to rationalize practices of domination of Black people in general and Black women in particular. Such images and stereotypes racialize, sexualize, and criminalize Black femininity, leading to dehumanization, devaluation, and disposability. Pathologization is implicit in these stereotypes, and mental health concerns may trouble such images further through the risk that diagnosis will inadvertently reinforce them. This would present a unique challenge or barrier for young Black women to acknowledge mental health distress and seek support for it.

More recently, research conducted in the US examined the mental health and service engagement experiences of 15 young Black women aged 18–30 years (Modeste-James et al.,

2024). Using a descriptive phenomenological approach and semi-structured interviews, the study found that participants' willingness to engage with mental health services was inhibited by the strong Black woman schema, mental health stigma in the Black community, and intergenerational mental health stigma (Modeste-James et al., 2024). While this study contributes to the field of mental health, no analysis was made in terms of the relation of mental health stigma specifically to anti-Blackness.

While mental health stigma is most spoken about in regard to help-seeking among Black populations in Canada, the connections between stigma and racism are least addressed. Typically, stigma and racism are conflated, without careful attention to the role that anti-Blackness plays in the mental health experiences of young Black women. Much of this literature was not grounded in critical theory, which contextualizes these experiences within historical and contemporary power dynamics, structures, and discourses. Further, much of this literature did not attend to the nature of walking through an anti-Black world in a Black body and the implications of this reality on young Black women and their engagements with mental health.

Racism and Mental Health in Canada

In her review of the literature on racial inequalities in health care, Nestel (2012) argued that Canadians prefer to see themselves as a raceless society that is more tolerant and multicultural than American society. This preference, or more accurately, this colour-blind idealization, is supported by governmental messaging and global positioning, and is so strong that race and racism are not fully accepted as appropriate areas of research in the health and mental health arenas, rendering issues regarding race relations unexamined and ostensibly erased within the Canadian context (Nestel, 2012).

Correspondingly, there is a limited body of research in Canada regarding the relationship between racism and mental health (Brondolo et al., 2009; West et al., 2014), even though racism has been associated with deleterious physical and mental health outcomes and reduced well-being in numerous studies conducted in the US and the UK (Fernando, 2012, 2017; Grollman, 2014; Williams & Mohammed, 2009). This research is supported by the few notable Canadian studies that focus on racism and mental health. For example, James and colleagues' (2010) study, titled "The Racism, Violence, and Health Project," explored the experiences of racism and violence of Black Canadians in Toronto, Montreal, and Halifax. In this study, the majority of Black Canadian participants from all levels of society reported experiences of racism that they felt negatively impacted their mental health (James et al., 2010).

According to the Canadian-based Black Health Alliance (2016), many young Black adults battle isolation, depression, social anxiety, low self-esteem, and other mental health concerns. In their examination of the incidence of psychotic and schizoid-affective disorders among first-generation immigrants and refugees aged 14–40 in Ontario, Anderson and colleagues (2015) found that 60% of Black people in Ontario are at an increased risk of psychosis relative to the general population. According to Ontario Health Study survey data, while the rate of mental health issues may be higher among Black people than in other racialized groups, such as South Asian, East Indian, and Southeast Asian populations, Black people are significantly less likely than members of other racialized groups to see a psychiatrist (OICR News, 2016). In an American study, Ward and colleagues (2013) found a similar reluctance to seek help amongst Black Americans. Dr. Natasha Browne, a Toronto-based psychologist whose clients are predominantly Black, supports the idea that not only are mental health concerns difficult for Black people to discuss, but they are also often hidden in Black communities. Here, Dr. Brown

speaks to the narratives among health professionals that link under-recognition and under-utilization of supportive services to fear of stigmatization (Black Health Alliance, 2015).

Black people, the third largest racialized group in Canada, remain the most stigmatized of all racialized groups (Adjei, 2018; DasGupta et al., 2020; Ontario Human Rights Commission [OHRC], 2018). A report from the OHRC in 2018 confirmed that Black people in Ontario have experienced and continue to experience a unique kind of racism. Findings released from Justice Michael Tulloch's *Independent Police Oversight Review* on carding revealed that Black and Indigenous people are disproportionately targeted by Toronto Police (OHRC, 2018). Furthermore, the report found no evidence that this practice affected the crime rate; yet police administrators have strongly opposed ending it (OHRC, 2018). This oppressive reality is alarming for Black people and members of other racialized groups in Canada. It does not foster trust in the people who are supposed to "protect and serve" all Canadians, but rather cultivates a climate of fear, risk, the threat of violence and death.

Along these lines, racial disparities are also evident in child welfare systems, with Black youth over-represented in child welfare cases (Pon et al., 2011), and newcomer families involved in the child welfare systems experiencing unprecedented racism throughout the process (Kikulwe & Maiter, 2024). It also follows to demonstrate that Black populations in Canada are further disadvantaged in housing as well as in educational systems (Codjoe, 2001; Do, 2020). Additionally, the COVID-19 pandemic further illuminated and deepened the health and mental health inequities faced by Black populations in Canada (Armstrong et al., 2022; Baidoobonso et al., 2025; Dixon et al., 2023; Kemei et al., 2023; Osman et al., 2025; Salami et al., 2024). Accordingly, the Public Health Agency of Canada has declared race as a social determinant of health (PHAC, 2020).

In the literature, some scholars conceptualize stigma as a by-product of racism that serves to attach negative values to these attributes that are identified in the categories of race, based on systems of oppression and inequity founded on ethno-racial differences in areas such as sociocultural beliefs, attitudes, and institutionalized practices (Jones, 2000; Shorter-Gooden, 2004). Stigma is not a static phenomenon, nor is its conceptualization uncontested (Pescosolido & Martin, 2015). Some researchers assert that stigma can never convey the harshness of its impact on varying populations, such as those living with marginalized identities or stigmatized circumstances, such as mental health (Link & Phelan, 2001; Pescosolido & Martin, 2015). Stigma can be understood as a discrediting attribute, usually associated with negative stereotyping and created through particular social interactions (Goffman, 1963). Jones (2000) described three forms of racism, all of which contribute to the formation and perpetuation of race-based stigma in different but overlapping ways, which include institutionalized (differential access to services, normative and structural exclusion), personally mediated (unintentional or intentional prejudice, discrimination), and internalized (acceptance of negative messages about oneself, abilities and one's community). The social interactions that create racial and mental health stigma are reinforced, particularly when the stigmatized individual internalizes relevant dominant beliefs and thus must become aware of and negotiate their consequences (Buzi et al., 2018). Racism "produces and sustains material inequities and is anchored in prejudice, exclusion and poverty" (Howarth, 2006, p. 443).

Within the context of mental health, stigma has been identified as a barrier to accessing mental health services and/or supports for youth populations in general, but as Chandra and Minkovitz (2006) remarked, "little is known about the role of stigma in the mental health service utilization of minority teens" (p. 754). Various types of stigmas that affect the experiences of

individuals with mental illness have been identified in discussions on mental health. For example, Clement and colleagues (2015) outlined six categories of stigma that detail how people perceive, experience, and reproduce stigma. Other discussions have made reference to intersectional stigma that occurs when concrete and identifiable social, economic, and political power allows for identification of difference to give way to the construction of stereotypes, and for exclusion and discrimination to proliferate based on those stereotypes (Campbell & Deacon, 2006; Parker & Aggleton, 2003). *Double stigma* (Gary, 2005) refers to members of racialized groups who already suffer from the burden of mental health challenges, combined with prejudice and discrimination because of additional group affiliations, such as those related to race or gender identity.

These different forms of stigma can undoubtedly further compound the challenges associated with experiences of mental health issues, especially for members of groups that are already oppressed. However, this area is under-researched in Canada, as are the social and structural inequalities that have resulted from stigmatization. The following section outlines the significant dearth of literature that exists at present. This dissertation not only adds to this literature but responds to calls to action to better understand the resulting challenges of mental health within Black communities in Canada and to address the added complexities of race, gender, and age on their experiences.

Race, Racism, and Mental Health

Historically, mental health issues have been used to justify the denial of full humanity to Black people and to legitimize treating them differently under the law. Thomas and Sillen (1974) recalled two mental diseases named by physicians during the time of slavery: *drapetomania*, which referred to an incurable urge among Black slaves to escape their enslavement, and

dysesthesia aethiopica, which was believed to be a mental disease that caused Black slaves to be resistant to slavery. Here, mental illness and race intersect as both prescription and description to consciously and subconsciously anchor a political ideology marking Black people as less deserving of human and humane treatment. More recently, Kumsa and colleagues (2014), Danquah (1998), and Adjei (2018) have argued that a prevalent model of Blackness continues to deny Black people agency in different ways. Adjei (2018), writing on the interconnection between race and disability in diagnoses applied to Black youth in public schools in Toronto, argued that the underlying assumptions of who Black people are get incorporated into a notion of Black genetic inferiority and mental pathology. The effect of these underlying assumptions is the denial of full human qualities to those who live and walk in a Black body.

Many scientific theories developed between the 1850s and 1960s deployed this language of disability to justify the unequal treatment of Black and other racialized people. In the nineteenth century, Darwin's (1871) theory of evolution was used as a model for theories of human psychological development, in which races were held to exist at different stages of a biological ladder of human evolution, a view known as Social Darwinism. An important proponent of 'evolutionary racism,' Herbert Spencer (1864), who coined the term 'survival of the fittest, suggested that "the brain of the civilized man is larger by nearly thirty per cent than the brain of the savage" (p. 502). Thomas and Sillen (1972), in their review of racism and psychiatry, noted it was widely believed that social practices, such as "monogamy had been developed only by the higher races" (p. 6). Reviewing Herbert Spencer and other scientists' work, there was a clear racial interpellation that the minds of "primitive" races were like the minds of children; simple and unable to higher process thinking (Thomas & Sillen, 1972).

Black people suffering from depression are often misdiagnosed with schizophrenia, given anti-psychotic medication, and even institutionalized involuntarily (Fernando, 2012, 2017). Young Black men in both the US and the UK are more likely to be diagnosed with schizophrenia than members of other groups (Fernando, 2012). Racism, inherent in the diagnosis and treatment of the mental health issues of Black people, can be correlated with disproportionate incarceration rates, overdiagnosis, and misdiagnosis (Fernando, 2017). Often going hand-in-hand with racism in mental health environments is the form of violence in psychiatry called *sanism* (LeFrançois et al., 2013; Perlin, 1993). Sanism is defined as a system of oppression that includes discrimination and stereotyping of those who are labelled mentally ill at the individual level (LeFrançois & Peddle, 2021). In this way, disability "is not about someone's individual physical, mental or emotional ability, but rather about the social meaning that is placed on who is determined to have or perceived to have unacceptably abnormal mental or emotional capabilities and presentations" (Withers, 2024, p. 19). According to Fernando (2017), the biomedical model of disability reduces complex human needs to simplistic, static, and individualized definitions of illness and abnormalcy, blaming and shaming the individual as deficient or a problem.

When sanism interlocks with racism, it creates a unique form of violence, or what Meerai and colleagues (2016) have called *anti-Black sanism*. In an anti-Black sanist environment, the psychiatrist is the expert who decides the humanity or inhumanity of the supposed abnormal 'other'. These determinations then serve as the basis for surveillance, control, and violence in the name of "helping" (Voronka et al., 2014). Like anti-Black racism, sanism presents a particular type of discrimination (Meerai et al., 2016) that highlights the need for an intersectional analysis and asks the questions: how do sanism and ABR intersect to affect the treatment of Black

people? How do mental health services respond to Black people who have been labelled mentally ill?

Historically, Black humanity has suffered at the hands of psychology, psychotherapy, and other mental health fields (Fernando, 2017; Wilcox, 2023), and yet, Black people's reluctance to acknowledge mental health challenges is seen as resulting from mental health stigma. This long history is rooted in scientific racism that was first articulated in the Enlightenment period by John Locke, who codified slavery into English colonial law in America. In his book *An Essay Concerning Human Understanding*, Locke (1689) argued that enslaved Africans were to blame for their own plight due to personal failings. This notion of racial difference and inferiority was further articulated by other Enlightenment scholars, such as Immanuel Kant, who developed the scientific method with racial difference (1764) at its centre, based on simple observation that resulted from racist assumptions (Eze, 1997). These antecedents persist over time in a linear trajectory, culminating in eugenics in the 1800s and 1900s, which persists in society as well-established norms to this very day. All of these and more negative experiences with health science and care have made Black people reluctant to seek out support that they know is likely to dismiss their concerns and cause further harm.

A case in point is the examination by Daley and colleagues (2012) of the gendered, sexed, and racialized bodies of women in psychiatric spaces. Using a critical feminist analysis, Daley and colleagues (2012) conducted a retrospective chart review of women psychiatric inpatients to explore institutional practices related to the documentation of gender, sexuality, and race in an urban Canadian psychiatric clinic. The researchers examined 10 clinical programs, five inpatient and five outpatient, where care was provided by interdisciplinary teams that included psychiatrists, psychologists, nurses, and social workers. Of the 25 women whose files were

reviewed, 10 were Black. According to Daley and colleagues (2012), documentation practices of language use, composition, and de-contextualization were found to objectify and medicalize women's gendered, sexualized, and racialized subjective experiences of mental illness. Their findings indicate that the social, psychological, and historical contexts of the women's lives were either minimized or outright ignored in these clinical psychiatric settings. When mental pathology is visited on Black bodies, it is easier to subject them to both micro and macro aggressions. Kumsa and colleagues (2014) and Adjei (2018) observed that for Black people in Toronto, whose bodies may already stereotypically evoke a sense of anxiety and distrust, being diagnosed with a mental illness can further compound their adverse experiences.

Help-Seeking: Access and Utilization of Mental Health Services

Help-seeking behaviour represents individuals making the decision and taking the initiative to seek psychological support for their mental health concerns. In the case of young Black adults, any mental healthcare is defined as services rendered that are responsive to the person's cultural, racial, and ethnic identities (Fante-Coleman & Jackson-Best, 2020). Help-seeking can also be viewed as the action of actively searching for help for mental health problems, including from informal (family, friends) or formal (general physicians, mental health professionals, psychiatrists, social workers) sources, based on interpersonal and social abilities (Aguiree et al., 2020). Notisha Massaquoi (2017), speaking at the Anti-Racism Conference as the Executive Director of Women's Health at Women's Hands, noted that race determines how and when Black people seek health care, particularly mental health care. She also noted that anti-Black racism limits access to service and deters help-seeking because it creates an anticipation of stigmatization of one's race and mental health status. She further shared that due to the lack of

race-based data it is often difficult to track to what extent Black people are voluntarily engaging in mental health services.

There is a paucity of research on the help-seeking behaviours of young Black adults living with mental health concerns in Canada; the few that exist are not specific to the experience of young Black women. A scoping review that examined barriers and facilitators to accessing mental health services in Canada found that many of the obstacles to mental health care for Black youth were structurally based. These barriers included wait times to access mental health practitioners, as well as geographical and financial barriers to care (Fante-Coleman & Jackson-Best, 2020). Salami and colleagues (2023) reported on participatory action research (PAR) conducted in Alberta that examined barriers to access and utilization of mental health services through a youth empowerment model. Similarly, they found that the main barriers to youth accessing mental health supports include a lack of cultural inclusion and safety, a lack of knowledge regarding services, financial barriers, and stigma. While these studies contribute to the knowledge gap in terms of Black youth experiences with mental health and help-seeking, they do not specifically address the unique experience of young Black women.

There is an extensive body of literature that speaks to help-seeking for mental health concerns in the US and to the stigma associated with seeking help. Several studies suggest that African Americans experience serious challenges in acknowledging, understanding, and addressing mental health issues (Matthews et al., 2006; Ward et al., 2013). Ward and colleagues (2013), using in-depth interviews and the Commonsense Model (a construction of lay theories based on common sense), examined beliefs about mental illness, coping behaviours, and barriers to treatment-seeking among African American women aged 25 years and over. The findings indicated that the participants' beliefs about mental illness were influenced by culturally specific

and age-related factors, as well as an ambivalence toward medications, stigma and lack of awareness about mental illness as barriers to help-seeking. Further, they noted a few differences between older and younger women, but the older participants had more favourable attitudes toward help-seeking. This study and others in this area focus on older adult populations and/or college students, with a paucity of research on Black women aged 18–25 years.

Only a few studies were found that specifically address the impact of stigma on the help-seeking behaviour of young adults or youth. Kranke and colleagues (2012) examined whether the attitudes toward seeking help for mental illness were the same among African American adolescents and African American adults. Using secondary data from a larger study of 40 adolescents, data from semi-structured interviews with 17 African American adolescents aged 12–17 were analyzed. They found that the adolescents' attitudes toward mental illness were similar to those found to be held by African American adults in other research studies, but they found that peers and media images had a greater influence on their attitudes than they did on those of African American adults (Kranke et al., 2012). The researchers found that the adolescents mistrusted mental health practitioners and endorsed a belief common to African American adults that psychiatric medication is for "crazy" people (Kranke et al., 2012, p. 66). While the findings of this study provide some insight into stigma around mental health, it only addressed one form of mental health-seeking behaviour and therefore does not provide a holistic picture.

Nadeem (2007) explored whether stigma kept poor, young immigrant and US-born Black and Latina women from seeking mental health care. Using questionnaires, the researcher examined the extent to which stigma-related concerns about mental health care account for non-use of mental health services among 15,383 low-income immigrant and U.S.-born Black and

Latina women who were screened for depression. Participants were asked to respond to questions about stigma and whether they wanted and/or were getting mental health care. It was found that stigma may play an important role in service use by racialized women, but that there were differences between the groups surveyed. Black women in the study group appeared to be more reluctant to seek help for their mental distress than either their Latina or White sample counterparts. Nadeem's (2007) study is informative for my research in that it supports the notion that stigma around mental illness may disproportionately affect Black women. It also raises further interesting questions; for example, to what extent did mental health stigma account for the women's reluctance to seek help as opposed to race-based stigma?

While stigma may often be cited as a major barrier to Black people seeking mental health support, it has also been demonstrated that the pathways to mental health services for Blacks present differently than they do for other groups. For example, the Wellesley Institute conducted a 2005 study examining the role of "Afro-Canadian" status in police and ambulance referrals to emergency psychiatric services (Jarvis et al., 2005). The study revealed that Afro-Canadian patients admitted to hospital with psychosis were more likely to have been brought there by police or ambulance than members of other groups. In addition, the 2006 Aetiology and Ethnicity of Schizophrenia and Other Psychoses (AESOP) study on the high rates of psychosis among African Caribbean and Black African patients in the US revealed that these two populations of patients were more likely to be referred to mental health services by the police via the criminal justice system than White patients were (Morgan et al., 2006). This raises the question of what impact these practices by police and mental health services have on young Black people's attitudes to mental health challenges and help-seeking.

CHAPTER 3: THEORETICAL FRAMEWORKS

Theory is the "explanation of a phenomenon and its meaning derived through analysis, critical thinking and an articulation of discourses and connection of ideas" (Schmid & Ferrer, forthcoming; Ives et al., 2020). However, few theories consider Black women's multiple identities and roles, and how these interact to shape unique experiences. This study utilizes critical race theory (CRT), Anti-Black racism (ABR), and critical disability studies (CDS) frameworks to guide the exploration of young Black women's experiences with mental health challenges and help-seeking. These three theoretical orientations centre on their critical foundations, which my research utilizes to identify current gaps, disparities, and injustices within individuals' lived experiences of mental health diagnoses and treatment. Such an approach enables me to understand the challenges and offer recommendations for how these challenges might be addressed at the end of the study.

Using CRT, ABR, and CDS together provides an opportunity to understand the historical and contemporary weaponization of disability language to justify the inhumane and dehumanizing treatment of Black people in general and young Black people in particular. For example, mental health conditions were used to justify the enslavement of Black people in the United States and Canada. In the article "Diseases and Peculiarities of the Negro Race," published in the *New Orleans Medical and Surgical Journal,* Dr. Samuel Cartwright (1851), a highly respected and widely published doctor from the University of Louisiana, made disturbing and racist arguments:

> It is this defective haematosis, or atmospherization of the blood, conjoined with a deficiency of cerebral matter in the cranium, and an excess of nervous matter distributed to the organs of sensation and assimilation, that is the true cause of

> that debasement of mind, which has rendered the people of Africa unable to take care of themselves.

Dr. Samuel Cartwright then coined two diseases peculiar to Black people:

> Drapetomania, a condition that caused slaves to run away— "as much a disease of the mind as any other species of mental alienation"— was common among slaves whose masters had "made themselves too familiar with them, treating them as equals." The need to submit to a master was built into the very bodies of African Americans, in whom "we see *'genu flexit'* written in the physical structure of his knees, being more flexed or bent, than any other kind of man." After attributing the condition to 'treating them as equal' or frightening them by cruelty, Cartwright advocated a mixture of 'care, kindness, attention and humanity', with punishment 'if any one or more of them, at any time, are inclined to raise their heads to a level with their master or overseer ... until they fall into that submissive state which was intended for them to occupy.' (pp. 319–320)
>
> Dysaesthesia Aechiopis— It was a disease affecting both mind and body, with 'insensibility' of the skin and 'hebetude' of mind. Cartwright reckoned it to be commoner 'among free slaves living in clusters by themselves than among slaves in our plantations, and attacks only such slaves as live like free negroes in regard to diet, drinks, exercise, etc.', but stating his disinterest in treating the 'disease' among 'free negroes.' (p. 321)

These two examples elucidate the historical antecedents of scientific racism that labeled Black people as different from White people. This history is still with us. Through the application of CRT, CDS, and ABR, I have the conceptual and theoretical clarity to understand why there is

resistance and instability within the Black community, particularly when mental health becomes a subject of conversation that foregrounds experience, history, and context. These overarching theories do not work in isolation but intersect inextricably, focusing on storytelling as a means toward systemic change. This chapter describes the guiding frameworks of this work, including a discussion of their historical contexts, their key concepts engaged throughout this research, and why they are effective at theorizing the mental health and support-seeking behaviours of young Black women.

Critical Race Theory (CRT)

Critical race theory (CRT) is a result of legal scholarship that emerged from the civil rights and critical legal studies movements in the United States (US) during the 1950s and 1960s. In the 1980s, a group of predominantly racialized civil rights activists and legal scholars—including Derrick Bell, Kimberlé Crenshaw, Richard Delgado, and Patricia Williams—observed that the enthusiasm that greeted racial reforms in the U.S. during the civil rights movement had gradually dissipated. They also noted that the former approaches of protesting and appealing to the moral sensibilities of American citizens were yielding fewer results. After a seminal critical legal studies alternative conference on the silence of race, CRT as an activist movement exploded, and scholars built on earlier discussions of race and racism in jurisprudence.

At its core, CRT is concerned with harms of racial bias and how to move through the legal system, as well as with the unjust practices and policies of economic, political, and social institutions (Aylward, 1999, 2002; Bell, 1980; Delgado, 1995; Delgado & Stefancic, 2012; Hayden, 2015; Valdes et al., 2002). In recent years, the use of CRT has extended into other disciplines, such as women's studies (Calliste & Dei, 2000), education (Ladson-Billings, 1998), and social work (Abrams & Moio, 2009; Constance-Huggins, 2012; Kolivoski, 2014; Rank &

Hirschl, 2002). CRT directly situates race and other identities at the centre of our theorization, thus enabling us to understand the claims of racelessness/post-raciality/colour-blindness that are common in our institutions, which invalidates and obscures those who experience the genuine, tangible impacts of racism and white supremacy.

Despite extensive evidence of experiences of racism throughout Canada's history, CRT did not appear in Canadian literature until the 1980s. Scholars such as Aylward (1999), Dua and colleagues (2005), and Razack (2002) have asserted that Canada's institutions fail to acknowledge the inherent history and legacy of racism within, from slavery, to the judicial system, to Canadian society in general. Pon (2009) referred to this non-acknowledgement as an ontological forgetfulness, asserting that liberal-democratic nation-states like Canada tend to forget the genocide of Indigenous peoples, of "White supremacy, racism and Western imperial projects that proved central to the states' formation and ascendancy" (p. 66). Despite this White supremacist amnesia, CRT is finding expression in Canada through the work of Carol Aylward and other scholars in the curricula of departments like social work and education, as well as through local community legal groups like the African Canadian Legal Clinic in Toronto.

Main Principles of CRT and Application to Research

As a theoretical framework, CRT is multifaceted, with broad applications that theorize the existence of racism, its dynamics, and how they shift over time and across different groups (Abrams & Moio, 2009; Delgado & Stefancic, 2000, 2021, 2012, 2017; Dixson et al., 2018). CRT operates from the standpoint that race is socially constructed, and that such constructions inform inequitable laws promoted through a legal system that privileges some races over others (Delgado & Stefancic, 2001). This theory "explains the reiterative ways race is socially constructed across macro and micro levels" (Brown, 2003, p. 294). CRT involves a commitment

to seeing the social construction of race as central to the way that people of colour are ordered and constrained in society, weaponizing perceived and arbitrary racial differences to justify differential treatment.

This dissertation focuses on three particularly relevant tenets of CRT: racism as an everyday, ordinary occurrence in the lives of racialized people, counter-storytelling as resistance, and intersectionality as a critical analytical lens. The crux of CRT is that racism is an ordinary, everyday occurrence, although it often remains hidden beneath a veneer of normalcy where only the undeniable and outward acts of racism are seen as problematic. CRT also challenges ahistoricism by emphasizing the importance of understanding the social, economic, and historical context of Black people's experiences and how these contexts influence the present (Matsuda et al., 1993). In doing so, it challenges the claims of post-raciality, that racism no longer exists in society, by foregrounding lived experience within context.

The CRT principle of counter-storytelling is instrumental in this research. Delgado and Stefancic (2001) define counter-storytelling as a way "to cast doubt on the validity of accepted premises or myths, especially ones held by the majority" (p. 144). CRT examines the relationship between race, racism, and power, more specifically, the ways that White supremacy saturates society and ignores the experiences of people of colour (Solórzano & Yosso, 2002). Counter-storytelling asserts that experiential knowledge allows racialized individuals to name their own realities (Ladson-Billings & Tate, 1995). According to Delgado and Stefancic (2001), this is especially important as "many victims of racial discrimination suffer in silence or blame themselves for their predicament" (p. 43). CRT draws attention to the individualizing nature of White supremacy, which focuses blame on individuals, establishing barriers and challenges as personal failures rather than intentional systemic gaps induced by Whiteness. By putting a name

to discrimination, counter-storytelling serves as "a tool to counter deficit storytelling" (Solórzano & Yosso, 2002, p. 23). Counter-stories challenge stories that reflect the experiences of the dominant group, embedded in institutions that continually (re)produce the dominant story as the *only* story.

Along similar lines, CRT understands race and racism as central constructs that intersect with other dimensions of individual identity, such as gender and class. For people of colour, these other dimensions can elicit multiple, complex, and intersecting forms of oppression (McCall, 2005). Emerging during the so-called second wave of feminism, *intersectionality* highlights the mutually constitutive forces of gender, sex, race, class, and disability (Combahee et al., 1977; Crenshaw, 1989, 1991, 2015; Nash, 2008; Puar, 2012). While Kimberlé Crenshaw coined the term, the earliest expression of this concept was a manifesto written by the Combahee River Collective in 1977, in which they stated, "We often find it difficult to separate race from class, from sexual oppression because in our lives they are most often experienced simultaneously" (p. 234). As the concept of intersectionality developed, however, it became clear that social categories do not merely interact but continuously mediate one another (Simien, 2007). Indeed, an intersectional approach purposefully examines the overlapping and intersecting social identities associated with structural and systemic oppression and discrimination (Crenshaw, 1989). According to Crenshaw, who is the co-founder and executive director of the African American Policy Forum (AAPF),

> intersectionality is a concept that enables us to recognize the fact that perceived group membership can make people vulnerable to various forms of bias, yet because we are simultaneously members of many groups, our complex identities can shape the specific way we each experience that bias. (Gillborn, 2015, p. 278)

Importantly, intersectionality highlights power within a dominant culture and discourse and what it means to be 'other' in normative settings. In the current study, intersectionality as an analytical tool supports a deeper examination of the influence of stigma on the mental health experiences of young Black women in Toronto.

CRT is a well-suited analytical tool for exploring the effects of race-based disparities on the help-seeking of young Black women in Toronto as they narrate their experiences of mental health concerns and the barriers they face in accessing support. Study participants' stories, in their own words, reveal the complex layers that contribute to their experiences with mental health concerns and other challenges due to their race, gender, age, and other aspects of their identity. Counter-stories act as an antidote to the insidious silencing of Whiteness, allowing the participants to name their reality on their terms (Bell, 1993; Delgado & Stefancic, 2000; Ladson-Billings & Tate, 1995; Parker, 2003; Solórzano & Yosso, 2002). CRT foregrounds the impact of race as a social construction and theorizes the ways White supremacy and mechanisms of Whiteness are built into institutions, thereby creating disparities and unjust treatment for racialized people. Further, it provides a basis to examine how social structures influence one's psychological health and subsequent response to mental distress. CRT is grounded in the everyday, practical ways that race, racialization, and racism impact the lives of racialized people, like the young Black women at the center of this study.

Anti-Black Racism (ABR)

The concept of anti-Blackness dates back to the 20th century, when W. E. B. Du Bois (1903) spoke to the "problem of the 'color-line,'" or the role of race and racism in the context of the U.S. and in the Western world in general. In Du Bois's (1903) book, *The Souls of Black Folks*, he considered the problem of the colour-line not only at the individual and national levels

but rather in the larger context of time and space. Anti-Black racism (ABR) as a conceptual framework has been developed by Black scholars in different contexts (Bernard, 1972; Mullings, 2022; Pinderhughes, 1970). ABR denotes the particular form of "systemic and structural racism in Canada and North American societies that have historically and contemporarily been perpetuated against Blacks" (Benjamin, 2003, p. ii).

Anti-Blackness was first recognized on a broad scale in Ontario in 1992, in the Stephen Lewis report, commissioned by the Ontario provincial government, which addressed anti-Blackness across all facets of Black people's lives (Lewis, 1992). ABR "differs in kind and extent of racism from that faced by many other groups and that merits distinct forms of intervention" in Canada (Hasford et al., 2013, p. 125; Lewis, 1992). In 2017, the United Nations declared that the inequities that Black people in Canada face are a direct result of historical anti-Black racism rooted in the legacy of enslavement and colonization (UNHRC, 2017). The United Nations report further asserted that ABR is sustained through the perpetuation of false stereotypes and assumptions that Black people are inherently angry, lazy, unintelligent, and undeserving (Mullings et al., 2021).

All racialized groups experience some degree of systemic discrimination. While CRT is frequently used as a frame of analysis in education, legal studies, and other disciplines to theorize race and racism, it also speaks more broadly to the heterogeneity of racism. With its guiding framework of intersectionality, theoretical offshoots of CRT have emerged, such as TribalCrit, LatinCrit, and AsianCrit. In the context of this research, CRT is strengthened through the use of ABR, a conceptual framework that also focuses on race and racism but highlights the particular history and manifestation of racism against Black people within the context of

Blackness in a White supremacist society. The most relevant definition of ABR for this research is the one proposed by the African Legal Clinic (ACLC) in Ontario that asserts:

> Anti-Black racism is prejudice, stereotyping and discrimination that is directed at people of African descent and is rooted in their unique history and experience of enslavement. Anti-Black racism in Canada is often subtle and is generally not accompanied by overt racial slurs or explicitly prohibitive legislation. However, it is deeply entrenched in Canadian institutions, policies and practices, such that anti-Black racism is either functionally normalized or rendered invisible to the larger white society. (Mullings et al., 2016, p. 23)

From this definition, it is clear that anti-Black racism is a deeply structural issue that seeps through all institutions and systems in our society.

Black communities in Canada experience broad health and mental health disparities due to the discrimination that they face (Bernard, 2008; James et al., 2010). I chose ABR as a theoretical approach in addition to a broader critical race focus to highlight the specific types of racism participants experience as young Black women living with mental distress and seeking support. Accordingly, ABR is a significant contributory factor to mental health distress within the Black community (Benjamin, 2003; Gajara et al., 2021; Goddard et al., 2023; Salami et al., 2022; Waldron, 2021). Combined with the strong analytical basis of CRT, ABR sheds light on the nuanced, historical, contextual and everyday experiences of young Black women living in Canada. Both CRT and ABR focus on counter-stories, thereby indicating "resistance against dominant and hegemonic systems of Whiteness and the building of agency and transformation against racism and other oppressions" in their very approach (Benjamin, 2003, p. ii).

In the current research, I use ABR to examine the historical and contemporary institutional practices and policies that perpetuate racism, thereby creating and maintaining adverse conditions that impede access to resources and opportunities for young Black women living with mental distress. Utilizing this framework supports the reclamation of the humanity and inherent dignity of Black people, whose identities have been historically deemed inferior. Additionally, ABR helps to deconstruct the mental health experiences of young Black women within historical and contemporary contexts, which I focus on in more detail in the following section.

Critical Disability Studies (CDS)

During much of the 20th century, the medical model of disability was the central paradigm for understanding disability, establishing "able-ness" as the normative standard against which disabilities were measured (Pothier & Devlin, 2006; Hosking, 2008). Critical disability studies (CDS), a theoretical framework that has been taken up in scholarship within the last several decades, is a "tool of analysis" (Larson, 2017, p. 257) that covers a broad range of interdisciplinary work, including identifying and combating ableism and (dis)ableism, advocating for disability rights, and challenging discrimination, oppression, and violence. In doing so, it theorizes the meaning of disabled identity in relation to race and gender.

CDS looks at forces external to the individual, including environmental barriers, as opposed to blaming the person living with a disability. CDS views disability as a

> social construct, not the inevitable consequence of impairment, [that] can be best conceptualized as a complex interrelationship between impairment, individual response to impairment and the social environment and social disadvantages that are caused by the physical, institutional and attitudinal environment. (Hosking, 2008, p. 7)

CDS explores how “people with disabilities are ostracized, medicalized and excluded from what society defines as normal” (Price, 2011, p. 29). It also “severs the notion of disability from personal tragedy, biological deficiency, and physical trauma and relocates disability to social, cultural, economic and social registers” (Goodley, 2013, p. 634). Critical disability theorists have argued that “disabled bodies risk becoming dis-embodied due to constructions around them that threaten to create a total invisibility of the disabled individual” (Goodley, 2013, p. 635). While disability in these spaces has traditionally referred to observable disabilities, invisible disabilities, such as mental health challenges, are now receiving attention from CDS scholars (Mollow, 2006).

One of the core elements that CDS considers is language, including how it is used and (mis)understood and how it holds and maintains power. Language is “inherently political as it carries ideological implications which are more or less transparent” (Goodley, 2013, p. 633). Accordingly, CDS focuses on linguistic conventions that structure meanings assigned to bearers of mental health and disability, and the patterns of response that emerge from and are attendant upon those meanings. Despite this critical intention and view, there have been critiques levelled at disability studies and spaces outlining the presence of racism and white supremacy in these spaces (Leonardo & Broderick, 2011; Meekosha & Shuttleworth, 2009; Schalk et al., 2025). As a result, what is meant to be a critical and transformative space can, at times, default to maintaining the status quo, rather than resisting or addressing it. In light of this criticism, I have chosen CDS for its strong focus on language and the pathology of ability, but view it as inextricable from the race-based analysis provided by both CRT and ABR. By merging the two together, and following Annamma and colleagues’ (2013) work, I argue that CDS, when paired with CRT and ABR, acts as a “framework that theorizes about the ways in which race, racism,

dis/ability and ableism are built into the interactions, procedures, discourses" of our institutions (p. 7). Along these lines of thought, this dissertation draws on the linguistic conventions of disability and their intersections with racism, focusing on the ways that language has been deployed in both historic and contemporary contexts to deny Black people's agency and humanity.

Baynton (2013) argues that the language of mental health and disability has been historically used to justify unequal and inhumane treatments, first, for people with disability and second, for racialized and marginalized groups. Baynton (2001) further argues that the language of disability has historically intersected with race to mark certain bodies, particularly Black people, as devoid of humanity and normalcy. As a result of this linguistic deployment, those deemed as 'disabled' were therefore deserving of any ill-treatment visited upon them. For example, the language of disability was prominent in justifying the enslavement of Black people. As mentioned earlier, Dr. Samuel Cartwright coined and deployed the languaging of disability through the diagnoses of drapetomania and dysaesthesia aechiopis; both of which pathologized the minds, resistance, and beings of Black bodies to justify the continued enslavement of Black people. Relatedly, Dr. J. F. Miller, in his argument against abolishment of Black enslavement, professed that Black freedom would result in increase cases of mental illness. Further, he noted that Black freedom would lead to the eventual extinction of Black race because Black people flourish in the "normalcy" of enslavement. Babcock (1895), a psychiatrist from South Carolina, also asserted that Black people were inherently incapable of coping with civilized life. Therefore, abolishing slavery and giving Black people freedom would result in increased cases of mental illness among them.

What is critical here is that through psychiatric language, Black people have been infantilized and treated as irrational objects to be feared (Baffoe, 2013). Psychiatrists Walter Bromberg and Frank Simon (1968) described schizophrenia as a "protest psychosis," or a mental disorder that caused Black people to develop "hostile and aggressive feelings" and "delusional anti-Whiteness" (as cited in Metzl, 2009, p. xiv). Not surprisingly, the second edition of the *Diagnostic and Statistical Manual* (*DSM*; American Psychiatric Association, 1968) published in 1968 recast the paranoid subtype of schizophrenia as a disorder of masculinized belligerence. This edition described schizophrenia as a condition that afflicted "Negro men," where the form of schizophrenia found in Black people was more hostile and aggressive than the form found in White people. This languaging made it possible to control and involuntarily institutionalize Black men suspected to be involved in civil rights movements. Instructively, many Black men involved in these movements were arrested, falsely diagnosed with "protest psychosis" and institutionalized at psychiatry hospitals (Adjei, 2024; Metzl, 2023; Singh et al., 2024).

Black populations experience the impact of what Meerai and colleagues (2016) have named anti-Black sanism in unique ways. Birnbaum (1960) coined the term "sanism" to describe the "oppression, belief system and a pervasive violence that makes it possible for psychiatric diagnoses, medication, and other therapeutics to strip away the dignity and livelihood of those deemed to be mentally ill" (as cited in Meerai et al., 2016, p. 21). Sanism, named notably by Poole and colleagues (2013), permeates all social institutions, such as schools, criminal justice systems, social services, and mental health services, and places sanctions on 'mad' people in the name of public safety.

Emerging as a "new force in mental health discourse and developments" (Beresford & Russo, 2016, p. 271), mad studies is a liberationist movement created for and by those deemed to

be “mad”: the people diagnosed with a mental illnesses and psychiatric survivors (LeFrançois et al., 2013). Mad studies provide another lens through which the experiences of people living with mental distress can be examined. However, the term “mad” has a long history of association with trauma in the Black community; therefore, it must be used cautiously (Fernando, 2012, 2017). Though I pull from some of the understandings in mad studies thinking, I have not fully engaged with this terminology for these reasons that indeed could be a dissertation in and of themselves.

Racism and ableism have been historically linked as logics of oppression, where both have been used as tools to determine intelligence levels and other capabilities (Annamma et al., 2013). In researching the experiences of living with mental health concerns among young Black women, it is critical to understand how “the language of ableism has been used to justify and rationalize the racist experiences of Black people” (Adjei, 2016, p. 10). Through CDS, I interrogate how the language of ableism constitutes different meanings for different bodies, particularly that impairment is inherently negative, something to be cured or eliminated.

Applying Theory to the Experiences of YBW Living with Mental Health Challenges

To bring CRT, ABR, and CDS into dialogue is to recognize the intersectionality of identities and the overlapping and mutually reinforcing forms of oppression (Larson et al., 2016). The intersection of race, disability, racism and mental health illustrates the complexities of navigating multiple systems when an individual is caught at the intersection of oppression (Willis et al., 2018). These emancipatory frameworks are grounded in a commitment to combat injustice, inequality, and discrimination against marginalized individuals rather than blaming individuals for their problems. Together, these three theories provide a unique lens through which to consider young Black women’s experiences of mental health concerns, including their understanding of how their identities intersect and affect the barriers they face. Ableism and

racism are both essential to explore when considering the experiences of young Black women with mental health concerns (Kumari Campbell, 2008). As Mollow (2006) argued:

> If race and disability are conceived of as discrete categories to be compared, contrasted, or arranged in order of priority, it becomes impossible to think through the complex intersections of racism and ableism in the lives of (dis)abled people of colour. (p. 69)

The combination of CRT, ABR, and CDS helps us to consider questions such as: How do Black people understand mental distress and disability? How does stigma help to explain Black people's experiences of mental distress? How has mental health been historically constructed through the language of ableism as it relates to Black populations?

Black people's experiences with mental health concerns must be understood in the context of their history of systemic oppression. Adjei (2013) and Poole (2011) argued that "the pathologization of Blackness in an anti-Black racism context constitutes such identity as a form of disability" (Adjei, 2013, p. 23). If the Black body is already historically pathologized, this in itself may make it more difficult for a young Black adult to accept and seek help for mental health concerns, as disclosing or identifying with mental health only compounds the perceived deficiencies that the White gaze sees as inherent in Blackness. Black people in Canada have profoundly negative experiences when accessing mental health care systems, creating barriers to care that have long-term impacts (Este & Bernard, 2003; James et al., 2010).

Summary

To use these frameworks effectively to explore the mental health challenges among young Black women, it is important to understand how they interrelate. While CRT did not initially embrace gender in its analysis, "second-generation CRT scholars have taken Bell, Delgado and Crenshaw's ideas and employed an intersectional analysis to include other social

categories such as gender, ethnicity, ability, culture, sexuality and other key markers of difference" (Morfin et al., 2006, p. 266). The notion of *intersectionality*, a term coined by Kimberlé Crenshaw (1989, 1991), emerged as one of CRT's fundamental tenets and has been subsequently developed in the social sciences and humanities. Intersectionality purposefully considers the impact of race, age, gender, ability, and other social categories as they intersect in different social, cultural, historical, and economic contexts. Intersectionality highlights where power exists within a dominant culture and what it means to be 'the other' in normative settings when one does not fit within the normative body. Intersectionality further considers the multi-dimensional nature and within-group heterogeneity of population subgroups.

Similarly, anti-Black racism (ABR) is an extension of race-based discrimination with particularity to Black populations within society at large. For example, young Black women between 18 and 25 years of age living with mental health concerns can have different experiences based on other intersecting identities (Harrison, 2017). Disability scholars are also making concerted efforts to theorize mental health and disability in a manner that demonstrates the ways that ability and race are co-constructed and perceived to be interdependent. When these two frameworks are combined, they provide a unique, multifaceted lens through which to consider the experiences of young Black women with mental health concerns and the ways they access (or do not access) support. Both theories take account of the politics of identity to allow for a fuller representation of their experiences, using stories and first-person accounts to foreground the perspectives of those who have experienced racism and ableism firsthand (Erevelles & Minear, 2010).

My study explores how race, gender, mental health distress and the pathologization of Blackness, along with other pieces of participants' identities, intersect in different social contexts to inform young Black women's experiences of mental health and seeking support.

CHAPTER 4: METHODOLOGY

The objective of this study was to explore how young Black women understand and construct their experiences with mental health in the Greater Toronto Area (GTA), centering their voices and experiences at the intersections of race, gender, mental health stigma and anti-Balckness. In exploring these experiences, the study was guided by the following research question: How do young Black women (18-25) in the Greater Toronto Area (GTA) experience mental health, and how do such experiences shape their help-seeking behaviours? This question has been further broken down into three sub-questions to focus on the scope of the research:

1. How do YBW become aware of and manage their mental health concerns?
2. How do the intersections of race and gender influence YBW's mental health experiences?
3. What role does mental health stigma play in YBW's experiences of service utilization for their mental health concerns?

This chapter provides an overview of the study's methodological framework and methods. It also makes explicit my epistemological and ontological orientation to this research, which led to the utilization of van Manen's (1990) hermeneutic phenomenological approach and McCracken's (1988) Long Interview Method (LIM). It further outlines the nature of hermeneutic phenomenology, the selected qualitative interpretative approach for this research, highlighting its key areas of focus and the rationale for its application to this research. This approach is inductive and allows an in-depth exploration of participants' experiences where they can convey their diverse realities with thick descriptions (Padgett, 1998; Rubin & Babbie, 2005), focusing on how young Black women construct their lifeworlds as they navigate mental health concerns in Toronto, Canada.

This chapter also delineates McCracken's (1988) long interview method (LIM), the data collection method chosen to deepen the data collection and analysis process, including its key features and the rationale for selecting this qualitative research method. Adding in McCracken's (1988) LIM as a complement to phenomenological analysis is a way to uncover and describe complex realities and situate them in larger social processes (Alaggia, 2004). The in-depth nature of this method allows "us into the mental world of the individual, to glimpse the categories and logic by which he or she sees the world" (McCracken, 1988, p. 9).

Unlike other research methods such as ethnography and grounded theory, combining hermeneutic phenomenology and LIM allows the researcher to study a cultural group from the "close" outside, utilizing a focused and highly intensive research process. They have also been used together in various studies around mental and physical health research, as well as research with racialized populations (Atkins et al., 2023; Genoe & Dupuis, 2011; Hand, 2012; Patterson & Macqueen, 2021). This particular combination of methodological choices illuminate how young Black women may identify racism, gender stereotyping, sexism, and ableism within the context of addressing their mental health concerns. Accordingly, this chapter outlines the steps for data collection, including sampling and recruitment, as well as the process of analysis from collection to the writing of this dissertation. The chapter concludes by discussing ethical considerations and methods to ensure rigour throughout the process.

Epistemological and Ontological Orientation

Before delving into the body of this chapter and in accordance with both my personal and theoretical foundations, it is necessary to outline how I understand these issues and this work. As researchers, we must always reflect on our epistemological and ontological position throughout the research process. Greenbank (2003) contends that "when researchers are deciding what

research methods to adopt they will inevitably be influenced by their ontological and epistemological position" (p. 792). Such positions are then influenced by the researchers' assumptions, historical and cultural positionality. Throughout my personal and professional lives, I have had to ask myself to which form of nature of reality do I subscribe?

Common in scholarly spaces and in both qualitative and quantitative research, positivism holds that social inquiry can occur without the confluence of human interpretation, asserting that "all knowledge must be generated through logical analysis or through systematic methodologies, the most important of which is the experiment" (Westheus et al., 1999, p. 131). That is to say that knowledge is acquired empirically, and deduction provides "the essential logic of science" (Hawkesworth, 2006, p. 30). This assertion leads to the de-legitimization of other ways of knowing, holding hegemony over what can or cannot count as knowledge (Guba & Lincoln, 1994). The positivist approach holds that the context of discovery is devoid of human interpretation. However, based on my personal and professional experiences, I do not believe that this is possible. Rather, I see discovery as human, relational, and contextual.

My own view of knowledge creation and reality is aligned with the interpretive paradigm that is embraced by hermeneutic phenomenology, my chosen methodology for this research. This approach, as discussed in detail in this chapter, moves away from traditional phenomenological analysis towards a focus on human experience and how it is lived within the multiple and many truths of participants' lifeworlds (Neubauer et al., 2019). As Schwandt (2003) asserts, our minds are active in the construction of knowledge, which we then constantly use and re-use to form abstractions and concepts through experience. Our interpretations, however, are not created "in isolation but against a backdrop of shared understandings, practices, and so forth" (Schwandt, 2003, p. 305). Accordingly, this critical paradigm assumes that he relationship between the

researcher, the study, its participants, and their context is mediated by socially constructed knowledge that comes to bear upon the nature of the inquiry. This approach embraces a historical realist stance, rooting our interpretations in socio-political, economic, cultural, and other contextual factors as they shift and change over time (Schwandt, 2003).

From my many years of professional experience working across racialized and Black youth populations and witnessing how they navigate around mental health challenges as well as racial, gender, and other daily forces, I am convinced that an interpretive approach to exploring YBW experiences with mental distress is most befitting. Not only does this approach resist positivistic notions that view experience as a fact in a vacuum, but it allows for an exploration of human life experiences in a co-constructed way. Further, by establishing these subjective experiences and co-creations as valid, and in line with both my theoretical and methodological choices, this paradigm establishes the narratives of young Black women as actionable knowledge that not only broadens our understandings but provides us with important insights on how to move forward together. Therefore, I proceed through this research with the understanding that knowledge creation is subjective, contextual, and relational.

Phenomenology

As a qualitative methodology, phenomenological research seeks to understand the 'essence' of the phenomenon of interest, as well as to describe and interpret the meaning of such experiences (Creswell, 2007; Genie & Dupre, 2011). According to Creswell (2007), the "basic purpose of phenomenology is to reduce individual experiences with a phenomenon to a description of the universal essence" (p. 58). In other words, phenomenology is the study of experience through the discovery of the essence of that experience (van Manen, 1990, 2014, 2016). A phenomenological approach attempts to uncover the meaning behind and understand

the lived experiences of individuals who share a common phenomenon, such as the mental health experiences at the center of this study. This study uses a hermeneutic phenomenological approach to understand how YBW participants attribute meaning to their experiences of living with mental health concerns (Merleau-Ponty, 1996; van Manen, 2016).

There are two overarching schools of phenomenology, eidetic (descriptive) and hermeneutic (interpretative) phenomenology, each with distinct approaches. The eidetic approach, developed by Edmund Husserl (1913/1931, 2012) and later expanded on by Moustakas (1994), is more concerned with describing the experience of the phenomenon than explaining and analyzing the human experience. This descriptive nature has the potential to remove the experience from the person who experienced it, focusing on the phenomenon rather than the individual's particular context. This approach also requires *bracketing* or suspension of the researcher's presuppositions, concepts, and theories (Moustakas, 1994) in order to discover and describe the truth as objectively as possible as presented in the participant's consciousness (Cohen & Omery, 1994; Kvale, 1996). In addition to the objective nature of eidetic phenomenology, this approach does not begin with theory, rather focusing on the phenomenon at hand at is most "pure." These features of eidetic phenomenology have been critiqued for the lack of critical thought infused into the methodological process.

Martin Heidegger (1927/2011), a student of Husserl, extended the phenomenological project by moving away from the eidetic approach to a focus on ontology, or the study of the nature and relations of being, which pushed the methodology toward an interpretivism paradigm. This hermeneutic approach involved the interpretation of texts, hence discovering the meanings within the phenomenon through applying theory and concepts to the everyday experiences and understandings of the participants (Gillam, 2014; Kvale, 1996). Heidegger focused on *Dasein*, or

the "situated meaning of a human in the world," where one is aware of mortality, relationality, and what it means to be (Groenewald, 2004, p. 4). Heidegger argued that consciousness cannot be studied as being separate from the world, as there is an inescapable historicity in our understanding that impacts how we construct "being" in the world (Groenewald, 2004). Accordingly, this approach to phenomenology understands that individual lifeworlds are "co-constructed and co-created in dialogue with and between the individual and the world; hence understanding the essence of an experience or structures that are essential for an experience to be what it is" (van Manen, 1997, p. 11). According to hermeneutic phenomenology, people exist with pre-understandings of the world based on their history and cultural background, such as race, gender, and other pieces of their identity. Each of these contexts contribute to how individuals experience and construct their world.

A hermeneutic phenomenological approach is concerned with a "focus on the situated nature of human experiences, closeness to subjects and a critical intersubjectivity that seeks to disrupt oppressive social discourses through the hermeneutic understanding that connects private troubles to public issues" (Newberry, 2012, p. 2). Hence, the researcher is not forced to make universal claims about the generalizability of findings (Newberry, 2012). My prior knowledge and racial affiliation with the study population gives me insight into the interpretation of their unique lived experiences, providing yet another source of knowledge throughout the research process. My critical exploration of YBW's experiences with mental health concerns is, therefore, more aligned with hermeneutical phenomenology. This approach allows me to value the voices of YBW as knowers of their own lived experiences that are historically and socio-culturally located.

Further, hermeneutic phenomenology also offers the opportunity for the insertion of critical theories such as CRT, CDS and the concept of ABR into the interpretative process from the formation of research questions, collection of data, and analysis of findings. It has been argued that theories and phenomenology approach oppose each other and therefore can create contradictions in research. Omery (1983) contends that "no preconceived notions, expectations, or frameworks be present or guide researchers as they gather and analyze the data" (p. 61). Accordingly, some scholars assert that phenomenological studies should never begin with theories or conceptual frameworks, as they have the potential to bias the research process. Traditional transcendental/descriptive phenomenology, as articulated by Husserl, certainly assumes such a position, requiring researchers to enter the research process with a clean slate, free of pre-understandings and assumptions to enable the phenomenological reduction inherent in the descriptive approach.

A hermeneutic phenomenological approach, however, affords a deep reflective process through which interpretation of the experiences of the phenomenon emerges. In hermeneutic phenomenology research, "theories help to focus the inquiry in making decision about the research participants and the way that research questions can be addressed" (Neubauer et al., 2019, p. 95). As Dowling (2007) asserts, bracketing out pre-conceived assumptions and knowledge is not desired or practical in interpretive or modern phenomenological research, as meaning is co-constructed between researcher and the researched. Retrospectively, hermeneutic principles are also aligned with the critical theories of CRT, ABR, and CDS utilized in this study. Hermeneutic phenomenology acknowledges that participants' language of their lived experiences with mental health, including the stories themselves and how they are narrated, along with the researcher's interpretation of the experiences in dialogue with each other can

illuminate new meaning (van Manen, 1990). Similarly, CRT, CDS, and ABR draw our attention to what is missing in dominant discourse, such as the authentic language of YBW's experiences with mental health concerns as they are lived. Researchers utilizing hermeneutic phenomenology in their research must also pay attention not only to what is being said but also to the "silence," or what is not being said (Gadamer, 1975). The chosen theoretical frameworks provide a particular lens through which to interpret these sayings and silences; a lens that focuses on racism, sexism, ableism, and other intersecting forces, as well as how young Black women navigate and conceptualize their engagements with mental health.

One of the critiques of phenomenology, particularly in the hermeneutic tradition, is it does not "adhere to a "rule-based process" (Bynum & Varpio, 2018, p. 253). In leaving space for the interpretive process involving the interplay of multiple analytical activities such as self-reflection, participant voices, literature, and the dialogue between them all, hermeneutic phenomenology has been said to at times leave *too* much space for interpretation (Bynum et al., 2019; Neubauer et al. 2019; Omery, 1983), As I came across this in my own research I thought about how to 'do' a hermeneutic phenomenological study, I sought an aligned but somewhat more structured method that would complement my methodological approach, which I found in McCracken's (1988) long interview method (LIM). This was one of the main reasons that I chose McCracken's LIM.

Methods: McCracken's Long Interview

McCracken's (1988) LIM was also chosen based on research questions, objectives, and context, focusing on exploring, describing, and interpreting the phenomenon of YBW's experiences with mental health concerns. In his landmark work, McCracken (1988) wrote:

> The long interview is one of the most powerful methods in the qualitative armoury. For certain descriptive and analytic purposes, no instrument of inquiry is more revealing. The method can take us into the mental world of the individual, to glimpse the categories and logic by which he or she sees the world. It can also take us into the lifeworld of the individual, to see the content and pattern of daily experience. The long interview gives us the opportunity to step into the mind of another person, to see and experience the world as they do themselves. (p. 9)

Uniquely, the LIM allows the gathering of information on cultural categories and shared meanings of experiences common to all participants (McCracken, 1988).

McCracken's LIM is frequently used in qualitative research as a whole, particularly in social work research (Alaggia, 2004; Anucha, 2010; Cullen, 2009; Pandalangat, 2011), mostly due the method's ability to "accomplish certain ethnographic objectives without committing the researcher to intimate, repeated, and prolonged involvement in the life and community of the respondent" (McCracken, 1988, p. 7). Accordingly, this method is phenomenologically informed and is therefore closely aligned with the methodological choices in this research. Indeed, both LIM and hermeneutic phenomenology are interested in capturing the rich and detailed experiences of each participant as they live them, their *lifeworlds* in their own everyday context, while also connecting these experiences to broader temporal, spatial, cultural, and social contexts.

McCracken (1988) proposed a clear and structured yet flexible four-stage method of inquiry that includes:

1) Review of analytical categories, including an extensive literature review.
2) Review of cultural categories, including researcher critical self-examination.

3) Discovery of cultural categories, including recruitment and data collection, and;
4) Discovery of analytic categories, including identifying utterances and making observations (coding), creating meaning units, comparing observations, developing themes and bringing them together as a whole.

The section below details the process of implementing these steps throughout the research process, blending together the systematic approach to data collection and analysis afforded by LIM with the strong interpretive and reflective nature of the hermeneutic approach to achieve a deeper understanding of YBW's experiences with mental health concerns.

Step 1: Review of Analytic Categories (Or, Literature Review)

The first step of LIM includes the review of analytic categories, entailing a detailed and focused review of the theoretical and empirical literature. According to McCracken (1988), a sound literature review "makes the investigator the master, not the captive, of previous scholarship" (p. 31). In my study, the literature review provided further insights by enabling me to identify my preconceptions, gaps in knowledge, and scholarly assumptions that may arise throughout the research process. It also helped in "identifying areas of interest in creating the research questions developing the interview guide, and in the data analysis, as it specifies categories and relationships that may organize the data" (McCracken, 1988, p. 31). In keeping with this method an extensive review of empirical, theoretical and grey literature (as presented in Chapter 2 of this dissertation) was undertaken to delineate what is already known about the topic and to identify knowledge gaps and research limitations related to young Black women's experiences with mental health concerns in the Greater Toronto Area. What is known and still needed to be explored due to limitations in existing research was identified, including limitations to theoretical, methodological analysis.

Step 2: Review of Cultural Categories (Or, Critical Self-Examination)

Phenomenological inquiry may be unstructured in the initial phases as it describes phenomena that have not been extensively explored. However, in keeping with McCracken's (1988) approach to the long interview method of inquiry, cultural review is a crucial step in the qualitative research process as it provides the researcher with a detailed and systematic approach to the topic of study. This step requires the researcher to use themselves as a research instrument of inquiry, demanding a more profound self-examination and reflexivity regarding their engagement with the research topic (McCracken, 1988). In conjunction with the literature review, it prepares the researcher to construct the interview guide, to mediate the relationship with the topic at hand, and "to listen to self in order to listen to the research participants" (McCracken, 1988, p. 33). In other words, the researcher must remain cognizant of their personal and professional experiences, expectations and assumptions surrounding the phenomenon being studied. Contemporary qualitative researchers have become more aware of the need for continuous self-reflexivity and reflection throughout the research process.

To a great extent, LIM works in harmony with hermeneutic phenomenological research, which allows the researcher to use their knowledge and experience to inform the study (Neubauer et al., 2019). By identifying one's beliefs, assumptions, and personal experiences around the subject area, the researcher can acknowledge their involvement in the research process and, hence, co-create more in-depth and meaningful data outcomes. In other words, hermeneutic inquiry requires the researcher to "operate from a position of closeness with the research participants" (Newberry, 2012, p. 14). Finlay (2009) agrees that "research can never be a value-free zone, as research subjectivity is always present" (p. 13). Shuftutinsky (2020) further asserts that the "use of self by the researcher is vital to credibility and rigour in qualitative

research" (p. 52). Accordingly, I offer a review of my relationship with the topic and the sample population to place the research design in context in my positionality section later in this chapter.

Acknowledging one's positional context helps the research process by mitigating potential bias when collecting and analyzing data, also adding to the research rigour, a key component of qualitative research. In situating my own subjectivity within this research, I make my own assumptions and prejudices regarding the research topic part of the study to reduce the influence of my own connections, unconscious bias and experiences conducting the research. In other words, knowing my biases will create a clearer picture of the data that emerges from my study participants and my co-construction of it (McCracken, 1988). The topic of my dissertation emanates from my professional experience working with young Black adults within social services and private practice settings, as well as from my own curiosity, connection, and interest. Having worked with young racialized clients, particularly with mostly young Black adults in my private practice, I noticed that in engagement with young Black women in conversations regarding mental health is often deflected, as they express they are too busy to worry about feeling "down" sometimes, or that they have no energy to get through the day but still have to do what needs to be done. These and other stories that have been shared with me piqued my interest in learning more about these experiences, their context, and how to move forward.

Researcher Reflexivity

As a Black woman, my engagement with young Black women aged 18–25 years emanates from both my personal and extensive professional experiences. My knowledge garnered from working with Black and other racialized young adults within the social services and youth services sector has enabled me "to bring an intimate and insightful perspective to the research" (McCracken, 1988, p. 32). As a previous clinician and subsequently registered social

worker for over 20 years, I approach this research with a number of assumptions. I worked extensively across populations, including young Black adults within the government sector, non-profit sector, and clinical practice. In my personal life, I have heard many narratives from individuals close to me about the struggles they have endured in naming, framing, and navigating mental health distress, as well as in seeking and obtaining relevant mental health supports. As a result, I have insights into some of the barriers and facilitators to mental healthcare for them. Through my practice, as well as my academic study, I have seen some of the challenges young Black adults, particularly young Black women, face in terms of acknowledging and managing mental health concerns and their subsequent struggles with service access and utilization. Based on my specialized knowledge, professional, and clinical experiences with this population, for more than 15 years I have had a keen interest in the phenomenon being studied.

Admittedly, I arrived at this research with several assumptions that must be acknowledged. I anticipated that the study participants might have experienced challenges acknowledging and sharing their mental health concerns with family and others, and that they might engage with self-blame for their mental health challenges. I also anticipated that they were likely to have had negative experiences with seeking and accessing mental health supports, with most these challenges rooted in mental health stigma, as well as racism and discrimination at the institutional and societal levels. As a result of these assumptions, I continued my self-reflection and memoing to keep my position as an insider while also acknowledging where I must remain open as an outsider to the nuances in experience shared by participants.

Step 3: Discovery of Cultural Categories (Or, Planning for and Collecting Data)

This third step involves constructing and formalizing the interview guide derived from the analytic and cultural categories in view of the literature and cultural reviews (see Appendix

A). As suggested by McCracken (1988), the interview guide starts with biographical questions to capture descriptive details of the participant's life. It then proceeds with broad categorical questions that allowed participants to provide a wide range of responses to questions to elicit narratives regarding their lived experiences with mental health concerns. The categories included the following: (a) perceptions regarding mental health and mental health concerns, (b) participants' experience with mental health concerns, (c) experiences with and access to mental health care services, both formal and informal, and (d) anything else they wanted to share.

Following McCracken's (1988) suggestion that the interview be as non-directive and unobtrusive as possible, the interview began with "grand tour" questions related to the perception of mental health in general, then moved to questions related to how mental health is viewed in their communities and families, and then to their specific experiences with mental health concerns. Floating prompts were also used to seek more in-depth responses when needed. For example, in trying to solicit responses to how mental health is viewed in the participant's worlds, a prompt such as "*Are there differences in how you think about mental health and how family and community members see it?*" may have been used when necessary to deepen the discussion (see Appendix A). Grand tour questions encourage participants to reveal rich, descriptive and detailed narratives of their experiences living with a mental health concern. Floating prompts are used to sustain a conversation such as showing curiosity to what is being shared or repeating a remark. Planned prompts on the other hand afford the participants an opportunity to consider and discuss phenomena that may not readily come to mind or speech.

Sample Method and Sample Size

Sample size in qualitative research has been the subject of much discussion, and "there are no straightforward answers" to how many participants should be included in qualitative

research samples (Vasileiou et al., 2018, p. 2). One of the “guiding principles of qualitative research sampling is that sample continues until data saturation has been achieved” (Moser & Korstjens, 2018, p. 9). Saturation is the point during the research process when no new data, themes, and codes emerge in relation to the study objectives (Guest et al., 2013, 2020; Morse, 1995; Rubin & Babbie, 2005). In phenomenological research, sample size can range from smaller groups with 5 participants to larger groups of 25 participants, varying with considerations around the quality of the data collected and the research's ability to effectively centre and amplify participants’ voices (Ahmed, 2025; Bartholomew et al., 2021; Polkinghorne, 1989). That is, participants should be selected based on the certainty that participants possess real experiences and intimate knowledge of the phenomenon being studied (Ramsook, 2018).

Hence, it is suggested that the sample size for phenomenological research range between 3 and 25 participants (Creswell, 2013). McCracken (1988) suggested that 8 participants are sufficient as a sample for qualitative inquiry, but I felt that this was too limited a number considering the nature of intersectionality in young Black women’s experiences. I sought a broader, more diverse pool of participants in an attempt to capture intersectional nuances, with a minimum of 10 and a maximum of 15 participants. I ultimately recruited 14 participants.

Upon approval by the York University Research Ethics Review Board (see Appendix B), consistent with interpretive inquiry designs and LIM, I recruited these participants through purposive or criterion sampling based on my knowledge of the study population and the nature of the research questions (Rubin & Babbie, 2005). Purposive sampling “involves selecting information-rich cases for study in-depth … those cases from which one can learn a great deal about the issues of central importance to the purpose of the inquiry” (Patton, 2002, p. 230). The participants selected were able to provide rich, in-depth knowledge of the phenomenon which

aligns with McCracken's (1988) assertion that "qualitative research does not survey the terrain, it mines it" (p. 17).

Research participants were recruited based on the following inclusion criteria:

a. Participants who identified as young Black women.
b. Participants who were between 18 and 25 years old at the time of the study.
c. Participants who have resided in Toronto for at least one year.
d. Participants who have been diagnosed or self-reported as having symptoms commonly associated with mental health concerns such as anxiety or depression, trauma, chronic stress or fatigue, and
e. can speak and understand English.

My decision to recruit not only individuals with formal diagnoses was intended to adopt a broader notion of mental health that does not focus on diagnoses as the ultimate manifestation of mental health challenges. Rather, I aimed to obtain a rich sample to shed light on how the intersections of race, gender, mental health stigma and mental health distress interact with each other.

Recruitment

As the research was conducted during the COVID-19 pandemic, with mandated restrictions such as social distancing, recruitment flyers were distributed virtually to various social services, mental health service agencies, churches, and community groups via email (see Appendix C). Additionally, recruitment flyers were distributed through listservs and word of mouth to social media forums, such as Instagram and Facebook, as well as virtual bulletin boards. I was also able to enlist the support of key contacts in my professional networks within the Black communities and colleagues in clinical practice to cascade to recruit participants that

would yield rich data. Woodley and Lockard (2016) speak to the power of social networking as imperative in accessing previously unheard voices and for counter-narratives.

To reach additional potential participants, I also employed snowball sampling, which is most appropriate for soliciting difficult-to-reach research populations and involves identifying and sampling cases within a network (Neuman & Robson, 2009; Robinson, 2014; Rubin & Babbie, 2005; Woodley & Lockard, 2016). Participants identified were asked to share information about the study and the recruitment flyer with others in their social networks who they believed met the inclusion criteria and wanted to participate. These recruitment methods yielded 16 responses, of which 14 participants met the inclusion criteria.

The Interview

The long interview is structured to gather information not on participants' affective states, but on cultural categories and the shared meanings of experiences (McCracken, 1988). Semi-structured in-depth interviews were used to generate ideas about how YBW construct their experiences with mental health concerns, with each interview lasting 1.5-2 hours. In-depth interviews are useful for grounding marginalized and often invisible actors as knowing subjects (Kirby & McKenna, 2004; Kobayashi, 2001). Because data were collected during the pandemic, all interviews were conducted virtually: 13 via Zoom and 1 telephonically, based on participant preference. All interviews were recorded via Zoom and later transcribed by a paid transcriber.

Prior to data collection, written and verbal consent were obtained from all participants (see Appendix C) to ensure that they understood the purpose and procedures of the study, the potential harms and benefits of their participation, their right to confidentiality, and their right to withdraw from the study at any time. They were also asked to complete a demographic information form, which captured information on their multiple identities to provide insight into

intersectional nuance, including age, race, ethnicity, immigration status, educational or employment status, gender identity, household and family composition, length of residency in Toronto, and engagement with formal mental health organizations (see Appendix E).

The interview guide (see Appendix A) utilized in this study solicited responses to YBW's experiences with mental health concerns, their access or pathways to mental health support, and experiences with formal and informal methods of support. The LIM entails intensive questioning of participants to elicit their extensive experience and insights into the phenomenon being studied. Accordingly, floating and planned prompts were utilized to obtain elaboration on specific responses from participants. Also, as the questions were non-directive and utilized a grand tour approach at the start, participants were afforded the opportunity to speak freely and continuously without frequent researcher interjection regarding the research topic (McCracken, 1988). This method allowed the study participants to share their lived experiences with mental health concerns in great detail, in their own words and from their own worldview. Given the sensitive nature of this research, I was aware that the questions could be triggering or upsetting. As a result, participants were advised that they could take breaks, pause, or withdraw entirely from the process at any point. This was present in the informed consent form and reiterated at the beginning of the interview. Prior to and throughout the interview, they were also reminded that support was available if needed, with accessible resources provided for participants to engage with if they found them helpful. Additionally, no participants declared that they had suicidal ideations at the time of the interviews and received support through debriefing throughout the process. All participants expressed their gratitude for being afforded the opportunity to participate in this research, stating it has given them some relief to be able to speak with a Black

woman who may understand the complexity of their experiences as young Black women living with mental distress.

Step 4: Discovery of Analytic Categories (Or, Data Analysis)

Data analysis is both a rigorous and creative process in qualitative research (Morse & Richards, 2002). A distinctive feature of qualitative research is that understanding emerges from the data as the analysis proceeds (Morse & Richards, 2002; Morse et al., 2012). In this final stage of McCracken's (1988) LIM, the researcher engages in the discovery of analytic categories, a rigorous process that promotes consistency, credibility, and flexibility (Kirk & Miller, 1986). McCracken (1988) informs that the object of such analysis is to:

> determine the categories, relationships and assumptions that inform the respondent`s view of the world in general and the topic in particular. The investigator comes to this undertaking with a sense of what the literature says ought to be there, a glancing sense of what took place in the interview itself. (p. 42)

Similarly, phenomenological research analysis requires the researcher to be immersed in the data. The insights into the "essence of a phenomenon prescribes an iterative process of reflecting, appropriating, clarifying and making explicit the structure of meaning of the lived experiences" (van Manen, 1997, p. 77).

Following all data collection, verbatim transcriptions of interviews were completed. A paid transcriber was used to transcribe audio recordings to written data. Specific instructions were given to the transcriber regarding expectations, and a sample transcription was shared for them to follow. The transcriber signed a confidential agreement form to comply with ethical procedures and maintain integrity and confidentiality (see Appendix F). The researcher checked and rechecked transcriptions against the audio to ensure the accuracy of recorded responses

(Creswell, 1998). Additionally, some transcripts were checked by the respective participants via phone, allowing them to review and confirm the accuracy of their statements. These procedures ensured accuracy and transparency by allowing participants to contribute throughout the collection process. In qualitative research, phone follow-up questions with participants "can be useful after the researcher has read the interview with a participant whom they have talked with" (Rubin & Babbie, 2005, p. 125).

After the interviews were transcribed, coding followed the five-stage process outlined by McCracken (1988). This model requires the researcher to move from examining the details and basic utterances to making general observations. This included: (1) utterance identification and making initial observations; (2) the expansion of observations; (3) the comparison of observations; (4) theme development; and (5) the comparison of different interview themes. The first stage of McCracken's (1988) analysis involves identifying utterances, which requires the researcher to read each interview transcript at least twice. In this literal line-by-line reading, I examined each utterance and concept in the transcript text independently for its own meaning. I compiled a set of observations that includes "key terms, interpretations, statements and metaphors. At this stage, I sorted out the "important from unimportant material in the transcripts" (Cheek & Piercy, 2004, p. 330). In stage two of the analytical process, I expanded on the initial observations by contextualizing their meaning within the entire transcript and subsequently within the parameters of the literature and cultural review (McCracken, 1988). In the third stage, I compared observations to develop key organizing concepts, noting both similar and contrasting themes or narratives (McCracken, 1988). I examined the second-stage observations and uncovered themes. In the fourth stage, I examined these observations for validity and linked them to form a pattern of meaning. In the fifth and final stage of this analysis, I reanalyzed all

patterns and themes emerging from the transcripts to ascertain answers to the research questions derived from the written data (McCracken, 1988). Here, the coding of utterances and themes was reviewed. Wherever discrepancies occurred, sections of audio-recorded interviews and/or transcripts were re-reviewed.

Simultaneously with this five-stage process, McCracken (1988) asks researchers to keep memos throughout, a practice similar to the reflexive journals researchers are encouraged to keep when conducting phenomenological research. These memos were handwritten either during interviews for specific observations or after the interview and served to inform the context in which participants' sharing takes place and the overall data analysis. In hermeneutic-phenomenological research, these memos are necessary for the data-gathering exercise (Denzin & Lincoln, 2012).

Ethical Considerations

As with any research project, the ethical implications of designing, implementing, and reporting must be considered. In the current study, ethical concerns include confidentiality, informed consent, and protection from psychological harm. To begin the process, I first reviewed and completed the York University Faculty of Graduate Studies Research Ethics Forms and Procedures, including the introductory tutorial on the Tri-Council Policy Statement (see Appendix G).

Written consent was obtained from all participants, and participation was voluntary. Ethical considerations also included benefits, reciprocity, potential harm and risk to participants, exploitative exchange relationships, and mechanisms to foster honesty and trust between the researcher and research participants (Finlay, 2011; González, 2000). Potential risks and benefits to participants were presented in informed consent forms along with measures taken to minimize

risk. Additionally, included in the consent forms was a list of support services if participants required them as a result of negative consequences to their mental health due to the interviews themselves.

Data management was also an ethical concern due to the content of the communication participants provided. Participants were asked to provide a confidential email for communication during the research process, to be used only for research, including follow-ups intended to clarify and member-check. Pseudonyms were also created for each participant that I use to refer to them in all study-related work. Once data transcription and analysis were completed, names and other identifying information were removed from the transcripts and replaced with numbers, and the data were later stored, along with consent forms, in a secure file on my personal computer.

Finally, because data collection was conducted via computer-mediated platforms such as Zoom and/or by phone, I paid close attention to ethical obligations regarding the collection of sensitive information (Lobe et al., 2020; Teti et al., 2020). I exercised caution to protect participants and the information they shared. For my study, participants were given the choice of an audio-only interview with their cameras off during the Zoom interviews to protect their identities.

Rigour, Credibility, and Trustworthiness

Credibility, trustworthiness, and rigour must be fostered in qualitative research (Lincoln & Guba, 1985). In phenomenological research in particular, “credibility, trustworthiness and audibility must be considered in order to ensure rigour and maintain orientation to the phenomena being studied” (Johnston et al., 2017, p. 574). Padgett (1998) defined a trustworthy study as “one that is carried out fairly and ethically and whose findings represent as closely as possible the experiences of participants” (p. 92). Additionally, credibility within research studies

questions how believable the research is, what its meanings are, and whether the data obtained holistically reflects the participant's experiences (Padgett, 1998). Trustworthiness and credibility were ensured through prolonged engagement with the data, by member-checking with eight of the 14 participants, and by creating an audit trail through memos of my interpretations of the data and of my behaviour to assist with the analytic process.

Yardley (2000) spoke to commitment and rigour in qualitative research regardless of the researcher's theoretical orientation, affirming that rigour can be demonstrated through prolonged engagement with the topic. In this case, my extensive engagement with literature, my may years of professional experiences of working within the context of youth mental health, and my immersion in the research data speak to the rigour inherent in my work. Each interview lasted between 1.5 to 2 hours, allowing me to build rapport with my participants and obtain clarification of the answers. In addition, I also conducted pre-screening with potential participants to ensure that they met the criteria for the study (see Appendix H), enhancing researcher-participant engagement and familiarity with the research process. This pre-screening was completed by phone for all individuals who expressed an interest in participating in the study, and it served as a forum to address any questions or concerns potential participants may have.

Summary

This chapter presented the research design and methods of the study. Utilizing a hermeneutic phenomenological approach combined with McCracken's (1988) LIM, the researcher interviewed 14 young Black women between the ages of 18 and 25 to explore their experiences with mental health and help-seeking behaviours. A demographic questionnaire was used to capture demographic characteristics, furthered by in-depth interviews via the interview

guide that captured participants lived experiences of mental health concerns. The data was collected in an open-ended manner, with both grand-tour questions and planned prompts to elicit and clarify responses. Additionally, the data was analyzed using McCracken's (1988) five-stage model alongside principles of phenomenological inquiry. I took steps to ensure that ethical guidelines for phenomenological research were adhered to, and to ensure trustworthiness and credibility.

CHAPTER 5: FINDINGS

The primary purpose of this research was to explore young Black women's experiences with mental health in the Greater Toronto Area (GTA). These findings address the overarching question: How do young Black women (YBW), aged 18–25, in the GTA experience mental health, and how do such experiences shape their help-seeking behaviours? The overarching question is divided into three sub-questions:

1. How do YBW become aware of and manage their mental health concerns?
2. How do the intersections of race and gender influence YBW's mental health experiences?
3. What role does mental health stigma play in YBW's experiences of service utilization for their mental health concerns?

This chapter presents an introduction to the study participants, including their demographic data and an overview of their mental health concerns, followed by the findings from the participants' narratives and counter-narratives. The chapter ends with a summary of the overall findings.

Introduction to Participants

The study involved 14 participants aged 18–25 who all identified as Black women from different ethnic-specific groups living with mental health concerns. Table 1 summarizes the participants' age, occupation, and housing status. The youngest participant was 18 years old, and the average age was 22, with most participants living with their parents at the time of the interviews. Ten (71%) participants were enrolled and attending university or college, two were unemployed, while two (14%) were unemployed on a part-time basis. While it was my intent to provide a detailed description of each participant to give context to their unique journeys through mental distress, I am cognizant that such details could jeopardize confidentiality. As a result, I have retained a snapshot of each participant's experience in the tables below.

Table 1

Participant Socio-Demographic Characteristics

Pseudonym	Age	Self-identification	Ethnicity	Employment/ Student Status	Housing Status
Jane	19	Black-Canadian	East African	Student	Family
Lisa	23	Black	Dominican Republic, Afro-Latina	Unemployed	Family
Jasmine	25	Black-Canadian	Jamaican	Student	Family
Tiffany	25	Black-Canadian	Jamaican	Unemployed	Family
Michelle	21	Black	Guyanese	Student	Family
Sasha	25	Black-Canadian	Dominican Republic, Afro-Latina, White	Employed (P/T)	Family
Naomi	22	Black, PR	Trinidadian	Student	Family
Jessica	24	Black, PR	Zimbabwean	Student	Roommates
Savannah	18	Black-Canadian	Barbadian-Jamaican	Student	Family
Mary	24	Black-Canadian	Jamaican	Student	Family
Sophia	18	Black-Canadian	Jamaican	Student	Family
Sam	21	Black-Canadian	African-White	Student	Alone
Joan	19	Black-Canadian	African Filipino	Student	Family
Lani	24	Black-Canadian	White-Latina Caribbean	Employed (PT)	Family

While a formal diagnosis of mental health concerns was not a specific prerequisite for participation in this research, some participants shared their experiences of obtaining mental health diagnoses. Table 2 outlines the age at which participants became aware of their mental health concerns, whether they sought mental health support (formal or informal), and if they have any formal diagnoses. Five (36%) of the participants had been diagnosed with mental health concerns such as anxiety disorder, depression, bipolar disorder, dissociative pain disorder, attention deficit hyperactivity disorder (ADHD), and borderline personality disorder (BPD). The remaining participants identified as having anxiety, depression, panic attacks, suicidality, and BPD, as well as being persistently and acutely overwhelmed. At the time of the interviews, three (21%) study participants were taking medication to manage their mental distress, and five (36%)

participants were accessing formal mental health support either through their family doctor, therapists, or counselling services.

Table 2

Participant Mental Health Overview

Pseudonym	Age	Mental Health Concerns	Age of Concern	Diagnosis	Current Support?
Jane	19	Anxiety & Depression	14	No	No
Lisa	23	Depression	15	No	No
Jasmine	25	Anxiety & Depression	16	No	No
Tiffany	25	Anxiety & Depression	14	No	Formal
Michelle	21	Depression	15	Yes	Formal
Sasha	25	Anxiety & Overwhelmed	Early 20s	No	Formal
Naomi	22	Anxiety & Depression	13	No	No
Jessica	24	Anxiety & Panic Attacks	16	No	No
Savannah	18	Anxiety	12	Yes	Formal
Mary	24	Depression & Dissociative Pain Disorder	20	Yes	Formal
Sophia	18	Anxiety & Depression	5	Yes	No
Sam	21	ADHD & BPD	12	Yes	Formal
Joan	19	Depression	15	No	No
Lani	24	BPD & Anxiety	13	Yes	No

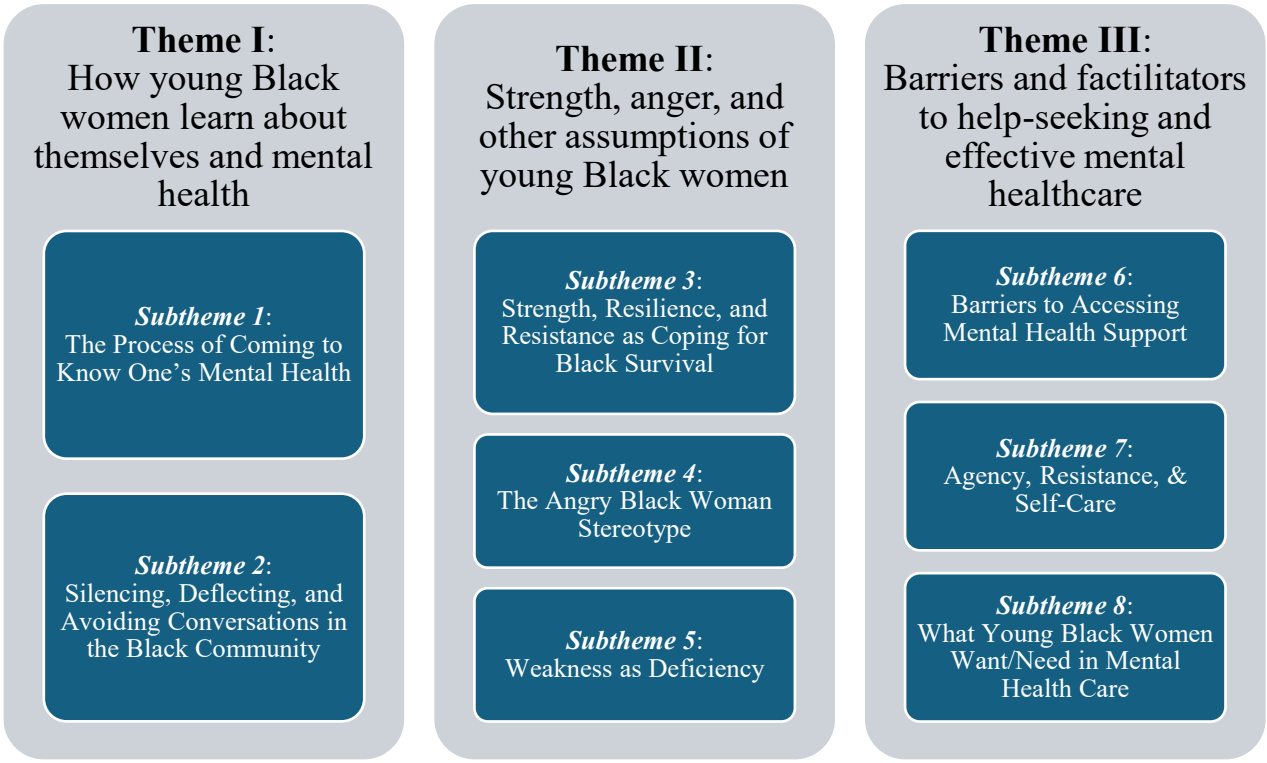
Presentation of Themes

After analyzing the experiences and stories shared by each participant, three main and eight subthemes emerged that cut across participants' stories. Theme I, focusing on *how young Black women learn about themselves and mental health*, includes the following subthemes: (1) The process of coming to know one's mental health, and (2) Silencing, deflecting, and avoiding conversations in the Black community. Theme II, focused on *strength, anger, and other assumptions of young Black women*, includes: (3) Strength, resilience, and resistance as coping for Black survival; (4) The angry Black woman stereotype, and (5) Weakness as deficiency. Theme III, focused on *barriers and facilitators to help-seeking behaviour and effective mental*

health care, includes: (6) Barriers to accessing mental health support; (7) Agency, resistance, & self-care; and (8) What young Black women want/need in mental health care.

Figure 1

Theme and Sub-theme Organization



Each theme is drawn directly from participants' words where possible and features direct quotes from their sharing.

Theme I: How Young Black Woman Learn about Themselves and Mental Health

Subtheme 1: The Process of Coming to Know One's Mental Health Conditions

In her memoir *Girl Interrupted*, Susanna Kaysen (1993) wrote about how she first became aware of her borderline personality disorder:

> People ask, how did you get in there [McLean hospital in Belmont, Massachusetts]? What they really want to know is if they are likely to end up in there as well. I can't

> answer the real question. All I can tell them is, it's easy. And it is easy to slip into a parallel universe. There are so many of them: worlds of the insane, the criminal, the cripple, the dying, perhaps of the dead as well. These worlds exist alongside this world and resemble it but are not in it. (p. 3)

Susanna Kaysen's memoir shows how she became aware of her mental health conditions. In the study, participants spoke about how their own experiences of becoming aware of their mental health concerns.

All 14 participants revealed that they knew that "something was wrong" much earlier than when they finally acknowledged their mental health concerns. Most participants shared that while they were aware that something was wrong, they did not acknowledge that they were living with mental health concerns until their late teens or early 20s. Sasha *age 25,* articulated that her mental health became unmanageable in her 20s, although she knew something was amiss much earlier:

> I feel like it had to be my early 20s, my early 20s. I feel like maybe before that because I always been… I just take it in; I take it in as time passes by. And I feel like I've always been a depressed person, or I have always suffered with it because I remember being a kid and being sad or crying myself to sleep… I was, I would say 10; earliest memory could be 10.

Lani (*age 24,* Sam (*age 21,* and Joan (*age 19,* mentioned living with their mental health issues until they felt like the situation was "alarming" enough that they needed to seek help:

> When I was in grade nine, so I had to have been 14 or 13, I think that's when I prominently started noticing my mental health declining or, or, or, or alarming enough for me to notice, 'Okay, there's something – I'm, like, wrong.'

Sam experienced an increase in severity of the physical, mental, and emotional manifestations of her mental health challenged—anxiety and depression in particular—before she accessed support:

> I can remember in childhood, I started out with severe anxiety, and eventually into my preteen, teen years, it was more of a depression. But I remember being in elementary school and stuff and having panic attacks constantly, or just I can't, like, things have to be a certain routine or else it was emotionally distressing for me… I never knew how to regulate the, like, just constant mood swings… In preteen to teen years, that really turned into depression as in, like, I just felt at a very low point in my life.

Similarly, Joan mentioned that she felt unable to cope as a teenager:

> Early high school… I think I just had a hard time, like, finding balance in life. And, like, I would just get, like, overwhelmed easily.

As participants learned to navigate these challenges, they thought significantly about what mental health means to them.

Savannah mentioned her understanding of mental health based on intergenerational ideas she inherited from her family. She simply lived with the concerns she had because she was taught it was just "nerves" that needed to be calmed, which was rooted in her family history of anxiety:

> I think when I started high school, I became more aware of my anxiety as a mental health… concern, I guess? Like, before, yeah, before that it was sort of just something I, I just dealt with… I was young at the time, so it was, like, 11, 12, 13… So my grandmother has always been anxious in a similar way that I am,

> but she never addressed it as being anxious. It was always just 'nerves' that she called it and she, she just didn't think of it in the same way.

Savannah's family connected mental health concerns to spirituality and connection to a higher power:

> In my extended family, I've heard, like, there's kind of an understanding that like, 'Oh, well, you should pray or look within,' type of thing. So I, I guess that insinuates that it is the result of non-prayer or not being connected to yourself, or some spiritual fault, shortcoming or failure.

Savannah's reflections show how definitions of mental health and how to treat them can be deeply rooted in family dynamics.

Most of the participants held a holistic view of their health in general while prioritizing their mental health. For Sasha, mental health was just as important as physical health:

> In a way, yes, because it's like, I feel like our mind, our mind is the most important thing to us I believe; it's like our mind, our body, and our soul, right? That's how I see it. So the same way we respect our bodies, we should always respect their mind as well, right?

Lani mentioned the work that she has put into learning to know how her brain works and how she can effectively manage her own mental health. As Lani succinctly stated:

> [Mental health] means what route has your mind been accustomed to always go down that you are now having to rework as an adult, all of that grew, all of that conditioning, that it's one way to realize that there is another. And I think it's just a lot of unconditioning, a lot of unpackaging, a lot of unlearning and actually, and still learning of, of how your mind actually was functioning. And now a new way

> of how you want to function and your mind to now assist you instead of break you, in a sense.

For Lani, having good mental health did not mean a lack of struggles in life, but rather a grounded understanding of how to navigate them:

> Because to think that there's one normal or norm, or to think that anyone essentially is not struggling in their mind, is to make it seem as if then there's no struggle in life. Everyone struggles in life, there's always struggle in life, that people, that mental health is accepting that and working with yourself instead of working against yourself or judging yourself or having feelings and reactions to what life is. So I think, I think mental… What good mental health is is accepting that not everything is daisies, roses, and happy and great.

Indeed, when asked why she decided to participate in this research, Joan shared the following:

> [I volunteered] to try to force myself to talk … because if I, if I feel comfortable talking for this long, because I know it's supposed to be, like, ninety minutes to, like, two hours. Then, that maybe I should be able to handle [talking to someone more].

These excerpts from participants demonstrate that while young Black women have come to their mental health struggles through various paths and they have diverse outlooks on what constitutes mental health concerns, the consensus remains that they must take care of their mental health, even as they seek help from outsiders at times.

Subtheme 2: Silencing, Deflecting, and Avoiding Conversations in the Black Community

In this study, all participants expressed the difficulty in initiating meaningful conversations about mental health in the Black community. Respondents spoke of beliefs regarding mental health in Black communities that often manifest in the absence of discussions on mental health

and an overall lack of knowledge about how to approach mental health concerns. Some participants shared that the stigma surrounding mental health distress in Black communities presents as shame, denial, and "not being a Black person's thing." As Joan shared, "We [members of the Black community] don't talk about feelings," implying there is no space within the Black community for open and frank conversation about mental health. Naomi spoke about her fear of discussing her mental health conditions openly in the community. Therefore, people who have mental health concerns keep their challenges to themselves for fear of being judged and stigmatized if they share them publicly.

Participants expressed that mental health is a taboo topic in their communities. Lani noted that discussions of mental health conditions position individuals as weak or crazy, which tends to silence and demean the individual suffering from a mental health condition:

> Now that I think about it, it would either be, if mental illness was spoken about, it was either because you're weak or you're crazy. Like, there was no in-between. It's either those two; you're crazy and, and you need help, but in a condescending way.

Sasha noticed a deficit-based understanding of mental health in her community as well, pointing to comments like:

> 'It's all in your head. Depression is all in your head.' Just because they, they might, because they ignored their situations, they feel like… They're in denial, they could be in denial of what reality is.

Tiffany (*age 25, self-identified as having depression and anxiety*) echoed similar comments by community members:

> People think that if you do have a mental illness, that means that you are messed up, you're not properly a part of, society, you are not, a human being or anything. You are just kind of a number, you're not nonexistent.

Sasha noticed that perceptions of mental health in her community also have connections to religion and her cultural background:

> Being of African descent and with a Christian background, it's more so if you aren't mentally sound, those people are kind of… crazy. 'They're erratic, they just need to be in a, in a facility,' you know?

Lisa (*age 23, self-identified as having depression*) shared similar reactions and feelings of invalidation in her community:

> And with the Black Spanish community, I feel like if you were, if you were to talk about it [mental health distress], everyone just, it would spread like wildfire. Everyone will be talking about it and be like, 'Oh, the daughter of so and so, she's been, like, acting up,' you know? 'She's, she's saying that she's depressed, but in reality, she's just sad, you know? She's just being overly sensitive and dramatic.'

Young Black women endure various forms of stigma when they attempt to reveal or seek support for their mental health concerns; they are faced with disbelief, opposition, and condescension. Participants further shared that their family members never talk about mental health distress, and when they sometimes do, different terms or phrases are used to distance themselves from any discourse of mental anguish. Consequently, participants feel inadequate, and, in some cases, they are treated as ungrateful, unappreciative, or lazy.

One participant shared an episode of mental health distress so acute that she attempted death by suicide; even in that situation, her parents were still resistant to acknowledging what she

endured. Tiffany shared that when her parents caught her planning to take her own life, they reacted by calling her selfish:

> There was a time where I was where my parents actually caught me, um, doing a suicidal attempt, um… they saw me and they're like, they were just upset… But my mother was asking me, 'Oh, why are you doing this?' And my father wasn't really like… he was concerned but he wasn't basing it off of, like, 'Are you okay?' Like, 'Are you alright?' He was just saying like, 'Oh, what you're doing is stupid.' Yadda, yadda, yadda, 'That's dumb.' Like, 'Why would you do that?'.

Sophia (*age 18, recently diagnosed with anxiety and depression*) also spoke to the intergenerational gap in understanding and accepting mental health concerns among Black people:

> My parents did not see mental health as an issue because their parents never saw it as an issue. And even so they know what it is, they know what depression and anxiety is, they just don't believe that their kids can have it. And since I was the only kid in my family – because I have three other brothers, so I was the only kid to have come to said to them, 'I have depression and anxiety.'

Naomi (*age 22, self-identified as having anxiety and depression in her late teens*) shared what happened when she shared her struggles with mental health distress with her family:

> And then one day I just broke down and they were like, 'Oh, she's being dramatic. She's looking for attention.' But they won't understand that I was frustrated.

Mary (*age 24, diagnosed with depression and dissociative pain disorder in her 20's after a car accident*) also connected mentioning her mental health struggles to assumptions that she is being ungrateful, especially among her first-generation immigrant family:

> We do come from a Jamaican background, so my grandparents aren't as open about it. They do tend to think, *Well, like, you're like* – How they would say, like, 'You're here in foreign, like, you're doing well in school, you shouldn't really have much to complain about.'… When it comes to the elders in my family, I think that they still have a very traditional, old-school mentality that, it's more complaining than it is an actual difficulty that people go through… On my grandma and my grandpa's side, it's more that they're just ungrateful.

Such reactions silence the bearer of mental health distress, leaving them with a feeling of invalidation. It makes them feel that they are overreacting, and even that their reactions are ungrateful or disrespectful. In some cases, these reactions make it difficult for YBW with mental health conditions to seek help. To speak about their mental health struggles is an act of courage and bravery, one that underscores the nature of young Black women's resistance.

Theme II: Strength, Anger, and Other Assumptions about Young Black Women

Subtheme 3: Strength, Resilience, and Resistance as Coping for Black Survival

This third theme, which features the strong Black woman (SBW) trope, presents as a barrier both to participants' acceptance of mental health concerns and to mental healthcare. The expectation of strength is forced on Black women by their communities and society, supporting the normalization of daily struggles in the participants' lives. This can serve to exacerbate their mental distress by forcing them to be performative in their expressions of strength. Participants feel pressured to "push through," even when they experience mental distress. Joan expressed this

sentiment in her interview, drawing attention to the complexities that this pressure presents in her relationships:

> I feel like I'm made to feel like I'm supposed to be okay. Like I should just push through things and get over things. … I feel like we're just expected to, like, get through it. Like to, yeah, because they [my parents] know that I put a lot of pressure on myself and, and, like, basically they say they're proud of me for whatever, but at the same time, like, they still continue to put pressure on me even though they say, like, they're proud of me for whatever I do.

Black women learn to uphold a strength facade at an early age because it is seen as a mechanism to shield and protect them from racism, sexism, and other forms of oppression.

This experience was further reflected in Naomi's comments that, among Black people, there is a particular perception for women to be superhuman without weaknesses. Therefore, anything that will make a person appear fragile should be hidden:

> I grew up, like, not really learning much about it because it's, like, they, like, how do I put it? Like, my family always says, how do I say… Black people are not allowed to have, yeah, like, stress or, like, even, like, having a mental problem, that's not Black, a Black person's thing in a sense.

Historically, Black women are perceived as the cornerstone of Black communities, with responsibilities to carry the burden of the Black community. How then can the Black women show weaknesses when the very survival of the Black community lies on them? Jessica (*age 24*, *self-identified as having anxiety and panic attacks*) shared this feeling, noting its double-edged nature:

> From a young age as a Black woman, you assumed the role of caretaker of others. And I think that's why it was so easy for that young lady to be like, 'Okay, well now let me take care of you.' 'Cause we're primed to be that way as Black women, but then also, like I alluded to at the beginning, the whole 'strong Black woman' trope, though it is great to be seen as someone with strength, it's also harmful in that the strong person can't possibly be weak. And so, being the person seen as the caretaker in my household, it's like, 'How, how could she, how could she be not okay? Like, she's taking care of everything, she seems to be okay. She's fine.' … They're like, 'How could she possibly be weak?'

Jasmine (*age 25, diagnosed with anxiety and depression at age 22*) also shared similar sentiments, drawing attention to the stereotypes that Black women must be aware of, particularly as they are expected to care for others:

> Every time I have to think of like, am I giving into stereotypes, like… And even another like, Black friend of mine, we're always laughing because – it's not funny but – we're always laughing and being like, "You know, we're like 24 turning 25, we cannot be mammies, like, we can't be, you know, taking care of people." … We're at the forefront of everything, you know, advocating for literally everybody else, and like, nobody really checks in, nobody advocates for us.

In essence, these narratives draw attention to the burdens placed on YBW to be carers of the Black family and community and, therefore, not show any weakness. The participants shared narratives and counter-narratives describing the SBW trope, and the ramifications of this stereotype. Several participants spoke of their fear of sharing their mental distress because the pressure is so strong. A common thread throughout participants' narratives was the pressure they

experience to mask their pain and perform as ‘normal.’ There is an expectation to prioritize other people’s needs and necessities over their own and not ask for help.

All participants spoke of the emotions evoked by their observations that their family, especially their women family members, embraced and forced them to demonstrate strength, as well as how this intergenerational practice compounds their experience of mental distress. Sam, for example, expressed that:

> In my family and my upbringing, it’s very, an internalized thing. It’s like, it’s a ‘you’ issue, like, you just deal with that on your own, you develop that on your own, it’s not the cause of it. … Basically, nobody would take responsibility for, I guess, in a childhood upbringing that could result in mental illness.

Participants expressed that they felt compelled to internalize strength in an effort to appear normal. For example, Jane stated that in her family and community, she must reckon with the “expectation to pick yourself up” because “you are not allowed to fail.” Jessica echoed this sentiment, connecting this pressure to be strong to the ways that Black women often must work to prove themselves as competent and worthy:

> We know in the Black community, there’s a saying, ‘You gotta work twice as hard to get half of what they get.’ Like, we’re always pressured to be excellent, we’re always pressured to be the best in the room and stuff. And that’s why it is so hard to share our pitfalls, because the public perception is you have to be great, you have to be perfect, you have to be, you know? … It’s hard to work through internally, it’s hard to work through once you share and people either don’t understand or people now cast this judgement on you.

Joan agreed, noting that wearing a mask of strength was necessary as the world is not set up for them to succeed:

> We kind of, like, want to, want to mask the mental health stuff too because we know that, like, this system makes it harder for us to, like, succeed. So, like, I'm, like, less concerned with, with my mental health and, like, more focused on, like, school and stuff and, like, a career because, because I do have to work harder.

For Savannah, mental health challenges compound the pressure to work twice as hard, with implications for her future:

> It's debilitating; that that seems to be the word that comes up the most just because it really, it makes you feel like you can't do anything, you don't want to do anything, nothing matters. And especially as a person, a Black person, a Black woman, who has, like, I've always been kind of ahead of the curve, I always have been very ambitious; the feeling of not wanting to do anything, feeling like you shouldn't have to do anything, feeling like it just, nothing matters. Especially in that context, I think can be a disability. Because we don't have that luxury of not having to do anything so you don't have, like, not wanting to do anything is not really an option.

Jasmine, in sharing her experience with expulsion from school, noted the difference in the way she and other non-Black peers were treated. She echoed similar sentiments, focusing on how Black women have different considerations:

> I have one friend who is Latina but she is White passing, and we got kicked out at the same time for school and she actually ended up getting kicked out again recently this year, and I've been like, checking up on her to be like, you know,

> ‘just petition,’ like, ‘you never know what’s gonna happen,’ you know, stuff like that, and I don’t know, just like her indifference to it is just like, I don’t –

Sasha summarized these competing pressures, identifying the mask that YBW must wear to navigate the world:

> It’s not the same: a White girl with a mental health and a Black girl with mental health. First of all, we’re already seen as we have to, whatever we’re going through as a Black woman today, we have to ignore and put on a new face to the world because we’re already perceived as rude; we’re already judged before we even open up our mouth. … I have always something to prove. … So besides dealing with my mental health and my insecurities, I have to deal with the fact that I have to now ignore everything and put on a new face and be likable and be accepted by others.

Mental health concerns are often hidden under a veneer of normalcy and strength for YBW, which presents barriers to their access to adequate care. While the performance of this strength can combat oppressions faced by YBW in society in general, its necessity is rooted in claims of gender and racial inferiority.

Subtheme 4: The Angry Black Woman Stereotype

Historically, Blackness and mental health have intersected in the concept of normalcy, as both prescription and description, to position Black people as a problem and, therefore, deserving of being treated differently. In the study, several participants spoke about the label of being perceived as the angry Black girl, as hostile, angry, bitter, and aggressive. This assumption of aggression and meanness not only voids the right of YBW to express their emotions but also serves to further invalidate their experiences. For example, Sam shared her experience:

> It's always been very known to me that people will put, people have higher expectations of me just for being a Black woman. … So I think that I've just naturally grown to suppress it and deal with it myself, internalize it, and be as pleasant as possible to appear as contained as possible. And also just the sense of that angry Black woman stereotype of, no, I'm not an angry Black woman in that sense of that terrible stereotype that is very dismissive and very minimizing of the women that look like me in the possible mental health concerns that they have

Jessica shared a similar experience, explaining the ways that young Black women must always be aware of stereotypes as they express themselves:

> I think maybe some of the ways that I used to act out is maybe being verbally aggressive I guess you could say, and then trying to balance between processing my feelings in however they come out of me. But then also not being seen as the 'angry Black woman' which, we know, oh my goodness (exasperated); any, any form of speaking out against your personal injustices and stuff like that, people all of a sudden see, "Oh, there she goes, being the angry Black woman." I know a lot of people would have seen me as aggressive when in reality if somebody else who did the same thing as me but was a different hue would have acted that way, it's an expression.

Naomi also shared similar sentiments, which she felt prevented her from making connections:

> People, they won't know me and they automatically, they would just look at me knowing that I'm Black or even if I say I'm Black, and they would always look at me as being this mean, angry person… It's like they automatically say, 'Oh, I

> don't wanna talk to her because she looks mean' or 'Because she's Black, she's mean.'

Sophia shared that, though she did express anger, she sometimes felt sad and did not know how to express it. This issue arose for her as a child when others only responded to the underlying anger rather than the underlying distress. This issue has continued to manifest in different ways as an adult:

> I was really, I was a very angry child, I picked fights. And sometimes the fights even got like really bad; I broke someone's jaw, broke someone's leg, broke someone's arm. And that was only at a young age, and everyone always told me, 'Why are you so angry? Why are you doing this? Why are you doing that?' And I would say, 'Because I'm sad. And I just, you know, like, I'm like, I'm angry. Because like, I was angry because I was sad.' But they only heard the 'I'm angry' part, they never heard the 'I'm sad' part.

Mary further explained her experiences based on trying to help her younger sister figure out how to navigate the same issues she navigated as a child:

> I have a 17-year-old sister… and I consistently have to make sure that she understands when you step out of the house, you have to be careful with how you act. Because as a Black woman, instantly people are going to be like, "Okay, let's be careful with how we act around her. Let's be careful with how we say certain things around her. Let's be 'careful' – you know?" People are always going to tippytoe around you no matter what, you know? I always have to, I always warn her, "Be careful how, you know, your tone is," and stuff.

The stories of Jessica, Naomi, Sophia, Mary, and others about the myth of the angry Black woman also have profound implications for how YBW are understood and engaged with, especially when experiencing mental distress. The participants' narratives revealed that they are also fearful of being surveilled and stereotyped. Living with such negative stereotypes compounds participants' mental distress as they struggle to negotiate or reclaim their genuine emotional responses to difficult life circumstances.

Subtheme 5: Weakness as Deficiency

Frantz Fanon (1967) argued that in a visceral anti-Black racism and ableism context, Black people *cannot* possess any "ontological resistance" (p. 110). Rather, they are expected to appear exactly as they have been (mis)represented in racist colonial scripts: lazy, illiterate, dirty, criminals, violent, sexualized, immoral, stupid, and dishonest. In their narratives, the young Black women shared feeling blamed and shamed for their mental health concerns, since others made them feel not strong or hard-working enough to overcome challenges. Such imposed messages led some participants to view their mental health concerns as character flaws. It is no wonder, then, that participants identified masking their mental distress to honour the performance of strength. The appearance of strength is rooted in sexist, racist, and ableist ideologies that construct Black people with mental health concerns as outside the realm of normalcy. Participants shared that YBW with mental health concerns are viewed as "lazy," "messed up," and "crazy," among other negative descriptors. As shared by Tiffany:

> People think that if you do have a mental illness, that means that you are messed up, you're not properly a part of, society, you are not, a human being or anything. You are just kind of a number, you're not existent.

When asked if she views her depression as a disability, Mary stated that:

> I feel like a lot of young Black women are just so afraid of judgement beyond what they already have to deal with that even if they know that mental health is okay, it's okay to sometimes struggle, it's okay to do, to have mental health issues, they feel like because there's such a scope on us from outside communities but then also within our own community, it's, it's very much a very hard subject. It's, they feel like it almost has to be buried or if they do deal with it, it has to be secretive, like, something that they only bear themselves not, something that's largely discussed.

Savannah agreed, focusing on the ways that mental health concerns further constrain the pressures on young Black women:

> Even though mental health in general is still heavily stigmatized, I would definitely say that the added layer of being a Black woman with multiple other identities is, it's not adding anything helpful. … I would still be, I still wouldn't be afforded the same grace that other people are, so if I add on extra stigma, it's only going to get worse.

In the study, participants viewed disability as another layer of discrimination that would only add to the existing challenges of being Black and a woman. In this sense, language has the power to construct mental health concerns as deviancy. Indeed, Jasmine felt weary of identifying with a disability because of how anti-Black assumptions around capacity are exacerbated by ableism:

> [The biggest part is] how people would label me. Because I feel like its such, that word is such a blanket statement, and so like, I feel like if I just say the word people are automatically going to think, like, 'Well, is it like, a learning disability?', like 'Is it like, is she not able to so her job properly?'

When mental health concerns are internalized or masked out of fear of repercussions or being negatively labelled, YBW are, in essence, silenced. Only 1 of the 14 participants identified that she saw her mental health concerns as a disability, while most others resisted the conflation of mental health and disability, provoking further discussion about Blackness and ableism that is reviewed later in this dissertation. In general, individuals living with mental health conditions are often perceived as being a problem and dangerous. This perception is only heightened for Black people, who already must deal with assumptions about their capacity and dangerousness. For YBW at the intersection of Blackness and mental health, it becomes all the more detrimental to their ability to feel safe sharing and seeking help for their concerns. The construction of problems, dangerous, laziness, weakness, and deficiency that are historically ascribed to Black people living with mental health conditions are in total opposition to how mental health conditions are interpreted with white people. As Danquah (1998) asserts in her memoir, *Willow Weep for Me: "When a Black woman goes on Prozac,* the world is gone mad" (p. 258).

Theme III: Barriers and Facilitators to Help-Seeking and Effective Mental Health Care

Subtheme 6: Barriers to Accessing Mental Health Support

This section presents findings on help-seeking, systemic barriers and facilitators to accessing support, and coping strategies used to avoid and resist negative help-seeking experiences. In addition, participants express, in their own words, what they want and need in mental health care and beyond. Here, the participants all spoke about their reasons for seeking (or not) mental healthcare, the effectiveness of services, what their needs are in terms of access and support, and coping strategies they utilize to resist negative experiences around their mental health concerns. Many of the participants did not seek mental health support until they were in their late teens or 20s, with many identifying informal supports or alternate coping strategies as

their main source of care. Participants were often unaware of the options available to them. Jasmine recalled her experience with challenges in school due to her mental health, sharing the following:

> I don't have problems seeking help, it's just I didn't know, so I didn't think I needed to seek help. Um, it's until… I was telling my TA that I was having issues and I was, like, failing my classes, and she was just like, 'Well, you should have told me from before.' And I was like, 'Well, dang, I didn't even know I could have done that.' Like, I didn't know that was an option.

Accordingly, participants' pathways to accessing support occurred not as they started noticing concerns, but often when their mental health had severely deteriorated.

Michelle explained her reluctance to seek help based partially on her commitment to taking care of herself on her own, without help:

> 'Cause I guess, right, I just wanted to be able to do things by myself and didn't wanna be able to get help. So I just went into university thinking that I don't need help even though I knew that was an option. And I should have taken it from the first year, but I really didn't go until last January. So like, that would have been second – well, that would have been my third year at university really. And I waited up until it was like, I was about to get kicked out of university that I was like, *Okay, I should now go get the help*. So I waited really late, and I shouldn't have waited late.

Jessica noted a similar reluctance to seek out help based on her fears around the medicalization of mental health treatment for young Black women:

> I feel like I always have to be in a state of being mentally sound or maybe I'll be taken advantage of maybe my concerns. 'Cause I know in – oh, here we go, here's the Black part. I know in the medical field at times, it's, it's easy to see the Black woman as being delirious. So if I was to share a concern, but I'm under the influence of a substance, it's easy to be like, 'Oh, she's overexaggerating. She's being delirious, you know how they get,' kind of thing. So I always wanna be in a place where I'm seen as mentally sound and what I'm saying holds weight because, you know, I'm of clear mind.

Jasmine also shared the extent to which Black women must be struggling in order to seek support, in contrast to non-Black women, who are largely provided support without question:

> I don't know, it's just like, talking to White women, they just have this freedom to just feel whatever what they want without repercussions, serious repercussions, like people just will allow them to like, stand in whatever their truth is, whether it is a truth or not, like it doesn't get challenged. But I feel like with Black women, we have to like, we have to be gasping for air for someone to really notice.

For young Black women who see these dynamics, especially when they are dismissed and denied, it can be demoralizing; they cannot be seen as worthy of help unless they are drowning. Even when they do reach this point, they still must be aware of, in Jasmine's words, the repercussions, including stigma, dismissal, and silencing.

Many of the participants contended that when they eventually considered seeking mental health support, they were confronted with the lack of affordability. The financial cost of delivering mental healthcare can itself make accessibility difficult for Black populations (Faber et al., 2023; Fante-Coleman & Jackson-Best, 2020; Whitley, 2016). Based on what participants

shared, paying for therapy and other forms of mental healthcare is a luxury many Black participants who struggle for their daily livelihood can afford. As Lisa shared:

> My sister actually did get me my first session with a therapist this Christmas… Finances definitely ended up being an issue afterwards… I still pay for the internet, the house phone, my cellphone, groceries, you know? And I give money to put into my savings, I have to give them to pay my credit cards, student loans, loans, you know, type of thing, car payments, insurance. … That's why my sister ended up giving to, to me as a gift because I remember talking to her so much about, like, I really feel like I need to talk to somebody about this.

Jessica also shared that she simply could not afford therapy, even though she felt she needed it:

> Therapy also looks, always looks so expensive. I'm like, (sigh) "Man, I can't afford, I can't afford a good doctor," you know what I mean? Once the, once I personally got rid of the stigma, through the learning that I went through, through being a psychology grad, that wasn't the issue, it was just I couldn't afford this especially long term.

Joan also shared financial concerns with seeking support, noting that it would only mean additional stress:

> Honestly, like, if I, if I were to mention, like, like, therapy or something, the first thing that comes to mind is money, even though I know this stuff of, like, insurance, like still like, money will be the first thing that comes to mind. It's like, it's just with another issue that has to be dealt with, on top of everything. … Like, it'll just add to the problems.

Participants like Mary shared that they were fortunate enough to receive some financial coverage for therapy at the initial stage but when she reached a certain age, she was removed from her parents' insurance plan:

> As of next year, I'm no longer covered and I'm concerned about how I will be able to pay for certain services… That little bit of help, helps. And then, for me, like you said, I'm fortunate that I even had that amount, but there's a lot of women that are Black who either come from immigrant families or lower income families that don't have those benefits, and it's, it's an impossible task for them to find someone who actually cares and actually can help them foster a proper and healthy relationship with understanding themselves and mental health and how they survive with that.

Experiences of Racism When Seeking Mental Health Support

For participants who did seek formal mental health support, their experiences were varied. Several participants expressed negative encounters with non-Black or non-racialized mental health professionals. In contrast, all 14 participants spoke about the importance of racial matching in offering mental health support for YBW. The six participants who have consulted or worked with mental health professionals noted there are differences in how they experienced services from White or non-Black identifying professionals compared to Black care providers. However, these representative care providers were few and far between, and participants often felt misunderstood, invalidated, and pathologized when working with non-Black providers.

Five participants shared that it was not until they were able to access support from Black mental health professionals that they finally felt that they had been heard and understood. For example, Sasha was eventually able to see a Black therapist who she felt a deep connection to:

> I found myself a Black, a Black therapist, and I feel, now I feel like I understand that there's a, I understand the fact that she's my therapist, but I feel like I can open up to her as if she were a friend.

Other participants expressed the safety they felt in working with a Black therapist who has lived experiences of racism. For example, Lani shared that:

> If we're talking the past, I had always wanted a, a, a doctor who would have a relatable history, personal history, so not having enough people of colour and specifically Black people in the field to go to – also just, just not knowing, like, what was out there.

Several participants expressed negative encounters with White and non-Black professionals. Jessica shared her experience of being misunderstood by a White therapist, who she shortly stopped seeing because of this invalidation:

> When I went to the therapist… it's a White woman's house and I just felt very out of place – not that I don't have White friends, but it just felt very different, it felt a lot more judgemental than it felt comfortable. Everything I would say, she'd be like, *Hm…* Almost like she didn't believe me or what I was saying was stupid. When I spoke about my issues with school… she's like, 'What's the point, who cares if you actually have goals of going to law school? Why do you need a back-up plan?' And I was like, I was trying to explain to her, 'I need a back-up plan because of who I am.' And I was trying to explain as a Black woman, you always have to have a back-up plan because the biggest of plans can go awry and I need to be able to provide for myself….. I was trying to explain myself and she was

> like, ‘Then that means that you’re not serious. That means that you don’t actually wanna be a lawyer, that means that you don’t know what you want.’

Similarly, Sam, who identifies as being of biracial (Black/White) ancestry, spoke to her experience of being dismissed and stereotyped when she tried accessing mental health care:

> I absolutely poured my heart out to this older White woman, knowing that she probably will not sympathize with me already had that preconceived understanding. But it was, the one thing that she said to me was that, ‘I think, in all honesty, that you are just a bratty teenage girl going through a phase.’ And it was like, you hear about that and you think, *Oh, well, physicians won’t speak to you like that,* or the, *She’s probably being dramatic*. But it’s like, to actually have a psychologist or a psychiatrist or a doctor of any kind, say that to somebody who was in such a critical state of mind at the time; it just absolutely ruined me and it made me disturbed to ever speak to a doctor again, to ever confide in somebody with this again – to just suppress it even more, because it validated all of the things that I was told as a child that, ‘You’re just being a brat, you need to grow up.’

Similarly, Naomi shared that:

> It was not really trying to, like, it wasn’t really helping… My voice wasn’t being heard in a sense… I wanted to talk to her about something that was really important to me and she was just looking at different things in a sense. She wasn’t really, like, hearing what I really had to say. Even in high school, I know my guidance counsellor always wanted to talk to me, but I feel like I could never really talk to her because she was a middle-aged white woman. What could you

> possibly understand about me, you know what I mean? So I'm sure if it was a Black woman, or even a Black man, or just starting with a person of colour, it would've made it that much easier.

The issue of invalidation when seeking mental healthcare was consistently expressed across most participants that had sought help. Most participants expressed their frustration with not feeling heard by mental health professionals.

Subtheme 7: Agency, Resistance, and Self-Care

Many of the participants were not involved with formal supports at the time of the interview, nor had they been over the course of their time living with mental health concerns. To fill this gap, they sought and found their own ways of managing their mental distress. They became proactive in seeking out creative coping strategies to manage their mental health concerns in a manner that befits what they need. Many of the participants, particularly those that have had negative experiences with accessing and working with mental health professionals, expressed that they came to realize that integral mental health support did not have to come from individuals with formal degrees. Rather, as Jessica asserted, the connection between two people was enough to make a difference:

> I have my mentor who, she's dabbled in psychology courses but she's not, she doesn't have any credentials of any kind, but, yeah, I seek help from her as well… She sought me out, because she could see that something wasn't okay… I don't know if I ever would have been able to reach out. Even to her, even though it was informal, it took her identifying things within me that she went through.

Jane was unable to share her mental health struggles with her parents and her family viewed going to a therapist as a foreign concept. Instead of formal and sometimes pathologizing

supports, she shared that she utilizes podcasts, videos, and mindfulness to "stay away from triggers" as mechanisms of managing her mental distress.

Sam identified her main mode of coping as distraction, particularly by creating structure and grounding herself:

> I think that I found a lot of assistance in or support, I guess, managing it in building structures for myself; so coming to school or pursuing a higher education, or having multiple jobs and sticking to them. Not allowing myself to be defined by a temporary emotion and establishing some sort of real life accomplishments for myself, and just maintaining my goals to have something to ground myself with for when I'm in those states of, 'it's end all be all.'

Other participants engage in activities such as painting, singing, writing poetry, and journaling, both in connection to their concerns and outside of them. Several participants advocated for themselves by researching potential diagnoses through the internet, self-help books, and other resources. Sasha shared a similar goal, achieved in her case through art:

> I used to keep it to myself. Now, my best friend told me that I have to share it. So I opened up an Instagram page where I've been posting my poetry work on it and I would sometimes make a video. And then this year, I was thinking about – I don't know, I just really want to feel a sense of accomplishment in a way. So I really wanted to put out even if it's like a smaller book of just all my poetry, because there's some poems that I haven't posted because I feel like they're really deep and meaningful to me, … I want to be able to put it in a book where if, if you appreciate poetry or if you appreciate words and emotion, it's something that's good for you.

As most participants embraced a holistic approach to mental health, they engaged in healthy eating and regular exercise to ensure their physical health supported their mental health. For Lisa, these physical health measures also coincided with connections to other YBW, who shared in their struggles and supported each other:

> I try to do walks, just be in a better mind-state. But I do my walks with my two regular friends, and I call them therapy walks because we just started (chuckle) … dishing out all our issues, our concerns. Like, whether something with home, work, love life, all that stuff; all that stuff, whatever, or school, whatever it is, we started all, like, talking about it and we were just so open and understanding. Because we all have our one issue … so like, we all understand that we have an issue and we're all understanding about it, so we're open to listening to each other and understanding of the issue when it comes to it too.

Lani, Jessica, Tiffany, and Sam adopted a peer-focused approach as well, especially as they relied on other YBW who are living with mental distress. Lani called out how critical it is that race be considered in any mental health supports rendered to Black people living with mental health challenges:

> I just feel like it's very, it's just very difficult connecting with, with people, essentially, because it's like, a lot of my issues are surrounded, or under an umbrella that are experiences because of my colour. And essentially, if that person doesn't want to get through that barrier of that umbrella that's above me, then essentially, they're not going to be helpful. All of their, all of their help will kind of be like rain droplets going on to my umbrella sliding right off and nowhere penetrating me and assisting me.

Jessica shared the importance of connections to other YBW with whom she can relate and share:

> Another Black woman, yeah, 'cause again, living in Alberta I felt like, everybody here is White. Coming to Toronto though, I've been able to share more because there's been more people like me who have gone through what I have been through, so I have friends in my inner circle who know that I can get into slumps sometimes.

Similarly, Tiffany spoke of the empowerment she feels sharing with other YBW who can relate to her mental distress:

> I have a Black girlfriend who we talk about, you know, like, mental health, we're in the same programs and stuff, and we go through some similarities when it comes to our families and our, our fathers and stuff, so it's just super empowering to find somebody who is on the same page.

Sam also shared the positive impact of connecting with other Black women:

> I look at my inner circle; the majority of my friends look the way I look and had been through shared experiences. So compared to when I was elementary to high school, I had about two Black girls that were my good friends at most throughout all of those years. And I think compared to now, it's about 80% of my friend group. … It's very relieving to just be surrounded by people that have gone through the same thing I've gone through… I consider it a type of support aspect for me.

Lisa focused on young Black girls and the common comments received around hair, beauty, skin, and worthiness, as well as cultural features:

> I feel like we have to talk to a lot of the younger women and it's not, I'm not talking about high school, I'm talking about even elementary, and teach them that Black is beauty… You don't have to fit into this standardized perception of people; like, you don't, you don't have to change the hair, the way your hair looks – unless that makes you happy – but you don't have to make yourself look a certain way, you don't have to act a certain way, like, you know? To just be who you are, embrace the skin you're in, teach them about the [diaspora] of your background. Like, teach them what they need to know, because it won't be such a factor, it'd be such a great benefit in the future for them, because no one can ever talk them down afterwards, … because you have grown up your whole life being talked to in such a positive way. … And not, and it doesn't have to do with, 'cause gender, you are the skin that you're in, it has nothing to do with the way you are, you just generalize 'beautiful human being' and you come from great people, the amazing history, food, and all that stuff.

Several participants embraced and practiced spirituality. Participants shared that having a spiritual connection, especially through prayer, affords them another avenue to minimize their experiences of mental distress. Joan, for example, stated that: "I pray… I used to pray a lot with my grandma… She just told me that that God always has the answer. So I just pray." Michelle shared a similar experience with prayer and other religious practices that supported her mental health:

> I did a lot of praying. It's actually like, I would say over when the pandemic first started, which would have been March 2020, I was really in depth in prayer during that time and that's really made me who I am today. So I would say prayer,

> I would fast sometimes, like, some days I would fast. And yeah, my family's really, they're pretty religious, so I grew up in the church and like I said, my dad passed away and my dad, I used to go to church with him every Sunday… So I feel like when I'm praying, it's also like I'm connecting to my dad in a way. Yeah, so that really gives me peace.

As seen through the findings the YBW coped with their mental distress through alternative coping strategies outside of traditional talk therapy, such as connection to others and a higher power that validated their struggles. Participants found a safe space to share, which provided them some relief from the mask they wore as they walked through the world.

Some participants found that safe space in this research, responding that they chose to participate because they thought it would be a supportive place to share. Apart from these coping mechanisms, participants' resistance to barriers that hinder help-seeking for their mental health concerns was also demonstrated in their response to the question of why they chose to participate in the current study. Almost all participants articulated their participation in this study as a move towards empowerment, whether for themselves, Black women, or Black people in general. Naomi saw the opportunity to participate in this study as illuminating her voice:

> 'Cause growing up, I seen there was a lot of studies like this, and I would never get involved. But like, I always wanted to, but in a sense, I always felt like I never had a voice… to actually speak up about it.

Lani felt that participating in this study was a way to "move things forward" and hold society accountable, as she stated:

> We can't stop pushing. We can't stop, not talking, like, we can't stop talking about it. We have to continue and further these conversations, we have to leave,

> we have to have people be accountable for their, their subconscious racial bias, and we need to call it out and talk about it so that we can move forward all of us in equity and no one gets left behind.

Joan saw her participation in research as an opportunity to use her voice and create change for herself. In her own words, she shared:

> [I chose to participate] to try to force myself to talk… Because if I, if I feel comfortable talking for this long, because I know it's supposed to be ninety minutes to two hours. Then, that maybe I should be able to handle, or start working on it.

Many viewed their participation in the study as enhancing their strength to acknowledge and work through their mental health concerns while simultaneously supporting others to be open regarding their mental distress.

Jessica also viewed her participation as a move toward disrupting dominant narratives regarding YBW. Speaking to other YBW, she shared:

> Don't let public perception keep you from speaking out. 'Cause I feel like, as Black women, we fear being painted in a bad light, and so it keeps us from sharing… If I would have spoken out there maybe would have been able to, I maybe would have been able to get intervention back then or even just an understanding of, "Okay, you're not acting out. You're, you're in a place right now where you're not understanding what's going on and maybe somebody can help you. You're not angry. You're not aggressive. You're not hard to work with. You're dealing with, you know, emotional… Being emotionally overwhelmed."

Tiffany explicitly shared this sentiment, stating that:

> I just like to talk about the things, the difficult things that Black people go through so we can make it easier for us to explain it and be easier for us to talk about it. Because even when you're saying, 'Oh, Tiffany, you know, you can stop at any time and come back and stuff, or you can call me back and we can talk about it if you, if it's too difficult.' It is difficult but, you know what? That's the main part about it, is to go through that difficult time so you can get to the easy part, you know? … This is why I'm more open about talking about it, is because more people need to be aware of it. My friends are not aware of the things that I go through half of the time, or half of the things that I've gone through so just talking about it with other Black people, it's just refreshing.

Furthermore, participants asserted that there must be a societal shift away from racist assumptions about Black communities towards a more strengths-based and positive understanding of what it means to be Black.

Subtheme 8: What Young Black Women Want/Need in Mental Health Care

Participants spoke to the critical need to destigmatize mental health and challenge sanist/ableist assumptions in Black communities. This theme speaks to the intersectional factors that impact their experiences with mental health and mental health supports. As Michelle stated:

> So I feel like it's always scary opening up to people about your mental health, you know, mental health challenges that you may face. But… there's a certain amount of time where it's like, you're gonna have to tell the person… So, I feel like, I think it's really important for people, everybody to know about, you know, this big issue because it's like, I feel like it's still looked down upon, especially in the

> Black community. So I feel like it's really important for people to gain knowledge on this.

Participants were forthcoming in sharing what they needed in terms of support for their mental distress. All participants agreed that to be effective, mental health supports must be intersectional and equitable, integrating understandings of race, gender, Black womanhood, sexuality, and other socially defining categories. Lani expressed this sentiment:

> There're so many levels, there are so many things that need to be involved in this conversation that you're engaging in, that it's not limited to only one area, that Black woman doesn't have to be, there's not one face for all of us. There's not one shade for all of us, that there's not, that there's no one experience that is, that is all of our experiences… It's not a contest. It's not, it's not to, it's not to prove whose life was harder than another, it's to acknowledge that, that our life is harder in whatever aspect that it was harder in, and it was due to the way the world perceives a Black woman, regardless of what shade, colour, place that Black woman is from.

Along the lines of intersectionality, a few participants also asserted that ethno-cultural backgrounds should be a consideration in mental heath service delivery. Savannah drew attention to the diversity of YBW in Toronto, who each carry their nuances in experience:

> I think you could even go further and look at Black women of specific ethnic backgrounds in the city of Toronto. Because I think the city is so diverse but also very… Like, women of Caribbean descent have a different experience than Black women of Black Canadians, or, you know, there's just differences there.

In addition to supports that are accessible and relevant for YBW, participants identified the need for grace and space to define themselves without being dismissed or invalidated as critical to mental health recovery. Savannah further stated that, in terms of her mental health and what she needs to succeed, she wanted space to learn these things about herself and be given support where necessary:

> I would like for people to give us more grace; more space to just be figuring it out. Because when I was spiralling and overwhelmed and miserable. … I think I also felt bad that I was being so negative, and I felt selfish, and I felt like, "Okay, maybe I'm just making these things up." Or, you know, like, "Why should I be complaining? I have graduated early, I've worked hard, I've done all these good things." Like, why are you still miserable? You got into university, you're going to university in January, like, get over it kind of thing… I felt like when I told people that it was like, "Well, you kind of – why are you being so flip floppy back and forth?" But it's like, I'm young, I'm figuring things out. I just went through, like, an identity crisis. I'm, like, it was just a lot and I was lost. And I feel like people were not as understanding as they could have been.

Along similar lines, participants felt that increased representation for Black women is necessary to make a change. Savannah connected this to the need to collect race-based data to illuminate where gaps and disparities lie in order to address social change:

> We should have more representation, especially in Canada, because I feel like a lot of Canada does this thing where they have this, 'Oh, we're so multicultural,' but fail to actually show data that is multicultural. It's kind of just, okay, this data that shows everybody but not data focused on Black people, data focused on this

> racialized group of people, which – so when I saw that you're doing a study for Black women in Toronto, I felt that it was important because we need studies that actually pinpoint data that represent us, so that when people are not understanding there is something to point to be like, 'Hey, this is actually proven. Here are the statistics that emphasize our point.'

Summary

During the interviews, participants spoke in-depth about their experiences with mental health concerns and accessing mental healthcare. In this chapter, the findings from the collected data were presented, and the responses to the sub-research questions supported an answer to the overarching research question. A summary of the responses to each sub-question is being provided here.

The first sub-question was "*How do YBW become aware of and manage their mental health concerns?*" YBW's shared that while they were aware that something was wrong, they did not acknowledge their mental health concerns and seek support until much later in their late teens or early twenties. Some participants also understand mental health as cognitively oriented and define their mental health concerns in biomedical terms, such as anxiety, depression, and bipolar.

The study further provided findings on the second sub-question, "*How do the intersections of race and gender influence YBW's mental health experiences?*" While each participant had different and varying life experiences, they shared that they felt burdened by the expectations placed on them both from the Black communities as well as from society in general, by the intersection of racism and sexism. Such oppression and marginalization are presented in

the sub-themes of the angry Black woman, strong Black woman and weakness as deficiency stereotypes..

Responses to the third sub-question, "*What role does mental health stigma play in YBW's experiences of service utilization for their mental health concerns?*" indicate that mental health stigma threads throughout and is implicated throughout participants' overall experiences of mental health. This is manifested in stereotypes and representations, and the detrimental impact these had on the participants.

The responses to the three sub-questions helped to address the overarching research question: "*How do YBW (18-25) in the Greater Toronto Area (GTA) experience mental health, and how do such experiences shape their help-seeking behaviours?*" Findings from the study indicate that YBW experience mental health concerns as invalidation and dismissal of their emotions and knowledge. While some participants expressed understandings of mental health being stigmatized in the Black communities, they also demonstrated that their experiences of mental health concerns are beyond stigma and more compounded by racist, sexist ideologies that they must be aware of and navigate in their daily lives.

CHAPTER 6: DISCUSSION

The purpose of this chapter is to describe and contextualize the experiences of young Black women (YBW) with mental health concerns in the GTA by analyzing narratives from 14 YBW who participated in semi-structured, in-depth interviews. The discussion below is based on the findings I established through a methodological combination of hermeneutic phenomenology and McCracken's (1988) long interview, both of which prioritize a deep, contextual understanding of experience rooted in participants' ways of viewing and interacting with the world around them.

This chapter frames the counterstories from the previous chapter with the theories that guide this study and contextualizes the findings within the current literature. My analysis is framed by critical race theory (CRT), anti-Black racism (ABR), and critical disability studies (CDS) due to their ability to centrally position racism, sexism, and ableism, as well as their interactions. Accordingly, this chapter considers the complexities in the narratives participants shared, with a focus on the commonalities in their stories, the use of language, and the trajectory of their experiences with mental health, mental health stigma, and mental health care. By closely attending to and considering these experiences, particularly with a focus on language and underlying dynamics, my findings spoke to the ways in which race and gender intersect in the lives of the participants as they navigate their mental health concerns. More importantly, I sought to understand how race and gender intersect to impact the experiences of YBW living with mental health concerns. I begin this chapter with a discussion of the study's main findings in relation to the overarching question and sub-questions.

This chapter connects my main findings to the research question and sub-questions that guided the inquiry process, focusing on young Black women's experiences with mental health,

stigma, and help-seeking behaviours. The discussion is organized into three parts based on the research questions that guided the study. The first section focuses on research question one, centring on the ways YBW became aware of and learned to address their mental health concerns in different moments throughout their life. The second section focuses on how participants navigate the intersections of race, gender, and their mental health conditions, highlighting the pressure to be strong and mask their true struggles as a method of survival. The third section answers my research question on mental health stigma and help-seeking, connecting the experiences of participants in this study to the broader pathologization of Blackness and its impacts on YBW.

In this chapter, I draw on young Black women's conceptions of their mental health, including how they come to understand their own mental health and how stigma, gendered racism, and the language of ableism complicate their help-seeking behaviours. These findings are then contextualized within the literature, drawing connections between the insights gleaned here with other findings, reports, and studies.

YBW's Understanding and Management of Mental Health Conditions

Almost all participants shared that they knew that "something was wrong" from an early age, with one participant stating that she knew that she was living with mental distress as early as age five. As a result, most participants shared a sense of emotional unsettledness. One significant finding in the study is that YBW see their mental health concerns as being invalidated and dismissed both in their homes and in society in general. Participants shared a common experience of not having their emotions related to mental distress taken seriously and being expected to perform their daily tasks and lives as usual even when they were at their worst. Their conceptualization of mental health was holistic and on a continuum of wellness, one that is

intimately connected to one's relationship to the world in which they live. Accordingly, the participants viewed racism, sexism, and generational trauma as the reason for dismissal and invalidation of their mental health conditions. Several participants spoke about how they have learned to become comfortable with the idea of suffering in silence, which comes at a great cost to their mental well-being (Crenshaw et al., 2015; Ncube et al., 2022). 11 of the 14 participants shared that they suffered in silence until their emotional pain became unbearable, often in their early twenties. Another YBW shared that only once she began experiencing suicidal ideations did she realize that she must address her mental health concerns. The phenomenon of suffering in silence is common thread throughout the narratives of most participants in this study. This is not surprising as, historically, there has been a huge (warranted) mistrust by Black people of both the physical and mental health care systems due to the lack of access to quality (or any) care for Black communities' health (Black Health Alliance, 2019; Nwoke & Leung, 2021; Yearby et al., 2022), and the legacy of violence upon Black bodies in the name of health and science (Cronin, 2020; Meghani et al., 2012; Tobin, 2022). These histories have lasting contemporary impacts for Black people and communities. For example, Black individuals are more likely than White individuals to be "receive diagnoses with poor long-term outcomes" (Richards, 2021, p. 2) and are more often (mis)diagnosed with schizophrenia or psychosis in comparison to White people (Fernando, 2017; Woods-Giscombe et al., 2021).

Further, studies conducted in the US has spoken to the fact that the lack or insufficient discussion of mental health in Black communities is major cause for young Black people's concealment of their mental distress. For example, Craddock and colleagues (2023), in their research exploring young Black women's perception of communication about mental health in Black communities, found that the participants did not find safe spaces within their families and

communities to discuss mental health challenges. Participants found that their families perceived that once your basic needs are met, then the young women just need to push through. Many articulated that when they tried discussing their emotional turmoil with their family, they were often dismissed and told that it was all their heads; they were expected to carry on with their daily lives as if nothing was wrong. YBW spoke to the need they felt to "carry on," "push through," "grow up," and "deal and cope with" their mental distress, often reflected in the comments they received from family members and mental health professionals when choosing to share about their distress. These invalidating comments only made participants more upset, further exacerbating their distress.

All participants in my study expressed difficulty initiating meaningful conversations regarding their mental health within their families. 13 of the 14 participants felt that the lack of discussion in Black communities on mental health distress equates to denial of its existence. When mental health is discussed, the participants contended that mental health distress positions individuals as weak, lazy and crazy. 6 of the participants spoke of what they experienced generationally within their families, with women such as their aunts, mothers, and grandmothers showing signs of mental distress, and yet these realities remain unacknowledged in order to perform 'normalcy.' Anglin and colleagues (2006) explored mental health stigma among African American communities and found that stigma-based attitudes towards mental health challenges dramatically differ from that of the dominant group. Some participants attributed the taboo nature of these discussions to intergenerational issues of mothers and grandmothers not wanting to name and accept the discourse of mental health distress' like YBW today, they felt pressure to be strong and persevere despite the personal cost.

In their narratives, YBW participants shared the burden of discussing their mental health conditions with family members, friends, and community members, especially in an environment where young Black women are adultified and expected to be emotionally and mentally strong to take care of family members and their own material needs. Carrying such burdens as a young Black woman is a trying and isolating experience, devoid of any public empathy. Unfortunately, this was a common thread throughout the narratives of all 14 participants.

While all 14 study participants identified that they are living with mental health concerns, only one participant, Michelle, termed her mental health as disabling, but also noted that she would not admit or share this with just anyone as a Black woman. Even those who spoke of having experienced self-harm, suicidal ideation, or attempted suicide confided that they were fearful to share with family members let alone outsiders. As clearly stated in the findings, participants are aware of all the harmful labels already attached to them, simply due to the ways Black women bodies are perceived by the world around them. These spheres of awareness illustrate the ways racism and ableism have been linked as logics of oppression, where both have been used as tools to render Black people as inferior to the hegemonic White race (Annamma et al., 2013).

Erevelles and Minear (2010) explained the ways in which racialized Black bodies became identified as disabled and the property of Whites through slavery, resulting in Black people being constructed as biologically and intellectually inferior. Through the brutal and dehumanizing system of slavery, the Black body became the epitome of the disabled figure, and Black bodies were disqualified from full participation in society based on the historical categorization of difference imposed on them. The language of ableism is used to construct Black people as being biological deficient, crazy, and lazy, hence sub-human (Erevelles & Minear, 2010; Fernando,

2012, 2017). To understand why YBW may be hesitant to acknowledge mental distress, to seek or delay help-seeking, it is necessary to understand how the "language of ableism has been used to justify and rationalize the racist experiences of Black people" (Adjei, 2016, p. 10). Given the historical and contemporary utilization of ableist language to justify Black de/sub-humanization, mental health systems within the Canadian context must work in tandem with Black professionals to develop targeted supports for young Black people living with mental health conditions.

From a critical disability perspective, the language of pathology has historically been weaponized against Black bodies, where mental health became and remains a mechanism through which White supremacy operates to deny and reject the humanity of Black people. As discussed in the literature review (Chapter 2), Black people's experience with mental illness must be understood in the context of their history of systemic oppression. Garland-Thomson (1997) and Davis (1995) characterized disability as working in tandem with ethnicity and race, arguing that disabled people are also members of oppressed groups. Adjei (2013) argued that "the pathologization of Blackness in an anti-Black racism context constitutes such identity as a form of disability" (p. 23), creating material consequences for young Black people as they seek help for mental health concerns, as adding a diagnosis can magnify existing stereotypes around Blackness and Black women in general. When YBW express mental health concerns, there is a risk that their acceptance of mental distress and diagnosis will inadvertently reinforce them.

Surviving at the Intersection of Race, Gender, and Mental Health Conditions

When conceptualized through the lens of CRT, CDS, and ABR, my findings show how dominant discourses socially construct race and gender to position Black women and other racialized people in inferior ways in dominant discourse (Essed, 1991; Jones, 2021; Wallace,

1999). Racist, sexist, and other ideologies inform the ways young Black women curate themselves in the world, making them feel pressure to perform 'ableism' in order to protect themselves (Jackson & Naidoo, 2012; Okeke, 2013). As such, many women identified pressure to put on a mask that renders their struggles invisible to maintain the illusion of mental wellness so as to avoid further surveillance or marginalization. Many spoke about how they have internalized the need to be strong and "push through," even in the face of significant adversity and challenges. One participant, Mary, spoke about the difficulty of admitting to having mental health conditions in a society where Blackness is already negatively perceived. For example, one participant mentioned that they had to work twice as hard as others to see results, and they still felt as though they were "not enough." Hence, when her emotional turmoil was at its worst, she kept going to classes and performing her everyday tasks. However, while the participants can mask the presentations of their mental health concerns, they cannot hide their gender and race, as these are visible categories of their identities.

Anti-Black racism dates back to slavery, when "stereotypes of Black women arose through mistreatment that portrayed the image of being overly sexual, overbearing and loud" (Godbolt et al., 2022, p. 610). Other conceptualizations of Black women include the hypersexual Jezebel, the verbally aggressive Sapphire, the Mammy—who is supposed to show physical and mental fortitude and care for others—and the resilient and emotionally tough Black woman (Collins, 2000; Harris-Perry, 2013; Parks, 2010). Such images and stereotypes dehumanize, devalue, and make disposable Black femininity. Such an example was shared by Naomi in relation to her negative experience of accessing mental health supports from a non-Black therapist for the first time. The woman therapist devalued her story of enduring sexual assault by suggesting that Naomi was at fault for the violent sexual experience. She interpreted that the

therapist viewed her as being promiscuous because she is Black. Narratives like the one shared by this participant must be interpreted within the context of ongoing histories of anti-Black racism, which constructs Black femininity as risky, promiscuous, and ultimately dangerous to the white nation's moral fabric, thereby leading to dehumanization, devaluation, and disposability (Curtis et al., 2022; Kelley, 2023; Gómez, 2023). Pathologization is implicit; however, there is a risk that diagnosis will inadvertently reinforce them. This then becomes a unique challenge/barrier for young Black women in acknowledging and seeking help for mental health conditions.

Post-slavery literature shows that sexual violence against Black women is an exercise of social dominance and control over Black bodies. According to John H. McCray, the editor of *The South Carolina Lighthouse and Informer*, rape and sexual violence against Black women were a common phenomenon in the time he was writing (Bedingfield, 2011); even in more recent times, almost every Black woman has a story to share of experiencing sexual violence (McGuire, 2006). Overall, the stories of the young Black women in my study suggest that their experiences of sexual harassment and violence are not only gender-motivated but also racially incentivized. This is not to suggest that White women do not experience sexual violence. Rather, what YBW in this study suggest is that anti-Black racism and sexism frequently interact in the context of violent sexual experiences. The long history of Black women's extensive sexual exploitation and rape during and post-slavery has fed into public misperceptions that Black women are sexually available for whoever desires them, but also are unreliable witnesses when they are raped (Adams, 1997).

Black women are constructed as weak while they are simultaneously expected to be strong (Beauboeuf-Lafontant, 2007; Danquah, 1998). Black girls and YBW are socialized in a

way that requires "suppressing negative emotions to avoid the appearance of being weak or inadequate," a trope founded in "historical narratives that cast Black women as the indefatigable pillars of their families and communities" (Modeste-James et al., 2024, p. 2). Black women have no choice but to be fearless, hardworking, ambitious, and resilient, which is a response to a racist society in which their very survival relies on strength (Jackson & Naidoo, 2012). Hence, the strong Black woman trope becomes the prototype for rearing and socializing YBW. Wallace (1999) described the strong Black woman myth this way: the "strong Black woman is seen as "the epitome of the selfless, self-sacrificing, 'good' woman" (p. 166). Some participants felt pressure to place everyone else's emotional and physical needs above their own, a common experience of Black women in society (Ncube et al., 2022).

In Michele Wallace's (2015) *Black Macho and the Myth of Superwoman*, she argued that the strong Black woman is the epitome of selflessness, self-sacrificing, and an embodiment of 'goodness' (p. 166). Wallace (2015) offers a detailed exploration of the cultural and social expectations of Black womanhood. In fact, Black women, regardless of age and social status, are expected to be caregivers and protectors of the home. They must be mentally strong and reveal no weakness even in the face of adversities and challenges.

Conducting this research during the height of the COVID-19 pandemic allowed me to document an atmosphere in which participants spoke about the challenges they faced, which further impacted their mental well-being. Many (92%) of the participants spoke of being tasked with additional responsibilities at home, where they were either taking care of younger siblings, doing household chores, studying, and working part-time while battling the compounding effects of their mental distress. It was clear from their stories that their mental health concerns took a backseat to other responsibilities, both within their families and their individual lives.

In addition to bearing the burden of the expectation to be a strong Black woman, YBW shared the burden of carrying the stereotype of the angry Black woman. The literature is filled with examples of stereotypes of Black women as angry and hostile (Jones & Norwood, 2017; Motro et al., 2022; Walley-Jean, 2009). Five of the YBW shared how they see this racialized and gendered stereotype as encouraging misinterpretation of their communication and emotional expression. In other words, they see how these stereotypes are applied to them, regardless of the intent behind the words. This subsequently further compounds their mental distress and impedes their social and interpersonal relations. One participant, Mary, shared how the trope of the angry Black woman is used to discredit women and how detrimental this has been to her own mental health. For other YBW in the study, the stereotype of an angry Black woman is pervasive and has been the ontological register through which the bodies of Black women are often read in society (Adjei & Richards, forthcoming).

Many studies have suggested that the stereotype of the angry Black woman is pervasive and negatively affects not only how others perceive and interact with Black women but also how Black women come to understand themselves in relation to others. West (1995) notes that some Black women internalize this stereotype to avoid appearing vulnerable. Fante-Coleman and Jackson-Best (2020) also contend that internalizing the Sapphire/angry Black woman stereotype is associated with negative consequences, such as anger suppression, which then creates or compounds mental distress. Hence, critically examining YBW being labelled as angry is important, as such negative images can hinder their ability exercise agency and resistance in the wake of mental distress. All participants to varying extents spoke about their vulnerabilities as being Black and living with mental health conditions. Other participants also hold the view that

living with a mental health condition further burdens Black people and "pushes YBW further down on the lower spectrum of social acceptance and respectability."

Ashley (2014) and Gregory (2010) further note that the stereotype of the angry Black woman affects YBW on multiple levels, including feeling unsafe, anxious, and unprotected as they relate and interact with others. Ashley (2014) even suggests that this stereotype can affect professional relationships between Black women and service users and therapists, reinforcing the myth and hindering mental well-being. As Rosenthal and Lobel (2016) share, when mental health professionals consciously or unconsciously hold stereotypes, their attitudes often lead to discriminatory practices in care, maintaining disparities in outcomes for Black women.

Mental Health Stigma, Help-Seeking, and Anti-Blackness

According to Clement and colleagues (2015), the most commonly cited forms of stigma experienced by those living with mental health concerns in general are public stigma, relating to societal attitudes towards those deemed to be mentally 'ill,' and self-stigma, which refers to the ways individuals internalize stereotypes and assumptions and apply them to themselves (Eisenberg et al., 2009, 2012). There is an abundance of research conducted in the US that indicates that mental health stigma is a major barrier among Black people living with mental health conditions (Alvidrez et al., 2010; DeLuca, 2020; Fields-Oriogun et al., 2024; Kranke et al., 2010, 2012; Planey et al., 2019). Findings from the sparse research conducted with Black youth and Black young adults in the Canadian context indicate that stigma is a barrier to acknowledging mental distress and help-seeking (Cénat, 2025; Fante-Coleman & Jackson-Best, 2020; Salami et al., 2022; Waldron et al., 2024). Similarly, two of the participants spoke to their awareness that while mental health conditions are heavily stigmatized, the added layer of being a

Black woman combined with other identities makes it more difficult for them to navigate their mental distress.

I began this research with the premise that stigma is the most significant barrier to Black people acknowledging mental distress and seeking help (Black Health Alliance, 2017; Black Experience in Healthcare, 2016). Stigma and discrimination are part of complex systems of beliefs about mental illness and illness in general that are grounded in social inequalities (Castro et al., 2005). There is a plethora of research that cites stigma as a major hindrance to help-seeking among Black individuals living with mental health conditions (Eylem, 2020; Fields-Origun et al., 2024; O'Connor et al., 2024). Howarth (2006) asserted that the "stigma of race acts to deny humanity, agency and liberty" (p. 446) of Black people. Fanon (1967) described the ontological stagnation and epistemological violence of showing up Black under White gaze as 'unmerciful imprisonment' where Black bodies are forced to memorialize Blackness as a site of trauma and the landscape of terror. In this way, as per Goffman (1963), the person is "reduced from a whole and usual person to a tainted and discounted one" (p. 3). Any stigma associated with race, such as mental health stigma, must be understood within historical and political contexts.

While Black communities in Canada have called for community programs to destigmatize mental health through mental health literacy education, Black youth are still less likely compared to non-Black populations to seek and maintain supports for their mental health concerns (Cénat, 2024; Cénat et al., 2025; Fante-Coleman et al., 2023; Salami, 2023; Waldron et al., 2023). A few of the research participants shared that living with mental health is stigmatized to the point that they do not feel able to express their feelings openly. Some participants further

believe that when they express emotional pain that appears invisible to everyone around, they feel rejected, invalidated, and dismissed when expressing or showing vulnerability.

However, while stigma is commonly listed as a hindrance to seeking or accessing mental health care, the counter-narratives of YBW participants reveal that racist, sexist, and other ideologies about embodied Blackness impact their ability to openly acknowledge, discuss, or seek support for their mental distress. What these participants experience cannot be explained solely by stigma. Stigma appears to be more individualizing, often manifesting as a function of cognition and attitudes (Corrigan, 2000). The findings show, instead, that oppression related to gender, race, and other forms of identity ultimately leads to the denial of mental health challenges in Black communities, particularly among the Black youth population, thereby hindering help-seeking. Indeed, recent data from the US shows that stigma is not one of the main reasons that Black women avoid seeking mental health care. Rather, their decision to seek help depends on their prior experiences with seeking help and the discrimination they face in society at large (Richards, 2021).

Research conducted with Black young adults living with mental conditions within the Canadian context found that many youths will not seek mental healthcare; for those that do, they often do not maintain care due to systemic anti-Black racism (Cenat et al., 2023; Cenat et al., 2025; Fante-Colemen & Jackson-Best, 2020; Goddard-Durant et al., 2023; Kalambay, 2023; Salami et al., 2022; Waldron et al., 2024). Race-related barriers to help-seeking leave Black people with unmet mental health needs, impacting their ability to survive and thrive in the world. This reality was reflected in the participants' engagements with formal mental health supports. Many of the participants in this study shared that they have sought formal mental health support in the past. However, at the time of data collection, only 6 of the 14 young Black women, less

than half, were engaged with formal mental health supports on an on-and-off basis, with 2 receiving supports via their primary healthcare provider and the others through mental health therapists. The remaining 4 participants were seeking support through monthly counselling: 3 were connected to Black mental health professionals, and 1 was involved in mentorship.

For these reasons, research conducted with Black youth about pathways to care for those living with mental health concerns indicates that Black youth prefer to receive services from professionals who look like them (Black Health Alliance, 2022; Lovell & Shahsiah, 2006). This aligns with my findings, within which all 14 participants shared that representation in mental healthcare for YBW matters. Only 2 participants reported positive experiences with supports, primarily because they were eventually linked to Black-centred supports. These positive experiences centred on the ways that these supports understood their histories and presents, understood how their culture and community were implicated in their experiences of mental health and mental health supports, and validated the ways they work to navigate the world. For this reason, many of the remaining 8 participants who were not formally engaged with mental health supports at the time of data collection noted that they relied on peer support.

As Jessica shared, she has come to realize that integral mental health support does not have to come from individuals with formal degrees, but that the connection between two people is sufficient to make a difference. This participant and others used mentors and other community members for peer-to-peer support. These relationships were mostly formed based on similarities in their experiences related to gender, race, and mental health concerns. One major consistency throughout the participants' narratives is that representation in mental health care matters, with the majority stating a preference for Black women mental health professionals, should they seek formal help. Research has shown that peer relationships are important to Black women’s well-

being (Adkins-Jackson et al., 2019). Along the same lines, others have argued that one of the ways that Black women cope with racial microaggressions is to seek support from other Black women, as Black women are more apt to respond to supportive resources when they come from someone of the "same racial-gender-in-group" (Davis & Afifi, 2019). Neal-Barnett and colleagues (2011) also found that sister circles were instrumental in treating Black American women living with anxiety, as they provided a community where Black women felt represented with others who could relate to the oppression and marginality based on their race and gender.

Even participants who used informal coping strategies drew on these similarities in understanding to address their needs. For example, participants took advantage of resources like podcasts, self-help books and blogs that they felt spoke to the nuances in their experience. Other participants used creative methods of coping, including painting, singing, poetry, other creative arts, and journalling, and felt they could share their authentic experience and voice without the pressure to keep their mask on.

Overall, the YBW all agreed on the need for representation when it comes to mental health supports, not only for mental health practitioners but for themselves, so they can better understand their complex and unique intersectional identities and navigate their lives while living with mental distress. They all viewed their participation in the study as being liberatory, which aligns with the theoretical orientations of CRT, CDS, and ABR that guided this study.

Towards Empowerment: Agency, Resilience, and Self-Care

> "*I lived in a world where women gained strength by sharing knowledge and resources, not by bonding on the basis of being victims.*" (hooks, 1995, p. 52)

While research on the mental health issues of young people has mostly focused on risk factors and problem behaviours and their consequences, recently, arguments are being made for the exploration and recognition of resilience and the strategies that young people use to cope

with adversities, such as mental health conditions. The factors that allow a person to experience a phenomenon differentially must always be considered (Yates et al., 2012). There have been various conceptualizations of resilience in relation to young adult populations. According to Ungar (2006), resilience is negotiated between individuals and their environments to maintain a sense of self as healthy. Research indicates that resilience can be used to mediate the experiences of negative mental outcomes as a result of racist incident exposure, such as gendered racism and discrimination (McCall et al., 2025). In other words, Black people must engage in collaborative strategies aimed at limiting the damage of racializing representations. Research conducted with Black women exploring their perceptions about mental distress and help-seeking found that participants saw resiliency as the top protective factor in helping them to maintain good mental health (McCall et al., 2025). The women also acknowledged that one cannot over rely on resilience at least not to the detriment of their own mental health (McCall et al., 2025).

However, with regard to race and racism and embodied young Black women living with mental health conditions, resilience must be seen as a multidimensional construct. Resilience in this regard is the "ability to persevere and maintain a positive sense of self when faced with omnipresent racial discrimination" (Brown & Tylka, 2011, p. 264). Several participants shared that participating in the study itself was a safe space to share 'real' sensitive issues. They chose to participate in the study because they saw it as a supportive space to share. Additionally, most of the YBW in the study viewed their participation in this study as a move towards empowerment, whether for themselves, other Black women, or Black people living with mental distress in general. One participant, Naomi, shared that, though she had seen studies recruiting young Black women before, she had never felt comfortable getting involved because she felt she "didn't have a voice." Another participant, Lani, sees her participation in this study as "moving

things forward." All participants shared that participating in this research finally afforded them the opportunity to "share their side of their stories" of the ways they experience mental distress, perceive mental health in general, experience challenges in society as embodied young Black women that create and maintain mental health conditions. These served as counter stories to the dominant narratives told about young Black women that work to invalidate, silence, and dehumanize them; ways to continue "speaking back" to the racism and pathologization so common in their lives.

Summary

This chapter discussed the study's findings in response to the overarching research questions, drawing on related literature and the theoretical framing of CRT, ABR, and CDS. The findings indicate that YBW in the GTA are forced to navigate gendered racism within anti-Black racism contexts, including mental healthcare systems and other institutions, all of which serve to exacerbate their mental health conditions. The findings further indicate that while mental health stigma is often cited as a main barrier to both acknowledgement of mental distress as well as help-seeking, it is imperative to understand young Black women's mental health experiences through the critical lens of historical and contemporary socio-political contexts. Further, this study also indicates that a critical examination of the ways language of mental health traps Black bodies in a pathological space of anti-Blackness and ableism is necessary to change the discourse to one that is humanizing and equitable. Young Black women's intersectional and marginalized status often renders their experiences invisible institutionally and structurally through entrenched anti-Black racism. As a result, there is a significant paucity of research that examines YBW`s lived experiences with mental health. When their experiences are recognized at the intersection

of their marginalized identities, or in other words, when they are made visible on their own terms, YBW may be more inclined to share and seek out support for their concerns.

CHAPTER 7: CONTRIBUTIONS, IMPLICATIONS, AND CONCLUSION

The central goal of this study was to gain a nuanced and deep understanding of the mental health experiences of 14 young Black women (YBW) (18-25 years) living in the Greater Toronto Area. More specifically, this study examined how these experiences shape their help-seeking behaviour, and the findings provide crucial insights that can inform how social workers, mental health institutions, and other institutions develop supports that truly respond to YBW's mental health care needs. In order to understand the experiences of YBW, this study was guided by hermeneutical phenomenology, grounded in van Manen's (1990) interpretive approach and McCracken's (1988) long interview process, and focused on the following overarching two-part research question: How do young Black women (18–25) in the Greater Toronto Area (GTA) experience mental health, and how do these experiences shape their help-seeking behaviours? This overarching question is supported by the following three sub-questions:

1. How do YBW become aware of and manage their mental health concerns?
2. How do the intersections of race and gender influence YBW's mental health experiences?
3. What role does mental health stigma play in YBW's experiences of service utilization for their mental health concerns?

In the previous chapter, I framed my discussion of the findings through the lens of critical race theory (CRT), anti-Black racism (ABR), and critical disability studies (CDS), outlining the ways that race, gender, and ableism interact in the lives of the young Black women as they navigate their mental health concerns. This chapter outlines the study's contributions to the knowledge base on how young Black women navigate mental health concerns. These findings have implications for theory, knowledge, and practice to better support and serve young Black women in mental health care settings. In this chapter, I also address the limitations of the study, highlight

key gaps, and provide recommendations for future research to address these limitations by broadening and deepening social work practices to improve mental health outcomes for YBW.

Contributions of the Study

This study adds to the very limited research (Darko et al., 2024; Goddard-Durant et al., 2023) on the lived experiences of young Black women (18–25 years) living with mental health concerns in the GTA, which can help inform policies and practices across Ontario. The data collected from this research make a unique contribution to disaggregated data that speaks to the diverse and changing experiences and needs of YBW in relation to their mental health. As stated in the literature review (see Chapter 2), while there is some research on Black girls and young Black women in the field of mental health in the United States and the UK, similar research is virtually non-existent in Canada. In fact, I argue that the limited research in Canada is indicative of the ways in which young Black women are largely obscured from discourses on mental health experiences in Canada (Goddard-Durant et al., 2023; George, 2020). The last known study on this topic in Ontario was conducted by the Women's Health Community Health Centre over 20 years ago. This study provides a much-needed systematic investigation of the mental health issues and their impacts on the well-being of young Black women within the current context.

Most of the data collected for this study happened at a critical time, when the COVID-19 pandemic highlighted and worsened the health and mental health disparities faced by Black Canadians (Cénat et al., 2025; Fante-Coleman et al., 2023; Osman et al., 2025). This was particularly true for YBW, who experienced social, familial, and psychological stressors at unprecedented levels, thus provoking calls for more in-depth and appropriate mental health research and improved mental health care. This study provides a deeper understanding of how YBW in the GTA conceptualize and manage their mental distress and the systemic barriers they

encounter in acknowledging their mental distress, initiating conversations regarding their distress with families, and in seeking and maintaining mental health care. The young Black women who participated in this study indicated that they experience mental distress through the lenses of their race and gender, which leads to hypervigilance around how they present and behave. Further, they noted that, in general, their concerns are invalidated and dismissed in their communities and in society at large.

More importantly, the study contributes to an enhanced understanding of the role that mental health stigma plays in help-seeking for mental health distress in Black communities, and specifically among young Black women. Despite the focus on stigma in much of the literature and formal response to the mental health crisis in Black communities, the narratives shared here indicate that young Black women see these barriers as deeper than mental health stigma. Rather, in their experience, it is systemic oppression grounded in ABR, not stigma, which makes it challenging for them to acknowledge and seek support for mental health distress.

This study establishes young Black women's experiences, narratives, and voices as distinct and unique, thereby offering valid and meaningful knowledge that has the potential to catalyze significant change in mental health care. Rooted in the theoretical lenses that guide this research, the participants' storytelling and counter-storytelling provide a means to centre their individual and collective experiences in their own language and voices, thereby providing a narrative that opposes the raced, gendered, and medicalized discourses of mental distress that shape their experiences. In this way, participants disrupt monolithic racialized understandings of young Black women's mental health experiences, particularly those that simultaneously racialize and blame YBW for their mental distress. By placing these young Black women's narratives at the centre of this research, we gain crucial insights from the ways that they live with and through

mental distress in the GTA, rather than relying on a Eurocentric vision that is obscured by racially biased assumptions about mental health and appropriate interventions. Further, these insights illuminate the need for approaches to practice that adequately capture and address the social, economic, and environmental factors influencing young Black women's mental health (Massaquoi et al., 2022).

Overall, this study addresses the paucity of research on Black youth mental health, specifically that of young Black women. The findings of this research contribute to our understanding of how race, gender and age adversely impact the lived experiences of YBW with mental health concerns in the GTA. I hope to inform changes in policy, practice, education, and research that lead to appropriate mental health care that is free of racism and sexism. Potential ways these insights can be applied are proposed in the following sections.

Implications of the Study

The findings of this study provide crucial insights into what it means to be a young Black woman navigating mental health concerns, while simultaneously navigating the complex, raced, gendered, and classed dynamics (among others) that impact their day-to-day lives. Their stories of racism and sexism, fear and shame, silencing and masking, along with those of resistance, connection, and hope for more in life, have important implications for the field of social work, mental health care, and Canadian society writ large. In this section, I focus on the insights gleaned from participants' narratives and their implications for young Black women's mental health care, theoretical considerations, and social work education, policy, and practice.

Implications for Young Black Women's Mental Health

Young Black women are often overlooked and excluded from research and mental healthcare within the Canadian context (George, 2020; Spates, 2012). As discussed in the

literature review (see Chapter 2), most of the literature either speaks to Black youth mental health in general or delves into a Black-White comparison (Sheftall et al., 2022), often in the US context. Very little attention has been given to understanding how YBW's mental health experiences are complicated by their intersecting and often marginalized identities and position within society (Abrams et al., 2019; Erving & Vaughan Smith, 2024; Spates, 2012). Research with YBW must also consider their complex intersectional identities and the impact these intersections have on their mental health and overall well-being. This study provides a deeper understanding of YBW's authentic stories, offering insight into their mental experiences and help-seeking behaviour.

The major findings from this study indicate that young Black women's mental distress is often invalidated both within their families and Black communities in general. Their mental distress is also misunderstood and dismissed in mental health systems, as well as within other major institutions such as post-secondary educational settings and employment (Cénat et al., 2025; Goddard-Durant et al., 2023). To address these deep-seated and systemic issues, transformative and integrative practice must intentionally validate young Black women's mental health experiences to provide the targeted supports that they need to adequately address their unique needs. YBW's experiences of mental distress are often perceived through the lens of racist and sexist ideologies that further impede and negatively influence the narration of their own experiences and subsequently inhibit their decisions to seek help. The dominant constructs of YBW as non-feminine, controlling, and independent (Collins, 2000) make it challenging for them to do anything *but* deny or remain silent about the existence of their mental distress (Beauboeuf-Lafontant, 2007; Ncube et al., 2022). The stereotypes of the strong Black woman (SBW) and the angry Black woman both appeared commonly in the stories of participants, and

they keep them trapped in a cycle of unrealistic social, ideological, and racial expectations buried in historical and contemporary White ideologies (Beauboeuf-Lafontant, 2007; Taylor & Richards, 2019; Wallace, 2015).

Consequently, instead of paying attention to their own needs or being welcomed as they seek help for their concerns, the expectation that they can overcome hardships on their own renders them silent in a manner that is detrimental to their overall mental health and well-being. The participants in this study described their journeys through mental distress as being "tiring," "exhausting," and "constant," during which they were repeatedly told that they were not allowed to feel what they were feeling. This is critical information that warrants social workers and other service providers paying careful attention to YBW narratives, which provide insights into how to challenge the hegemonic narratives of normalcy entrenched within the structures of the mental health system in Canada.

In the same vein, eight of the fourteen (57%) participants shared that when they finally decided to reach out for help from their primary care providers or community mental health agencies, they were met with constant doubt and endless barriers, such as disbelief, opposition, condescension, and outright dismissal when seeking to have others understand their experiences. For example, many of the participants were dismissed by medical doctors, psychiatrists, and mental health practitioners when they finally decided to seek help, which often only occurred when their mental health was at its worst. Some of the participants who sought professional support discontinued treatment due to feelings of being misunderstood and not truly heard, particularly by White and other non-Black professionals who did not understand the complex dynamics young Black women must navigate daily. Oftentimes, this discouraged them from seeking continuing support for their distress. As a result, YBW explained that they often turn to

their own peers and friends for guidance and support, which is helpful but often insufficient for their needs. Participating in this study afforded participants a safe space, often for the first time, to authentically speak about how they have been experiencing their mental distress; this revelation speaks to the significance of hearing and validating young Black women's mental health and their own unique lived experiences, which are unique and shaped by the forces of racism, sexism, and other forms of oppression that they must navigate.

Participants clearly explained that when they share their stories, they need to receive validation, respect, and empathy from mental health providers and professionals. All participants contend that in order for mental health supports to be effective for them, they must take their intersecting and complex lives into account, integrating understandings of race, gender, Black womanhood, sexuality, and other socially defining categories such as ableism. Furthermore, while mental health stigma may be a factor that hinders help-seeking for mental health among Black people and young Black women in particular, framing mental distress and help-seeking behaviour among Black people exclusively as resulting from mental health stigma ignores the complex historicity and presence of anti-Blackness. Mental health providers and mental health systems in Canada, in general, must understand that mental health stigma is a byproduct of Black pathology that has plagued Black populations since the time of slavery, as a mechanism to justify their dehumanization. A multifaceted and targeted approach that embraces an anti-racist, culturally sensitive, and gender-specific approach is critical in providing effective mental health services that will support effective healing of young Black women living with mental health conditions.

Theoretical Implications

Critical race theory (CRT), critical disability studies (CDS), and anti-Black racism (ABR) were all instrumental to this study as they facilitated the unravelling of the complexities of mental health experiences shared by the participants in Toronto. In particular, CRT helped me to theorize YBW's experiences of mental health as deeply rooted in their histories and meaning-making processes as they connect their individual struggles and interactions to the broader social, economic, and historical context (Matsuda et al., 1993). As a frame of analysis and key tenet within CRT, intersectionality (Collins, 2015; Combahee River Collective, 1977; Crenshaw, 1989, 1991; Nash, 2008; Puar, 2012) enabled a deeper examination of participants' doubly marginalized status along race and gender lines. The intersectionality of oppressions they spoke to here complicated their experiences with mental health challenges; their challenges were not associated with being "woman" or "Black" on their own, but the specific intersection between "woman" and "Black" that makes them "Black women." An intersectional theoretical approach is necessary to account for YBW's multiple identities.

In addition, another tenet of CRT, counter-storytelling (Delgado & Stefanic, 2001; Ladson-Billings & Tate, 1995), focused on language and meaning-making processes, affording participants the opportunity to tell their stories in their own words, or "telling the stories of those people whose experiences are not often told" (Solórzano & Yosso, 2002, p. 26). Historically, the emphasis in mental health fields has been on White experiences and knowledge, particularly in WEIRD (Western, Educated, Industrialized, Rich, and Democratic) contexts like Canada (Hendriks et al., 2019; Henrich et al., 2010). Hence, "incorporating the lived stories of the oppressed, narratives in CRT are a critical tool to undermine dominant discourses" (Moodley et al., 2018, p. 81). CRT offered me a way to centre participants' stories while simultaneously analyzing their challenges in accessing mental health care in the context of the overarching

Eurocentric hegemony, thereby serving as a mechanism of resistance. Utilizing CRT as a theoretical frame in this research illuminates the impact of racism and discrimination on the lives of young Black women, along with the adverse effects of these experiences on their mental health. CRT centres the role of race and racism as a main barrier to the experiences of mental health and help-seeking of the participants. An understanding informed by CRT helps us not only understand the relationship between race, racism, and power but also how to transform these structures to bring about social justice.

Researchers and literature often position mental health stigma and its complexities as the main culprit preventing young Black people from acknowledging mental distress and seeking appropriate mental health supports (Alvidrez et al., 2008; Fante-Coleman & Jackson-Best, 2020; Kranke, 2012). Utilizing CDS in conversation with CRT helps to dismantle the notion that stigma is the main barrier to seeking mental health support. According to my findings, the participants' resistance to addressing mental health concerns and accessing relevant supports is rooted in the language of pathologization and its historical and contemporary weaponization to further their marginalization, rather than just a simple explanation of stigma. CDS helps us to understand how mental health challenges are constructed in society, particularly around certain bodies. It forces a re-examination of the assumption that stigma is the main barrier to help-seeking among Black people living with mental health distress; in fact, I argue that this reluctance is related to the historical and contemporary contexts of systemic oppression.

In combination with CRT and CDS, ABR enabled me to analyze the dynamics that young Black women face, both in mental health care settings as well as society at large. ABR facilitates a deeper understanding of the ways that mental health systems, embedded within White supremacy and misogyny, pathologize Black mental health. This study engaged the memories of

participants about the social conditions of showing up and living while Black within "a visceral anti-Black racism and ableism context" (Adjei, 2018, p. 275). Their stories reveal the significant vulnerabilities that young Black women with mental health conditions experience in such a context. Historically, mental illness has been used to establish measures of 'normalcy' in an effort to determine who is well or unwell, who is human or inhumane, and who is permitted to be different or should be surveilled (Erevelles & Minear, 2010; Fernando, 2012, 2017). Indeed, as discussed in the literature review, Black people were deemed to have a flawed psyche through scientific racism (Fernando, 2017); this enduring racist assumption maintains that Black people must be surveilled, diagnosed, and treated in order to keep them in line (Fernando, 2012, 2017; Rollock & Gordon, 2000). To bring the appropriate frame in capturing the unique intersectional experiences of YBW living with mental distress, as well as to what role mental health stigma plays in their help-seeking behaviours, it was necessary to utilize these concepts in my analysis.

The study revealed that a critical and multifaceted approach centred on anti-racism/ableism—exemplified here through the use of CRT, CDS, and ABR—can serve as an emancipatory tool in dismantling the racism and discrimination that adversely impact the mental health experiences of YBW living in the GTA. Conversations around YBW living with a mental health condition often ignore social conditions that impact the collective experience, which can itself elicit mental distress. Mental health conditions within Black populations cannot be studied through ahistoric, objective/neutral, or uncritical theoretical frames.

Implications for Social Work Education, Research, and Practice

Implications for Social Work Education

The Canadian Association of Social Workers (CASW, 2024) Guiding Principle 2.1 acknowledges that social work has been historically complicit in the perpetuation of ABR

through education and the practice of segregation, surveillance, and the exclusion of Black communities from health and social services. This Guiding Principle calls for higher education institutions to dedicate resources to developing social work curricula and teaching that addresses ABR through collaboration with Black students, scholars, and community networks, as "teaching and learning about ABR is a liberatory act" (Varghese, 2016, p. 223). Social workers in both practice and pedagogical spaces have an obligation to bring awareness about ABR and its deep roots in societal institutions, such as mental health systems. Social work education's approach to systemic ABR must be intentional; there is a distinct need to deliver curricula in a manner that can shift dominant discourses regarding young Black people and young Black women towards challenging systemic oppression (Thomas Bernard & Smith, 2018).

A social justice approach that centres Black epistemology and understandings, particularly in relation to mental health, should be a central part of social work curricula. Researchers have critiqued the lack of curricular content on race, racism, and anti-Blackness within social work education. For example, as Varghese (2016) contended, faculty members in social work, particularly in clinical social work, tend to have "limited content knowledge or pedagogical preparedness to incorporate issues of race and racism into classroom teaching and practice" (p. 145). It is imperative that critical theories such as CRT, CDS and ABR be part of the curricula in social work education, considering the ongoing systemic issues encountered by young Black adults living with mental health and the future of social work students who will engage not only with these systems but with Black people within them. As bell hooks (1994) asserted, critical pedagogy represents a "practice of freedom, aimed at transformation and the abolishment of subjugation and oppression" (p. 21). To achieve liberation in social work pedagogy, particularly in clinical social work education, it is essential to integrate a deep,

intentional understanding of how Black people understand, interpret, and communicate their mental distress. These experiences cannot be understood as individualized medicalized experiences, but rather as being connected to historical and contemporary systemic violence, racism, sexism, social pathology, and other intersectional forms of oppression.

Moreover, embedding CRT as a viable and, indeed, important mode of theorization within social work pedagogy can equip soon-to-be social workers with the knowledge and analytical skills they need to serve vulnerable populations. A soon-to-be-published scoping review examining the use of CRT and ABR in social work from 2000 to 2022 found that these modes of theorization and the concept of ABR are not widely used in the field within the Canadian context (Edwards et al., forthcoming). Rather, most studies remain deeply entrenched in Eurocentric theories that tend to reinforce systems of oppression rather than challenge them (Constance-Huggins, 2012; Edwards et al., forthcoming).

In terms of advocacy and the transformation of the mental health and other institutional systems with which young Black women may interact, social workers must advocate for and transform oppressive and racist policies and practices that create and maintain racial injustices. Such advocacy must pay critical attention to reforming mental health assessments, ensuring that the language they use is race-sensitive and that they do not serve as a mechanism to further devalue service users. Social workers must not replicate the racist, patriarchal, colonizing and sexist practices that have created mistrust and other barriers to young Black women. engagement in mental health services. The findings of the study also underscore the need for social work settings to understand and utilize integrative approaches that consider the complex intersectional identities of YBW and their bearing on mental health experiences (Erving et al., 2021).

Implications for Research

There is a paucity of research on young Black adults' mental health experiences within the Canadian context, and most existing research is disaggregated by race but not by gender (Cénat, 2025; Fante-Coleman & Jackson-Best, 2020). Therefore, I advocate for an increase in research that specifically examines the unique and complex experiences of YBW living with mental health distress. Research with YBW should adopt methodologies and theoretical frameworks that capture the essence of their lived experiences, particularly through participatory research methods, to increase their visibility and address their marginalization in research. Further, this research must endeavour to expand recruitment and the populations of focus to examine unique experiences across spatial, temporal, linguistic, and ethno-cultural lines, thereby deepening our understanding and better addressing mental health distress and barriers to seeking support.

Implications for Practice

Social workers are tasked with working with young Black adults within mental health settings in Ontario, particularly in the GTA. The profession of social work has undertaken efforts to incorporate diverse understandings into practice, particularly through cultural competency, which has been seen as the cornerstone of meaningful support in social work settings for more than two decades. Cultural competency is defined by Cross and colleagues (1989) as " a set of congruent behaviours, attitudes, and policies that come together in a system, agency, or among professionals, enabling that system, agency, or those professionals to work effectively in cross-cultural situations" (p. 13). Bassey and Melluish (2013) viewed cultural competency as an instrumental mechanism for addressing disparities in mental health care systems.

However, focusing only on cultural competency can shift the focus to differences and catalyzing individual-level responses, thereby leaving the mechanisms that support structural

oppression intact. Speaking within the context of child welfare in Ontario, Pon (2009) contended that cultural competency acts as a form of "new racism" that "otherizes non-whites, using culture to do so, all the while never having to invoke racialist language" (p. 63). Addressing systemic ABR should be a top priority at all levels of social services, from the individual to the community. When working with Black populations, it is imperative that such approaches be complemented by an understanding of the complex history of Black people in Canada, including the history of enslavement, segregation, and anti-Black racism that is still prevalent today. In other words, "the social work profession must institute the intentional inclusion of racial equality as an ethical imperative" (Wilson et al., 2020, p. 617). There are some shifts in the profession attempting to address the limits of cultural competency; one example includes cultural responsiveness in education, practice, and research with racialized bodies (Bennett et al., 2016; Green et al., 2016; Melendez & Thompson, 2020; Stothers et al., 2021; White, 2024). This is just one example of the work being done that remains to be implemented on an organization-to-organization basis; there is no concrete regulatory framework to mandate these measures on a larger scale.

As this study reveals, based on the participants' negative experiences when attempting to access services, representation in mental health care matters. Many of the YBW described a significant difference in how they experienced their mental distress, whether they felt understood, validated, and respected by different health care providers. Several participants who tried accessing formal mental health supports shared that they felt uncomfortable and judged, were met with condescension or contempt, and that the non-Black therapists did not show empathy towards them as they attempted to share their stories of mental distress. Participants identified the distinct benefits of working with a Black mental health practitioner compared to a

non-Black service provider. It is therefore imperative to create mental health supports or programs specific to young Black women based on consultations with Black service providers who can take the lead or act as key resources to inform programs and interventions, and concerted efforts to enable pathways for Black people (especially women) to get into mental health professions.

Furthermore, including young Black women as key stakeholders in program planning and proposals holds significant potential to increase their service provision effectiveness by integrating young Black women's intersectional identities, such as age, gender, class, and race, into the fabric of the programs themselves, therefore aiding in the mitigation of gender stereotypes and racism that YBW experience in the world at large.

Strengths and Limitations of the Study

My social location as a Black woman and a former service provider in both clinical mental health care and social assistance and non-profit settings are strengths that allow me to better understand young Black women's perspectives and experiences regarding mental distress and help-seeking. Identifying with the population under study also allowed me a more "rapid and complete acceptance by the participants" (Dwyer & Buckle, 2009, p. 58), as I appeared to them as an insider, someone who had some insight into the things they experience. Additionally, this familiarity with the participants also contributed to participants sharing their experiences in a more open and uninhibited manner. Recruitment for participants was also eased because of my insider status and my strong affiliation with the Black communities at large.

Limitations are potential disadvantages within any research study (Creswell, 2012). In this research, one of the limitations was my inability to include participants who do not speak English and Black YBW who, due to a lack of funds to pay interpreters to help with interviewing

and transcribing. This means my conclusions cannot speak to the experiences of young Black women whose linguistic context may shift their experiences in navigating mental health. Further research may thus be required to capture the experiences of non-English speaking young Black women and to investigate a broader array of insights into young Black women's help-seeking behaviours. Another limitation can also be attributed to the nature of the topic of research itself; as mental health concerns are stigmatized and Black women face the pressure to be normal and perform regardless of what they endure, some individuals may not have participated because they were not comfortable sharing. Some participants spoke to this discomfort, noting that it was difficult for them to decide to participate.

The interviews with participants were also completed via Zoom video conferencing, which made it difficult to recognize non-verbal cues, especially for those participants who chose to have their cameras off. While online qualitative research data collection yields many benefits, such as the greater likelihood of obtaining the desired sample size, one drawback can be the inability to detect deeper underlying meaning of participants narrative, especially in research regarding health or illnesses (Carter et al., 2021; Denham & Onwuegbuzie, 2013). In qualitative research, non-verbal cues can be beneficial to the over quality of the data and data analysis.

In addition to methodological limitations and ethical considerations, there is also potential for theoretical limitations. As I noted on page 65, one of the critiques of phenomenology, particularly in the hermeneutic tradition, is that it does not "adhere to a 'rule-based process" (Bynum & Varpio, 2018, p. 253). In leaving space for the interpretive process involving the interplay of multiple analytical activities such as self-reflection, participant voices, literature, and the dialogue between them all, hermeneutic phenomenology has been said to at times leave *too* much space for interpretation (Omery, 1983; Bynum et al., 2019; Neubauer et al.,

2019). This is also a limitation of how I applied phenomenology in this research. In thinking through how to 'do' a hermeneutic-phenomenological study, I sought an aligned yet somewhat more structured method that would complement my methodological approach, which I found in McCracken's (1988) long interview method (LIM).

Recommendations for Future Research

Future research with young Black women, particularly on the topic of mental health, is necessary across Canada in diverse contexts with diverse participants. There is a paucity of research on YBW's health and mental health experiences. Research with this population should be a priority, as young Black adults are among the fastest growing populations in Canada (Domey & Patsiurko, 2024). Accordingly, future research with young Black adults should draw attention to the intersectional identities participants inhabit, thereby validating and placing importance on their voices. Using critical theories as a foundation for research offers a structural analysis that sets the stage for social justice and substantive change.

Additionally, special focus must be placed on young Black women, as their lived experiences are often made invisible or conflated with the experiences of young Black men or white women. Research should also be done from the perspective of YBW in order to truly understand how they experience their mental health experiences. Mental health research must fully "transition from expert-based objective research to participant-based transformative research" (Williams, 2001, p. 237).

Another area of future research is to explore the phenomenon of suicidal ideation among young Black adults, as suicide among young Black women is said to be a growing crisis in the U.S. as well as in Canada (Cénat et al., 2025; Darius et al, 2024; MHCC, 2024). Three of the participants in this study shared that they had experienced suicidal ideations, and one participant

admitted that she was self-harming. One participant also shared that she attempted suicide in the past. Suicidal ideation is said to be a serious concern in Canada yet there is virtually no research that explores the prevalence or and related factors among Black individuals (Cénat et al., 2025; Darius et al., 2024).

Conclusion

This phenomenological study examined the mental health experiences of 14 young Black women, aged 18–25 years, living in the Greater Toronto Area. This study is the first to explore this phenomenon within the GTA, particularly within the context of the global COVID-19 pandemic that brought the health and mental health disparities among Black populations into sharp relief. The hermeneutical-phenomenological methodology and long interview method utilized in this research proved ideal for other related studies, as focusing on participants' lived experiences in their own words enabled the full illumination of their voices.

Additionally, the theoretical lenses of CRT and CDS, along with ABR as a concept, enabled a deeper analysis of YBW experiences with mental distress, and an interrogation of the extent to which mental health stigma hinders help-seeking. CRT centers the experiences of YBW with mental distress and help-seeking, illuminating systemic anti-Black racism in terms of their race and gender and the impact on psychological distress. The core tenets of racism as endemic in all institutions and structures in society, along with intersectionality and counter-storytelling, allowed for the authentic narratives of the research participants, as they describe the complex and nuanced intersectional oppression that they endure. CDS offers a historical lens on the pathologization of Blackness, and, when combined with CRT, explains it through the co-construction of ability and race. Additionally, using hermeneutic phenomenology as a qualitative approach, along with McCracken’s (1988) LIM, supported the amplification of participants'

narratives, empowering them to tell their stories in their own voices as they live them in the everyday world.

The main findings facilitate a better understanding of the construction of young Black women's mental health experiences at the intersections of race, gender, and mental health. This exploration also illuminates the systemic issues that YBW with lived experiences of mental distress face in Canada. The findings help to inform mental health care practices, social work pedagogy, and policy development. The findings also highlight the need to engage critical theories in research with young Black people and to incorporate Black historical contexts into any health-related care. I would like to end this dissertation by thanking the participants who so courageously shared their stories, allowing their voices to be heard in ways that challenge hegemonic knowledges about their experiences. Historic and systemic factors have largely rendered young Black women's suffering invisible; their struggles obscured by discourses of racism, sexism, ableism, and other oppressive forces that work to essentialize, deny, and silence their voices. It is my hope that this work can add to these voices demanding change; the participants' voices, the voices of those in my personal professional lives, and the voices of other Black women who live with mental health distress. By documenting these counterstories as valid knowledge, I seek to make visible the ways young Black women navigate this world and, in doing so, further build the foundation for supports that better meet their needs and help them thrive.

REFERENCES

Abrams, J. A., Maxwell, M., Pope, M., & Belgrave, F. Z. (2014). Carrying the world with the grace of a lady and the grit of a warrior. *Psychology of Women Quarterly, 38*(4), 503–518. https://doi.org/10.1177/0361684314541418

Abrams, J. A., Hill, A., & Maxwell, M. (2019). Underneath the mask of the strong Black woman schema: Disentangling influences of strength and self-silencing on depressive symptoms among US Black women. *Sex Roles, 80*(9–10), 517–526. https://doi.org/10.1007/s11199-018-0956-y

Abrams, S., & Moio, J. A. (2009). Critical race theory and the cultural competence dilemma in social work education. *Journal of Social Work Education, 45*(2), 245–261.

Adams, J. H. (1997). Sexual harassment and Black women: A historical perspective. In W. O'Donohue (Ed.), *Sexual harassment: Theory, research, and treatment* (pp. 213–224). Allyn & Bacon.

Adjei, P. B. (2018). The (em)bodiment of Blackness in a visceral and anti-Black racism and ableism context. *Race, Ethnicity and Education, 21*(93), 275–287. https://doi.org/10.1080/13613324.2016.1248821

Adjei, P. B. (2024). Psychopathology and structural dehumanization of Blackness: The “silent” scandal of science. In D. Nyaga & R. A. Torres (Eds.), *Reimagining mental health and addiction under the Covid-19 pandemic* (Vol. 2: The Covid-19 pandemic, mental health, and Black/Afro identity, pp. 29-33). Springer Nature.

Adkins-Jackson, P. B., Turner-Musa, J., & Chester, C. (2019). The path to better health for black women: Predicting self-care and exploring its mediating effects on stress and health.

Inquiry: A Journal of Medical Care Organization, Provision and Financing, 56, 46958019870968. https://doi.org/10.1177/0046958019870968

Aguirre Velasco, A., Cruz, I. S. S., Billings, J., Jimenez, M., & Rowe, S. (2020). What are the barriers and facilitators and interventions targeting help-seeking behaviours for common mental health problems in adolescents? A systematic review. *BMC Psychiatry, 20*, Article 293. https://doi.org/10.1186/s12888-020-02659-0

Ahmed, S. K. (2025). Sample size for saturation in qualitative research: Debates, definitions, and strategies. *Journal of Medicine, Surgery, and Public Health, 5*, Article 100171. https://doi.org/10.1016/j.glmedi.2024.100171

Alaggia, R. (2004). Many ways of telling: Expanding conceptualizations of child sexual abuse disclosure. *Child Abuse & Neglect, 28*(11), 1213–1227. https://doi.org/10.1016/j.chiabu.2004.03.016

Allen, A. M., Drain, A., Galán, C. A., Goharzad, A., Tung, I., & Bekele, B. M. (2024). Why DON'T we "Say Her Name"? An intersectional model of the invisibility of police violence against Black women and girls. *Perspectives on Psychological Science*. Advance online publication. https://doi.org/10.1177/17456916241277554

Alvidrez, J., Snowden, L., & Kaiser, D. (2008). The experience of stigma among Black mental health consumers. *Journal of Health Care for the Poor and Undeserved, 19*(3), 874–893. https://doi.org/10.1353/hpu.0.0058

American Psychiatric Association. (1968). *Diagnostic and statistical manual of mental disorders* (2nd ed.). American Psychiatric Association. https://www.madinamerica.com/wp-content/uploads/2015/08/DSM-II.pdf

Anderson, K. K., Flora, N., Ferrari, M., Tuck, A., Archie, S., Kidd, S., Tang, T., Kirmayer, L. J., & McKenzie, K. (2015). Pathways to first-episode care for psychosis in African-, Caribbean-, and European-origin groups in Ontario. *The Canadian Journal of Psychiatry, 60*(5), 223–231. https://doi.org/10.1177/070674371506000504

Anglin, D. M., Link, B. G., & Phelan, J. C. (2006). Racial differences in stigmatizing attitudes toward people with mental illness. *Psychiatric Services, 57*(6), 857–862. https://doi.org/10.1176/ps.2006.57.6.857

Annamma, S.A., Connor, D., & Ferri, B. (2013). Dis/ability critical race studies (DisCrit): Theorizing at the intersections of race and dis/ability. *Race, Ethnicity and Education, 16*(1), 1–31. https://doi.org/10.1080/13613324.2012.730511

Anucha, U. (2010). Housed but homeless? negotiating everyday life in a shared housing program. *Families in Society: The Journal of Contemporary Social Services*, *91*(1), 67–75. https://doi.org/10.1606/1044-3894.3953

Anucha, U., Srikanthan, S., Siad-Togane, R., & Galabuzi, G. E. (2017). *Doing right together for Black youth: What we learned from the community engagement sessions for the Ontario Black Youth Action Plan.* Youth Research and Evaluation eXchange (YouthREX). https://doi.org/10.15868/socialsector.33742

Anyiwo, N., Stanton, A. G., Avery, L. R., Bernard, D. L., & Abrams, A. G. (2021). Becoming strong: Sociocultural experiences, mental health, & Black girl's Strong Black Woman schema endorsement. *Journal of Research on Adolescence, 32*(1), 89–98. https://doi.org/10.1111/jora.12707

Armstrong, T. D., Pinson, V. M., Avent-Alston, L., & Buckner, D. N. (2022). Increasing mental health service utilization in Black populations during COVID-19: Clarifying clinician responsibility. *Practice Innovations*, *7*(3), 188–202. https://doi.org/10.1037/pri0000155

Ashley, W. (2014). The angry Black woman: The impact of pejorative stereotypes on psychotherapy with Black women. *Social Work in Public Health, 29*(1), 27–34. https://doi.org/10.1080/19371918.2011.619449

Atkins, K. M., Tollerud, T. R., Roy-White, T., Brdecka, L. E., & Chrones, D. (2023). Infusing military culture in multicultural counseling frameworks: A phenomenological study. *The Qualitative Report, 28*(7), 1950–1967. https://doi.org/10.46743/2160-3715/2023.5900

Aylward, C. A. (1999). *Canadian critical race theory: Racism and the law*. Fernwood Publishing.

Ayodeji, E., Dubicka, B., Abuah, O., Odebiyi, B., Sultana, R., & Ani, C. (2021). Editorial perspective: Mental health needs of children and young people of Black ethnicity – Is it time to reconceptualise racism as a traumatic experience? *Child and Adolescent Mental Health*, *26*(3), 265–266. https://doi.org/10.1111/camh.12482

Baffoe, M. (2013). Stigma, discrimination & marginalization: Gateways to oppression of persons with disabilities in Ghana, West Africa. *Journal of Educational and Social Research*, *3*(1), 187-198. https://doi.org/10.5901/jesr.2013.v3n1p187

Baidoobonso, S., Etowa, E., Nnadi, J., Mba, S., Tharao, W., Daboné, C., Giwa, S., Ogunleye, A., Ndongmo, L. A., & Etowa, J. (2025). The impact of the COVID-19 pandemic on the mental health of African, Caribbean, and Black (ACB) people in Canada. *Journal of Immigrant and Minority Health*, *27*(1), 42–52. https://doi.org/10.1007/s10903-024-01654-x

Bakare, B. (2024). *The relationship between racial trauma and mental health outcomes in young adulthood: A UK context* [Doctoral dissertation, University of Essex]. Essex Research Repository. https://repository.essex.ac.uk/39133/

Bartholomew, T. T., Joy, E. E., Kang, E., & Brown, J. (2021). A choir or cacophony? Sample sizes and quality of conveying participants' voices in phenomenological research. *Methodological Innovations*, *14*(2), 1-14. https://doi.org/10.1177/20597991211040063

Bassey, S., & Melluish, S. (2013). Cultural competency for mental health practitioners: A selective narrative review. *Counselling Psychology Quarterly, 26*(2), 151–173. https://doi.org/10.1080/09515070.2013.792995

Baynton, D. C. (2001). Disability and the justification of inequality in American history. In P. K. Longmore & L. Umansky (Eds.), *The new disability history: American perspectives* (pp. 33–57). New York University Press.

Baynton, D. C. (2013). Disability and the justification of inequality in American history. In L. J. Davis (Ed.), *The disability studies reader* (4th ed., pp. 17–33). Routledge.

Beauboeuf-Lafontant, T. (2007). You have to show strength: An exploration of gender, race, and depression. *Gender & Society, 21*(1), 28–51. https://doi.org/10.1177/0891243206294108

Bedingfield, S. (2011). John H. McCray, accommodationism, and the framing of the Civil Rights struggle in South Carolina, 1940-48. *Journalism History*, *37*(2), 91-101. https://doi.org/10.1080/00947679.2011.12062848

Bell, D. A. (1980). *Brown v. Board of Education* and the interest-convergence dilemma. *Harvard Law Review, 93*(3), 518–533. https://doi.org/10.2307/1340546

Bell, D. A. (1993). *Faces at the bottom of the well: The permanence of racism.* Basic Books.

Benjamin, L. A. (2003). *The Black/Jamaican criminal: The making of ideology* [Doctoral dissertation, University of Toronto]. TSpace Repository. http://hdl.handle.net/1807/117761

Benn-John, J. (2016). (Re)colonizing Black Canadian women & routes to resistance. *Race, Gender & Class*, *23*(1–2), 150–165.

Bennett, B., Redfern, H., & Zubrzycki, J. (2018). Cultural responsiveness in action: Co-constructing social work curriculum resources with Aboriginal communities. *The British Journal of Social Work, 48*(3), 808–825. https://doi.org/10.1093/bjsw/bcx053

Beresford, P., & Russo, J. (2016). Supporting the sustainability of Mad Studies and preventing its co-option. *Disability & Society, 31*(2), 270–274. https://doi.org/10.1080/09687599.2016.1145380

Bernard, V. W. (1972). Interracial practice in the midst of change. *American Journal of Psychiatry, 128*(8), 978–984. https://doi.org/10.1176/ajp.128.8.978

Billups, S., Thelamour, B., Thibodeau, P., & Durgin, F. H. (2022). On intersectionality: Visualizing the invisibility of Black women. *Cognitive Research: Principles and Implications*, *7*(1), Article 100. https://doi.org/10.1186/s41235-022-00450-1

Black Experience Project (BEP). (2017). *The Black Experience Project in the GTA: Overview report*. https://www.theblackexperienceproject.ca/wp-content/uploads/2017/07/Black-Experience-Project-GTA-OVERVIEW-REPORT-4.pdf

Black Health Alliance. (2015). *A sound mind: Mental health in the Black community* (Forum report). https://blackhealthalliance.ca/wp-content/uploads/A-Sound-Mind-2015-Forum-Report.pdf

Black Health Alliance. (2016). *A sound mind II: Mental health and youth* (Forum report). https://blackhealthalliance.ca/wp-content/uploads/BHA-forum-report-2016.pdf

Black Health Alliance. (2019). *Perspectives on health and wellbeing in Black communities in Toronto: Our health, our way.* https://blackhealthalliance.ca/wp-content/uploads/Perspectives-on-Health-and-Wellbeing-in-Black-Communities-in-Toronto-Our-Health-Our-Way.pdf

Bowden, O. (2023, August 23). *His brother died in an Ontario jail. Advocates say calls for reform to prevent such deaths are being ignored*. CBC News. https://www.cbc.ca/news/canada/toronto/inmate-suicide-toronto-jail-1.6943729

Bromberg, W., & Simon, F. (1968). The “protest"psychosis: A special type of reactive psychosis. *Archives of General Psychiatry*, *19*(2), 155-160. https://doi.org/10.1001/archpsyc.1968.01740080027005

Brouillette, K., Aiello, O., Egbedeyi, O., Loggale, O., Renzaho, A. M., Maduforo, A., & Salami, O. (2025). Impacts of the COVID-19 pandemic on the mental health of Black youth. *Canadian Journal of Public Health*. Advanced online publication. https://doi.org/10.17269/s41997-025-01017-5

Brown, D. L., & Tylka, T. L. (2010). Racial discrimination and resilience in African American young adults: Examining racial socialisation as a moderator. *Journal of Black Psychology, 37*(3), 259–285. https://doi.org/10.1177/0095798410390689

Brown, T. N. (2003). Critical race theory speaks to mental health: Mental health problems produced by racial stratification. *Journal of Health and Social Behaviour, 44*(3)*,* 292–301. https://doi.org/10.2307/1519780

Busfield, J. (1996). *Men, women and madness: Understanding gender and mental disorder*. Palgrave Macmillan.

Butler, J. (1990). *Gender trouble: Feminism and the subversion of identity*. Routledge.

Buzi, R. S., Weinman, M. L., Smith, P. B., Loudd, G., & Madanay, F. L. (2018). HIV stigma perceptions and sexual risk behaviors among Black young women. *Journal of HIV/AIDS & Social Services, 17*(1), 69–85. https://doi.org/10.1080/15381501.2017.1407726

Bynum, W., & Varpio, L. (2018). When I say … hermeneutic phenomenology. *Medical Education*, *52*(3), 252–253. https://doi.org/10.1111/medu.13414

Bynum, W. E., Artino, A. R., Uijtdehaage, S., Webb, A. M. B., & Varpio, L. (2019). Sentinel emotional events: The nature, triggers, and effects of shame experiences in medical residents. *Academic Medicine*, *94*(1), 85–93. https://doi.org/10.1097/ACM.0000000000002479

Calliste, A., & Dei, G. J. S. (2000). *Anti-racist feminism: Critical race and gender studies.* Fernwood Publishing.

Campbell, C., & Deacon, H. (2006). Unravelling the contexts of stigma: From internalization to resistance to change. *Journal of Community & Applied Social Psychology, 16*(6), 411–417. https://doi.org/10.1002/casp.901

Canadian Association of Social Workers (CASW). (2024). *Code of ethics, values and guiding principles*. https://www.casw-acts.ca/files/attachements/CASW_-_Code_of_Ethics_Values_Guiding_Principles_-_2024.pdf

Canadian Institute for Health Information (CIHI). (2009). *Improving the health of Canadians 2009: Exploring positive mental health* (Summary report). https://secure.cihi.ca/free_products/summary_mh_mar0309_e.pdf

Canadian Institute for Health Information (CIHI). (2025). *Who is most affected by mental health disorders?* CIHI Child and Youth Mental Health. https://www.cihi.ca/en/child-and-youth-mental-health

Canadian Mental Health Association (CMHA). (2016). *Mental health statistics* [Fact sheet]. https://ontario.cmha.ca/wp-content/uploads/2016/10/CMHA-Mental-health-factsheet.pdf

Carter, S. M., Shih, P., Williams, J., Degeling, C., & Mooney-Somers, J. (2021). Conducting qualitative research online: Challenges and solutions. *The Patient: Patient-Centered Outcomes Research, 14*(6), 711–718. https://doi.org/10.1007/s40271-021-00528-w

Cartwright, S. (1851). Diseases and peculiarities of the negro race. *DeBow's Review, 11*(1), 64–74.

Castro, A., & Farmer, P. (2005). Understanding and addressing AIDS-related stigma: From anthropological theory to clinical practice in Haiti. *American Journal of Public Health*, *95*(1), 53–59. https://doi.org/10.2105/AJPH.2003.028563

Cénat, J. M. (2020). How to provide anti-racist mental health care. *The Lancet Psychiatry, 7*(11), 929–931. https://doi.org/10.1016/S2215-0366(20)30309-6

Cénat, J. M. (2024). Racial discrimination in healthcare services among Black individuals in Canada as a major threat for public health: Its association with COVID-19 vaccine mistrust and uptake, conspiracy beliefs, depression, anxiety, stress, and community resilience. *Public Health, 230*, 207–215. https://doi.org/10.1016/j.puhe.2024.02.030

Cénat, J. M., Manoni-Millar, S., David, A., Darius, W. P., Kogan, C. S., & Dalexis, R. D. (2025). Barriers to mental health care for Black youth in Canada: A socioecological perspective. *Canadian Psychology.* Advanced online publication. https://doi.org/10.1037/cap0000419

Chandra, A., & Minkovitz, C. S. (2006). Stigma starts early: Gender differences in teen willingness to use mental health services. *Journal of Adolescent Health, 38*(6), 754–762. https://doi.org/10.1016/j.jadohealth.2005.08.011

Chapdelaine, R. P. Thompson, M. D., & Asare, A. A. (Eds.). (2023). *When will the joy come? Black women in the ivory tower.* New Books Network.

Cheek, C. & Piercy, K. W. (2004). Quilting as age identity expressions in traditional women. *International Journal of Aging & Human Development, 59*(4), 321–337. https://doi.org/10.2190/T1R0-D8TW-ML6Y-VYYL

Clement, S., Schauman, O., Graham, T., Maggioni, F., Evans-Lacko, S., Bezborodovs, N., Morgan, C., Rüsch, N., Brown, J. S. L., & Thornicroft, G. (2015). What is the impact of mental health-related stigma on help-seeking? A systematic review of quantitative and qualitative studies. *Psychological Medicine, 45*(1)*,* 11–27. https://doi.org/10.1017/S0033291714000129

Codjoe, H. M. (2001). Fighting a 'public enemy' of Black academic achievement—the persistence of racism and the schooling experiences of Black students in Canada. *Race Ethnicity and Education, 4*(4), 343–375. https://doi.org/10.1080/13613320120096652

Cohen, M. Z., & Omery, A. (1994). Schools of phenomenology: Implications for research. In J. M. Morse (Ed.), *Critical issues in qualitative research methods* (pp. 136-156). SAGE Publications.

Collins, P. H. (2000). *Black feminist thought: Knowledge, consciousness, and the politics of empowerment* (2nd ed.). Routledge.

Collins, P. H. (2004). *Black sexual politics: African Americans, gender, and the new racism*. Routledge. https://doi.org/10.4324/9780203309506

Combahee River Collective. (1977). *The Combahee River Collective statement*. http://circuitous.org/scraps/combahee.html

Constance-Huggins, M. (2012). Critical race theory in social work education: A framework for addressing racial disparities. *Critical Social Work*, *13*(2). https://doi.org/10.22329/csw.v13i2.5861

Cooke, C. D., & Hastings, J. F. (2024). Black women social workers: Workplace stress experiences. *Qualitative Social Work, 23*(3), 499–514. https://doi.org/10.1177/14733250231151954

Cooper, M., Mellis, S., & MHRC Team. (2024). *A generation at risk: The state of youth mental health in Canada.* Mental Health Research Canada. https://www.mhrc.ca/youth-mental-health

Corrigan, P. W. (2000). Mental health stigma as social attribution: Implications for research methods and attitude change. *Clinical Psychology: Science and Practice, 7*(1), 48–67. https://doi.org/10.1093/clipsy.7.1.48

Cotton, P. A. (2022). *Exploring the impact of medical apartheid on maternal health outcomes for Black women in the United States* [Master's thesis, Bowie State University] (Publication no. 30530458). ProQuest Dissertations & Theses.

Craddock, J. B., Adams, V., Gladden, A., Netty, B., & Ajenifuja, O. (2023). Black families don't talk about it: Young Black women`s perceptions of mental health communication in Black communities. *Journal of the Society for Social Work and Research*, 14(3), 553-755. https://www.journals.uchicago.edu/doi/full/10.1086/716188

Crenshaw, K. (1989). Demarginalizing the intersection of race and sex: A Black feminist critique of antidiscrimination doctrine, feminist theory, and antiracist politics. *University of*

Chicago Legal Forum, 1989(1), 139–167. http://chicagounbound.uchicago.edu/uclf/vol1989/iss1/8

Crenshaw, K. (1991). Mapping the margins: Intersectionality, identity politics, and violence against women of colour. *Stanford Law Review, 43*(6), 1241–1299. https://doi.org/10.2307/1229039

Crenshaw, K. W., Ocen, P., & Nanda, J. (2015). *Black girls matter: Pushed out, overpoliced and underprotected.* Center for Intersectionality and Social Policy Studies. https://www.atlanticphilanthropies.org/wp-content/uploads/2015/09/BlackGirlsMatter_Report.pdf

Creswell, J. W. (2007). *Qualitative inquiry and research design: Choosing among five approaches* (2nd ed.). SAGE Publications.

Creswell, J. W. (2012). *Educational research: Planning, conducting and evaluating quantitative and qualitative research* (4th ed.). Pearson Education.

Creswell, J.W. (2013). *Qualitative inquiry & research design: Choosing among five approaches* (3rd ed.). SAGE Publications.

Crichlow, W., & Lauricella, S. (2018). An analysis of anti-Black crime reporting in Toronto: Evidence from news frames and critical race theory. In M. Bhatia, S. Poynting, & W. Tufail (Eds.), *Media, crime and racism* (pp. 301–316). Palgrave Macmillan.

Crocker, J., Major, B., & Steele, C. (1998). Social stigma. In D. T. Gilbert, S. T. Fiske, & G. Lindzey (Eds.), *The handbook of social psychology* (4th ed., Vol. 2, pp. 504-553). Academic Press.

Cronin, M. (2020). Anarcha, Betsey, Lucy, and the women whose names were not recorded: The legacy of J Marion Sims. *Anaesthesia and Intensive Care, 48*(Suppl. 3), 6-13. https://doi.org/10.1177/0310057X20966606

Cross, T. L., Bazron, B. J., Dennis, K. W., Isaacs, M. R., & Benjamin, M. P. (1989). *Towards a culturally competent system of care: A monograph on effective services for minority children who are severely emotionally disturbed*. National Institute of Mental Health. https://spu.edu/-/media/academics/school-of-education/Cultural-Diversity/Towards-a-Culturally-Competent-System-of-Care-Abridged.ashx

Cullen, J. (2004). *Understanding the experiences of gay men in addiction treatment: a phenomenological study* [Doctoral dissertation, University of Toronto]. TSpace Repository. http://hdl.handle.net/1807/118420

Curtis, M. G., Karlsen, A. S., & Anderson, L. A. (2022). Transmuting girls into women: Examining the adultification of Black female sexual assault survivors through Twitter feedback. *Violence Against Women, 29*(2), 321-346. https://doi.org/10.1177/10778012221083334

Daley, A., Costa, L., & Ross, L. E. (2012). (W)righting women: Constructions of gender, sexuality and race in the psychiatric chart. *Culture Health & Sexuality, 14*(8), 955–969. https://doi.org/10.1080/13691058.2012.712718

Danquah, M. N. A. (1998). *Willow weep for me: A Black woman's journey through depression*. Ballantine.

Darius, W. P., Farahi, S. M. M. M., Kogan, C. S., Ndengeyingoma, A., & Cénat, J. M. (2024). Depression and suicidal ideation among Black individuals in Canada: mediating role of traumatic life events and moderating role of racial microaggressions and internalized

racism. *Social Psychiatry and Psychiatric Epidemiology, 59*(11), 1975–1984. https://doi.org/10.1007/s00127-024-02641-1

Darko, N. A., Wilson, C. L., & Oliver, V. (2024). “We are mothers, sisters, and lovers too”: Examining young Black women’s experiences navigating sex and sexual health. *American Journal of Community Psychology*, *74*(3–4), 196–209. https://doi.org/10.1002/ajcp.12753

Darwin, C. (1871). *The descent of man, and selection in relation to sex.* John Murray.

DasGupta, N., Shandal, V., Shadd, D., & Segal, A. (2020). *The pervasive realities of anti-Black racism in Canada: The current state and what to do about it.* CivicAction and BCG. https://www.bcg.com/en-ca/publications/2020/reality-of-anti-black-racism-in-canada

Davis, L. J. (1995). *Enforcing normalcy: Disability, deafness, and the body.* Verso Books.

Davis, S. M., & Afifi, T. D. (2019). The Strong Black Woman Collective Theory: Determining the prosocial functions of strength regulation in groups of black women friends. *Journal of Communication, 69*(1). https://doi.org/10.1093/joc/jqy065

Delgado, R., & Stefancic, J. (2000). Critical race theory: The cutting edge (2nd ed.). Temple University Press.

Delgado, R., & Stefancic, J. (2001). *Critical race theory: An introduction* (1st ed.). NYU Press.

Delgado, R., & Stefancic, J. (2012). *Critical race theory: An introduction* (2nd ed.). NYU Press.

Delgado, R., & Stefancic, J. (2017). *Critical race theory: An introduction* (3rd ed.). NYU Press.

Delgado, R., & Stefancic, J. (2023). *Critical race theory: An introduction* (4th ed.). NYU Press.

DeLuca, J. S. (2020). Conceptualizing adolescent mental illness stigma: Youth stigma development and stigma reduction programs. *Adolescent Research Review, 5*(2), 153–171. https://doi.org/10.1007/s40894-018-0106-3

Denham, M. A., & Onwuegbuzie, A. J. (2013). Beyond words: Using nonverbal communication data in research to enhance thick description and interpretation. *International Journal of Qualitative Methods, 12*(1), 670–696. https://doi.org/10.1177/160940691301200137

Denzin, N. K., & Lincoln, Y. S. (2012). *Strategies of qualitative inquiry* (4th ed.). SAGE Publications.

Dixon, S., Batta, M., & Jidong, D. E. (2023). Using intersectionality theory to explore the impact of COVID-19 pandemic on Black Canadian people's health. *Medical Research Archives, 11*(11). https://doi.org/10.18103/mra.v11i11.4722

Dixon, S., Parks, S., Scarlett, S., & Yohani, S., (2023). Moving beyond the mosaic: Exploring the impacts of racial trauma on Black Canadians. *CAP Monitor,* (73), 18–23. https://www.cap.ab.ca/Portals/0/pdfs/Monitor/CAP-Monitor-73-FINAL.pdf

Dixson, A., Gillborn, D., Ladson-Billings, G., Parker, L., Rollock, N., & Warmington, P. (2018). *Critical race theory in education: CRT methods and epistemology.* Routledge.

Do, D., Houle, R., & Turcotte, M. (2020). *Canada's Black population: Education, labour and resilience.* Statistics Canada. https://www150.statcan.gc.ca/n1/pub/89-657-x/89-657-x2020002-eng.pdf

Domey, N., & Patsiurko, N. (2024). *The diversity of the Black populations in Canada, 2021: A sociodemographic portrait.* Statistics Canada. https://www150.statcan.gc.ca/n1/pub/89-657-x/89-657-x2024005-eng.htm

Dua, E., Razack, N., & Warner, J. N. (2005). Race, racism, and empire: Reflections on Canada. *Social Justice, 32*(4), 1–10.

Du Bois, W. E. B. (1903). *The souls of Black folk*: *Essays and sketches* (2nd ed.). A. C. McClurg & Co.

Dumas, M. J., & ross, k. m. (2016). “Be Real Black For Me”: Imagining BlackCrit in Education. Urban Education, 51(4), 415– 442

Dwyer, S. C., & Buckle, J. L. (2009). The space between: On being an insider-outsider in qualitative research. *International Journal of Qualitative Methods, 8*(1), 54–63.

Edge, D. (2013). *Why are you cast down, o my soul?* Exploring intersections of ethnicity, gender, depression, spirituality and implications for Black British Caribbean women’s mental health. *Critical Public Health*, *23*(1), 39–48. https://doi.org/10.1080/09581596.2012.760727

Edwards, F., Gateri, H., & Richards, D. (forthcoming). Critical Race Theory in social work education, research and practice in Canada. In B. P. Vareed, P. H. Gateri, & P. B. Adjei (Eds), *Critical multicultural social work in Canada*. Springer International.

Eisenberg, D., Downs, M. F., Golberstein, E., & Zivin, K. (2009). Stigma and help seeking for mental health among college students. *Medical Care Research and Review, 66*(5), 522–541. https://doi.org/10.1177/1077558709335173

Eisenberg, D., Speer, N., & Hunt, J. B. (2012). Attitudes and beliefs about treatment among college students with untreated mental health problems. *Psychiatric Services, 63*(7), 711–713. https://doi.org/10.1176/appi.ps.201100250

Erevelles, N., & Minear, A. (2010). Unspeakable offenses: Untangling race and disability in discourses of intersectionality. *Journal of Literary & Cultural Disability Studies, 4*(2), 127–145. https://doi.org/10.3828/jlcds.2010.11

Erving, C. L., & Vaughan Smith, M. (2022). Disrupting monolithic thinking about Black women and their mental health: Does stress exposure explain intersectional ethnic, nativity, and

socioeconomic differences? *Social Problems, 69*(4), 1046–1067. https://doi.org/10.1093/socpro/spab022

Erving, C. L., Patterson, E. J., & Boone, J. (2021). Black women's mental health matters: Theoretical perspectives and future directions. *Sociology Compass*, *15*(9), Article e12919. https://doi.org/10.1111/soc4.12919

Esposito, J., & Edwards, E. B. (2018). When Black girls fight: Interrogating, interrupting, and (re)imagining dangerous scripts of femininity in urban classrooms. *Education and Urban Society, 50*(1), 87–107. https://doi.org/10.1177/0013124517729206

Essed, P. (1991). *Understanding everyday racism: An interdisciplinary theory*. SAGE Publications.

Este, D., & Bernard, W. T. (2003). Social work practice with African Canadians: An examination of the African Nova Scotian community. In A. Al-Krenawi & J. Graham (Eds.), *Multicultural social work in Canada: Working with diverse ethno-racial communities* (pp. 306–337). Oxford University Press.

Etowa, J., Keddy, B., Egbeyemi, J., & Eghan, F. (2007). Depression: The 'invisible fog' influencing the midlife health of African Canadian women. *International Journal of Mental Health Nursing, 16*(3), 203–213. https://doi.org/10.1111/j.1447-0349.2007.00469.x

Etowa, J. E., Beagan, B. L., Eghan, F., & Bernard, W. T. (2017) "You feel you have to be made of steel": The strong Black woman, health and well-being in Nova Scotia. *Health Care for Women International, 38*(4), 379–393. https://doi.org/10.1080/07399332.2017.1290099

Eze, E. C. (1997). The color of reason: The idea of "race" in Kant's anthropology. In E. C. Eze (Ed.), *Postcolonial African philosophy: A critical reader*. Wiley-Blackwell.

Eylem, O., de Wit, L., van Straten, A., Steubl, L., Melissourgaki, Z., Danisman, G. T., de Vries, R., Kerkhof, A. J. F. M., Bhui, K., & Cuijpers, P. (2020). Stigma for common mental disorders in racial minorities and majorities a systematic review and meta-analysis. *BMC Public Health, 20*, Article 879. https://doi.org/10.1186/s12889-020-08964-3

Faber, S. C., Roy, A. K., Michaels, T. I., & Williams, M. T. (2023). The weaponization of medicine: Early psychosis in the Black community and the need for racially informed mental healthcare. *Frontiers in Psychiatry, 14*, Article 1098292. https://doi.org/10.3389/fpsyt.2023.1098292

Fante-Coleman, T., & Jackson-Best, F. (2020). Barriers and facilitators to accessing mental healthcare in Canada for Black youth: A scoping review. *Adolescent Research Review, 5*(2), 115–136. https://doi.org/10.1007/s40894-020-00133-2

Fante-Coleman, T., Booker, M., Craigg, A., Plummer, D., & Jackson-Best, F. (2022). *Factors that impact how Black youth access the mental healthcare system in Ontario: Pathways to Care project*. Black Health Alliance. https://blackhealthalliance.ca/wp-content/uploads/pathways-to-care-focus-groupenglish-web-lu-6TF.pdf

Fante-Coleman, T., Jackson-Best, F., Booker, M., & Worku, F. (2023). Organizational and practitioner challenges to Black youth accessing mental health care in Canada: Problems and solutions. *Canadian Psychology, 64*(4), 259–269. https://doi.org/10.1037/cap0000370

Fernando, S. (2012). Race and culture issues in mental health and some thoughts on ethnic identity. *Counselling Psychology Quarterly, 25*(2), 113–123. https://doi.org/10.1080/09515070.2012.674299

Fernando, S. (2017). *Institutional racism in psychiatry and clinical psychology: Race matters in mental health.* Palgrave Macmillan.

Few, A., Stephens, D. P., & Rouse-Arnett, M. (2003). Sister-to-sister talk: Transcending boundaries and challenges in qualitative research with Black women. *Family Relations, 52*(3)*,* 205–215. https://doi.org/10.1111/j.1741-3729.2003.00205.x

Fields-Oriogun, D., Foley-Nicpon, M., & Thornburg-Suresh, M. (2024). Mental health stigma and service use among Black American youth: A systematic review. *American Journal of Orthopsychiatry*, *94*(6), 655–667. https://doi.org/10.1037/ort0000749

Finlay, L. (2008). A dance between the reduction and reflexivity: Explicating the "phenomenological psychological attitude." *Journal of Phenomenological Psychology, 39*(1), 1–32. https://doi.org/10.1163/156916208X311601

Finlay, L. (2009). Embracing research subjectivity in phenomenological research: A response to Ann Scott. *European Journal for Qualitative Research in Psychotherapy,* (4), 13–19. https://ejqrp.org/index.php/ejqrp/article/view/22

Finlay, L. (2011). *Phenomenology for therapists: Researching the lived world.* Wiley-Blackwell. https://doi.org/10.1002/9781119975144

Garland-Thomson, R. (1997). *Extraordinary bodies: Figuring physical disability in American culture and literature.* Columbia University Press.

Gary, F. A. (2005). Stigma: Barrier to mental health care among ethnic minorities. *Issues in Mental Health Nursing, 26*(10), 979–999. https://doi.org/10.1080/01612840500280638

Genoe, M. R., & Dupuis, S. L. (2011). “I’m just like I always was”: A phenomenological exploration of leisure, identity and dementia. *Leisure, 35*(4), 423–452. https://doi.org/10.1080/14927713.2011.649111

George, R. C. (2020). Holding it down? The silencing of Black female students in the educational discourses of the Greater Toronto Area. *Canadian Journal of Education*, *43*(1), 32–58. https://journals.sfu.ca/cje/index.php/cje-rce/article/view/3801

Gillborn, D. (2015). Intersectionality, critical race theory, and the primacy of racism: Race, class. gender, and disability in education. *Qualitative Inquiry, 21*(3), 277–287. https://doi.org/10.1177/1077800414557827

Godbolt, D., Opara, I., & Amutah-Onukagha, N. (2022). Strong Black Woman: Linking stereotypes, stress, and overeating among a sample of Black female college students. *Journal of Black Studies, 53*(6), 609–634. https://doi.org/10.1177/00219347221087453

Goddard-Durant, S. K., Doucet, A., Tizaa, H., & Sieunarine, J. A. (2023). “I don’t have the energy”: Racial stress, young Black motherhood, and Canadian social policies. *Canadian Review of Sociology, 60*(4), 542–566. https://doi.org/10.1111/cars.12457

Goffman, E. (1963). *Stigma: Notes on the management of spoiled identity*. Prentice Hall.

Gómez, J. M. (2023). *The cultural betrayal of Black women and girls: A Black feminist approach to healing from sexual abuse.* American Psychological Association.

González, M. C. (2000). The four seasons of ethnography: A creation-centered ontology for ethnography. *International Journal of Intercultural Relations, 24*(5), 623–650. https://doi.org/10.1016/S0147-1767(00)00020-1

Goodley, D. (2013). Dis/entangling critical disability studies. *Disability & Society, 28*(5), 631–644. https://doi.org/10.1080/09687599.2012.717884

Government of Ontario. (2017). *A better way forward: Ontario's 3-year anti-racism strategic plan*. Government of Canada. https://files.ontario.ca/ar-2001_ard_report_tagged_final-s.pdf

Greenbank, P. (2003). The role of values in educational research: the case for reflexivity. *British Educational Research Journal*, *29*(6), 791–801. https://doi.org/10.1080/0141192032000137303

Groenewald, T. (2004). A phenomenological research design illustrated. *International Journal of Qualitative Methods, 3*(1). http://www.ualberta.ca/~iiqm/backissues/3_1/pdf/groenewald.pdf

Grollman, E. A. (2014). Multiple disadvantaged statuses and health: The role of multiple forms of discrimination. *Journal of Health and Social Behaviour, 55*(1), 3–19. https://doi.org/10.1177/0022146514521215

Green, S., Bennett, B., & Betteridge, S. (2016). Cultural responsiveness and social work – A discussion. *Social Alternatives, 35*(4), 66–72.

Guba, E. G., & Lincoln, Y. S. (1994). Competing paradigms in qualitative research. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 105–117). SAGE Publications.

Guest, G., Namey, E. E., & Chen, M. (2020). A simple method to assess and report thematic saturation in qualitative research. *PLoS One, 15*(5). https://doi.org/10.1371/journal.pone.0232076

Guest, G., Namey, E. E., & Mitchell, M. L. (2013). *Collecting qualitative data: A filed manual for applied research.* SAGE Publications.

Hall, J. C., Everett, J. E., & Hamilton-Mason, J. (2012). Black women talk about workplace stress and how they cope. *Journal of Black Studies, 43*(2), 207–226. https://doi.org/10.1177/0021934711413272

Hand, T. (2012). *A phenomenological study of teacher qualifications in a technology pure classroom: Perspectives from the field* [Doctoral dissertation, New Mexico State University]. ProQuest Dissertations and Theses. https://www.proquest.com/docview/1334933069?sourcetype=Dissertations%20&%20Theses

Harris-Perry, M. V. (2013). *Sister citizen: Shame, stereotypes, and Black women in America*. Yale University Press.

Harrison, L. (2017). Redefining intersectionality theory through the lens of African American young adolescent girls' racialized experiences. *Youth & Society, 49*(8), 1023–1039. https://doi.org/10.1177/0044118X15569216

Hasford, J., Amponsah, P., & Hylton, T. (2018). Anti-racist praxis with street-involved African Canadian youth. In S. Kidd, N. Slesnick, T. Frederick, J. Karabanow & S. Gaetz (Eds.), *Mental health & addiction interventions for youth experiencing homelessness: Practical strategies for front-line providers* (pp. 125–137). Canadian Observatory on Homelessness Press. https://homelesshub.ca/wp-content/uploads/2024/04/COH-MentalHealthBook_0.pdf

Hatzenbuehler, M. L., Phelan, J. C., & Link, B. G. (2013). Stigma as a fundamental cause of population health inequalities. *American Journal of Public Health, 103*(5), 813–821. https://doi.org/10.2105/AJPH.2012.301069

Hayden, W. (2015). *Appalachian Black people: Identity, location and racial barriers*. 91 South.

Hawkesworth, M. E. (2006). *Feminist inquiry: From political conviction to methodological innovation*. Rutgers University Press.

Haynes, C., Stewart, S., & Allen, E. (2016). Three paths, one struggle: Black women and girls battling invisibility in US classrooms. *Journal of Negro Education*, *85*(3), 380-391.

Heidegger, M. (2011). *Being and time* (J. Macquarrie, E. Robinson Trans). Harper & Row. (Originally published 1927)

Hendriks, T., Warren, M. A., Schotanus-Dijkstra, M., Hassankhan, A., Graafsma, T., Bohlmeijer, E., & de Jong, J. (2019). How WEIRD are positive psychology interventions? A bibliometric analysis of randomized controlled trials on the science of well-being. *The Journal of Positive Psychology, 14*(4), 489–501. https://doi.org/10.1080/17439760.2018.1484941

Henrich, J., Heine, S. J., & Norenzayan, A. (2010). The weirdest people in the world? *Behavioral and Brain Sciences, 33*(2–3), 61–83. https://doi.org/10.1017/S0140525X0999152X

hooks, b. (1981). *Ain't I a woman: Black women and feminism*. South End Press.

hooks, b. (1994). *Teaching to transgress: Education as the practice of freedom.* Routledge.

hooks, b. (1995). *Killing rage: Ending racism*. Henry Holt and Company.

Hosking, D. L. (2008, September 2–4). *Critical disability theory* [Conference paper]. The 4th Biennial Disability Studies Conference, Lancaster University, UK. https://www.lancaster.ac.uk/fass/events/disabilityconference_archive/2008/papers/hosking2008.pdf

Howarth, C. (2006). Race as stigma: Positioning the stigmatized as agents, not objects. *Journal of Community & Applied Social Psychology, 16,* 442–451. https://doi.org/10.1002/casp.898

Husserl, E. (1931). *Ideas: General introduction to pure phenomenology* (W. R. B. Gibson, Trans.). Palgrave Macmillan. (Originally published 1913)

Husserl, E. (2012). *Ideas: General introduction to pure phenomenology*. Routledge. https://doi.org/10.4324/9780203120330

Ives, N., Denov, M., & Sussman, T. (2020). *Introduction to social work in Canada: Histories, contexts and practices* (2nd ed.). Oxford University Press.

Jackson, F. Z., & Naidoo, K. (2012). "Lemeh check see if meh mask on straight": Examining how Black women of Caribbean descent in Canada manage depression and construct womanhood through Being Strong. *Southern Journal of Canadian Studies, 5*(1–2), 223–240. https://doi.org/10.22215/sjcs.v5i1.296

James, C., Este, D., Thomas Bernard, W., Benjamin, A., Lloyd, B., & Turner, T. (2010). *Race and well-being: The lives, hopes, and activism of African Canadians.* Fernwood Publishing.

Jarvis, G. E., Kirmayer, L. J., Jarvis, G. K., & Whiteley, R. (2005). The role of Afro-Canadian status in police or ambulance referral to emergency psychiatrist services. *Psychiatric Services, 56*(6), 705–710. https://doi.org/10.1176/appi.ps.56.6.705

Jerald, M. C., Cole, E. R., Ward, L. M., & Avery, L. R. (2017). Controlling images: How awareness of group stereotypes affects Black women's well-being. *Journal of Counseling Psychology, 64*(5), 487–499. https://doi.org/10.1037/cou0000233

Johnston, C. M., Wallis, M., Oprescu, F. I., & Gray, M. (2017). Methodological considerations related to nurse researchers using their own experience of a phenomenon within phenomenology. *Journal of Advanced Nursing*, *73*(3), 574–584. https://doi.org/10.1111/jan.13198

Jones, C. P. (2000). Levels of racism: A theoretic framework and a gardener's tale. *American Journal of Public Health, 90*(8), 1212–1215. https://doi.org/10.2105/ajph.90.8.1212

Jones, E. E., Farina, A., Hastorf, A. H., Markus, H. Miller, D. T., Schott, R. A., & French, R. d. S. (1984). *Social stigma: The psychology of marked relationships.* W. H. Freeman & Co.

Jones, J. M. (2021). The dual pandemics of COVID-19 and systemic racism: Navigating our path forward. *School Psychology, 36*(5), 427–431. https://doi.org/10.1037/spq0000472

Jones, L. V., & Guy-Sheftall, B. (2015). Conquering the black girl blues. *Social Work, 60*(4),

Jones, M. S., Womack, V., Jérémie-Brink, G., & Dickens, D. D. (2021). Gendered racism and mental health among young adult US Black women: The moderating roles of gendered racial identity centrality and identity shifting. *Sex Roles*, *85*(3), 221–231.

Jones, T., & Norwood, K. J. (2017). Aggressive encounters & white fragility: Deconstructing the trope of the Angry Black Woman. *Iowa Law Review, 102*, 2017-2069. https://scholarship.law.duke.edu/faculty_scholarship/3761

Kalambay, M. (2023, February 7). *Breaking down barriers to mental health in Black communities*. Dialogue. https://www.dialogue.co/en/blog/addressing-mental-health-challenges-in-black-communities

Kant, I. (1764). *Observations on the feeling of the beautiful and sublime*. Cambridge University Press.

Kaufman, M. R., Eschliman, E. L., & Karver, T. S. (2023). Differentiating sex and gender in health research to achieve gender equity. *Bulletin of the World Health Organization*, *101*(10), 666–671. https://doi.org/10.2471/BLT.22.289310

Keating, F., & Robertson, D. (2004). Fear, black people and mental illness: A vicious circle? *Health & Social Care in the Community*, *12*(5), 439-447. https://doi.org/10.1111/j.1365-2524.2004.00506.x

Kelley, S. M. (2023). Post-sexual assault decision making: Centering Black women's experiences. *Feminist Criminology, 18*(2), 133-155. https://doi.org/10.1177/15570851221150912

Kemei, J., Tulli, M., Olanlesi-Aliu, A., Tunde-Byass, M., & Salami, B. (2023). Impact of the COVID-19 pandemic on black communities in Canada. *International Journal of Environmental Research and Public Health*, *20*(2), Article 1580. https://doi.org/10.3390/ijerph20021580

Keyes, C. L. M. (2002). The mental health continuum: From languishing to flourishing in life. *Journal of Health and Social Behavior, 43*(2), 207–222. https://doi.org/10.2307/3090197

Keyes, C. L. M. (2006). Mental health in adolescence: Is America's youth flourishing? *American Journal of Orthopsychiatry, 76*(3), 395–402. https://doi.org/10.1037/0002-9432.76.3.395

Khanlou, N. (2010) Migrant mental health in Canada. *Canadian Issues, 2010*(Summer), 9-18. https://multiculturalmentalhealth.ca/wp-content/uploads/2019/07/Immigrant_mental_health_10aug10.pdf

Khenti, A. A. (2013). Homicide among young Black men in Toronto: An unrecognized public health crisis? *Canadian Journal of Public Health, 104*(1), e12–e14. https://doi.org/10.1007/BF03405647

Kikulwe, D., & Maiter, S. (2024). Newcomer families with child welfare involvements facing racism during the COVID-19 pandemic: Insights from child welfare workers and

managers. *Journal of Progressive Human Services, 35*(3), 224–246. https://doi.org/10.1080/10428232.2025.2450178

Kirby, S. & McKenna, K. (2004). Methods from the margins. In W. K. Carroll (Ed.), *Critical strategies for social research* (pp. 67–74). Canadian Scholars' Press.

Kirk, J., & Miller, M. L. (1986). *Reliability and validity in qualitative research.* SAGE Publications. https://doi.org/10.4135/9781412985659

Kobayashi, A. (2001). Negotiating the personal and the political in critical qualitative research. In M. Limb & C. Dwyer (Eds.), *Qualitative methodologies for geographers: Issues and debates* (pp. 55–72). Arnold Publishing.

Kolivoski, K. M., Weaver, A., & Constance-Huggins, M. (2014). Critical race theory: Opportunities for application in social work practice and policy. *Families in Society, 95*(4), 269–276. https://doi.org/10.1606/1044-3894.2014.95.36

Kranke, D., Floersch, J., Townsend, L., & Munson, M. (2010). Stigma experience among adolescents taking psychiatric medication. *Children and Youth Services Review*, *32*(4), 496–505. https://doi.org/10.1016/j.childyouth.2009.11.002

Kranke, D., Guada, J., Kranke, B., & Floersch, J. (2012). What do African American youth with mental illness think about help-seeking and psychiatric medications? Origins of stigmatizing attitudes. *Social Work in Mental Health, 10*(1), 53–71. https://doi.org/10.1080/15332985.2011.618076

Kumari Campbell, F. A. (2008). Exploring internalized ableism using critical race theory. *Disability & Society, 23*(2), 151–162. https://doi.org/10.1080/09687590701841190

Kumsa, M. K., Mfoafo-M'Carthy, M., Oba, F., & Gaasim, S. (2014). The contours of anti-Black racism: Engaging anti-oppression from embodied spaces. *The Journal of Critical Anti-*

Oppressive Social Inquiry, 1(1), 21–38. https://caos.library.torontomu.ca/index.php/caos/article/view/97/101

Kurki, T., & Rask, S. (2025). Hyper(in)visibility of Blackness in spaces of whiteness: representations of race, gender and mental distress in the imageries of youth mental health services. *Journal of Youth Studies*. Advanced online publication. https://doi.org/10.1080/13676261.2025.2468486

Kvale, S. (1996). *InterViews: An introduction to qualitative research interviewing*. SAGE Publications.

Ladson-Billings, G. (1998). Just what is critical race theory and what's it doing in a nice field like education? *International Journal of Qualitative Studies in Education, 11*(1), 7–24. https://doi.org/10.1080/095183998236863

Larson, E., George, A., Morgan, R., & Poteat, T. (2016). 10 best resources on… intersectionality with an emphasis on low- and middle-income countries. *Health Policy and Planning*, *31*(8), 964–969. https://doi.org/10.1093/heapol/czw020

LeFrançois, B. A., Menzies, R., & Reaume, G. (Eds.). (2013). *Mad matters: A critical reader in Canadian mad studies.* Canadian Scholars' Press.

LeFrancois B. A., Peddle C. (2022). Mad studies, mad theory. In S. S. Shaikh, B. A. LeFrançois, & T. Macías (Eds.), *Critical social work praxis* (pp. 463–476). Fernwood Publishing.

Leonardo, Z., & Broderick, A. A. (2011). Smartness as property: A critical exploration of intersections between whiteness and disability studies. *Teachers College Record, 113*(10), 2206–2232. https://doi.org/10.1177/016146811111301008

Lewis, S. (1992). *Report of the Advisor on Race Relations to the Premier of Ontario, Bob Rae.* Government of Ontario.

https://www.siu.on.ca/pdfs/report_of_the_advisor_on_race_relations_to_the_premier_of_ontario_bob_rae.pdf

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry*. SAGE Publications.

Link, B. G., & Phelan, J. C. (2001). Conceptualizing stigma. *Annual Review of Sociology, 27*, 363–385. https://doi.org/10.1146/annurev.soc.27.1.363

Lobe, B., Morgan, D., & Hoffman, K. (2020). Qualitative data collection in an era of social distancing. *International Journal of Qualitative Methods, 19*. https://doi.org/10.1177/1609406920937875

Locke, J. (1689). *An essay concerning human understanding.* Oxford University Press.

Lorde, A. (2007). *Sister outsider: Essays and speeches*. Crossing Press.

Lovell, A., & Shahsiah, S. (2006). *Mental well-being and substance use among youth of colour.* Across Boundaries.

Malla, A., Shah, J., Iyer, S., Boksa, P., Joober, R., Andersson, N., Lal, S. & Fuhrer, R. (2018). Youth mental health should be top priority for health care in Canada. *The Canadian Journal of Psychiatry, 63*(4), 216–222. https://doi.org/10.1177/0706743718758968

Malla, A., & Gold, I. (2024). Public discourse on mental health: a critical view. *Journal of Psychiatry & Neuroscience*, *49*(2), E126–E131. https://doi.org/10.1503/jpn.230161

Marcus, M., & Westra, H. (2012). Mental health literacy in Canadian young adults: Results of a national survey. *Canadian Journal of Community Mental Health, 31*(1), 1–15. https://doi.org/10.7870/cjcmh-2012-0002

Martínez-Vega, R., Maduforo, A.N., Renzaho, A. (2024). Scoping review on mental health standards for Black youth: identifying gaps and promoting equity in community, primary

care, and educational settings. *Child and Adolescent Psychiatry and Mental Health*, *18*, Article 113. https://doi.org/10.1186/s13034-024-00800-5

Massaquoi, N. (2007). Introduction: Future imaginings of Black feminist thought. In N. Massaquoi & N. N. Wane (Eds.), *Theorizing empowerment: Canadian perspectives on Black feminist thought* (pp. 5-24). Inanna Publications.

Massaquoi, N., Ashcroft, R., & Adamson, K. (2022). Health disparities, social determinants of health, and systemic anti-Black racism during COVID-19: A call to action for social work. *Canadian Social Work Review, 39*(2), 101–110. https://doi.org/10.7202/1096803ar

Masuda, A., Anderson, P. L., & Edmonds, J. (2012). Help-seeking attitudes, mental health stigma, and self-concealment among African American college students. *Journal of Black Studies, 43*(7), 773–786. https://doi.org/10.1177/0021934712445806

Matsuda, M. J., Lawrence, C. R., Delgado, R., & Crenshaw, K. W. (1993). *Words that wound: Critical race theory, assaultive speech, and the First Amendment*. Routledge.

Matthews, A. K., Corrigan, P. W., Smith, B. M., & Aranda, F. (2006). A qualitative exploration of African-Americans' attitudes toward mental illness and mental illness treatment seeking. *Rehabilitation Education, 20*(4), 253–268. https://doi.org/10.1891/088970106805065331

Matthews, K., Morgan, I., Davis, K., Estriplet, T., Perez, S., & Crear-Perry, J. A. (2021). Pathways to equitable and antiracist maternal mental health care: Insights from Black women stakeholders. *Health Affairs, 40*(10), 1597–1604. https://doi.org/10.1377/hlthaff.2021.00808

Maynard, R. (2017). *Policing Black lives: State violence in Canada from slavery to the present*. Fernwood Publishing.

McCall, L. (2005). The complexity of intersectionality. *Signs: Journal of Women in Culture and Society, 30*(3), 1771–1800. https://doi.org/10.1086/426800

McCall, T., Foster, M., Tomlin, H., Adepoju, B., Bolton-Johnson, M., & Bellamy, C. D. (2025). "I think we're on a cusp of some change:" Coping and support for mental wellness among Black American women. *Frontiers in Psychology*, *15*, Article 1469950. https://doi.org/10.3389/fpsyg.2024.1469950

McCann, T. V., Mugavin, J., Renzaho, A., & Lubman, D. I. (2016). Sub-Saharan African migrant youths' help-seeking barriers and facilitators for mental health and substance use problems: A qualitative study. *BMC Psychiatry, 16*, Article 275. https://doi.org/10.1186/s12888-016-0984-5

McCracken, G. (1988). *The long interview.* SAGE Publications.

McGuire, D. L. (2006). "It was like all of us had been raped": Sexual violence, community mobilization, and the African American freedom struggle. In J. Appleby (Ed.), *The best American history essays 2006* (pp. 123-150). Palgrave Macmillan.

McKenzie, K. (2020, January 27). *Toronto's Black community faces far greater risk of having mental health problems.* Toronto Star. https://www.thestar.com/opinion/contributors/2020/01/27/torontos-black-community-faces-far-greater-risk-of-having-serious-mental-health-problems.html

Meekosha, H., & Shuttleworth, R. (2009). What's so 'critical' about critical disability studies? *Australian Journal of Human Rights, 15*(1), 47–75. https://doi.org/10.1080/1323238X.2009.11910861

Meghani, S. H., Byun, E., Gallagher, R. M. (2012). Time to take stock: A meta-analysis and systematic review of analgesic treatment disparities for pain in the United States. *Pain Medicine, 13*(2), 150–174. https://doi.org/10.1111/j.1526-4637.2011.01310.x

Melendez, K., & Thompson, A. (2020). Cultural competency: A call to action to address microaggression in preservice health education. *Health Education Journal*, *79*(7), 851-859. https://doi.org/10.1177/0017896920921501

Meerai, S., Abdillahi, I., & Poole, J. (2016). An introduction to anti-Black sanism. *Intersectionalities: A Global Journal of Social Work Analysis, Research, Polity, and Practice, 5*(3), 18–35. https://doi.org/10.48336/IJFXWF8702

Mental Health Commission of Canada (MHCC). (2012). *Changing directions, changing lives: The mental health strategy for Canada*. https://www.mentalhealthcommission.ca/wp-content/uploads/drupal/MHStrategy_Strategy_ENG.pdf

Mental Health Commission of Canada (MHCC). (2024). *Experiences with suicide: African, Caribbean and Black communities in Canada*. https://mentalhealthcommission.ca/resource/experiences-with-suicide-african-caribbean-and-black-communities-in-canada/

Merleau-Ponty, M. (1996). *Phenomenology of perception* (C. Smith, Trans.). Motilal Banarsidass Publishers.

Metzl, J. M. (2009). *The protest psychosis: How schizophrenia became a black disease*. Beacon Press.

Metzl, J. M. (2023). The protest psychosis & the future of equity & diversity efforts in American psychiatry. *Dædalus*, *152*(4), 92-110. https://doi.org/10.1162/daed_a_02033

Misra, S., Jackson, V. W., Chong, J., Choe, K., Tay, C., Wong, J., & Yang, L. H. (2021). Systematic review of cultural aspects of stigma and mental illness among racial and ethnic minority groups in the United States: Implications for interventions. *American Journal of Community Psychology*, *68*(3-4), 486-512. https://doi.org/10.1002/ajcp.12516

Modeste-James, A., McClain, T., & Hanna, M. (2024). "The system isn't set up for us": Stories of young Black women's mental health journey. *Women's Health*. https://doi.org/10.1177/17455057241297106

Mollow, A. (2006). "When Black women start going on Prozac": Race, gender, and mental illness in Meri Nana-Ama Danquah's *Willow Weep for Me*. *MELUS,* 31(3), 67–99. https://doi.org/10.1093/melus/31.3.67

Moodley, R., Mujtaba, F., & Kleiman, S. (2018). Critical race theory and mental health. In B. M. Z. Cohen (Ed.), *Routledge international handbook of critical mental health* (pp. 79–88). Routledge.

Morfin, O. J., Perez, V. H., Parker, L., Lynn, M., & Arrona, J. (2006). Hiding the politically obvious: A critical race theory preview of diversity as racial neutrality in higher education. *Educational Policy, 20*(1), 249–270.

Morgan, C., Dazzan, P., Morgan, K., Jones, P., Harrison, G., Leff, J., Murray, R., & Fearon, P. (2006). First episode psychosis and ethnicity: Initial findings from the AESOP study. *World Psychiatry, 5*(1), 40–46.

Morse, J. M. (1995). The significance of saturation. *Qualitative Health Research, 5*(2), 147–149. https://doi.org/10.1177/104973239500500201

Morse, J. M., Barrett, M., Mayan, M., Olson, K., & Spiers, J. (2012). Verification strategies for establishing reliability and validity in qualitative research. *International Journal of Qualitative Research Methods, 1*. https://doi.org/10.1177/160940690200100202

Morse, J. M., & Richards, L. (2002). *Read me first for user's guide to qualitative methods.* SAGE Publications.

Moser, A., & Korstjens, I. (2018). Series: Practical guidance to qualitative research. Part 3: Sampling, data collection and analysis. *European Journal of General Practice, 24*(1), 9–18. https://doi.org/10.1080/13814788.2017.1375091

Motro, D., Evans, J. B., Ellis, A. P. J., & Benson, L. III. (2022). Race and reactions to women's expressions of anger at work: Examining the effects of the "angry Black woman" stereotype. *Journal of Applied Psychology, 107*(1), 142–152. https://doi.org/10.1037/apl0000884

Moustakas, C. (1994). *Phenomenological research methods.* SAGE Publications.

Mowatt, R. A., French, B. H., & Malebranche, D. A. (2013). Black/female/body *hypervisibility* and *invisibility*: A Black feminist augmentation of feminist leisure research. *Journal of Leisure Research*, *45*(5), 644–660. https://doi.org/10.18666/jlr-2013-v45-i5-4367

Mullings, D. V., Clarke, J., Giwa, S., Thomas Bernard, W., & Este, D. (2021). A foundation for the social work profession. In D. V. Mullings, J. Clarke, W. Thomas Bernard, D. Este, & S. Giwa (Eds.), *Africentric social work* (pp. 1–26). Fernwood Publishing.

Mullings, D. V., Morgan, A., & Quelleng, H. K. (2016). Canada, the great white north, where anti-Black racism thrives: Kicking down the doors and exposing the realities. *Phylon, 53*(1), 20–41.

Murney, M. A., Sapag, J. C., Bobbili, S. J., & Khenti, A. (2020). Stigma and discrimination related to mental health and substance use issues in primary health care in Toronto, Canada: A qualitative study. *International Journal of Qualitative Studies on Health and Well-being, 15*(1), Article 1744926. https://doi.org/10.1080/17482631.2020.1744926

Nadeem, E., Lange, J., Edge, D., Fongwa, M., Belin, T., & Miranda, J. (2007). Does stigma keep poor young immigrant and U.S. born Black and Latina women from seeking mental health care? *Psychiatric Services, 58*(12), 1547–1553. https://doi.org/10.1176/ps.2007.58.12.1547

Nash, J. C. (2008). Re-thinking intersectionality. *Feminist Review, 89*(1), 1–15. https://doi.org/10.1057/fr.2008.4

Ncube, N. N., Evans-Winters, V., Greenlee, E. G., Francis, A., Crooks, G., McCallum, E., McIntosh, C., & Taylor, H. (2022). The "strong Black girl" dilemma: Reflections on young Black women's mental health during dual pandemics. *Journal of African American Women and Girls in Education, 2*(2), 65–85. https://doi.org/10.21423/jaawge-v2i2a117

Neal, D. M., Campbell, A. J., Williams, L. Y., Liu, Y., & Nussbaumer, D. (2011). "I did not realize so many options were available": Cognitive authority, emerging adults, and e-mental health. *Library & Information Science Research, 33*(10), 25–33. https://doi.org/10.1016/j.lisr.2010.07.015

Neal-Barnett, A., Stadulis, R., Murray, M., Payne, M. R., Thomas, A., & Salley, B. B. (2011). Sister Circles as a culturally relevant intervention for anxious African American women. *Clinical Psychology: Science and Practice*, *18*(3), 266–273. https://doi.org/10.1111/j.1468-2850.2011.01258.x

Neeganagwedgin, E. (2013). Narratives from within: Black women and schooling in the Canadian context. *Alberta Journal of Educational Research*, *59*(2), 226–246.

Nestel, S. (2012). *Colour coded health care: The impact of race and racism on Canadians' health.* The Wellesley Institute. https://www.wellesleyinstitute.com/wp-content/uploads/2012/02/Colour-Coded-Health-Care-Sheryl-Nestel.pdf

Neubauer, B. E., Witkop, C. T., & Varpio, L. (2019). How phenomenology can help us learn from the experiences of others. *Perspectives on Medical Education, 8*(2), 90–97. https://doi.org/10.1007/S40037-019-0509-2

Neuman, W. L., & Robson, K. (2009). *Basics of social research: Qualitative and quantitative approaches*. Pearson.

Newberry, A. M. (2012). Social work and hermeneutic phenomenology. *Journal of Applied Hermeneutics*, (2012). https://doi.org/10.11575/jah.v0i0.53219

Newton, V. A. (2023). Hypervisibility and invisibility: Black women's experiences with gendered racial microaggressions on a White campus. *Sociology of Race and Ethnicity*, *9*(2), 164–178**.** https://doi.org/10.1177/23326492221138222

Nwoke, C. N., & Leung, B. M. Y. (2021). Historical antecedents and challenges of racialized immigrant women in access to healthcare services in Canada: An exploratory review of the literature. *Journal of Racial and Ethnic Health Disparities, 8*(6), 1447–1455. https://doi.org/10.1007/s40615-020-00907-3

OICR News (2016, June 16). *Study examines mental health in common ethnic minorities in Ontario.* Ontario Institute for Cancer Research. https://news.oicr.on.ca/2016/06/study-examines-mental-health-in-common-ethnic-minorities-in-ontario/

Okeke, A. (2013). *A culture of stigma: Black women and mental health* (Undergraduate thesis, Georgia State University). ScholarWorks@GSU. https://hdl.handle.net/20.500.14694/7452

Okusanya, I. G., & Meyer, S. B. (2025). Barriers to accessing mental health services that impact Black Canadians: A scoping review and thematic analysis. *Journal of Racial and Ethnic Health Disparities*. Advanced online publication. https://doi.org/10.1007/s40615-025-02306-y

Olanlesi-Aliu, A., Giwa, A., & Salami, B. (2025). Mental health of Black Canadians: A scoping review. *International Journal of Social Determinants of Health and Health Services, 55*(3), 303–317. https://doi.org/10.1177/27551938241311875

Omi, M., & Winant, H. (1994). *Racial formation in the United States: From the 1960s to the 1990s* (2nd ed.). Routledge.

Ontario Human Rights Commission (OHRC). (2018). *A collective impact report on the inquiry into racial profiling and racial discrimination of Black persons by Toronto Police Service* (Interim report). https://www3.ohrc.on.ca/en/public-interest-inquiry-racial-profiling-and-discrimination-toronto-police-service/collective

Ontario Ministry of Labour. (2018). *Ministry of Labour, Immigration, Training, and Skills Development.* https://www.labour.gov.on.ca/english/atwork/youngworkers.php

Orridge, C., Marshall, L. J., Bernard, C., Baliey, P., Quaison, G., & Hinds, R. (2020). *Black experiences in health care symposium report: Bringing together community and health systems for improved health outcomes.* Black Experiences in Health Care Symposium. https://blackhealthalliance.ca/wp-content/uploads/Full-Report-Black-Experiences-in-Health-Care-Symposium-2020.pdf

Osman, S., Aiello, O., Brouillette, K., Taylor, M., McKenzie, K., Renzaho, A. M. N., Henderson, J., Hamilton, H., & Salami, B. (2025). “Dual pandemics”: Intersecting influences of anti-Black racism and the COVID-19 pandemic on the mental health of Black youth. *Canadian Journal of Nursing Research, 57*(1), 24–32. https://doi.org/10.1177/08445621241253116

Padgett, D. K. (1998). *Qualitative methods in social work*. SAGE Publications.

Pandalangat, N. (2011). *Cultural influences on help-seeking, treatment and support for mental health problems – A comparative study using a gender perspective* [Doctoral dissertation, University of Toronto]. TSpace Repository. http://hdl.handle.net/1807/31890

Parker, R., & Aggleton, P. (2003). HIV and AIDS-related stigma and discrimination: A conceptual framework and implications for action. *Social Science and Medicine, 57*(1), 13–24. https://doi.org/10.1016/S0277-9536(02)00304-0

Parks, S. (2010). *Fierce angels: The strong black woman in American life and culture.* One

Patton, M. Q. (2002). *Qualitative research & evaluation methods* (3rd ed.). SAGE Publications.

Patel, A. (2015, June 30). *Stigma and silence: Black Canadians and the fight for mental health awareness*. HuffPost. https://www.huffingtonpost.ca/2015/06/29/black-canadians-mental-health_n_7345182.html

Patterson, C., & Macqueen, S. (2021). Drawing on two methodological approaches: A collaborative approach to interview interpretation. *Issues in Educational Research, 31*(1), 188–203.

Perlin, M. L. (1993). On sanism. *SMU Law Review*, *46*(2), 373–378. https://scholar.smu.edu/smulr/vol46/iss2/4

Pescosolido, B. A., & Martin, J. K. (2015). The stigma complex. *Annual Review of Sociology, 41*(1), 87–116. https://doi.org/10.1146/annurev-soc-071312-145702

Planey, A. M., Smith, S. M. N., Moore, S., & Walker, T. D. (2019). Barriers and facilitators to mental health help-seeking among African American youth and their families: A systematic review study. *Children and Youth Services Review, 101*, 190–200. https://doi.org/10.1016/j.childyouth.2019.04.001

Polkinghorne, D. E. (1989). Phenomenological research methods. In R. S. Valle & S. Halling (Eds.), *Existential-phenomenological perspectives in psychology: Exploring the breadth of human experience* (pp. 41–60). Plenum Press.

Poole, J. (2011). *Behind the rhetoric: Mental health recovery in Ontario*. Fernwood Publishing.

Poole, J. M., Jivraj, T., Arslanian, A., Bellows, K., Chiasson, S., Hakimy, H., Pasini, J., & Reid, J. (2012). Sanism, "mental health" and social work/education: A review and call for action. *Intersectionalities: A Global Journal of Social Work Analysis, Research, Polity, and Practice, 1,* 20–36. https://doi.org/10.48336/IJDBHR4913

Pon, G. (2009). Cultural competency as new racism: An ontology of forgetting. *Journal of Progressive Human Services, 20*(1), 59–71. https://doi.org/10.1080/10428230902871173

Pon, G., Gosine, K., & Phillips, D. (2011). Immediate response: Addressing anti-Native and anti-Black racism in child welfare. *International Journal of Child, Youth & Family Studies, 2*(3/4), 385–409. https://doi.org/10.18357/ijcyfs23/420117763

Pothier, D., & Devlin, R. F. (Eds). (2006). *Critical disability theory essays in philosophy, politics, policy, and law*. UBC Press.

Price, M. (2011). *Mad at school: Rhetorics of mental disability and academic life.* University of Michigan Press.

Puar, J. K. (2012). “I would rather be a cyborg than a goddess”: Becoming-intersectional in assemblage theory. *philoSOPHIA: A Journal of Continental Feminism, 2*(1), 49–66. https://doi.org/10.1353/phi.2012.a486621

Public Health Canada. (2019). *Addressing stigma: Towards a more inclusive health system*. https://www.canada.ca/content/dam/phac-aspc/documents/

Public Health Agency of Canada (PHAC). (2020). *Social determinants and inequities in health for Black Canadians*. Government of Canada. https://www.canada.ca/en/public-health/services/health-promotion/population-health/what-determines-health/social-determinants-inequities-black-canadians-snapshot.html

Ramsook, L. (2018). A methodological approach to hermeneutic phenomenology. *International Journal of Humanities and Social Sciences, 10*(1), 14–24.

Rank, M. R., & Hirschl, T. A. (2002). Welfare use as a life course event: Toward a new understanding of the U. S. safety net. *Social Work, 47*(3), 237–248. https://doi.org/10.1093/sw/47.3.237

Razack, N., & Jeffery, D. (2002). Critical race discourse and tenets for social work. *Canadian Social Work Review*, *19*(2), 257–271.

Reimer-Kirkham, S., & Anderson, J. M. (2002). Postcolonial nursing scholarship: From epistemology to method. *Advances in Nursing Science, 25*(1), 1–17. https://doi.org/10.1097/00012272-200209000-00004

Richards, D., Gateri, H., & Massaquoi, N. (2018). The effects of intersectional stigma and discrimination on the mental well-being of black, LBQ, female youth 18–25 years old. In S. Pashang, N. Khanlou, & J. Clarke (Eds.), *Today’s youth and mental health: Hope, power, and resilience* (pp. 119-133). Springer.

Richards, D., & Adjei, P. (forthcoming). “Finally, a girl that is no one”: The narrative experiences of young Black women with mental health concerns in Ontario, Canada. *Cultural and Pedagogical Inquiry* [Accepted with revisions, pending publication].

Richards, E. (2021). The state of mental health of Black women: Clinical considerations. *Psychiatric Times, 38*(9), 14-15.

Rickwood, D., & Thomas, K. (2012). Conceptual measurement framework for help-seeking for mental health problems. *Psychology Research and Behavior Management, 5*, 173–183. https://doi.org/10.2147/PRBM.S38707

Robinson, O. C. (2014). Sampling in interview-based qualitative research: A theoretical and practical guide. *Qualitative Research in Psychology*, *11*(1), 25–41. https://doi.org/10.1080/14780887.2013.801543

Rollock, D., & Gordon, E. W. (2000). Racism and mental health into the 21st century: Perspectives and parameters. *American Journal of Orthopsychiatry, 70*(1), 5–13. https://doi.org/10.1037/h0087703

Rosenthal, L., & Lobel, M. (2016). Stereotypes of Black American women related to sexuality and motherhood. *Psychology of Women Quarterly, 40*(3), 414–427. https://doi.org/10.1177/0361684315627459

Royson, J. (2020, February 28). *After 400 years of racism, Black Mental Health Day is way overdue.* Toronto Star. https://www.thestar.com/opinion/contributors/2020/02/28/after-400-years-of-racism-black-mental-health-day-is-way-overdue.html

Rubin, A. & Babbie, E. R. (2005). *Research methods for social work* (5th ed). Nelson Canada.

Ryan, R. M., & Deci, E. L. (2001). On happiness and human potentials: A review of research on hedonic and eudaimonic well-being. *Annual Review of Psychology, 52*, 141–166. https://doi.org/10.1146/annurev.psych.52.1.141

Sadlier, R. (2010). *The kids' book of Black Canadian history*. Kids Can Press.

Salami, B. (2023). Decolonizing research with Black youths. *Nursing Philosophy, 24*(2), Article e12435. https://doi.org/10.1111/nup.1243

Salami, B., Salma, J., Okeke-Ihejirika, P., Jackson, M., & Harvey-Blankenship, M. (2020). *A participatory action research project to promote the mental health of African, Black and Caribbean Youth in Alberta*. Health and Immigration Policies and Practices Research Program. https://policywise.com/wp-content/uploads/resources/2020/03/2020-03MAR-24-Final-Report-17SM-Salami_.pdf

Salami, B., Denga, B., Taylor, R., Ajayi, N., Jackson, M., Asefaw, M., & Salma, J. (2021). Access to mental health for Black youths in Alberta. *Health Promotion and Chronic Disease Prevention in Canada: Research, Policy and Practice, 41*(9), 245–253. https://doi.org/10.24095/hpcdp.41.9.01

Salami, B., Idi, Y., Anyieth, Y., Cyuzozo, L., Denga, B., Alaazi, D., & Okeke-Ihejirika, P. (2022). Factors that contribute to the mental health of Black youth. *Canadian Medical Association Journal, 194*(41), E1404-E1410. https://doi.org/10.1503/cmaj.212142

Schmid, J., & Ferrer, I. (forthcoming). The contribution of a diverse theory base to radical, ethical social work. In S. Schmid & M. Morgenshtern (Eds.), *The Routledge international handbook of radical ethical social work*. Routledge.

Scott, J. W. (1991). The evidence of experience. *Critical Inquiry*, *17*(4), 773–797. https://doi.org/10.1086/448612

Seaton, E. K., Caldwell, C. H., Sellers, R. M., & Jackson, J. S. (2010). An intersectional approach for understanding perceived discrimination and psychological well-being among African American and Caribbean Black youth. *Developmental Psychology, 46*(5), 1372–1379. https://doi.org/10.1037/a0019869

Schalk, S., Torres, W., Annamma, S., Davis, L. M. B., Hinton, A., Kim, J. B., Khuc, M., Lau, T. C. W., Nishida, A., & Virdi, J. (2025, October 15). *The state of critical race disability studies: A white paper report from the Disabled Scholars of Color Collective.* Disability Visibility Project. https://disabilityvisibilityproject.com/2025/10/15/

Shefer, G., Rose, D., Nellums, L., Thornicroft, G., Henderson, C., & Evans-Lacko, S. (2012). 'Our community is the worst': The influence of cultural beliefs on stigma, relationships with family and help-seeking in three ethnic communities in London. *International Journal of Social Psychiatry, 59*(6), 535–544. https://doi.org/10.1177/0020764012443759

Sheftall, A. H., Vakil, F., Ruch, D. A., Boyd, R. C., Lindsey, M. A., & Bridge, J. A. (2022). Black youth suicide: Investigation of current trends and precipitating circumstances. *Journal of the American Academy of Child & Adolescent Psychiatry, 61*(5), 662–675. https://doi.org/10.1016/j.jaac.2021.08.021

Shorter-Gooden, K. (2004). Multiple resistance strategies: How African American women cope with racism and sexism. *Journal of Black Psychology, 30*(3), 406–425. https://doi.org/10.1177/0095798404266050

Shorter-Gooden, K., & Washington, N. C. (1996). Young, Black, and female: The challenge of weaving an identity. *Journal of Adolescence, 19,* 465–475. https://doi.org/10.1006/jado.1996.0044

Showunmi, V. (2023). Visible, invisible: Black women in higher education. *Frontiers in Sociology*, *8*, Article 974617. https://doi.org/10.3389/fsoc.2023.974617

Shufutinsky, A. (2020). Employing use of self for transparency, rigor, trustworthiness, and credibility in qualitative organizational research methods. *Organization Development Review*, *52*(1), 50–58.

Simien, E. M. (2007). Doing intersectionality research: From conceptual issues to practical examples. *Politics & Gender, 3*(2), 264–271. https://doi.org/10.1017/S1743923X07000086

Singh, P., Carney-Knisely, G., Spates, K. S., Griffin, M., Fairchild, A., & Bruckner, T. A. (2024). Black emergency department visits for schizophrenia/psychosis following the police killing of George Floyd: An empirical test of "protest psychosis". *SSM-Mental Health*, *6*, Article 100342. https://doi.org/10.1016/j.ssmmh.2024.100342

Solórzano, D. G., & Yosso, T. J. (2002). Critical race methodology: Counter-storytelling as an analytical framework for education research. *Qualitative Inquiry, 8*(1), 23–44. https://doi.org/10.1177/107780040200800103

Sotero, M. (2006). A conceptual model of historical trauma: Implications for public health practice and research. *Journal of Health Disparities Research and Practice*, *1*(1), 93-108.

Spates, K. (2012). "The missing link": The exclusion of Black women in psychological research and the implications for Black women's mental health. *SAGE Open, 2*(3). https://doi.org/10.1177/2158244012455179

Spencer, H. (1864). *The principles of biology*. Williams and Norgate.

Statistics Canada. (2021). *A portrait of Canadian youth*. https://www150.statcan.gc.ca/n1/pub/11-631-x/11-631-x2018001-eng.htm#a1

Statistics Canada. (2024). *Black history month 2024… by the numbers.* https://www.statcan.gc.ca/en/dai/smr08/2024/smr08_278

Stoll, N., Yalipende, Y., Byrom, N. C., Hatch, S. L., & Lempp, H. (2022). Mental health and mental well-being of Black students at UK universities: A review and thematic synthesis. *BMJ Open*, *12*(2), e050720.

Stothers, K., Rollins, W., Egan, R., & Murray, D. (2021). Integrating cultural responsiveness into the social work field education curriculum: Lessons from the community. In R. Egan, N. Hill, & W. Rollins (Eds.), *Challenges, opportunities and innovations in social work field education* (Vol. 1, pp. 73–83). Routledge. https://doi.org/10.4324/9780429453618-8

Taylor, D., & Richards, D. (2019). Triple jeopardy: Complexities of racism, sexism, and ageism on the experiences of mental health stigma among young Black Canadian women of Caribbean descent. *Frontiers in Sociology, 4*, 1–10. https://doi.org/10.3389/fsoc.2019.00043

Taylor, J. K. (2020). Structural racism and maternal health among Black women. *Journal of Law, Medicine & Ethics, 48*(3), 506–517. https://doi.org/10.1177/1073110520958875

Teti, M., Schatz, E., & Liebenberg, L. (2020). Methods in the time of COVID-19: The vital role of qualitative inquiries. *International Journal of Qualitative Methods, 19*. https://doi.org/10.1177/1609406920920962

Thomas, A., & Sillen, S. (1972). *Racism and psychiatry*. Brunner/Mazel.

Thomas, A. J., Hacker, J. D., & Hoxha, D. (2011). Gendered racial identity of Black young women. *Sex Roles: A Journal of Research, 64*(7), 530–542. https://doi.org/10.1007/s11199-011-9939-y

Thomas Bernard, W., & Smith, H. (2018). Injustice, justice, and Africentric practice in Canada. *Canadian Social Work Review, 35*(1), 149–157. https://doi.org/10.7202/1051108ar

Thornicroft, G. (2008). Stigma and discrimination limit access to mental health care. *Epidemiology and Psychiatric Sciences, 17*(1), 14–19. https://doi.org/10.1017/S1121189X00002621

Timothy, R. K. (2007). "Third world women," "women of colour," and "minority women": An African/Black feminist analysis of our identities. In N. Massaquoi & N. N. Wane (Eds.), *Theorizing empowerment: Canadian perspectives on Black feminist thought* (pp. 155–176). Inanna Publications.

Tobin, M. J. (2022). Fiftieth anniversary of uncovering the Tuskegee Syphilis study: The story and timeless lessons. *American Journal of Respiratory and Critical Care Medicine, 205*(10), 1145–1158. https://doi.org/10.1164/rccm.202201-0136SO

Ungar, M. (2004). A constructionist discourse on resilience: Multiple contexts, multiple realities among at-risk children and youth. *Youth & Society, 35*(3), 341–365. https://doi.org/10.1177/0044118X03257030

Ungar, M. (2006). Nurturing hidden resilience in at-risk youth in different cultures. *Journal of the Canadian Academy of Child and Adolescent Psychiatry, 15*(2), 53–58.

United Nations Human Rights Council (UNHRC). (2017). *Report of the Working Group of Experts on People of African Descent on its mission to Canada.* United Nations. https://www.refworld.org/reference/mission/unhrc/2017/en/118673

Valdes, F., Culp, J. M., & Harris, A. P. (Eds.). (2002). *Crossroads, directions, and a new critical race theory.* Temple University Press.

van Manen, M. (1990). *Researching lived experience: Human science for an action sensitive pedagogy*. SUNY Press.

van Manen, M. (1997). From meaning to method. *Qualitative Health Research, 7*(3), 345–369. https://doi.org/10.1177/104973239700700303

van Manen, M. (2014). *Phenomenology of practice: Meaning-giving methods in phenomenological research and writing*. Taylor & Francis.

van Manen, M. (2016). *Phenomenology of practice: Meaning-giving methods in phenomenological research and writing*. Routledge. https://doi.org/10.4324/9781315422657

Varghese, R. (2016). Teaching to transform? Addressing race and racism in the teaching of clinical social work practice. *Journal of Social Work Education, 52*(Suppl 1), S134–S147.

Vasileiou, K., Barnett, J., Thorpe, S., & Young, T. (2018). Characterising and justifying sample size sufficiency in interview-based studies: systematic analysis of qualitative health research over a 15-year period. *BMC Medical Research Methodology, 18*, Article 148. https://doi.org/10.1186/s12874-018-0594-7

Voronka, J., Harris, D. W., Grant, J., Komaroff, J., Boyle, D., & Kennedy, A. (2014). Un/helpful help and its discontents: Peer researchers paying attention to street life narratives to inform social work policy and practices. *Social Work in Mental Health, 12*(3), 249–279. https://doi.org/10.1080/15332985.2013.875504

Waldron, I. (2019). Archetypes of Black womanhood: Implications for mental health, coping, and help-seeking. In M. Zangeneh & A. Al-Krenawi (Eds.), *Culture, diversity and mental health – Enhancing clinical practice* (pp. 21–38). Springer International.

Waldron, I. (2021). The wounds that do not heal: Black expendability and the traumatizing aftereffects of anti-Black police violence. *Equality, Diversity and Inclusion: An International Journal, 40*(1), 29–40. https://doi.org/10.1108/EDI-06-2020-0175

Waldron, I., Ogba, P., Green, D., Olasupo, O., Adjekum, S., & Bourmand, R. (2024). *Improving access to mental health services among Black youth in Hamilton, Ontario*. McMaster University. https://arms.mcmaster.ca/app/uploads/2024/08/Final-Study-Report-2024-1.pdf

Waldron, I., Senger. B., Cookey, J., Crown. M., & Tibbo, P. (2023). Addressing stigma and promoting help-seeking among African Nova Scotian youth experiencing psychosis and other mental health problems. *The Canadian Journal of Psychiatry, 68*(3), 200–207. https://doi.org/10.1177/07067437221125305

Walker-Harding, L. R., Christie, D., Joffe, A., Lau, J. S., & Neinstein, L. (2017). Young adult health and well-being: A position statement of the society for adolescent health and medicine. *Journal of Adolescent Health, 60*(6), 758–759. https://doi.org/10.1016/j.jadohealth.2017.03.021

Wallace, A. (2015). [Review of the book *Sister citizen: Shame, stereotypes, and Black women in America*, by M. Harris-Perry]. *Journal of Women, Politics & Policy, 36*(1), 116–118. https://doi.org/10.1080/1554477X.2014.955410

Wallace, M. (1999). *Black macho and the myth of the superwoman*. Verso.

Walley-Jean, J. C. (2009). Debunking the myth of the "angry Black woman": An exploration of anger in young African American women. Black Women, Gender + Families, 3(2). 68–86. https://doi.org/10.1353/bwg.0.0011

Walmsley, C., Thomas Bernard, W., & Este, D. (2021). Social work pioneers. In D. V. Mullings, J. Clarke, W. Thomas Bernard, D. Este, & S. Giwa (Eds.), *Africentric social work* (pp. 44 –72). Fernwood Publishing.

Ward, E., Wiltshire, J. C., & Detry, M. A., & Brown, R. L. (2013). African American men and women's attitude toward mental illness, perceptions of stigma, and preferred coping behaviors. *Nursing Research, 62*(3), 185–194. https://doi.org/10.1097/NNR.0b013e31827bf533

Watkins, D. C., & Neighbors, H. W. (2007). An initial exploration of what 'mental health' means to young Black men. *Journal of Men's Health & Gender, 4*(3), 271–282. https://doi.org/10.1016/j.jmhg.2007.06.006

Wells, J., Barlow, & J., Stewart-Brown, S. (2003). A systematic review of universal approaches to mental health promotion in schools. *Health Education, 103*(4), 197–220.

West, M. C., Yanos, P. T., & Mulay, A. C. (2014). Triple stigma of forensic psychiatric patients: Mental illness, race, and criminal history. *International Journal of Forensic Mental Health, 13*(1), 75–90. https://doi.org/10.1080/14999013.2014.885471

West, N. M., Payne, A. N., Smith, M. D., Bonds, N. T., Alston, A. D., & Akalugwu, W. N. (2021). A collaborative autoethnography of six Black women walking tightropes in higher education. *Negro Educational Review, 72*(1–4), 131–163.

Westhues, A., Cadell, S., Karabanow, J., Maxwell, L., & Sanchez, M. (1999). The creation of knowledge: Linking research paradigms to practice. *Canadian Social Work Review, 16*(2), 129–154.

White, E. S. (2024). Preservice elementary teachers and future civic teaching. *The Journal of Social Studies Research, 48*(4), 261–273. https://doi.org/10.1177/23522798241252939

Whitley, R. (2016). Ethno-racial variation in recovery from severe mental illness. *The Canadian Journal of Psychiatry, 61*(6), 340–347. https://doi.org/10.1177/0706743716643740

Wilcox, M. M. (2023). Oppression is not "culture": The need to center systemic and structural determinants to address anti-Black racism and racial trauma in psychotherapy. *Psychotherapy, 60*(1), 76–85. https://doi.org/10.1037/pst0000446

Williams, B. M. (2023). "It's just my face:" Workplace policing of Black professional women in higher education. *Journal of Women and Gender in Higher Education*, *16*(2), 67–89. https://doi.org/10.1080/26379112.2023.2172730

Williams, C. C. (2001). Confronting the racism in research on race and mental health services. *Canadian Social Work Review, 18*(2), 231–248.

Williams, D. R., Lavizzomourey, R., & Warren, R. C. (1994). The concept of race and health status in America. *Public Health Reports, 109*(1), 26–41.

Williams, D. R., & Mohammed, S. A. (2009). Discrimination and racial disparities in health: Evidence and needed research. *Journal of Behavioural Medicine, 32*(1), 20–47. https://doi.org/10.1007/s10865-008-9185-0

Williams, D. R., & Williams-Morris, R. (2000). Racism and mental health: The African American experience. *Ethnicity & Health, 5*(3-4), 243–268. https://doi.org/10.1080/713667453

Wilson, D. B., Solomon, T. A., & McLane-Davison, D. (2020). Ethics and racial equity in social welfare policy: Social work's response to the COVID-19 pandemic. *Social Work in Public Health, 35*(7), 617–632. https://doi.org/10.1080/19371918.2020.1808145

Winks, R. W. (1971). *The Blacks in Canada: A history*. Yale University Press.

Winks, R. W. (1997). *The Blacks in Canada: A history* (2nd ed). McGill-Queen's University Press.

Withers, A. J. (2024). Disability politics and theory (3rd ed.). Fernwood Publishing.

Women's Health in Women's Hands. (2003). *Racial discrimination as a health risk for female youth: Implications for policy and healthcare delivery in Canada.* Canadian Race Relation Foundation. https://www.crrf-fcrr.ca/en/resources/clearinghouse/author/229-w8427

Wong, C. (2024, December 9). *Two research projects to explore suicide among Black youth, and accelerating accessibility in arts*. Faculty of Community Services, Toronto Metropolitan University. https://www.torontomu.ca/fcs-news-events/news/2024/12/two-research-projects-to-explore-suicide-among-black-youth--and-/

Woodley, X. & Lockard, M. (2016). Womanism and snowball sampling: Engaging marginalized populations in holistic research. *The Qualitative Report, 21*(2), 321-329. https://doi.org/10.46743/2160-3715/2016.2198

World Health Organization (WHO). (2023, March 7). *Disability* [Fact sheet]. https://www.who.int/news-room/fact-sheets/detail/disability-and-health

Wun, C. (2016a). Against captivity: Black girls and school discipline policies in the afterlife of slavery. *Educational Policy, 30*(1), 171–196. https://doi.org/10.1177/0895904815615439

Wun, C. (2016b). Unaccounted foundations: Black girls, anti-Black racism, and punishment in schools. *Critical Sociology, 42*(4-5), 737–750. https://doi.org/10.1177/0896920514560444

Yardley, L. (2000). Dilemmas in qualitative health research. *Psychology and Health, 15*(2), 215–228. https://doi.org/10.1080/08870440008400302

Yates, C., Partridge, H., & Bruce, C. (2012). Exploring information experiences through phenomenography. *Research Methodology in Library and Information Studies, 36*(112), 96–119.

Yearby, R., Clark, B., & Figueroa, J. F. (2022). Structural racism in historical and modern US health care policy. *Health Affairs, 41*(2). https://doi.org/10.1377/hlthaff.2021.01466

APPENDICES

Appendix A: Interview Guide

Guide for Interviews with Young Black Women

This interview guide is flexible and will guide the interviewer to ensure that all subject areas within the study are covered during the interview. The prompts will be used when needed to gain enhanced clarity.

1) **Perceptions regarding mental health and mental health concerns:**
   a) What does mental health mean to you?
   b) How is mental health viewed in your family or community? (***Prompt: Are there differences in how you think about mental health and how it is seen by family and community members?***)

      Note to interviewer: listen for community held beliefs, role of environment in mental health distress, stigmas and help-seeking.
   c) What do you perceive to be the cause of mental health concerns? (***Prompt: Commonly held beliefs, is it seen as a disability, etc.***)
   d) Do you think mental health concerns are a form of disability?

2) **Participants' experience with mental health concerns:**
   a) When did you begin to have concerns about your mental health?
   b) What is it like to be a young Black woman with mental health concerns? (***Grand tour question***)

      Note to interviewer: Move to questions below if not addressed at this juncture.
   c) Did you share your experiences of mental health concerns with anyone? What was the response? (prompt)
   d) Do you consider yourself as having a disability? Why/why not? (***Grand tour question***)

      Note to interviewer: Listen for any messages regarding ableism/sanism/Black pathology.
   e) How do you think your experiences as a young Black woman with mental health concerns differ from that of other young women in Toronto?
   f) Can you tell me a story about your experiences with mental health concerns?
   g) What would you like others to know about your experiences with mental health concerns?
   h) Why did you volunteer to participate in this study?

3) **Experiences with and access to formal mental health care services:**
   a) Have you sought support for your mental health concerns? If so, where? And how often?

b) What has your experience been with these services?
   i) What worked for you? Were there things that made you uncomfortable?
c) Have you experienced barriers in accessing supports/services?
   i) If so, how did you overcome those barriers?
d) Do you believe that your identity as a young Black woman influences your experience with formal supports?
e) Are there other aspects of your identity that you think influence your experiences with mental health services?

4) Informal methods of supports accessed:

a) In what ways do you cope with your mental health concerns? (***Grand tour question***)
b) What types of informal supports have you utilized for your mental health concerns? (***Prompt: Any religious practices, rituals, alternative crisis intervention, elder support.***)
c) Have you ever been reluctant to share your mental health concerns with others? If so, why?
d) How have you shared your mental health concerns with family and friends, if at all? What were their reactions? (***Prompt***)

5) Is there anything else you would like to share?

Appendix B: Ethics Approval

YORK
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UNIVERSITY

Certificate #:	**STU 2021-062**
Initial Approval:	**06/08/21 - 06/08/22**
Amendments:	**Amendment approved: 06/25/21**
Renewals:	
Current Approval Period:	**06/08/21 - 06/08/22**

OFFICE OF RESEARCH ETHICS (ORE)
309 York Lanes

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Toronto ON
Canada M3J 1P3
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Fax 416 736-5512
www.research.yorku.ca

ETHICS AMENDMENT APPROVAL

To: **Donna Richards - Graduate Student**
Social Work
dricfos1@yorku.ca

From: Alison M. Collins-Mrakas, Sr. Manager and Policy Advisor, Research Ethics
(on behalf of Veronica Jamnik, Chair, Human Participants Review Committee)

Date: Friday, June 25, 2021

Title: **At the intersection of Race and Mental Health Stigma: Exploring the Help Seeking Behaviours of Young Black Women with Mental Health Concerns: A Qualitative Research**

Risk Level: ☒ Minimal Risk ☐ More than Minimal Risk

Level of Review: ☒ Delegated Review ☐ Full Committee Review

With respect to your research project entitled, **"At the intersection of Race and Mental Health Stigma: Exploring the Help Seeking Behaviours of Young Black Women with Mental Health Concerns: A Qualitative Research"**, the committee notes that, as there are no substantive changes to either the methodology employed or the risks to participants in and/or any other aspect of the research project, a renewal of approval re the proposed amendment(s) to the above project is granted.

Any further changes to the approved protocol must be reviewed and approved through the amendment process by submission of an amendment application to the HPRC prior to its implementation.

Ongoing research – research that extends beyond one year – must be renewed prior to the expiry date.

Any adverse or unanticipated events in the research should be reported to the Office of Research ethics (ore@yorku.ca) as soon as possible.

For further information on researcher responsibilities as it pertains to this approved research ethics protocol, please refer to the attached document, **"RESEARCH ETHICS: PROCEDURES to ENSURE ONGOING COMPLIANCE".**

Please note that prior to commencing any research activities, researchers are advised to review the latest updates on research involving human participants at: *https://www.yorku.ca/research/researchers-faqs/*

Should you have any questions, please feel free to contact me at: 416-736-5914 or via email at: acollins@yorku.ca.

Yours sincerely,

Alison M. Collins-Mrakas M.Sc., LLM
Sr. Manager and Policy Advisor,
Office of Research Ethics

Appendix C: Recruitment Flyer

Research Volunteers Needed!

Young Black Women with Mental Health Concerns

Are you a Young Black Woman aged 18-25 years living in Toronto? Do you sometimes feel depressed, anxious, experience mood variance, or feel overwhelmed by daily life demands?

This is an opportunity to share your experiences! Whether you are using mental health services, have used them in the past, or have never used them before, I would like to speak with you.

I am a doctoral student in the Social Work Program at York University, conducting a study titled *At the Intersection of Race and Mental Health Stigma: Exploring the Help-Seeking Behaviours of Young Black Women with Mental Health Concerns in Toronto.*

Who can participate: Young Black women with mental health concerns, ages 18-25.
What is involved: Selected participants will be asked to give a 1.5- to 2.0-hour interview.
All interviews will be kept strictly confidential

All study participants will receive a $20 Honorarium in appreciation of their time

To learn more about this study or if you are willing to be interviewed, please contact Donna Richards at dricfos1@yorku.ca or by phone at (416) 317-9138

This research has been reviewed and approved for compliance with research ethics protocols by the Human Participants Review Subcommittee of York University.

Appendix D: Informed Consent Form

Study Name: *At the Intersection of Race and Mental Health Stigma: Exploring the Help-Seeking Behaviours of Young Black Women with Mental Health Concerns in Toronto*

Researcher: Donna Richards, PhD thesis research
School of Social Work, York University
4700 Keele Street, Toronto, Ontario, M3J 1P3
Email: dricfos1@yorku.ca

Purpose of the Study

The purpose of this study is to gain an understanding of what are the influences of mental health stigma, race, and gender are on the trajectory of young Black women's help-seeking in Toronto. This study will seek to gain young Black women's perceptions and understandings of mental health and mental illness to better support their mental health needs and young people in Black communities as a whole.

What You Will Be Asked to Do

You will be asked to participate in a 1.5 to 2.0 hours confidential interview with the researcher. Over the course of the interview, you will be given a 10 minute break. The interview will be conducted in English and will take place by Zoom or by phone. You will be asked to have your interview audio recorded. You can stop recording at any time and the interview will continue without recording; if you choose not to be recorded, the researcher will take handwritten detailed notes on the information you provide.

This study will use telephone calls and Zoom platform to collect data, which is an externally hosted cloud-based service. When information is transmitted over the internet privacy cannot be guaranteed. There is always a risk your responses may be intercepted by a third party (e.g., government agencies, hackers). Further, while York University researchers will not collect or use IP address or other information which could link your participant to your computer or electronic devices without informing you, there is a small risk with any platform such as this of data that is collected on external servers falling outside the control of the research team. If you are concerned about this, we would be happy to make alternative arrangements (where possible) for you to participate, perhaps via telephone. Please contact me for further information.

Recordings (audio/video) will be saved in a password protected file to researcher's local computer, not the cloud-based service. Recordings will only be used to facilitate transcription and will then be deleted. They will be transcribed by either by either the principal investigator, Donna Richards, or a professional transcriber, both of whom are trained in and committed to maintaining your privacy and confidentiality.

Please note that it is the expectation that participants agree not to make any unauthorized recordings of the content of a meeting / data collection session.

Risks and Discomforts

You will be asked to talk about your personal experiences. While I will try to create a safe space and reduce the potential for harm, the risk of participating is similar to you sharing your experiences with others, which may include discomfort or emotional distress. I have included a list of resources to support you if needed. Please be advised that sharing this mental health resource list does not constitute

counselling or referrals. Instead, this step will be taken to safeguard participants from minimal risk of stress or heightened anxiety that may arise during the interview. Participants can at any time decide not to answer a particular question or not tell the interviewer things that they find sad or stressful.

Family Services Toronto: 416-595-9230
Catholic Family Services of Toronto: 416-921-1163
TAIBU Community Health Centre: 416-644-3536
Wellness Together Canada: 1-866-585-0445
Centre for Addiction and Mental Health (SAPACCY) 416-535-8501

Benefits of the Research and Benefits to You

There are no direct benefits in participating in this study, except that it provides you with an opportunity to share your opinions and experiences as part of an ongoing effort to promote positive changes within our mental health system, its policies and practices, to encourage and enhance the experiences of young Black women with service access.

Voluntary Participation

Your participation in this research is completely voluntary, and you may refuse to answer any questions. Your decision not to participate or to discontinue participation will not influence the nature of your relationship with me or the nature of your relationship with any related agencies, or with York University, either now or in the future. An honorarium of $20 will be provided as an incentive for your participation upon completion of participation.

Withdrawal from the Study

You may withdraw from your participation in the study for any reason at any time. If you choose to withdraw, your collected data will be destroyed unless you advise that the researcher can keep them. Your decision to withdraw from the study will not negatively impact the relationship between you and the researcher, or any organizations closely linked to the study (such as York University). The information you share will be included in the study unless you ask for it to be removed. You will still be eligible to receive the $20-dollar honorarium even if you withdraw.

Confidentiality and Anonymity

The information you provide will be kept confidential. The information you share will only be used for research, and your real name and any information that could identify you will not be used in any type of publication, presentation, or analysis. A pseudonym will be used to protect your identity. You may choose an identifier that you would like me to use when referring to you in the dissertation study report if you wish. Only the principal investigator (Donna Richards) will know your real name and be able to connect your story to your identity. To support the research process, I may use a professional transcriber who will have access to interview recordings *only* for the purpose of transcription. They are trained in privacy, confidentiality, and ethical research, and have signed a confidentiality agreement to make sure they are committed to keeping your information safe and confidential. During and after transcription, all identifying information about people, situations, and organizations will be removed so you will remain anonymous.

Transcriptions will be stored on a password-protected computer and on a USB drive. Hard copies will be locked in a file cabinet and accessible only to the principal investigator at her place of residence. All data will be completely anonymized (i.e. any identifying information will be removed). Pseudonyms will be used in the transcribed audio to keep your information anonymous. Any interview recordings that will be transcribed by a professional transcriber will be stored on a safe, secure, encrypted, and password-protected server, such as Google Drive. All interview recordings will be deleted after transcription, so only anonymized data will be used. The data will be securely kept until December 31, 2024. This time frame allows for completion of the PhD program, dissemination of findings and publications. After which, all of the data will be destroyed. I will delete all information before physically destroying the USB that stores the electronic copy. I will use a professional shredding service to dispose of hard copies of the data.

Questions About the Research?

You can contact me, Donna Richards, if you have any questions about the research or your role in the study. You can contact me directly during work hours (10 a.m.- 6:00 p.m., Monday-Friday) at 416-317-9138 or by e-mail: dricfos1@yorku.ca. You can also contact my supervisor, Professor Uzo Anucha, in the School of Social Work at York University, by e-mail at anucha@yorku.ca. Additionally, you can contact the Faculty of Graduate Studies at York University at 416-736-2100 (ext. 66329).

This research has been reviewed and approved by the Human Participants Review Sub-Committee of York University's Ethics Review Board and conforms to the standards of the Canadian Tri-Council Research Ethics guidelines. If you have any questions about this process or about your rights as a participant in the study, you may contact the Senior Manager and Policy Advisor for the Office of Research Ethics, 5th Floor, York Research Tower, York University, telephone 416-736-5914 or e-mail ore@yorku.ca.

Legal Rights and Signatures

I, _____, consent to participate in the study entitled "**At the Intersection of Race and Mental Health Stigma: Exploring the Help-Seeking Behaviours of Young Black Women with Mental Health Concerns in Toronto,"** conducted by Donna Richards. I understand the nature of this study and wish to participate. I understand that I am not waiving any of my legal rights by signing this form. My signature below indicates my consent.

Please read the following, then sign below it to indicate your understanding:

_____ I understand the procedures and consent to participate in this study.
_____ I consent to being audio-recorded during the interview.
_____ I consent to being contacted about participating in a follow-up telephone interview after the initial interview.
_____ I consent for the researcher to use direct quotations (words or phrases from the interview) that will be anonymous/only a pseudonym in a final report and in papers and publication.

I consent for the interview to be audio taped: Yes ☐ No ☐

I have read and understand the above information. I have received a copy of this form and I agree to participate in this study. My signature below indicates my consent.

Signature Date

_____ _____

Participant

Signature Date

_____ Date:

Donna Richards (Principal Investigator)

Appendix E: Demographic Information Form

Demographic Information for the study: *At the Intersection of Race and Mental Health Stigma: Exploring the Help-Seeking Behaviours of Young Black Women with Mental Health Concerns in Toronto*

Confidentiality: This information is being collected strictly for the purposes of this academic research project. It will be kept confidential and not shared with any government agencies or other organizations. The information will be kept anonymous in the research report.

1. Age
2. Race
3. Ethnicity
4. Immigration Status
5. Educational or Employment Status
6. Gender identity
7. Family composition (marital status, children, age of children, etc.)
8. Housing Status (living alone; with partner, parents, other family members; insecurely housed)
9. Length of residency in Greater Toronto Area (GTA)
10. Engagement with formal mental health organizations

Appendix F: Confidentiality Agreement and Proof of Training by Researcher

Project Title: At the Intersection of Race and Mental Health Stigma: Exploring the Help-Seeking Behaviours of Young Black Women with Mental Health Concerns: A Qualitative Research

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Principal Investigator: Donna Richards, MSW, RSW, Ph.D.(Candidate)

Contact Information: dricfos1@yorku.ca or 416-317-9138

I Samantha Zerafa (name of the transcriber) understand confidential information will be made known to me for a study being conducted by Donna Richards in the School of Social Work York University. I agree keep all information collected during this study confidential, and will not reveal by speaking, communicating or transmitting this information in written, electronic (disks, transcripts, email) or any other manner to anyone outside the research team. Further, I agree that final disposition of all data must be in accordance with the approved protocol and/or agreement with the Principal Investigator.
I am familiar with the Tri-Council Policy statement and have been apprised of my responsibilities with respect to the ethical conduct of research involving human participants and adhering to the approved protocol.

Name of the Transcriber: Samantha Zerafa

Signature of the Transcriber: 

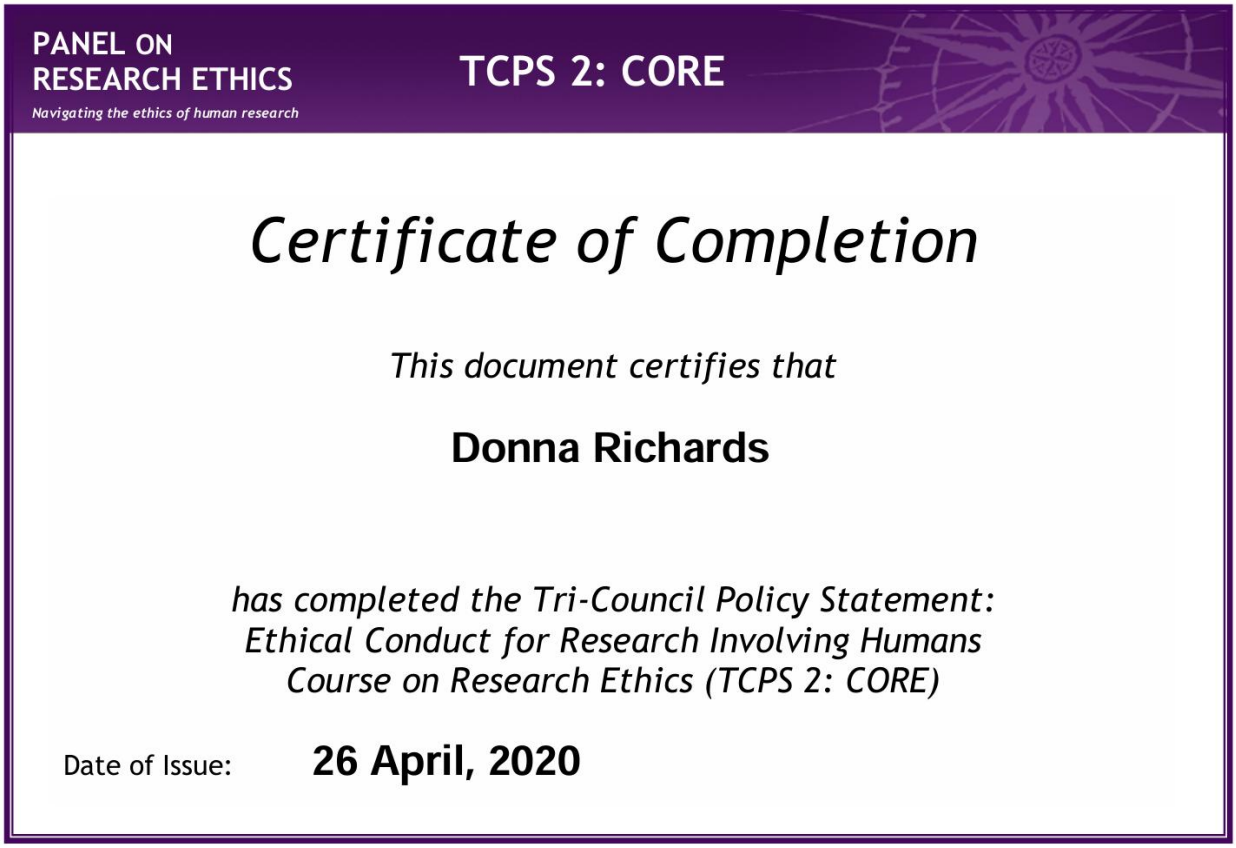
Date: June 24, 2021

Name of Principal Investigator: Donna Richards

Signature of Principal Investigator:

Date: June 24, 2021

Appendix G: Tri-Council Policy Statement Certificate of Completion


PANEL ON RESEARCH ETHICS

Navigating the ethics of human research

TCPS 2: CORE

Certificate of Completion

This document certifies that

Donna Richards

has completed the Tri-Council Policy Statement:
Ethical Conduct for Research Involving Humans
Course on Research Ethics (TCPS 2: CORE)

Date of Issue: **26 April, 2020**

Appendix H: Pre-Screening Questionnaire

Script: Thank you for calling. I would like to ask you a few questions to ensure that you meet the criteria for this study. It will only take about 5 minutes of your time. Is now a convenient time for you to respond to a few questions?

As you know, this study is seeking to recruit young Black women 18-25 years old, who have resided in Toronto for at least one year and who identify as having mental health concerns.

- Are you a resident of Toronto?
- How long have you lived in Toronto?
- Would you identify yourself as having mental health concerns?

Study Information:

- You will be asked to participate in a Zoom or telephone interview that lasts 1.5 to 2 hours
- The interview questions are open-ended so that you can discuss aspects of the topic that are most important to you
- All participants will remain anonymous
- Each participant will receive $20.00

Based on this information, are you interested in participating in the study?

(If participant agrees date and time for an interview will be scheduled)
Thank you for your time.