

Exploring the Attitudes, Beliefs and Practices Concerning Mental Health Amongst African
Immigrant Youth Living in Canada: An Interpretive Description Study

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Abstract

There has been limited research in Canada on the mental health of African immigrant youth. An Interpretive Description methodology was utilized to interview eight African immigrant youth on their attitudes and beliefs towards mental health, their mental health practices, and factors affecting their mental health. Themes that were identified surrounded transitioning into adulthood, between geographical locations, and between identities; protective factors, including resilience, religion, and hyper-masculinity, and the differing immigration experiences of African immigrant youth. This research brings attention to intersectional factors that play a role in the mental health of African immigrant youth, as well as gender differences in their mental health experiences. It also highlights the need for cultural humility in care as well as the importance of critical inquiry when interacting with immigrant populations. Implications for practice and future research are suggested to help advocate for and effectively treat African immigrant youth experiencing mental health challenges.

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Dedication

This thesis is dedicated to immigrant youth who have struggled with or are currently struggling with any mental health challenge. Your feelings are real, they are acknowledged and you deserve to place value on what you feel. Never forget that. To my parents, Matthew and Mary Olawo for always pushing me to be the best I can be.

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Chapter One: Introduction

Canada is a diverse country with immigrants arriving from various countries around the world. According to Statistics Canada (2017), more than one in five Canadian residents, about 21.9%, is foreign born. Canada's immigration population has faced a cultural shift over the last 40 years, with the total number of immigrants from non-European countries outnumbering those from European countries (Statistics Canada, 2017). According to the 2016 census, Africa became the second highest source of immigrants to Canada, behind Asia, with African immigrants making up 13.4% of new immigrants that year (Statistics Canada, 2017). With the increase of immigrants and visible minorities in Canada, it is not surprising that settling into a new country can be accompanied by some challenges and difficulties (Ng & Omariba, 2010). Migration can pose a risk to one's mental health, especially when coupled with factors such as unemployment, language barriers and discrimination (Robert & Gilkinson, 2012). Stress can also be a precursor to mental illness, and immigrants, including refugees, are exposed to pre-migration stressors such as internment in refugee camps or poverty and post-migration stressors like unemployment and separation from family that may put them at a higher mental health risk (Robert & Gilkinson 2012).

Youth, especially those aged 18-25, who are in the stage classified as emerging adulthood, are at an age of self-focus, instability, identity exploration, feeling in-between, and possibilities (Munsey, 2006). At this stage in life, youth are susceptible to developing mental health challenges (Cheng, McDermott & Lopez, 2015). The mental health of African immigrant youth is of particular interest because of their experiences due to the intersection of gender, language, religion, ethnicity, class, cultural and racialized status in relation to migration (Khanlou & Crawford, 2006). It is also worth noting that while they are facing these challenges, they are also

going through the additional developmental process of identity formation, specifically, their migrant youth identity. When African youth arrive in a country outside of the continent, they are confronted with going through life with a racialized status that may feel foreign to them. These compounding factors could potentially have a negative impact on their mental health. In African countries, mental health is less promoted than it is in Canada, and it remains highly stigmatized (Amuyunzu-Nyamongo, 2013). The views of African immigrant youth on mental health/illness could also be influenced by cultural beliefs. There has been very little research on mental health amongst African immigrant youth in Canada. In order to put supports and services in place and make practice changes to help promote and maintain mental health, we first need to gain some firsthand knowledge from African immigrant youth themselves. In particular, this study will explore their attitudes toward, or beliefs about mental health, how these beliefs arise and to what extent they influence their mental health practices.

Background

I have a personal interest in the mental health of African immigrant youth that developed during my undergraduate program. At the age of 10, I emigrated from Nigeria to Canada with my immediate family. While I was completing my undergraduate degree, I, along with other students helped to develop the African Students Association at Ryerson University. This student group was created to give both domestic and international African students studying at Ryerson a sense of community and to educate the student body at large about Africa. It was through my work with this group that I witnessed many students experiencing some form of mental health distress, though they may not have defined it as such. This ranged from anxiety and stress to exhibiting symptoms of depression for various reasons. For one student, the experience of racism and discrimination was quite foreign to him, and when he began experiencing this, he did not

know how to cope. I found that these students were reluctant to seek help from professional sources or even speak to their peers about their mental health, and instead attempted to fend for themselves, sometimes using unhealthy coping mechanisms such as drinking, experimenting with drugs and practicing unsafe sex. Some were unable to speak to their parents about their struggles due to the cultural beliefs that their parents held about mental health. Though the university offered counseling services and was quite explicit about it, they were still resistant towards the idea of seeking help.

I also went through my own mental health challenges, particularly dealing with depression in my undergraduate years. Although as a nursing student I had learned all about mental health, I was unable to apply the knowledge to myself, mostly due to the cultural belief that mental health challenges were rooted in supernatural causes. One of the contributing causes to my bout with depression was at times being the only Black person in my classroom and having other students question the legitimacy of my occupying that space. Fortunately, I eventually sought help by utilizing my university's counseling services, but this was after much persuasion from my friends. I was still resistant towards the idea and in the beginning, did not truly believe in it. But as time went on, I saw the benefits of seeking help. I believe that what made the difference was the counselor's consideration of my cultural and religious background and my social experiences.

This study seeks to enhance understanding about the views African immigrant youth hold towards mental health. It also explores the factors that have an effect on the mental health of African immigrant youth. It is my hope that the findings from this study can not only influence nursing practice, but also shed some light onto the mental health practices of African immigrant youth.

Statement of Purpose

The purpose of this study is to enhance understanding about the attitudes, beliefs and practices concerning mental health amongst African immigrant youth and the factors that influence their mental health in order to inform practice. Eiser (1997) defines attitudes as the judgments or preferences that one holds that go beyond factual evidence. Beliefs are the claims that one holds to be either true or false as matters of facts (Eiser, 1997). For the purpose of this research, I am defining practices as the ways in which persons take care of and maintain their mental health either by self-care methods or through help seeking.

The research questions are as follows: 1) What are the attitudes and beliefs held by African immigrant youth towards mental health and mental illness and how do they originate? 2) How do these attitudes and beliefs influence the mental health practices of African immigrant youth? 3) What other factors influence the mental health of African immigrant youth? 4) What practices do African immigrant youth follow to protect and maintain their mental health?

Theoretical Perspectives

The chosen theoretical perspectives and concepts listed below guided my research and interview questions, how I viewed the participants' answers on their experiences, and how I interpreted and analyzed the data. The use of transcultural nursing theory, critical theory and intersectionality together was expected to provide much deeper knowledge than using any of these perspectives alone. Transcultural nursing theory was chosen for its acknowledgment of the role culture plays in one's view of health and wellbeing. Although cultural belief is an important factor in one's views of health and their health practices, applying this perspective alone ignores the implications that social categories such as race, class, age, gender, sexual orientation and more have on health, hence, the addition of critical theory and intersectionality.

Transcultural Nursing Theory

Nurse anthropologist Madeleine Leininger developed Transcultural Nursing and defined it as an area of study and practice that focuses on individuals or groups of people from similar or different cultural backgrounds, their cultural values, beliefs and practices, and aims to provide culture-specific nursing care in order to promote health and well-being (Leininger, 1995).

Transcultural nursing theory focuses on the relationship between culture and wellbeing, health, illness and death (Leininger, 2002). It gave rise to the notion of culturally competent care, which enables a nurse to care effectively within the cultural context of clients of diverse backgrounds (Gustafson, 2005). Transcultural nursing theory recognizes that one's worldview, which includes cultural, religious and social factors, has an influence of care patterns and practices (Leininger, 2008). This theory was chosen as a guide for my study because it highlights the importance of culture and culturally competent care in meeting the unique healthcare needs of individuals, families and communities in nursing practice (Papadopoulos & Omeri, 2008).

Leininger's (2002) Transcultural nursing theory along with the work of other scholars who valued the role culture plays in health led to the development of the term "cultural competency" (Ansuya, 2012; Shen, 2015). Cultural competency in nursing requires one to be respectful of diversity and promote inclusivity, and it is an entry-to-practice level competency for registered nurses in Canada (Canadian Nurses Association, 2010). The promotion of culturally competent care in nursing is important, as it helps bring some cultural understanding and knowledge into the nurse-client relationship. It provides some understanding that health behaviors may be influenced by culture. Cultural competency is meant to help prevent stereotyping and judgmental nurse-client relationships, as care is adapted to the client's culture (Ansuya, 2012).

Critical Theory

Critical theory has its roots in social science, and emerged from Marxism, though it departs from traditional Marxism, as it focuses on power relationships involving gender, race and ethnicity, rather than class relations (Willis, 2007). Critical theory research critiques current ideologies and challenges the status quo, by exposing and questioning dominating relationships and power imbalances that exist within societal structures (Fontana, 2004; Willis, 2007).

According to Kilgore,(as cited in Willis, 2007) critical theory research “requires the researcher and participants to be willing to become aware of how a false understanding [of society] contributes to oppression and resistance” (p. 82). Research from a critical theory paradigm is not only concerned with uncovering the truth about power differentials, but also with empowering others and helping those who do not hold power to acquire or reclaim it (Willis, 2007). Critical theory research often uses subjective inquiry and does not assume that the researcher will be objective, as the process of critical research is based on the values and beliefs of the researcher (Willis, 2007). A critical researcher must employ an anti-oppressive approach in their work because this approach posits the research participants as being on an equally important level as the researchers themselves (Strega & Brown, 2015). A critical approach looks for meaning within research findings that can enable social change and attempts to understand the complex causes of injustice and inequities (Strega & Brown, 2015).

Browne (2000) explains that critical theory is used as a framework to examine power dynamics within communities and the health care system and to critique the socio-political context of nursing theory, practice and education. Critical theory offers nursing a conceptual structure to consider the social inequalities that may threaten health, and the application of this knowledge can lead to greater health equity for all (Mosqueda-Díaz, Vélchez-Barboza,

Valenzuela-Suazo, & Sanhueza-Alvarado, 2014). Nurses are often in a unique position to witness the impact of social injustice on their patients, and critical theory enables them to illuminate these disparities and work towards improving the quality of life for their clients (Mosqueda-Díaz et al., 2014). Nursing practice from a critical theory perspective is focused on creating emancipatory changes for patients, families and communities (Browne, 2000).

Approaching this study from a critical perspective is beneficial because it provides a voice for African immigrant youth, as they possess expert knowledge on their mental health practices. This approach disrupts the traditional nursing/client power imbalance, in which the health care providers are typically deemed the experts in the relationship. The experiences that African immigrant youth experience, such as systemic racism, marginalization and sexism can negatively impact one's mental health and may be a source of mental health disparities from the general population. There is no singular truth to be discovered through this research, but perhaps an understanding of the socio-cultural context of African immigrant youth mental health can be developed.

Intersectionality

Intersectionality is an important concept that draws upon critical social sciences and postcolonial feminist teachings and offers an alternate view to theories that prioritize one social identity category above another (Hankivsky & Christoffersen, 2008). It posits that people's experiences are the result of the intersection or interrelation of two or more identities and strives to shed light on intersecting systems of oppression and privilege (Hankivsky & Christoffersen, 2008). Intersectionality influenced by critical theory also challenges the idea that the categories of difference used to identify individuals such as race, gender, religion or sexuality are distinct and separate (Gustafson, 2005). Instead, it acknowledges that people's identities are

interconnected socially, politically and ideologically and they work together to create either positive or negative outcomes (Gustafson, 2005). Negative outcomes are displayed in society as unequal access to power, opportunity, wealth and other resources that further marginalize and disempower individuals. Van Herk, Smith and Andrew (2011) explain that an intersectionality paradigm assumes that people's experiences can be a result of how they view and identify themselves, how society sees them, and how they interact with others in society. This concept is quite relevant to my population of interest, as the intersections of age, gender, racialized status, migration conditions and more, could have an impact not only on how they view mental health, but also on their mental health outcomes and mental health practices.

This chapter included an introduction and background of the study, the purpose of the study and my chosen theoretical perspectives. The next chapter will present the literature review conducted pertaining to relevant topics in this study. In chapter three, I will discuss my chosen methodology, Interpretive Description, including a discussion on participant recruitment, data gathering and data analysis. Chapter four will present the findings from the study. Chapter five provides an interpretive analysis of my findings, while Chapter six is a discussion of the significance of the findings and implications for practice. Finally, chapter seven provides a conclusion and summary of the study conducted.

Chapter Two: Literature Review

In order to determine the current state of knowledge on mental health amongst African immigrant youth, I retrieved information from EBESCO, ProQuest, Google scholar, as well as internet websites. My search was conducted with the following keywords used individually and in combination with each other: mental health, African immigrants, African immigrant youth, African youth and immigrant youth; mental health promotion, cultural competent care, critical social theory and nursing. Due to the limited amount of literature on my population of interest, I included research from the year 2000, onward. I also decided to include literature pertaining to immigrant youth in general, not only African immigrant youth.

Mental Health

The World Health Organization (2016) defines mental health as “a state of well-being in which every individual realizes his or her 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”. An individual’s overall health is affected not only by their physical health status, but also by their mental health status. Mental health is essential to a person’s ability to live a fulfilling life. It can be affected by a range of factors including socioeconomic, psychological, and physiological factors. Not only is mental health affected by these, but it can in turn positively or negatively impact one’s socioeconomic, psychological and physiological status (Centre for Addictions and Mental Health [CAMH], 2012). Mental health is not stagnant and can change at any time depending on circumstances in one’s life such as trauma, loss, genetics, stressful situations, lifestyle choices and more. When problems begin to develop due to these changes, and they are diagnosed by a health care professional, this is then referred to as mental illness (CAMH, 2012). Anxiety disorders, panic disorders, depression, schizophrenia, eating disorders

and many more are all examples of mental illness. Mental illness is generally stigmatized and many people either avoid seeking care or avoid speaking about their mental illness due to this stigma (CAMH, 2012). For the purpose of this study, I will be focusing mental health, broadly understood, as well as the stigma surrounding mental illness in the African youth population, with the goal of contributing to knowledge relevant to promoting and maintaining mental health. The promotion of good mental health along with physical health is needed in order to maintain a healthy balance in an individual's life.

Immigration and Mental Health

Hansson, Tuck, Lurie and McKenzie (2010) note that the process of immigration can either build resilience or undermine one's mental health. Immigrants must adjust to a new life and this integration process might be difficult for some to get through. Those of non-European background face the added stressors of racism and discrimination that they may have never experienced before. They may be highly educated but belong to a lower income class than their Canadian-born peers (Hansson et al., 2010). This is due in part to the lack of recognition of foreign degrees, discrimination and language barriers. In 2011, immigrants of African origin had the lowest employment rate and highest unemployment rate compared to immigrants from other regions, though they are more likely to be educated than the overall population (Statistics Canada, 2007; 2012). The intersections between perceived discrimination, racism, and immigration have been shown to be associated with lower levels of both physical and mental health (Viruell-Fuentes, Miranda & Abdulrahim, 2012).

A study conducted on Somali and Chinese immigrants in Canada found that some participants experienced mental health challenges such as an increase in stress and anxiety due to barriers they faced during the migration and integration process (Makwarimba, Stewart, Beiser,

Nefeld, Simich & Spitzer, 2008). Some of these barriers included financial constraints, unemployment, language barriers and the lack of health insurance for some (Makwarimba et al., 2008). The lack or presence of social support was also found to be interconnected with mental health, as some participants reported that separation from family was linked to their feelings of loneliness, anxiety and distress (Makwarimba et al., 2008).

The amount of research on immigrant populations and mental health in Canada has increased in the last 20 years, but a lot of this research is focused on the general immigrant population (Hansson et al., 2010). There is much need for more research on immigrant youth populations, the senior population as well as immigrants who belong to the LGBTTTTIQQ population and those who are low income (Hansson et al., 2010). It is also important to account for demographic differences amongst immigrant groups with respect to their specific identities, as general research on immigrants may not be sufficient to tackle specific mental health needs amongst diverse cultural groups.

Mental Health in Africa

In Africa, mental health care and mental health literacy are often not considered a priority due to other pressing issues the continent faces such as poverty, insufficient funding, communicable diseases and internal conflicts (Gureje & Alem, 2000; Okasha, 2002; Monteiro, 2015). Unfortunately, political conditions such as internal conflicts can cause hunger, displacement and diseases and often leads to post-traumatic stress disorder and other mental illnesses (Amuyunzu-Nyamongo, 2013). People can often find themselves in conditions that are not conducive to their mental health, and this is complicated by the lack of mental health support either from family members, community members or the health care system. In addition, Gureje and Alem (2000) identified that the influence of traditional beliefs in supernatural causes of

illnesses can impact the perception and attitudes about mental health. People tend to seek help from traditional healers who can provide psychosocial support and explanations regarding the cause of mental illness that are congruent with one's spiritual beliefs (Petersen & Lund, 2011). The traditional beliefs behind the concept of mental illness causation are to some extent shared amongst people of African origin (Patel, 1995). These beliefs typically pose a barrier to acknowledging a state of mental distress and seeking care from mental health professionals (Gureje & Alem, 2000). They can also pose a barrier to the integration of mental health care into primary health care services (Petersen & Lund, 2011). Other factors such as the misuse of substances, personal failure or punishment, stress and trauma have also been identified as the cause of mental illness in African societies (Gureje, Lasebikan, Ephraim-Oluwanuga, Olley & Kola, 2005; Monteiro, 2015).

Another factor that comes into play when it comes to mental health in Africa is the stigma of both experiencing mental health challenges and of seeking help. A study conducted in Nigeria found that people reacted with fear, anger and avoidance when in contact with someone who was mentally ill (Amuyunzu-Nyamaongo, 2013). Another study in Uganda found that the term *depression* was not socially accepted (Amuyunzu-Nyamongo, 2013). The social implications of mental illness have a particularly negative impact in Africa and this has caused what Amuyunzu-Nyamongo (2013) describes as a silent epidemic. Families often hide members who have either been diagnosed with mental illness or are experiencing mental health challenges for fear of social discrimination (Amuyunzu-Nyamongo, 2013). Thus, the issues surrounding mental health/illness in Africans include acknowledgement of the illness, mental health literacy, stigma, cultural beliefs, and access to care.

African Immigrant Mental Health

There is a very small body of research on mental health in the African immigrant population in Canada. In Fenta, Hyman and Noh's (2006) study on Ethiopian immigrants and mental health service utilization in Canada, they found that Ethiopian immigrants were more likely to seek out the help of non-professional practitioners such as those who practice traditional medicine or faith healers, rather than mental health professionals. There is a strong interconnection between religion or spirituality and mental health in African immigrant groups (Fenta et al., 2006; Adekeye, Kimbrough, Obafemi & Strack, 2014). This is consistent with Wolf, Zoucha, McFarland, Salman, Dagne and Hashi's (2016) findings from their study on perceptions of mental health amongst Somali immigrants living in the United States that reading verses from the Qur'an would be the first line of treatment for any illness they were experiencing, be it physical or mental. They also found that tribe and family involvement was very important to Somalis when accessing mental health services (Wolf et al., 2016). A screening done at a community organization serving African immigrants in New York found that although 83% of those surveyed identified mental health as amongst their top three health challenges, only 5% of them were on medication for mental health problems (Venters, Adekugbe, Massaquoi, Nadeau, Saul & Gany, 2011). The majority of research conducted specifically on African immigrant mental health was done in the United States (Adekeye et al., 2014; Orijako & So, 2014; Venters et al., 2011; Wolf et al., 2016), with a small amount of research conducted in Canada (Fenta et al., 2006).

Immigrant Youth Mental Health

Youth are a crucial population when discussing mental health because they are in a key stage of identity formation and psychosocial development (Khanlou, 2004). During these years,

youth face issues like bullying, identity crises and self-esteem issues. It is important that mental illness is identified early on in this population in order to reduce the potentially negative long-term effects (Osuch, Summerhurst, Wrath & Wammes, 2017). Treatment for mental illness and mental health promotion need to be youth specific, and the lack of available youth specific programs can sometimes pose a barrier to seeking help (Osuch et al., 2017). Khanlou (2004) noted that immigrant and mainstream youth differ in terms of mental health, because of the effects of post-migration stressors on the mental health of immigrant youth. The majority of newcomer youth to Canada (approximately 80%) are from racialized backgrounds (Shakya, Khanlou & Gonsalves, 2010). Guruge and Butt (2015) identified some post migration factors that could be determinants of mental health amongst this group. They included ethnicity, language, knowledge of the health care system, discrimination, poverty, and family socio-economic status. A study conducted on Somali youth in Canada showed that their experiences of pre-migration trauma including exposure to war and staying in a displacement camp were less related to depressive symptoms and more related to poorer adaptation when they migrate (Jorden, Matheson & Anisman, as cited in Guruge & Butt, 2015). Another study conducted on immigrant youth in Canada found that emotional problems were more likely to be reported by those who had experienced personal trauma (Perrson & Rousseau, as cited in Guruge & Butt, 2015). Guruge and Butt recommended that more research should be done on the topic of youth mental health, particularly immigrant youth mental health. There is a lack of relevant research on African immigrant youth mental health in Canada, specifically. This creates a gap in knowledge, as it is not known how these youths perceive mental health or mental illness or their experiences with mental illness.

Culturally Appropriate Services for Immigrants

The cultural makeup of new immigrants to Canada poses a challenge to the Canadian health care system, as it has long been designed from the perspective of, and for users of White European origin (Chen, 2010). Fenta et al. (2006) found that immigrants from non-European countries face more cultural barriers and language challenges to accessing the Canadian health care system compared to their European counterparts. In Makwarimba et al.'s (2010) study, newcomers were more likely to underuse services and supports that they did not believe were culturally or linguistically relevant to them. Some immigrants have identified perceived discrimination and institutionalized racism as a barrier to accessing mental health care (Hansson et al., 2010). Although practitioners themselves may not be racist, institutionalized racism allows a system of care to deliver poorer treatment or services to certain groups (Hansson et al., 2010). Spirituality, religion and community have been identified as important to some immigrant groups, and care plans that include alternative therapies or treatments may facilitate better care for immigrant groups (Hansson et al., 2010). There is a wealth of research that supports the need for culturally appropriate services.

Canadians live in a country that realizes the importance of mental health and promotes it through various strategies. A widely popular strategy is Bell Let's Talk, which seeks to end the stigma that surrounds mental health (Bell Let's Talk, 2017). While this is an important initiative, it is questionable whether this is enough to reach a population whose perceptions of mental health could be ingrained in cultural beliefs, and that experiences unique factors that could cause mental distress. It is my belief that culturally adapted strategies that are developed from a critical perspective and take into consideration pre-migration factors such as cultural beliefs, poverty, and internal strife in immigrants' home countries and post-migration factors such as

discrimination and marginalization would be the most appropriate for this group. It is important to note that immigrant populations cannot be treated as a homogenous group, because differences exist between immigrant groups (Khanlou, 2010). The provision of services must be specific enough to take into account the intersections of age, race, gender, cultural backgrounds and other factors that could have an effect on the usage rates and acceptability of services. The increase of immigrants into Canada and the cultural and ethnical makeup of new immigrants require that the health care system adopts a culturally sensitive and competent approach rather than a one-size-fits-all approach to health.

Chapter Three: Methodology

Given the dialectic nature of nursing, it is important that once theory is developed, the knowledge should be put into practice (Mosqueda-Díaz et al., 2014). Thorne (2016) offered interpretive description as a methodology that would go beyond the description that other qualitative methodologies offered and would venture into the ‘so what’ domain that seeks to produce knowledge that informs practice. Interpretive description offers the opportunity to deconstruct assumed and established knowledge about a subject and to generate new insights that can lead to further inquiry and evidence to guide future practice (Thorne, 2016). It “seeks to discover associations, relationship and patterns within the phenomenon that has been described”, and searches for underlying meanings that may shed light on the current nature of the phenomenon and lead to a practice response (Thorne, 2008, p.50). I chose to use interpretive description because of its foundational assumptions; namely, a) that reality is not fixed and can involve multiple constructed realities that may contradict each other; and b) that value is placed on subjective and experiential knowledge as a source of insight regarding practice (Thorne, 2016). Interpretive description utilizes naturalistic form of inquiry and acknowledges that the researcher and the “object” of inquiry influence one another in the research process and are inseparable (Thorne, 2016). Thorne’s interpretive description is not a prescriptive manual to conducting research; rather, it serves as a guide, allowing the researcher to borrow different design elements from other methodologies depending on the research context. It also provides guidance on what to avoid in order to ensure the integrity of a research study. This approach offers the opportunity to deconstruct prior knowledge, in order to gain new understanding that can lead to further inquiry and practice changes (Thorne, 2016).

Thorne (2016) explains the importance of theoretical scaffolding, which has two elements,

prior to undertaking a research study. The first element involves conducting a literature review to see what prior information exists on a research problem in order to see if it is worth studying (Thorne, 2016). This gives the researcher an insight into what has been studied on the subject and the conclusions that have been drawn (Thorne, 2016). The second element of theoretical scaffolding involves the researcher taking into account their own knowledge and thinking on the subject, which requires the researcher to situate the study in a disciplinary orientation that “shapes what [the] study is meant to represent in the larger sense of evolving knowledge” (Thorne, 2016 p. 60). Thorne (2016) discusses the importance of locating the researcher’s theoretical allegiances prior to undertaking the study, as this ensures that the study will “contribute to a larger theoretical project of concern to the discipline” (p.71). Though the importance of theory is evident, Thorne warns that a researcher cannot assume that a priori theory can encompass the multiple realities that exist in a study, but rather theory must emerge from the study or “be grounded in the phenomenon” (p.82). As such, interpretive descriptive studies acknowledge both the individual and collective representations of data and seek to understand how these representations came about (Thorne, 2016).

I used the theoretical perspectives of transcultural nursing theory, critical theory and intersectionality to guide and inform all aspects of the research process, and it was my hope that the knowledge generated from the participants in this study could inform clinical practice in the domain of mental health care of immigrant youth.

Sampling

Both purposive and snowballing samplings were utilized in this study. This strategy was used so that the eventual findings would be relevant to the group being studied (Thorne, 2008), which is African immigrant youth. Purposive sampling involves recruiting participants who can

provide information to help better understand the phenomenon that is being studied, as they have some experience of the phenomenon (Thorne, 2016). Snowball sampling is typically used with hard-to-reach populations, and it involves the recruitment of participants through referral from the initial wave of participants (Heckathorn, 2011). I began by recruiting participants through purposive sampling and implemented snowball sampling at the same time until I had an adequate sample size. Thorne (2008) noted that studies using interpretive description are generally conducted on sample sizes between five and thirty participants, but almost any size of sample could be used, depending on the research question. I planned to have a sample size of 7-10 participants, and eventually interviewed eight participants. I chose this range because of my intent to conduct an in-depth exploration of the topic from the point of view of those who are a part of the community of African immigrant youth. Feasibility was also a consideration because of time constraints for a master's thesis project. I determined that the sample size of 8 participants was enough after conducting interviews and no new information was emerging from participants. I was able to recruit three participants through purposive sampling and five through snowball sampling between November 2017 and February 2018.

The United Nations Educational, Scientific and Cultural Organization (UNESCO) categorizes those who are age 15-24 as youth (UNESCO, 2017). However, it is explained that this is a fluid category, rather than fixed. The African Youth Charter considers anyone between the ages of 15 and 35 years as a youth. For the purposes of this research, I employed Arnett's (2000; 2014) developmental category of emerging adulthood, which is youth between the ages of 18 and 25.

Participants were included in the study if they had been born in an African country, were between the ages of 18 and 25, had immigrated to Canada during grade school years and beyond,

and were currently living in Canada. I chose to include these specific criteria to increase the likelihood that they would remember their migration experience. Although one of my participants was born in Saudi Arabia, her family was from Gambia and she moved back to Gambia as a baby and was raised there for five years before moving to Canada at the age of five. For this reason, I chose to include her in the study. Participants were excluded if they were currently hospitalized or receiving services from a mental health facility for a mental health crisis.

Participant Recruitment

Study participants were sought from different avenues such as African students' associations in universities in the Greater Toronto Area (GTA), faith groups, a listserv for women's mental health, and community centres catering to African immigrants. The African Students' Association serves as a community for students that come from various African countries and there are several in universities across the GTA. I have been involved in an organization like this in my undergraduate years and thought it would be a suitable source of recruitment of participants. Members include those who are new immigrants to the country, those who were born in Canada and those who immigrated at a young age. The age of participants in these organizations typically ranges from 15-30. I contacted three universities through email to gain permission to send a recruitment flyer (Appendix 1) to their member base. Two participants were recruited through a university African student association. In addition, faith groups that have a large African immigrant membership as well as community centres were contacted through email. This use of various recruitment strategies was intended to ensure that I had a good mix of participants that were not limited to students. I received permission from two West African churches in the GTA to send out my flyer to their youth member base, and I was

initially able to recruit two participants from this avenue, though one eventually declined to participate. This volunteer who wished to participate but decided not to, posted the flyer on their social media and referred volunteers to me. I was able to recruit three participants through this individual and another two through referrals from another one of the participants.

Participants were encouraged to contact me through email to set up face-to-face interviews according to their convenience. Some participants showed interest in being interviewed by telephone which I had not gotten permission for in my initial research proposal. Therefore, I submitted an amendment to this effect to the Research Ethics Board, which was approved. Participants were offered a \$10 cash gift as a token of appreciation for their time commitment and participation. Three participants declined the \$10 cash gift.

Ethical Considerations

Ethics approval was sought from York University's Office of Research Ethics and the Faculty of Graduate Studies. Informed consent detailing the nature and purpose of the study was obtained from each participant. The consent form included a withdrawal clause stating that participants may withdraw from the study at any time should they choose to. It also included mention of potential benefits or harm to the participants. A copy of the consent form can be found in Appendix 2. Process consent was utilized as the topic of discussion could have led to sensitive areas for some participants. For instance, some questions involved participants sharing how they view their mental health and any mental health challenges they may have experienced. These questions could have potentially caused some distress for the participants, although unintended. Although none of the participants became distressed during the interviews, I had a plan should a participant become upset or emotional. I would have offered to move on to a less sensitive topic or offered the participant the option of taking a break or stopping the interview

completely. I also had readily available a list of mental health services and programs that provide culturally congruent care to the African population. Some participants disclosed current mental health challenges, but they were already seeking help for this. Participants were given a pseudonym to maintain their anonymity and these were used for interview transcripts and the data analysis process. The demographic sheet and consent form are stored in a locked file cabinet that can only be accessed by me, and electronic copies of the transcribed interviews were to be made available to my thesis committee if requested. My field notes as well as hard copies of transcribed interviews have also been kept in a locked file cabinet.

Data Gathering

Semi-structured interviews with participants were the data source for this study. Individual interviews provided subjective knowledge about the phenomenon being studied. In order to understand what aspects of experiences were unique to the individual and what aspects were commonly shared amongst the group, multiple people were interviewed (Thorne, 2008) using an interview guide (Appendix 3). A total of eight participants were interviewed and data collection took place between November 2017 and February 2018. I conducted four face-to-face interviews and four phone interviews. The interviews ranged between 40 minutes to an hour. Prior to the interviews, participants were asked to complete a demographic form (Appendix 4). In order to fully answer my research questions, I asked several open-ended questions on personal and cultural beliefs, the immigrant experience, and mental health practices. I also asked participants about their personal experiences with mental health. Informed by critical theory and the concept of intersectionality, I probed on social challenges experienced by participants after moving to Canada and if these had any impact on their mental health. Interviews were audio-recorded and transcribed after each interview had taken place, as data analysis was done concurrently with the

interviews. This allowed me to revise questions based on the data that emerged and add questions for my follow up interview with participants. I also made notes following each interview as a form of reflective practice. Member checking was done with study participants in order to share with them the synthesis of what I gained from their contributions and to have them reflect on the extent to which it rings true to their experiences (Thorne, 2008). Member checking is the act of returning to study participants in order to share findings with them to determine whether or not they find the interpretations accurate (Streubert & Carpenter, 2011). These member checks served as an opportunity to check the truth value of my interpretations.

Thorne (2016) suggested that the researcher acknowledges and documents the nature of ideas or thoughts that they hold on the phenomenon being studied before they gain entry into the field. Keeping this in mind, I documented the ideas I currently hold about the topic under exploration before interviews were conducted, and I continued doing this throughout the research process. I wrote down any biases or previous thoughts that I had towards the topic at hand. I believe that reflexivity is crucial in this research because of my previous experiences with mental health challenges as well as the insider view I have on the topic. My experiences and insider view served as a source of knowledge on the topic, and documenting these helped me understand the implications of my role in analyzing and interpreting data (Thorne, 2016). I believe that my insider view on the topic helped in shaping the interview questions (Appendix 3) and other probing questions once I got into the interviews. In addition, I expected that writing down my experiences and beliefs held about this topic would allow me to openly and genuinely attend to the participants' views without the undue influence of my presuppositions and assumptions (Finlay, 2002). I came to realize this process was much more difficult than I initially expected. As I conducted interviews, I found that I could relate to some of the experiences of the participants,

because I had either experienced or witnessed something similar. I also found it difficult at times to step out of my role as a nurse and not engage in practice related activity during interviews, such as providing health teaching or offering advice. I had to make notes to remind myself to be mindful of my facial expressions and certain words that I may have used that could be seen as encouraging, approving or disapproving of participants' actions. After each interview, I documented in my reflective journal my thoughts about and reactions to the interview.

Reflexivity serves as an important aspect of qualitative research because it helps researchers understand the implications of their role in data collection, analysis and the discussion of findings (Thorne, 2016).

Data Analysis

When I began the interview process, I also started my data analysis. I transcribed each interview no more than two days after the interview took place and immersed myself in the data. After the first two interviews, additional questions arose that I decided to include in the following interviews, in order to fully describe my findings. These included questions on parenting and its effects on mental health and gendered differences in mental health practices. Streubert and Carpenter (2011) state that researchers must fully immerse themselves in the data and be attuned to what they hear, see and experience in the data in order to construct meaning. Thorne (2016) does not offer specific directions for data analysis, instead, she provides various suggestions for sorting and organizing data. I decided to use Thorne's (2016) suggestion of organizing data into indeterminate or undefined categories to avoid constraining the data into a rigid structure. I had four different categories, labelled A, B, C and D in which I placed similar ideas.

During thematic analysis, I looked for information in the data with similar content or

meanings, and I also looked at how the data differed from one participant to another. I attempted to determine what themes were common amongst the group, and noted what ideas were unique to particular participants. As mentioned earlier, one of the goals of interpretive description is to make sense of relationships and patterns within the phenomenon. I tried to make sense of and establish relationships between the themes and patterns that emerged, with the aid of a concept map. The concept map provided a visual representation of relationships that were starting to take shape and I was able to make linkages between and within categories. Thorne (2008) suggests that the researcher shift back and forth between individual cases and the whole data set for the sake of achieving some clarity on what relationships exist in the data. I did not foresee any two of my participants having the exact same response to the questions asked; rather, I expected some variation in the responses, and that different factors such as age of migration, migration experience, gender, and perceived discrimination would contribute to variation in responses. I explored the similarities and differences that existed amongst the responses in a socio-cultural context, taking into account the factors mentioned above and examining the data from a critical perspective. I also made sure to remember the purpose of the study and my research questions in order to provide a direction for my analysis, while also providing room for new information to emerge that did not fit into my purpose. Thorne (2016) recommends that going back to the purpose can help the researcher “distinguish relevant patterns” in the data, but cautions against holding on to it tightly, so that no new information about the phenomenon arises (p. 165). Thorne (2016) also mentions that researchers may come across “quotable quotes” that contain an important insight as they go through the data (p.163). I created a separate section for these “quotable quotes” so they did not get lost and included them in my findings.

Repeat interviews would have been a way to confirm, clarify or elaborate on the

relationships that I uncovered during this process (Thorne, 2008). However, I was unable to arrange follow up interviews with participants due to geographical challenges and time constraints. Instead, I opted to draft a document highlighting the findings and my interpretation (Appendix 5), which I sent in an email to the participants, in order to verify that my interpretation of their responses held true to them. I received responses from four out of eight of the participants, who agreed with my interpretation of the findings. They also felt their voices and truths were represented in both the findings and in the interpretation.

During the interpretation phase, I often asked myself how I came to a certain conclusion or understanding, and the reflective notes I made after the interviews on evolving connections supported these conclusions. Though the practice of reflexivity helped me in keeping my boundaries, I found that I could not separate myself entirely from the study. It was especially difficult to do so when certain interpretations came to light, and I could relate to it. In my reflective notes, I documented that it may be impossible to truly separate myself from a study in which I hold an insider view.

Rigor and Trustworthiness

Guba and Lincoln's (as cited in Streubert and Carpenter, 2011) criteria to assess the rigor of a study were adopted for this study. Rigor in a qualitative study involves validating findings and ensuring that the study accurately represents participants' experiences (Streubert & Carpenter, 2011). The criteria identified by Guba and Lincoln are credibility, transferability, dependability, and confirmability. Prolonged engagement with the participants prior to conducting the study can help the researcher gain an understanding of the phenomenon under study, which in turn ensures credibility (Shenton, 2004). Shenton (2004) suggests that this can be done with the development of an early relationship with the participants in order to foster

familiarity and trust. I got in touch with each participant before the interviews were conducted to establish a prior relationship. This was done either by text message or by email. However, Shenton (2004) cautions against getting too close as this can influence the researcher's judgement and lead to researcher bias. Credibility was also established by the carefully documented and explicit use of Thorne's interpretive description methodology, as well as member checks. Member checks bolster a study's credibility by verifying the accuracy of the emerging theories and inferences (Shenton, 2004).

Although the findings of my study are specific to a small group of people, I have provided enough descriptive data to establish transferability to a similar population. In particular, information has been provided on the number of participants, inclusion and exclusion criteria, and data collection methods. I also included the number of data collection sessions, and the time frame in which the data were collected.

Dependability has been ensured through the provision of a detailed description of my research design, participant recruitment, data collection methods and use of a reflective journal. , This description should enable another researcher to recreate the study and gain similar, if not the same results (Shenton, 2004).

Lastly, to establish confirmability, member checks were used to verify with the participants that the interpretation of the data is relatable, and not an invention of the researcher (myself). I also had several meetings with my supervisor to review, discuss and confirm my findings as they emerged during the study. As stated previously, reflexivity has been used to limit the influence of my biases and previous thoughts on the data analysis and interpretation process.

Chapter Four: Findings

Demographic Information

I interviewed eight participants; two participants identified as male and six identified as female. The ages of the participants ranged from 19 to 25 years, with the mean age being 22.5. Four of the participants identified as Nigerian, but one of them was born and raised in South Africa. The rest of the participants were from Zambia, Gambia, Ghana and Ethiopia. The participant from Gambia was born in Saudi Arabia to Gambian parents but moved to Gambia as a baby and was raised there until she came to Canada. All the participants identified as Black, with their ethnicity either described as African, their nationality, or their tribal group. All participants spoke English as their primary language, with one participant speaking both English and Amharic as primary languages. They arrived in Canada at different ages. Two participants arrived between the ages of five and 10, five participants arrived between the ages of 11 and 15, and one participant arrived at the age of 18, with the average age of arrival being 12. Three participants had completed a Bachelor's degree, and the other five had completed some college or university. A demographic chart is included below in Table 1.

Participants were asked to rate their family financial stability when they arrived on a scale of 0-10, where 0 was none at all, and 10 was the most possible. One participant rated financial stability as 4, one participant rated at 5, three participants rated at 6, one rated at 7 and two at 10. This is shown in Table 2.

I will first present a descriptive summary of the findings from the data, and in the next chapter, I will present an interpretation of the data, focusing on emergent themes. Participants names have been changed to protect their identities. The next section is organized according to the research questions that I sought to answer with this study.

Table 1. *Demographic Profile of Participants*

	<u>n= 8</u>	
	<u>n</u>	<u>%</u>
Country of Origin		
Zambia	1	12.5
Gambia ¹	1	12.5
Nigeria ²	4	50
Ethiopia	1	12.5
Ghana	1	12.5
<u>Gender</u>		
Male	2	25
Female	6	75
<u>Current Age</u>		
18-21	3	37.5
22-25	5	62.5
<u>Age at Arrival</u>		
5-10	2	25
11-15	5	62.5
15-20	1	12.5
¹ Born in Saudi Arabia and raised in Gambia		
² For one participant, parents Nigerian; born and raised in South Africa		

Table 2. *Rated Family Financial Stability*

Financial Stability Range	<u>n= 8</u>	
	<u>n</u>	<u>%</u>
0-5	2	25
6-10	6	75

Attitudes Towards Mental Health

All participants currently held a positive attitude toward mental health. For example, Thandi (age 24) related mental health to coping, stating “[it means to] cope and maintain a certain level of functioning, despite whatever troubles may come their way”. She also advocated for awareness, saying, “I think honestly we need to have more awareness in the African community about mental health, mental illness and what encompasses mental health”. Miriam’s (age 21) view on mental health involved self-care. She said, “[it is] taking care of yourself. Like not your outer, but your inner self. Like having—giving yourself time to be you”. Bunmi (age 24) stated that mental health is “very important to me. It means kind of just being open about how you feel”. Two participants, including Sarah (age 19), acknowledged that their perception of mental health had previously been negative. Sarah said, “when I was younger, I’m not going to lie, I myself didn’t like the idea of mental illness either. Because I wasn’t exposed to it. And with the positions around me, I perceived it in a negative way.” But, after receiving some education or witnessing someone they knew experience mental health challenges, they were more open to discussing the topic. Faith stated that she grew up in a culture where, “mental health is basically a taboo...and it’s non-existent”. She also mentioned that,

I was very much a part of that culture. I never believed it was real, until I've experienced and met with friends and coworkers and just people that I socialize with that are dealing with these mental health issues. So, I guess I would say I was part of the problem. (Faith, age 24)

Sarah's views changed through exposure. She stated,

My school had mandatory community service. So, through that, I was exposed to not only people who were mentally ill, but who are physically disabled, and I got to spend time with them. And I really liked that it opened my eyes. So, I did grow up in a closed-minded space but as I was able to have the experiences, I was able to branch away from that. (Sarah, 19)

All participants described being raised in a culture that denied the existence of mental health issues. For example, when asked how mental health is viewed in her culture, Bunmi stated,

I don't think there's anything like that in my culture to be honest. As I said earlier, like for me, umm...on Yorubaland, I feel like there's not—like as long as you're like—especially as a Christian too, as long as you have Jesus and you know, you're ok. There's no real view of mental health. It's kind of like, why are you complaining about situations when other people have it worse than you...So, yeah there is no mental health. (Bunmi, 24)

Beliefs About Mental Health

When asked to describe what mental health meant to them and what they would describe as “mentally healthy,” participants mostly related it to the mind and to one's psyche. Some phrases and words used to describe mental health included: “wellness as it relates to your psyche”, “illness of the mind”, “state of being”, “mature in their mental and emotional thinking”, “being open about how you feel”, “mental stability”, “you're able to face or overcome life's

challenges”, “balance”, and “taking care of yourself”.

The general belief was that being mentally healthy involved being able to deal with challenges that arise in life, being able to cope effectively while maintaining a certain level of functioning, and being able to achieve goals and plans. One participant related mental health to other aspects of health, stating, “it can trickle down to affect other parts of your health; emotional, spiritual, physical as well” (Thandi, age 24). Another participant described mental health in relation to mental illness and defined someone who is mentally healthy as “anybody who is free from any of the mental illness...doesn’t suffer from any mental anxiety or depression or psychosis or any of that” (Faith, age 24). Some participants believed that mental health was related to a sense of self and putting oneself first. Miriam stated “...maybe taking care of yourself. Like not your outer but your inner self, like having time...giving yourself time to be you...Someone who knows when to give themselves time to relax”. Felicia ascribed valuing oneself and having strength to having mental health. She stated, “they just have a lot of respect for themselves...they put themselves first...I think the number one cause of mental illness is actually self-worth...I think it’s just like whether you’re strong enough to handle things that are thrown at you”. Participants identified various causes of mental illness, including stress, difficult times, genetics, physiological issues, drugs and medication side effects, society and social life, school, parenting, and trauma in childhood. Key aspects of beliefs about mental health that were mentioned by all the participants are expanded upon below and shown in Figure 1.

Stigma. All participants acknowledged that amongst African people there was a significant amount of stigma attached to mental illness. Participants used various phrases to describe how mental health is viewed in their community, including “taboo and non-existent”; “a hefty topic”; “highly stigmatized”; “denied”; and “hidden”. Thandi described a culture in which someone

experiencing mental health challenges isn't taken particularly seriously.

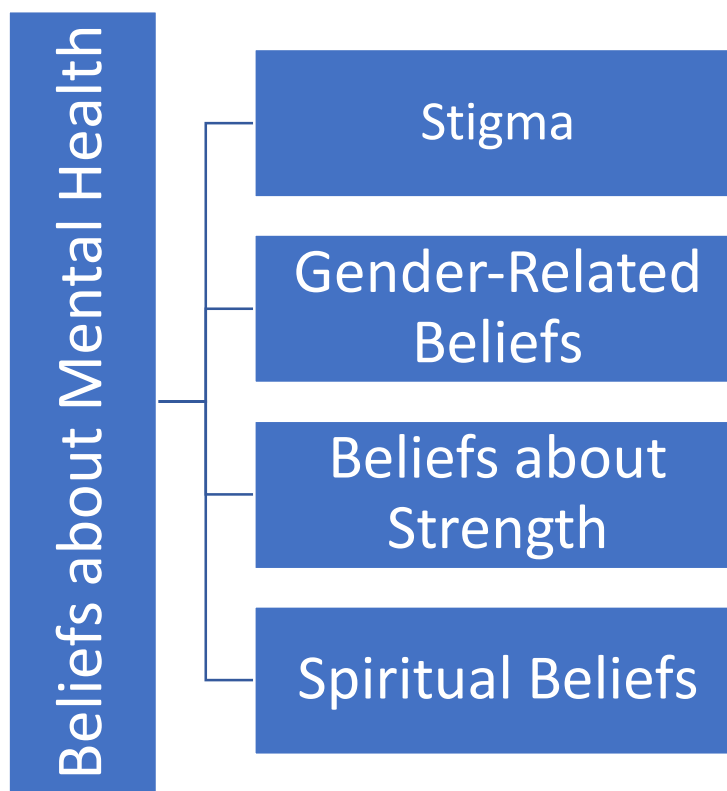


Figure 1. Key aspects of participants' beliefs about mental health

She also described how people with mental illness are viewed by others. She stated,

I think it's the generic 'oh, they're crazy' or something you know? It's not really seen as an actual illness, like they have a cold or they broke their leg or something like that. It's seen as like you know the crazy stereotype. Or something that happens to White people...Like back home, the crazy person is the person with like free form dreadlocks and they're naked selling plastic bottles on the street. Like that's what crazy is. (Thandi, age 24)

Faith echoed this sentiment, saying she came from a culture in which a physical manifestation of mental illness was needed before it would be acknowledged that one was mentally ill. She said, "mental health, the only person in our culture we view who has mental

health [issues] I guess is somebody who, like ‘mad woman’. Somebody who is running around, physically insane or psychotic. That’s all”. Otherwise, it’s simply viewed as “it’s in your head”. Sarah described an experience in which she witnessed people reacting negatively to an artistic depiction of mental health/illness:

Well, mental health is really looked down upon in Ethiopian culture. It’s really stigmatized. And umm...I remember going...my mom is an artist and I was going to an exhibition. She shared an area with another artist, and his paintings were done on mental illness. And I remember seeing the reaction of the people because he had painted a portrait of one side with a normal face, and another side with the person’s face really distorted. And it was an example of bipolar disorder. I remember people being so disgusted. Because they didn’t like the idea. They were like “what is this, it looks like skank!”, you know mental illness. They were just so against the idea. (Sarah, age 19)

There also seemed to be a strong culture of denial and dismissal due to the stigma, as described by some participants. Participants stated that mental health challenges are not seen as “a big deal”, experiences are dismissed, and that people could be seen as complainers if they were to discuss their mental health. One participant also described the stigma of help seeking, stating,

When you talk about African kids who are growing up in a society of how mental illness is just perceived negatively, and they’re flown over to a new place, mental illness may or may not affect them. Usually it affects about 1 in 4 people, but it’s extremely embarrassing and it hurts one’s pride to go to counsellors. It took me forever, you know? I was actually forced. (Sarah, age 19)

Thandi suggested that this leads to a lack of visibility of those living with mental illness. She

said, “the reality is that it happens, and it happens to a lot more people that we’re willing to admit, than we know, but it’s not seen. And I think that’s why it’s harder to talk about. We can easily hide it”.

Gender-related beliefs. Both male participants interviewed readily related their mental health to the completion or achievement of goals that they had set out for themselves. David stated, “my mental health revolves around me meeting my goals. I don’t really ever focus around how I’m feeling. My feelings are dependent on goals. So, if I’m meeting those goals, I’m feeling great. If I’m not meeting those goals, I’m not feeling great” (David, age 25). Dami also gave a similar response. He said, “For me, I’d say that mental health is related to some sort of goal or plan. Or sort of an idea of what I should be doing or looking forward to. That’s how I see it” (Dami, age 20). The two male participants also acknowledged that in their experience, men generally were expected to keep a level head and be emotionally stable while dealing with the challenges of life. David stated that, “from a guy’s perspective, you have to keep a level head when you’re outside. You can break down or whatever when you’re inside. That’s personally how I see it”.

Five of the participants stated that men were not really expected to speak out much about their feelings. Felicia mentioned that she had always expected men to be strong and to never cry or open up too much about things. Sarah described an experience in which a Nigerian male youth told her that he could not confide in others because he did not want to put his problems on others, which was met with agreement from another African male youth that was present for the conversation. Dami stated that he noticed that amongst his male friends, conversations can be somewhat superficial. David also mentioned that he has noticed that a lot of guys don’t discuss emotions, and conversations are general. Several participants stated that they believed that it was

much easier for women to speak about their feelings.

Beliefs about strength. Three participants noted that being mentally healthy meant that they had to be strong no matter the situation. In addition, two other participants stated that they believed they were not meant to complain about what they go through because others have it worse than they do, or because they were built to be strong and overcome tough times. Felicia noted that because of this mentality, and the influence of religion, perhaps Nigerians cannot truly be suicidal:

I always think that Nigerians are always strong and hustlers. So, because of that mentality, I believe that generally, if you feel that anything is going wrong with you there's always someone else that's suffering worse. So generally, I felt like the consensus is that as Nigerians, we're all ok. We're never doing so bad that we're like suicidal, sort of thing.
(Felicia, 24)

David stated that he believed the experiences that Black people, especially Black men, go through builds them to be strong and leaves no room for "weakness". He stated that he had to build a wall in order to not let emotions affect him, especially in the workplace. He mentioned working twice as hard to be recognized, dealing with potentially offensive situations at work and other societal experiences, and stated,

How do I think it can affect mental health? It basically asks the question, "Why should you be weak?" There's no reason for you to be weak. If certain people have gone through the struggle or way more struggle than you've gone through, and you as a Black person want to be weak? Because you went through half of the struggle the other person is going through. And if you know, ancestors or whatever went through harder struggles especially in North America, you have people that went through slavery, and then you want to

complain that your struggles of not being able to make your rent money is a lot? I mean, it asks that question.

Spiritual beliefs. Several participants noted that religion was a strong influence on both their culture and on their perception of mental health. Dami stated,

A lot of things are attributed to spiritual forces. So, [it's] the one thing, I don't fully like agree with, but it sort of paints things--it's always seen as the first case for anything. So, I feel like it sort of leads people to not seek medical help initially.

Sarah acknowledged similar sentiments, stating that as a Christian, she has noticed that “there’s the belief that if someone is mentally ill and something happens to them, maybe the devil has something to do with it”. She also stated that “there’s this idea that if you pray everything is gonna be ok.” Felicia believed that the influence of religion was the reason for the sense of hope being strong in Nigerians and was possibly related to a lack of suicidality. She stated, “I’ll also say that because of religion being so strong, I feel like Nigerians always have hope as well. I don’t think that even if people are going through some things, as Nigerians, that anybody is truly suicidal”. Bunmi noted that as a Christian, there was the belief that one wasn’t supposed to complain about situations they were experiencing. She stated,

Especially as a Christian, too, as long as you have Jesus and you know, you’re ok, there’s no real view of mental health. It’s kind of like, why are you complaining about situations when other people have it worse than you. So, there’s no room for how you’re feeling.

(Bunmi, 24)

Origin of Attitudes and Beliefs

Participants attributed the origins of their attitudes toward and beliefs about mental health to different sources. These included personal experience, parenting, observation of cultural

norms, and a lack of education or awareness as seen in Figure 2.

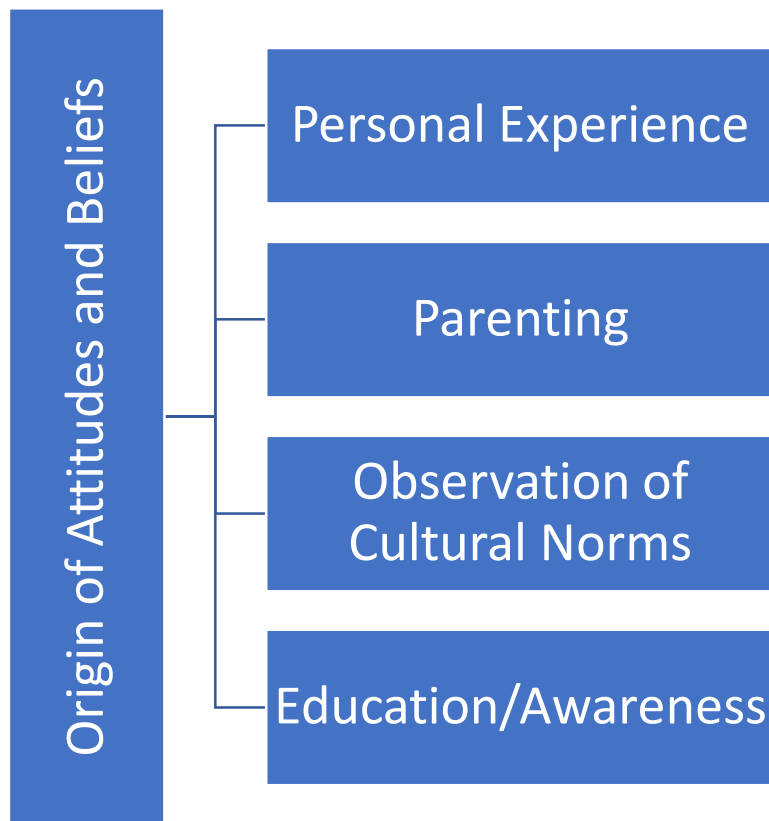


Figure 2. Origin of Participants' Attitudes and Beliefs towards Mental Health

Personal experience. Several participants had dealt with a personal experience with a mental health challenge or had been diagnosed with mental illness, or witnessed a family member's mental health challenges. Miriam described her experience with depression and anxiety, and how she realized she was dealing with a crisis. She stated:

There was one point last year during the school year where I literally could not concentrate. I would wait till 12 am to start essays. Like I could not concentrate so I finally went to my sister crying like there's something wrong with me. I remember in my first year I sent her this long text about how I was depressed and I was sad and then she called me and so like she'd just been helping me. So, then we went to the doctor and we did the little thing [diagnostic testing] and she's like, oh yeah, I have depression and anxiety...

David described how he had dealt with anxiety that was related to parental pressure growing up and also coming to the realization that his mother might have also gone through some mental health challenges. He said,

I know she was also experiencing some things at the time in which I used to see her whole behavior and personality a lot different from the person I knew her to be. And I seen the consequences of what happened back then and now. And I've seen the fact that the mental health topic should have been brought up at the time. (David, 25)

Thandi also acknowledged that her beliefs stem from her personal experiences: "I went through depression. So obviously, when you're experiencing something yourself, then you have a firsthand view of what it is also". Faith disclosed that she had bouts of anxiety and panic attacks, and Sarah stated that she had also experienced depression that led to her seeking counselling. Dami stated that he had once witnessed his aunt have a breakdown, and the response was a "spiritual one". He described his experience as follows:

So, I remember like, there was a time in my childhood where I was 12 or 11. My aunt pretty much had like, she had a mental breakdown, she essentially just lost it for a few moments. She just started walking. She almost walked out of the house naked. She was seeing her dead grandma or something. And it was...it was very freaky, but after that happened, I don't think she got counselling or anything. It was just like they prayed for her and stuff, and that was pretty much it. (Dami, 20)

Parenting. Several of the participants stated that some their beliefs on speaking out about mental health arises from parenting. Two participants mentioned that parents "sweep mental health issues under the rug", and the majority of participants mentioned that some parents go along with a culture that doesn't necessarily discuss mental health openly. Others mentioned that

their parents had been encouraging when it came to speaking about mental health. On the other hand, Faith said,

I just wish our parents or our culture was more accepting of this issue because it does affect more of us than they realize. And the more they push it aside, the more harmful it is to us...It's just hush hush, 'don't talk about it, keep it moving'. I won't say it's their fault, because it's society and the way they grew up. (Faith, 23)

Miriam said, "I think for me I got lucky because my parents--I think my parents are more open and understanding about mental health". Felicia said, "I do know, personally in my family, it's something that we're very much aware of. And something that we always try to speak about if we can. So, it's not something we consider shameful or something like that". Dami said, "if it's my family specifically, they're not very explicit with anything. So, I'd say that we've not-- from what I've experienced, there's no particular, direct, like it's not something that's like, many things, it's not something that's really tackled directly". Sarah said,

When I went back home and kind of opened up to my parents, they understood me, but I could still see a little bit of worry in the sense that, "is she just being dramatic? Let's hope it's not a real thing". (Sarah, 19)

Observation of cultural norms. Some participants described how observation of cultural norms in their respective communities has had a hand in shaping their own views and beliefs of mental health. Thandi said,

Especially in the African community, we just don't talk. If it's like outside your house when you're jacked [i.e., messed up], like if someone's going through some real stuff you might not even know it right? So yeah, if something's so far removed from you it becomes harder to like even grasp that that's what it could be. (Thandi, 24)

Dami said his cultural background has “definitely given me a very spiritual definition of mental health in a way”. David stated, “It’s not really something that’s put out in the public in my culture. But it’s something that they try to deal with internally. So, I think there’s a stigma to the whole mental health situation”. Bunmi said,

Like feelings are not usually really...like especially from an African background...you’re not really supposed to complain about things. Like at least you’re alive, like that’s what everyone says, “at least you’re alive, and like you’re ok. You’re eating”. And I feel like mental health for me is just more of being able to speak freely about how you’re feeling at that moment. (Bunmi, 24)

Felicia stated that for some families in Nigeria, mental health challenges are questioned, and people are supposed to be strong no matter what. Miriam stated that there was a sense of secrecy amongst Gambians that makes people keep information to themselves. She said, “I think it’s really just you’re not able to really express how you’re feeling to anyone else outside of your group and I think that has to do with a lot of Gambians because Gambians are very secretive”.

Education/Awareness. For some participants, receiving education increased awareness on mental health and made them more receptive to opening up and speaking about the topic. The majority of the participants also cited the lack of education and awareness in their communities as the origin for the stigma that exists. Sarah described an experience of community service that found her interacting with some people living with mental illness and how that opened her eyes. Dami credited his current knowledge of mental health to his move to Canada. He stated, “I’d say like a lot of education that I received here. Like people would say that the culture is a lot more direct; good things. So, I’d say there’s a lot more direct recommendations on how to deal with it”. Faith stated that her perceptions on mental health changed from negative to positive when

she received more education about it. She also stated that she was able to open up to her father, who is a nurse, about her mental health challenges and he was very supportive, because of his knowledge on mental health. On the lack of education, Sarah stated that this could be the reason it's not talked about at all, and perhaps there's a lack of education because it's so uncommon.

When speaking about parents, Miriam stated that, "they don't really talk about it and I think they know what it is but they don't know what it is". When describing her experiences discussing mental health in her community, Thandi stated,

I think honestly, we need to have more awareness in the African community about mental health, mental illness, and what encompasses mental health.... because the reality is that it happens, and it happens to a lot more people than we're willing to admit we know, but it's not seen. And I think that's why it's harder to talk about. We can easily hide it. (Thandi)

Influence of Beliefs on Mental Health Practices

Participants stated that several factors influenced their beliefs on their mental health practices. These included self-stigma and denial, lack of trust, dismissal of feelings and the fear of speaking up (Figure 3).

Self-stigma and denial. Some participants mentioned growing up in a culture of denial which affected the way they were able to come to terms with their mental health challenges. For Thandi, the lack of visibility of those experiencing mental health challenges in her African community added to her denial. She stated:

Because there's just certain things that feel so far way, like far removed from you that you don't really think that it could happen to you...It just never crosses your mind that maybe this could happen. Because you don't really see many people around you going through-- or at least you don't hear about it. Especially in the African community, we just don't

talk...So yeah, if something's so far removed from you it becomes harder to like even

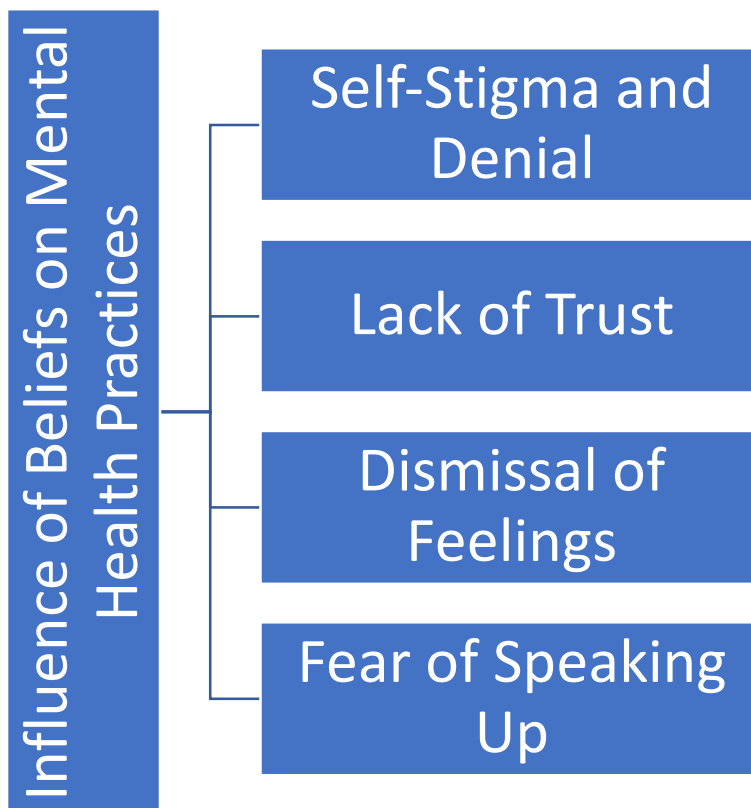


Figure 3. Influence of Participants' Beliefs on their Mental Health Practices

grasp that that's what it could be. You're looking at other stuff and you're like oh maybe it's this, maybe it's that. But you're like no there's no way that's me. No, I can't you know? I have a good life, this and that. But then like you realize and then it's hard to like admit you know? It's hard to admit... (Thandi)

Felicia also alluded to self-stigma and denial being the reason she did not fully acknowledge her feelings. She stated,

The reason I didn't get over my mental health issues for a long time is that I felt like the way I was feeling was not valid. Or that I was making it out to be a big deal when it wasn't. So, like when you feel like it's hurting you, but there are people who are hurting way worse. So, you feel like it shouldn't be that bad you know? And you're like you need

to forget about it, but you never really forget about it. (Felicia, 24)

Sarah spoke about how internalizing the stigma of mental health and help seeking led her to cancelling multiple appointments with a counsellor. She said,

I had wanted to go to a counsellor, but I was so embarrassed. And that was a part of how I grew up. Because counsellors were frowned upon. And then I was like, “I’m not mentally ill”. And I was kind of like in denial. So, I didn’t want to go to a counsellor. So, I made several appointments and ended up cancelling them. (Sarah, 19)

Some participants had discussed how their beliefs about mental health had led them to the practice of not speaking about it. This was due to several reasons, such as a lack of trust, the fear of their feelings being dismissed and a fear of backlash from those they were speaking to.

Lack of trust. David and Miriam both spoke about how the lack of trust led them to keeping their feelings either to themselves or only within family. Miriam stated,

You talk about it only to your family, you don’t go off to other Gambians about it, because that’s how rumors spread. So, it’s just like keep it in the family, don’t tell anyone. My mom’s biggest line is “don’t trust anyone”. That’s like her most famous line, so I think it’s really just you’re not able to really express how you’re feeling to anyone else outside of your group, and I think that had to do with a lot of Gambians because Gambians are very secretive. (Miriam, 21)

David also explained why it is difficult to speak up. He stated,

In terms of things that have changed my perception or my outlook on mental health, it’s the fact that I’ve had discussions with people in which, and it goes different ways. I’ve had discussions in which people tell me, “ok, open up,” or whatever. And I tell them. And I seen those people stab me in the back. So, like, why should I be talking about mental health

to these people? I'd rather keep it to myself and share with, I don't know, a close friend that is at least distant so I don't have to see them all the time. At least I know like they wouldn't be as disappointing, because it's only now and then that I talk to that person.

(David, 25)

Dismissal of feelings. The practice of not speaking up about one's mental health can also be influenced by the belief that one's feelings and experiences can be easily dismissed. Thandi spoke about this, saying,

Because I've had those situations where I'll say I'm going through this thing and someone's said to me "oh, that's only White people going through that". And like it really took a lot of courage for me to open my mouth and admit to you that this is what I'm going through and then you're gonna like dismiss my experience with that foolish comment?

(Thandi, 24)

Also, David said,

So, I think sometimes people want to talk, but sometimes they're afraid as to how other people will receive it. Because I may talk to you as a person and expect you to receive it a certain way. And you just don't see it as a big deal. So, I think that also plays a huge factor into it. Because Africans, Nigerians have a lot of dignity and pride. So, the last thing you want is you telling someone about how you're feeling and your emotions and they say "oh it's not a big deal. Cut it off. I don't know why you're stressing about that". So, I think that plays into the scenario as to why people don't necessarily talk about it. (David, 25)

Sarah mentioned that when she spoke to her parents about her symptoms of depression, she had the fear that they believed she was being overly dramatic. Faith stated that there was the tendency of parents to push mental health issues under the rug or not approve of speaking about

it.

Fear of speaking up. Bunmi discussed how the practice of speaking up was discouraged in her experience. She said,

Talking is...yeah, no definitely not encouraged. Talking is always a backlash. It's either they don't listen or it's like, "why did I even talk"? so, it's definitely not encouraged, usually because...especially if you're younger and you're talking to older people right. It's like you're being rude or you don't know what you're talking about. (Bunmi, 24)

For some participants who had developed the practice of not speaking to outsiders about their mental health, it became easier for them to open up to their immediate family members. Miriam explained that her sister was the first person she was able to open up to about her depression and how that had helped her. Sarah was able to talk to her parents about her depression as well, despite the fear of dismissal. Faith stated that although she did not expect her father to grasp what was going on with her, she was able to speak to him about what she was experiencing. Felicia mentioned that she has developed the practice of confiding in her family only. Thandi also said that her mother was the first person she called when she realized that she may have depression. On the other hand, Dami stated that the practice of speaking to immediate family members had not been encouraged and that he would rather speak to other people, such as a pastor or a doctor.

Practices African Immigrant Youth Follow to Protect their Mental Health

All participants had different practices they followed in order to protect their mental health. The practices ranged from self-care, to seeking help, removing stressors, increased self-awareness and other practices shown in Figure 4.

Self-care. Dami and David both mentioned living a healthy lifestyle by eating properly,

getting enough sleep and working out. Dami also mentioned taking walks to help him whenever



Figure 4. Practices African Immigrant Youth Follow to Protect their Mental Health

he was feeling stressed out. Faith mentioned practicing deep breathing and distracting herself from stressors as a way of coping. Felicia stated that changing simple things in youths' lives opens up one's mind and makes them not feel trapped in what they're feeling at that point.

Speaking up and seeking help. Despite the fact that seeking help and talking about mental health was looked down upon, many of the participants mentioned that seeking help either from friends and family or from professionals was how they protected their mental health. Bunmi stated that her friends helped her out when she went through a rough time. She said, "having a good support system. Like, I had my friends with me, so I was able to tell them what was happening, they really, like, they really helped me with that situation and just really made me

feel at ease”. David suggested that finding a mentor can help one’s mental health because “it’s good to have someone you can lean on”. He also suggested that because men don’t discuss feelings much, perhaps finding female friends that one can speak to can help. He stated, “you should have one or two people in your circle. That if you don’t have that guy, then have one or two lady friends, I don’t know, that you can talk to, you can really get down and real with”.

Miriam stated that she talks to her friends whenever she’s overwhelmed. Some participants also advocated for reaching out to health care professionals if needed. Although Faith stated she has not yet spoken to a mental health professional in an official sense, she is currently seeking out a therapist. She also reached out to her father who is a nurse when she was going through a difficult time. Thandi stated that she currently has a therapist, though she wishes her therapist was of African descent. She stated, “though I have a therapist, I don’t see her too often now. I kind of wish I had a fellow African or at least a Black person. Because the level of understanding is sort of different”. Sarah has also sought out counselling, and though she received hers at a time of emergency, she said that, “if I were to go now, with like more specific things, then I would try to look for more, like African descent counsellors”. Bunmi stated that seeking out counsellors who are open minded and diverse can be helpful, but these counsellors don’t necessarily have to be African.

Removing stressors. Faith acknowledged that removing herself from “the stressors and triggers” that affect her mental health has helped her maintain stability. Bunmi stated that because her mental health challenges stemmed from family issues, she had to distance herself from them. She said, “sometimes you just have to either cut them off, or you just have to create a space, so that they don’t enter that, that space”. Dami stated that because he gets very stressed out and irritable after writing exams, he has to put it behind him as soon as he writes the exam in

order not to let it affect him too much.

Meeting goals. Felicia mentioned that she had problems following through on plans, which got her down at times. She stated that in order to help her follow through with plans, she would use others to keep her accountable. David said his anxiety was brought on by parental expectations and pressure, academic expectations and his own personal expectations of himself. In order to cope with this, he said that,

The way to deal with it is to meet the goals. It was to make sure I measured up, right? And like, honestly, to put it into the perspective of mental health, I kinda seen it as a way like it's made the strong type of character that I am right now...I feel like it's molded me. It's brought out a certain sense of maturity. (David, 25)

Self-awareness. Four participants mentioned that being aware of what they were going through and acknowledging it can help protect one's mental health. Thandi stated that though she can still be in denial some days about her symptoms, she has to be honest with herself in order to recognize what's happening. She said,

For me, it's kind of about self-talk, just like acknowledging and encouraging myself. Just kind of pushing myself as well as to know that something is happening, you can't ignore it. And that's actually something that I wanna do a better job at, because I find I still can be in denial sometimes and I'm like "no, I'm fine, I'm just tired", and then it's been like two weeks and I haven't done anything. And I've just been sleeping. So, it's just like being honest with myself to recognize this is what's happening. (Thandi, 24)

Felicia stated that until she was able to place value on what she was feeling, she was unable to get over her mental health challenges. She encouraged others not to compare their problems with anybody else's and to never invalidate their feelings. Bunmi also had similar sentiments, stating

that it's important for one to express themselves and to always be true to their feelings.

Finding community. Several participants mentioned that finding a community of like-minded people can help foster good mental health. Miriam stated that she was lucky to find a community of Gambians in Toronto, who she grew up with. She was able to relate to this group and feel comfortable around them, so when she needs to talk, she simply goes to her friends in that community. Dami also mentioned that meeting up with friends regularly can help someone who is going through a mental health crisis. He suggested that being around people and interacting with others helps one not stay “too long in [their] own head”. He cautioned against isolating oneself and going a long time without speaking to a friend. He mentioned that when he lost his job, this helped ground him and made him not feel as bad about the issue. Bunmi also stated something similar. She said that getting involved in activities with like-minded people can help to promote one's mental health. She stated that these people don't necessarily have to be African, but people who one has some things in common with because when you're both able to understand each other, “you don't have to second guess yourself around them”.

Gendered practices. Some of the participants noted that their expectations of mental health practices amongst men were generally to keep things in. They believed that men were more resistant to the idea of speaking up about mental health issues than women. Sarah spoke about how she found out about a difficult situation her brother had gone through years after it occurred. She stated,

I had just spoken to my brother some months ago, and I literally did not know that he was going through anything. Until he had finally opened up to me years and years later. Only when I kind of forced him to. And it was in conversation that he had brought it up. (Sarah, 19)

Thandi also stated that she has had to continually tell her younger brother to speak to her about whatever he's going through. She mentioned that being a Black male in a predominantly White neighborhood may have led him to have certain experiences that he may not be able to articulate properly, so she has had to create an environment of openness in their relationship for those conversations to take place. She stated,

I have a younger brother too and I'm really protective over him so, like I'll be like, "you better talk to me, what's going on? You can always talk to me". So, it's like at least having that environment with me where he feels like ok, whatever is going on, because he's gonna have his own experiences too, and he might not know how to articulate it. He's in a unique position. He's a Black male in a predominantly White neighborhood where we live at. He doesn't have like a close Black friend, so there's certain experiences that he's not able to share with those friends, right. So, at least being able to talk to him and tell him "this happens, that happens, this is life. If anything, whenever, talk to me". I think we need to foster that kind of environment. (Thandi, 24)

For both male participants, their mental health practices involved maintaining stability and balance. Dami mentioned that not getting too "frazzled" or rattled by the little things. David mentioned the importance of keeping a level head when outside; one is able to break down from time to time, but only when inside. Both men related mental health to meeting goals and expectations. They mentioned that the outcome of this is a healthy lifestyle. David mentioned that as he tries to balance his goals, he runs out of steam sometimes, and has to take the time to re-energize himself by healthy living. Dami echoed these sentiments, saying that he also lives a healthy lifestyle by working out, sleeping properly, and watching what he eats in order to accomplish his goals.

Factors Influencing the Mental Health of African Immigrant Youth

When asked about factors that affected their mental health, all participants mentioned several things that have affected their mental health in both a positive and negative way. These factors are illustrated in Figure 5 and will be discussed below.

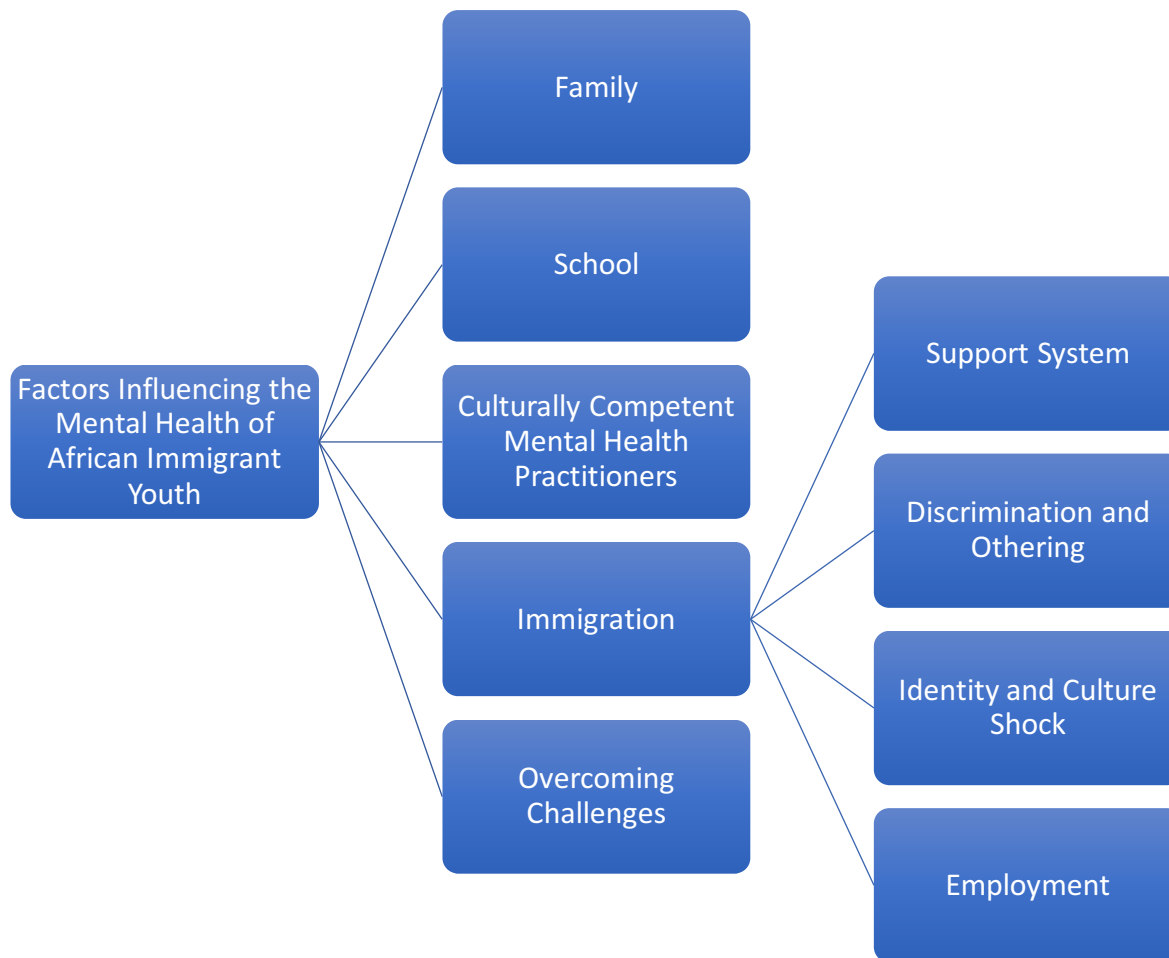


Figure 5. Factors Influencing the Mental Health of African Immigrant Youth

Family. Several participants spoke in-depth about how family can have a both a positive and negative effect on one's mental health. Bunmi discussed how she entered a depression because of some experiences she had with certain family members. She said,

Every time I was around certain people, they'd just kind of like put me down. Or they always compared me with other people. You know when you enter somewhere, and it's

just negative space and it definitely affected the way I viewed myself. And just affected like everything around me--I got to a point where I was very frustrated, very sad, very depressed, and like not in a good state at all. And it just affected my school, my relationships, just everything.

She also mentioned that strict or authoritative parenting can affect one's mental health because it hinders one's ability to speak freely with their parents. She stated,

Especially in Nigerian culture, a lot of parents, they don't have that relationship where you can just talk freely, like be yourself basically. You kind of have a façade, or you're the good kid and you always have to be that child, so I definitely think that parenting affects mental health.

Thandi offered similar thoughts, stating that,

...even in other families like I feel like certain African parents are just like, you're the general of the house and you just give orders and that's it. That's not really conducive to like a good place for someone to maintain good mental health...Because I know for a fact that a lot of people experience traumas from their parents. It's so damaging and hurtful and it's crazy how visible the difference can be.

Thandi's knowledge of this came from her mother's experiences with Thandi's grandmother and from witnessing others as well. She mentioned that because of this, her relationship with her mother has had to change recently, in order to break down a barrier and become closer. Being able to have that closeness and the openness to talk gave her the chance to open up to her mother when she entered a depression.

David spoke about having to take on the role of a father figure because when he moved to Canada, his father stayed back in Nigeria in order to work and send money for the family. The

parental pressure led to him developing anxiety at that time. On this experience, David stated,

I didn't come to this country with my father. Well I had my father with me, he wasn't always with me, you know. He was working back in Nigeria to pay bills to send money to the family. So, in terms of-- there's another aspect there. The emotional stability. I'm dealing with emotions of coming into a new school. I'm also dealing with my mother's emotions. She was pregnant at the time. She gave birth to a new kid, my brother. And like she's adjusting to a new country. I also had to deal with being a somewhat fatherly figure, you know, while also balancing school and everything...often times, sometimes, it's a challenge between balancing school and doing household chores so I can at least make my mother happy, knowing the fact that she didn't really have much support in a new country...so although I had anxiety at the time, and it was being caused by, it was triggered by pressure, intense pressure and expectations, academic expectations, and even expectations I have in terms of like being able to help out with my mom and my siblings.

Sarah believed that some mental health challenges can arise from childhood and the way a person is raised. She stated,

Like for example, someone grew up not being able to like deal with situations because their parents didn't let them have that opportunity. Or maybe their parents are people that freak out at the small things, so that maybe they would also become too sensitive and not be able to deal with it. I think that like a lot of issues that originate from childhood do grow and it becomes like a proper mental health issue.

Faith described a positive relationship with her father, which like Thandi and her mother, had to evolve over the years. She mentioned that they had never gotten along, but when her father started seeing her as an adult, and when they were able to come together and have agreements

and good conversations, their relationship grew tremendously. They were able to form a closeness that allowed her to reach out to him when she was struggling with her mental health.

School. School was a stressor for some of the participants. Dami noted that whenever he wrote exams, he would typically get stressed out, irritable, and uneasy, and he noticed that he would have difficulty sleeping. He stated that although he was a good student, he did not test well, so this added to his stress. Miriam also stated that school was the number one stressor; although things were still tough when out of school, it was much harder when she was in school. David also stated that academic expectations and pressure contributed to his anxiety. Sarah stated that transitioning into university was particularly difficult for her emotionally, and she experienced a lot of difficulties.

Culturally competent mental health practitioners. Some participants spoke about how counsellors or therapists they could relate to can enhance the therapeutic relationship. Sarah discussed seeking out a counsellor at school, and how she was connected with a Canadian female counsellor who was extremely helpful. However, she stated that,

When I talked about cultural things, I would see that it would be more difficult for her to help. Because she wasn't-- it was like a new thing for her to talk about. She wasn't used to it. She was used to Canadian kids coming to her, talking about their feelings, but I was talking about my culture-wise, and she didn't really know how to console me in some situations when I talked about that.

She mentioned that it would be more helpful if her counsellor had been someone who she could relate to. Thandi also spoke about her experience with her therapist, who although she was not Black or African, "understood a lot of the things that [she] would say, when [she] brought up certain culture aspects", which was very helpful to her treatment. She said that despite this, she

wished she had a fellow Black or African person because “the level of understanding is sort of different”. She also spoke about her friend who had experienced “bad anxiety” and was connected to a psychiatrist who was a White male. She said that their sessions involved “pretty much him telling her about herself like this is wrong”, and how the entire process was a headache for her friend. She mentioned that perhaps having someone of the same background can “enhance the experience where everyone can have a fruitful time, like not jumping from therapist to therapist”, as this probably adds “to the trauma in itself”. Miriam also stated that,

I think maybe something like similar [background], because there’s only so much those people can know about a culture you know? And like it’s nice that they’re trying to educate and learn and help but I think personally for me, I would feel more comfortable if someone from the same kind of culture was talking to me because I feel like we could relate on a different level. Or even just like, ‘cause there’s different types of immigrants, not just Africans. So, I feel like when it comes to like immigrants, I’d rather talk to someone who’s also an immigrant from it doesn’t matter what country in the world.

When asked about services that could be helpful for African immigrant youth, Bunmi suggested reaching out to open-minded counsellors. She said, “counsellors that are diverse, like African counsellors, or it doesn’t have to be African, but people that are more open minded”. Faith suggested therapy and support groups, and stated that for those running these programs, “I’d recommend it to be someone of the same culture or background. Because then, you understand that this is almost like the same-- like you can relate better”. David did not explicitly suggest counselling but stated that, “I think the services that should be provided to African immigrants should be different from those that should be provided to North American people”.

Immigration. There were several factors that came up in the discussion of immigration

and mental health. These included a support system, discrimination, and identity struggles.

Support System. Some participants spoke about how leaving family and coming to a new country affected them. Bunmi said, “yeah, it does affect the way you feel about yourself. And you just don’t have the support system, especially when you don’t know anyone here as well”. Thandi stated that having no family and no support system in a new country can add to the stress of immigration, and she noticed that her family actually became closer once they immigrated, because, “all we had was each other at the time”. Dami came to Canada as an international student and attended a boarding school when he first arrived. He stated that the experience for him was very positive because he had friends throughout the building and he “very rarely felt lonely”. The only stress he experienced was not being with his family. Sarah also came to Canada as an international student and for her, university was “ten times harder” because she was away from her family. David stated that it was a challenge for him to balance school and household chores, but he had to in order to “make my mother happy, knowing the fact that she didn’t really have much support in a new country”.

Discrimination and othering. There were different levels of discrimination participants faced when they came to Canada. Miriam explained that she grew up in a town that was predominantly Caucasian, and there was a total of four Black people in her elementary school. Describing a situation she experienced, she stated,

One of the first things I remember someone said to me was “did you paint your skin”? But I was so young I didn’t even realize. I was like no, but that’s one thing I don’t think I’ll ever forget. And she was also in like kindergarten, so I was like, “ok you’re so young” but still, it’s just little things like that. It’s always like little things you notice.

She stated that “living in a White town, you face racism, but in a weird like quiet way” that she

wasn't able to understand until she got older. Dami also stated that he faced some discrimination in the form of microaggressions, but he tries not to let it affect him much. He stated,

I wouldn't say I've experienced any-- like in Nigeria, it's a lot more explicit because people are just very direct with their discrimination in Nigeria. But here, I can possibly count my experiences, and they're mostly like drunk people walking down the street sort of things. I don't think I've had any direct explicit discrimination. Like there's microaggressions within work and in my class, but I generally, like I try not to point those things out. So, it doesn't affect me too much, well I think it doesn't affect me. Yeah, like microaggressions in class maybe is the most amount of discrimination I've faced.

Faith and David both stated that at times the way they spoke and their accents were looked down upon, especially in cities that were predominantly White. Faith also spoke about bullying and name-calling, recalling a term that was often used, "African booty scratcher". Sarah had the unique experience of living in multiple countries before coming to Canada for university. She stated that her experience with discrimination is that it was mostly ignorance. She stated, "some people are very ignorant. If I say I'm from Ethiopia, they always ask me, 'why don't you have an accent?' They just assume that my education level is a lot lower because I'm from an African country". She also stated that at times at school when she was younger, whenever the topic of slavery was brought up, people would ask her if her parents were slaves, and turn it into a joke. She also spoke about experiencing discrimination from Black Americans that she encountered, and she found that they treated Africans like "a different tribe".

Identity and culture shock. The struggles with one's identity and finding where they belonged in a different culture and society was another factor that affected the mental health of some of the participants. Bunmi's experience with discrimination tied into an identity crisis for

her. She stated,

...like in terms of discrimination, and just not knowing your place. It's kind of like you're in between. Like, even when I go back home sometimes, like it's kind of like, you're different. Like, you're not--you're Nigerian, but people don't see you as that. You come here--it's like an identity crisis in a way. So, also, it affects the way you think about yourself.

For Miriam, she also felt like she was somewhat stuck in the middle and it was difficult finding her place. She stated,

I also think it's a lot of--people don't know how to fit in. We don't know where we fit in Canada and where we fit back home also. When you immigrate, I think it's hard to find that middle ground, as in you want to conform to Canadian society, like be a part of it, but you also don't want to lose your background too. So, I think that adds a lot of pressure and a lot of it scares people because they just want to be able to find that ground. And it's hard because people-- when you come to Gambia, people are like "you're so freaking Canadian". They're like "oh this Canadian girl is here" blah, blah, blah and for the Canadians, it's like "oh she's not Canadian". You know what I mean? It's hard.

Felicia stated that for her, the experience of integrating with Canadians wasn't very pleasant. She said,

It was weird. I don't know-- it was a huge culture shock. It wasn't pleasant. I didn't necessarily-- I just found it weird. I didn't understand things they cared about. I just never got on a deep level with any Canadian. So, I just kind of shut them out and kept with my African circle.

Sarah spoke about the difficulty of adjusting to a society that came with new traditions that one

may not be familiar with. She also mentioned the cultural gap and differences that exist between her as an Ethiopian who was born in Ethiopia, can speak and write Amharic and is deeply rooted in the culture and Canadian Ethiopians that were born here, but don't speak the mother language and "haven't been home in forever". David mentioned the cultural shift that he experienced when he went from a classroom back home with all Black people and coming to a classroom in Canada where he became a minority. On the difference between Canadians and African immigrants, he said, "Like I'm hearing things from North American people, to be honest, although I have to be respectful, I'm like, I don't even know why this is an issue or stuff like that". He also gave a different perspective of an identity crisis that he experienced. He discussed how one can create a completely different identity for themselves in order to fit in and protect themselves from the effects of being an outsider. He said,

In Nigeria, or African culture, there's certain insecurities if you don't belong in a group. Or if you know like, you're not getting a certain amount of girls. Or if you know your friend has this and you don't have that. Those kinds of things. And some people come to North America and they feel like you know, 'I'm going to come and recreate myself, and have this bad boy image'. In which, sometimes those are not necessarily the types of people those people are. Those guys are, when you actually talk to them. You may see they're so sensitive, in which you're like, 'ok, what's the image about?'...Like that's a complete 360 degrees from who you were and your values. And all of a sudden you decide to be a rebel because society wasn't accepting of you at the time...Because I think it's a mental health issue...It's an identity crisis.

Employment. Felicia noted that her mental health had been "very low" because she was not able to find a job. She came to Canada as an international student, and concerning life after

university, she said, “I think the main challenge is that there are so many obstacles placed in front of us to move forward in becoming a permanent resident or a citizen here or even just getting a job”. She worried about her visa expiring and when searching for grants for a project she was working on, she was unable to get any because they were mostly for Canadian citizens. She stated that, “you kind of feel hopeless in Canada during that period of time”. Going for multiple job interviews and not getting a job put her mood at a “full-time low”. For Dami, he had a job lined up for two semesters of his co-op, and the job was canceled suddenly at the last minute. As someone who likes to have his life planned out in advance, he stated that the effects of this were quite stressful for him.

Overcoming challenges. Three participants spoke on overcoming challenges that they had faced. Faith mentioned that the bullying involved with coming to a new country as a young child amongst other things was something that could be overcome because as Africans, “we’re built to be tough”. When Dami lost his job, although he was very stressed out about the sudden change in his life, he found positivity in it, by attending multiple interviews and building his interview skills. David said the pressure that he felt from his parents, academics and himself helped build character in him and it “brought out a certain sense of maturity.” He also mentioned that the expectations that society at times puts on Black people “builds us to be strong”.

Chapter Five: Interpretive Analysis

The purpose of this study was to understand the views African immigrant youth living in Canada hold towards mental health. I wanted to explore where these views came from and what they meant to participants. I also sought out to share their perspectives on what influenced their mental health and how they protected their mental health. The responses I received from participants were multifaceted which led to the emergence of multiple themes. Thorne (2016) mentions that interpretation helps the researcher better understand the “reasons and rules” surrounding certain findings from the data (p.224). Interpretative description seeks to understand how certain social, historical, cultural, and structural contexts plays out in individual experiences (Thorne, 2016). Thus, the interpretation of the findings should include and explanation of the influences that shape certain circumstances and the interaction of those influences with one another to shape how individuals live. As such, the interpretation of the findings was guided more by the theoretical scaffolding of critical theory and intersectionality and less by transcultural nursing theory, along with my previous experiences and literature I had originally reviewed. I will discuss more in chapter six why transcultural nursing theory played a minimal role in my analysis. I also explored new sources to shed light on new findings that came up in the study. The main themes revolved around transitioning between life phases and the impact it has on African youths’ mental health, protective factors that serve as a “double edged sword” and the different experiences of immigration and its effects on mental health outcomes.

Transitioning: The Unknown

There were three subthemes that emerged under transitioning. The Merriam-Webster Dictionary (2018) defines a transition as “a passage from one state, stage, subject, or place to another”. Participants were transitioning between childhood and adulthood, changing

geographical locations with migration and shifting between identities. All participants mentioned that they had faced some sort of mental health challenge related to transitioning, whether it was the transition into adulthood, the transition from their home country to Canada, or their transitioning identities. When contemplating this theme, the metaphor, “The Unknown” stood out to me. In the process of transitioning, a person is leaving what they’re familiar with and embarking on a brand-new journey that they may have heard of but have never experienced. Their ideas or expectations of what the new phase entails may not be met, and those on this journey might be thrown off course by challenges. For participants in this study, this is what happened at different phases in their lives.

Emerging adulthood: Unfamiliar territory. The transition into adulthood is what Arnett (2000; 2007) describes as “emerging adulthood”, and it brings about a new set of challenges, priorities and responsibilities that a young person may not be familiar with. It is not surprising that this is the stage where the symptoms of most mental health challenges and illnesses manifest themselves (Mental Health Commission of Canada, 2015). It also provides an opportunity for one to grow and mature. Participants described how this transitional phase both matured them and threw them off course. High school and university are two different environments and the reality that a young person is faced with as a student in university might not necessarily be pleasant. For example, Miriam stated that when she entered university, she had trouble concentrating on school work, struggled with procrastination and was eventually diagnosed with depression and anxiety. Another participant faced similar struggles in the academic realm of university. Although Dami had a good record academically before he entered university, that changed since starting university. He stated that exam season is always mentally challenging for him, but he has taught himself how to deal with the stress. Adjusting to a new

environment is challenging, especially when the support provided when living with parents is missing. For Sarah, who moved away for university, her depression was triggered when she came back to school after a visit to her parents after her first semester. Though she did well in her first semester, going back home may have brought her that familiar sense of belonging and support that she knew was not readily available when she returned to school.

Emerging adulthood was introduced as a theory of development by Arnett (2000) who described it as being distinct from adolescence and adulthood. Arnett explains that in industrialized countries, changes have occurred over the last half century that have made the transition from adolescence to adulthood much longer. He suggests that the period between the ages of 18 and 25 be looked at as its own developmental phase. This life stage of emerging adulthood can be unsettled in terms of work and relationships as young people stay in school longer before embarking on a career path, and may possibly spend time in a series of relationships before taking on marriage and parenthood (Arnett, Žukauskienė, & Sugimura, 2014). For minority youth, this phase of life could be even more complicated than other emerging youth, given the identity challenges that minority youth face (Schwartz, Tanner & Syed, as cited in Schwartz, Zamboanga, Luyckx, Meca & Ritchie, 2013). There is a generational gap that exists between African parents and their children who are in this age group. One participant explained that the world and society in which her mother grew up is much different than the one she is currently living in. Thandi explained that for her parents, “life moved so fast for them”. Immediately after college, if parents went to college, they were married and had children. She stated that parents did not have the time to discover themselves because they were faced with the responsibility of having a family head on. On the other hand, African youth today are provided with a lot more options and more time than their parents had. They can attend

university if they choose, take the time to discover what they want to be in their adult life and work towards those goals. With that, comes its own set of challenges. This transition process is unpredictable for young adults and they are susceptible to the difficulty of coping during this extended period (Kok, 2015).

During this emerging adulthood phase, youth are often faced with disappointments that they have never dealt with before. For example, seeking employment related to one's field of study and navigating the workplace environment is something that is relatively new to this age group. Drawing from a critical perspective allowed me to understand the intersecting factors that affected African immigrant youths' mental health when it came to employment. For example, when Felicia finished school, she had difficulty finding a job in her field. Although she attended multiple interviews, she was not able to secure a position. As an international student, the stress of this coupled with worries about her student visa expiring took a toll on her mental health. Dami also faced challenges with employment. He attends a university in Canada, but his parents live back home in Nigeria. Although his parents pay his school fees, he depends on his co-op job to supplement living costs. When a job that he had lined up was cancelled at the last minute, he stated that it had a "jarring" effect on him and his mental health ended up "not in a particularly good place". David mentioned that being a Black man working specifically in a corporate setting has allowed him to "build a wall to protect yourself to advance to the next level". He stated that he had learned that though he may be offended at some things said or done at his workplace, he can only stand up so much before he gets labelled a "nuisance". It begs the question of how much one should censor themselves in a workplace setting before it takes a toll on their mental health.

Through participants' responses, I was able to examine the role employment plays in the mental health of African immigrant youth, either as an intersecting factor, or as a setting in which intersecting identities interact. Analyzing this from a critical theory framework brought to light some new information that I had not previously considered. Although I had discussed how racialized statuses assigned to African immigrant youth could place them at a social disadvantage, I had never considered immigration status as well. Amongst African immigrant youth, immigration status hierarchies exist, which positions some youth as more advantaged than others. African youth whose citizenship status is not secured might have this weigh on them, which can lead to negative mental health consequences. Viruell-Fuentes et al. (2012) suggest that while multiple dimensions of health inequality are examined, citizenship or immigration status should be considered as an intersecting factor. Class should also be considered when examining intersecting factors. Felicia rated her family's financial stability as 10/10, while Dami rated his as 6/10. Although Felicia might be considered as someone in a higher socioeconomic status, that did not prevent her from facing obstacles associated with immigration and employment. David's experience speaks to a power differential that exists in workplaces, and his choice to not speak out so as to not be labelled a "nuisance" is unfortunately a process that perpetuates racial inequalities in workplaces. Having to silence himself while dealing with racialized interactions in order to advance in his career not only reinforces the power imbalance that already exists but can also have a negative effect on his mental health. The participants' experience supports research conducted on how the interaction of different but interdependent factors affect health outcomes, including mental health (Guruge & Khanlou; 2004; Hankivsky & Christoffersen, 2008; Kirmayer et al., 2011; Viruell-Fuentes et al., 2012).

The transition into adulthood also provided some positive changes for the participants and brought about a sense of maturity amongst them. This new-found maturity helped participants to understand their mental health and their ability to speak about it. For Faith, the transition into adulthood provided an opportunity to grow her relationship with her father. Though she stated that growing up they had a somewhat tumultuous relationship, her maturity enabled both of them to engage in respectful conversations, and they have grown closer. Because of this, her father was the first person to whom she disclosed her mental health challenges. Similarly, Thandi grew closer to her mother during the transition to adulthood. Again, because of this, she was able to reach out to her mother when she was going through a difficult time in school. This is consistent with findings that parent-child conflicts reduce and cohesion increases as the child transitions into adulthood (Parra, Oliva & Raina, 2015). This phase of emergent adulthood also brings about a sense of self-awareness. As youth get to discover themselves, they are able to prioritize and pay attention to feelings that are important to them. This was the case for Bunmi, who said that getting older encouraged her to address certain feelings and to recognize that mental health issues are real. This is consistent with Arnett's (2007) findings that in emergent adulthood, social cognitive maturity grows, which enables young adults to get to know themselves and others better.

Migration: Where am I? Migrating to a new country can both be a positive and negative experience depending on the resources available to support a person and how well they are able to cope with the stressors associated with migration. This transition to a new country involves leaving a familiar environment, and it brings with it a distinct set of challenges that one might not have experienced before. Some participants described the move to Canada as a "culture shock". One participant, Miriam, described "culture shock" as a scary experience

because of the amount of pressure that came with the expectations of success in a new country. Navigating a new country with a different set of rules, traditions and laws can be considered post-migration stressors that can make it difficult for one to adjust, as it was for two participants, Miriam and Sarah. The culture change can also pose a challenge to one's identity and sense of self (Kirmayer et al, 2011); this shall be discussed in depth later. It becomes particularly difficult when one moves to another country with no social support system in place outside immediate family members. This was the case for the majority of the participants. Three participants moved to Canada without their parents, and two of them reported that it was stressful not being with family. One participant reported that she was diagnosed with depression after coming back from a visit to her family in Ethiopia. For those who moved to Canada with their parents, they still reported a lack of social support and found that they got closer to their immediate family members during that time. The presence of social support is an important determinant of mental health for immigrants and can lead to positive health outcomes and development of coping skills in individuals (Makwarimba et al, 2010; O'Mahoney & Donnelley, 2010; Robert & Gilkinson, 2012).

Finding a community to belong to in a new country can be a tasking journey. The social stigma associated with mental illness in African communities both in Africa and in African diasporas can elicit disparaging comments and actions from those within the community according to participants in this study and in other research (Amuyunzu-Nyongo, 2013; Barke, Nyarko & Klecha, 2010; Gureje et al., 2005). This can lead to social isolation for those who acknowledge their mental illness. Participants in this study attributed this stigma mostly to a lack of knowledge or awareness on mental health, the strong influence of religion on Africans and the resilient nature of Africans. The social stigma of mental illness and the fear of dismissal from the

community leads many to a state of denial or concealment, which may serve as a coping mechanism for them (Barke et al., 2010). This was the case for three participants, Thandi, Sarah and Felicia. In Thandi's case, she has spoken about her depression in her community and has been met with comments like, "oh that's only White people that go through that". Comments like this can be highly discouraging and can lead one to hide one's mental health challenges. For instance, Sarah was in denial of her depressive symptoms and delayed help seeking because going to counsellors was frowned upon in her culture. Felicia felt that her feelings were not valid because of the stigma associated with mental health in her community, and she had to learn to place value on her feelings. This stigma creates a cyclic situation, illustrated in Figure 6, that only works to reinforce the stigma.

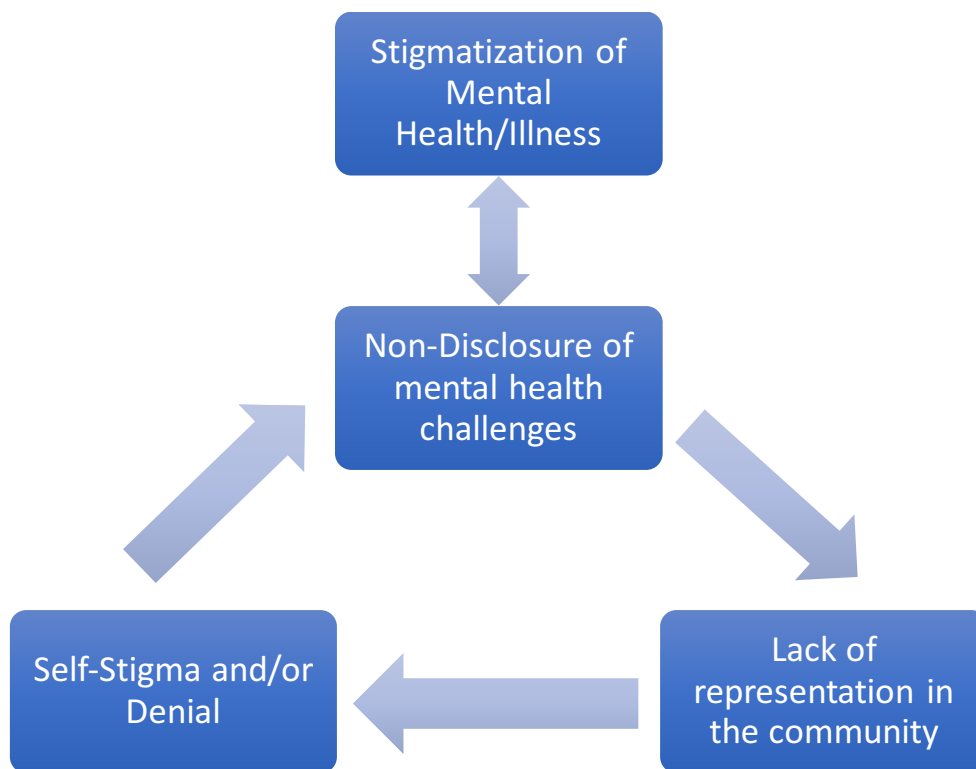


Figure 6. Reinforcement of Stigma in the African Community

People do not disclose their mental health challenges because of the need to belong. When they don't disclose their mental health challenges, there is a lack of representation of those experiencing mental health challenges or mental illness in the community. This lack of representation can lead to the feeling of being the "abnormal" one of the group, which then leads to self-stigma and denial. This denial and internalization of the stigma can then lead to the non-disclosure of mental health challenges, which works to reinforce the stigma of mental illness in the community. This is consistent with research done on the need for social support in immigrant communities and how stigma can further isolate one from their community (Makwarimba et al., 2012, Mantovani et al., 2016; Saechao et al, 2012; Wynaden, Chapman, Orb, McGowan, Zeeman & Yeak, 2005). It is not surprising, then, that all participants stated that mental health is not a topic that is discussed much in their communities. Miriam, a Gambian, stated that mental health issues are only discussed within families for fear of rumors spreading and because of this, she finds that Gambians are quite secretive.

In some African cultures, immediate family members are not solely responsible for raising a child, but also extended family members such as grandmothers, aunts, uncles, cousins and perhaps close neighbors with whom trust is developed (Amos, 2013). When one migrates, they leave behind this valued extended family network and come into a country where they don't have the same support. There is a popular proverb that has been attributed to African origins: "It takes a village to raise a child" (Goldberg, 2016). Without this village present, parents are tasked with parenting in an individualistic style that they may not be used to. Furthermore, the lack of familiarity with the neighborhoods in which new immigrants settle can prove to be a safety concern for them. Some new immigrants settle in low-income neighborhoods when they first arrive, which may have higher crime rates than they are used to. In an effort to maintain their

traditions and culture in a foreign land, some African immigrant parents may warn their children against socializing with other children who are born in Canada, similar to research conducted in Europe and America (Akinsulere-Smith et al., 2016; Rasmussen et al., 2018; Semyonov et al., 2012). This can lead to their children feeling they are being overprotected and constricted. Two participants mentioned that once they moved to Canada, they were not allowed to go out with their friends and often had to stay indoors. When a friend asked David why he could not stay out past midnight, his response was, “I’m African”. For Miriam, this feeling of overprotection was attributed to the lack of trust in the surrounding community when her parents first moved to Canada. But she noticed that this parenting style was not present with her younger sister who was born in Canada. Perhaps this could be due to her parents’ development of a support network by the time her sister was born; or, it may be attributed to the level of acculturation her parents had achieved as years went by. The experiences of first generation immigrant youth might be different than the experiences of second generation immigrants when it comes to parenting and this may warrant further study. However, Amos (2013) found that more recently in Africa, more families are abandoning the extended family style of parenting in favor of more nuclear family style parenting. This could also serve as an explanation for why parents choose this parenting style when they move to a new country.

Identity: Stuck in the middle. The sense of belonging that an African immigrant youth feels and their identity development when they migrate to Canada can be influenced by their experiences. Youth in this study described coming into a culture that they either did not understand or did not fit in with. For these participants, culture is a multidimensional and multilayered concept. Culture for African immigrant youth has to be examined beyond ethnic differences from the general population. Their culture is based on intersectional experiences of

race, gender, religion, and shared group behavior. And because of this, their identity is tied closely to their defined culture. Some of the participants felt the need to identify with either the Canadian culture or their culture of origin. There was the risk of being ‘othered’- within the dominant Canadian culture. In critical race studies, “othering” is an exclusionary process that seeks to differentiate individuals from the dominant, nativist society (Canales, 2000; Viruell-Fuentes, 2011). The dominant population may see visible differences in race as a sign of fundamental differences, or a difference in ideology or moral and rational capacity (Alcoff, 2006). Participants’ feelings of being “othered” was validated by experiences of perceived and experienced discrimination. This included experiences of being bullied, name calling, accents being made fun of and ignorant comments directed at the youth.

The experiences of discrimination and othering for African immigrant youth may be linked to a concept called global valuation (Khanlou, Koh & Mill 2008). Khanlou et al., (2008) explain that global valuation is defined as “the prevailing societal-esteem of a particular cultural group” (p. 497). Global valuation considers the global positioning of one’s cultural group and suggests that it can influence how youth identify with that culture and how youth are treated by others outside the culture (Khanlou et al., 2008). Historically, racial theories had pushed the narrative that Africa was a barbaric and uncivilized continent in need of saving and civilization at the hand of superior races (Poncian, 2014). This was the justification for colonization and the Western domination of Africa. Post-colonization, there tends to be a less-than-positive focus on Africa, and negative depictions continue to be pushed by Western media sources and films (Adekoya, 2013; Poncian, 2014). This leads to negative stereotypes of Africans that can perpetuate racism and discrimination against Africans living in Canada. One participant, Faith, described being bullied and called an “African booty scratcher”. Another participant, Sarah,

stated that she did not want to come to the Western world because she had encountered Westerners who held negative and ignorant views of Africa and its people. These findings indicate that because of these experiences the participants felt more accepted amongst peers of a similar background. This can also be a reason why some participants felt a disconnect between the Canadian culture and their own culture. When an individual is alienated and othered by those who belong to the dominant culture, it furthers the distance between both cultures and can make it difficult to assimilate.

While African-Canadian youth may want to conform to the broader society, there is the fear of losing their cultural identity in the process, as some participants described. As they tried to fit into the Canadian culture, they faced the risk of being “othered” in their home country for being “too Canadian”. Individuals who have been raised in and embody two distinct cultures are known as bicultural (Stroink & Lalonde, 2009). These individuals are typically raised with their heritage cultural values and ideals while also encountering Western culture values and ideals (Stroink & Lalonde, 2009). The potential cultural conflict between these two integrating cultural identities is a concept that has been studied over time. In this study, there was the sentiment of being stuck in the middle of two conflicting cultures, and this process was described as an identity crisis for some of the participants. Two participants, David and Miriam who felt that they had to abide by certain cultural norms with which they were raised, discovered there was a clash between those norms and Canadian cultural norms. If they were to completely immerse themselves in the Canadian culture, there would be backlash from those in their heritage culture. This backlash could come in the form of one’s heritage culture rejecting them and calling them “Canadian”, instead of Gambian, or Nigerian, etcetera. This was the case for Miriam and Bunmi. Miriam stated although there is a desire among African-Canadian youth to conform to

the Canadian culture, the repercussions can involve losing one's heritage culture. She described this as being scary and adding to the pressure of trying to find a middle ground between both cultures. She also described the feeling of being too Canadian for back home, and not Canadian enough for Canada. Integrating both cultures can be confusing and distressing for youth. Going back home may prove to be a distressing experience of one's identity because one may not be fully accepted by their heritage culture. This feeling can be worse if one does not speak the language of their country of origin but identifies strongly with their cultural background. There may be a sense of othering as one returns home with a new accent, new mannerisms and perhaps a different set of values and ideals that are a combination of both the heritage culture and the Western culture (Stroink & Lalonde, 2009; Altweck & Marshall, 2015). Power and privilege may also play a role in the "identity crisis" that African immigrant youth face when "stuck in the middle". At any given time, an individual can possess a privilege that others do not have. All participants who participated in the study either have a university degree or are in the process of completing their degree. For those who grow up in the Western world, or travel to the Western world for education, they may be looked at as privileged by others back in their home country. In that sense, African immigrant youth may possess a sense of dominance over those who are left back home. However, roles become reversed when they go back to their home country where people possess the privilege of completely belonging in their culture and do not have to go through the stress of being bicultural and the feeling of being stuck in the middle. This does not mean continental Africans are immune to mental health challenges, but when it comes to having an "identity crisis" due to the distress of not being fully accepted by two cultures, they escape this.

It is important to acknowledge the effects that being stuck in the middle of two cultures can have on immigrant youths' mental health. Three of the participants who discussed identity issues in depth acknowledged that this feeling can take a toll on one's mental health. Perez (2016) explains that the stress of being bicultural and trying to acculturate to a new, dominant culture combined with the vulnerability of adolescence can have consequences for one's mental health. This stress can manifest itself as anxiety, depression and poor mental health outcomes. It can also have significant impact on one's self esteem. David gave an example of this, when speaking on "recreating" himself and developing a "bad boy image" because of insecurities of not belonging to the dominant group. The exclusion that youth may feel in peer groups may lead to peer pressure to engage in activities that are contrary to how they are raised and may conflict with their values. This can have a negative impact on one's identity development and in turn their mental health. Bicultural stress leading to mental health challenges is consistent with research conducted in Asian-American youth living in the United States (Cho & Haslam, 2010; Perez, 2016).

The discourse on African immigrant youth identity issues is not complete without situating it in a historical and political context. Analyzing this from a critical theory perspective allows a thorough examination of the power dynamics that influence the identity struggles of African immigrant youth. The Western world, Anglo-European cultures have been recognized as the originators of racial categories that are used today (Alcott, 2006). Socially constructed racial categories assign differences in humans in a hierarchy that suggests that some people are worth more than others according to their skin color (Madibbo, 2016). As such, Whiteness is often looked at as the highest level in this socially constructed hierarchy, which in turn determines the power and privilege that people are afforded in society. In Canada, Canadians of European

descent are often looked at as “normative Canadians”, while those of racialized groups fit outside of this box and are not considered Canadian (Madibbo, 2016, p. 858). The determination of who is and isn’t Canadian by the dominant group in society leads to rejection and othering, and can also lead to identity confusion. Several of the participants described feeling “different” when they arrived in Canada. This feeling of difference came mostly from the way they were treated by others. Although the participants spoke English when they first arrived, their accents were different, and one participant, David, stated that he was “looked at as weird...as if you can’t be understood”. This feeling of “difference” was strong enough to make some find a community of African youth that shared similar experiences in order to get a sense of belonging. In these spaces, the youths find “identity safety” in an environment where they feel valued, accepted and welcomed (Madibbo, 2016 p. 861). In a study conducted on Somali youth living in Canada, Berns-McGown (2013) suggests that the rejection that immigrant youth face when they are told they do not belong does not necessarily mean they do not believe themselves to be Canadian, but it is simply a reaction to the otherness they experience. The relationship between discrimination, social exclusion, mental health and identity amongst immigrant youth is consistent with previous research (Khanlou, et al., 2008; Khanlou & Crawford, 2006; Perez, 2016; Shakya, et al., 2010).

Protective Factors: Double Edged Sword

Participants described three major reasons for overcoming difficult situations they went through, and in turn protecting their mental health. They included resilience, religion and hypermasculinity for men. Although these protective factors had positive outcomes, participants also described how they could potentially be negative. Thus, protective factors serve as a double-edged sword that could prevent African immigrant youth from acknowledging mental health issues or seeking mental health care.

Resilience: glass half full. Some of the participants described having to overcome challenges that could have affected their mental health. Some of these challenges were related to the immigration process, while others were about other life circumstances. Several factors aided participants' abilities to bounce back from challenging situations. These factors included social support, goal orientation, religion and internal strength, which is consistent with other studies done on racialized youth resilience and mental health (Johnston, Pilkington, Khanlou & MacNevin, 2018; Khanlou, Shakya, Islam & Oudeh; 2014). Resilience, the ability for individuals to bounce back when faced with stress, trauma or adversity (Chung, Hong & Newbold, 2013), was evident in this group of participants.

The study did not explore the pre-migration stress that participants encountered back in their home country, but some participants discussed post-migration stress that they experienced and how they were able to recover from it. For example, Faith mentioned that she had been bullied when she first arrived. But she stated that she was able to overcome this, because "we've been through so much more". She alluded to her family's pre-migration situation in Ghana, stating,

We weren't born with a silver spoon like those who were born here...it's something that's very menial [minimal]. Because if you look back as to how we got into this country, or other life issues, or economic issues, in the mind, this is nothing.

She also stated something that seems very important to this specific group of immigrant youth. She said, "we're built to be tough". This idea of inner strength was repeated by two other participants. David mentioned that knowing African history and how ancestors went through "harder struggles" builds one to be strong. He also mentioned that families tend to mold children to be able to handle society and what comes with it. Felicia mentioned that Nigerians tend to be

“strong and hustlers” and they “always have hope as well”. This internal strength seems to hold one up, especially when comparing their situation to others who may be worse off than they are. The relation of past situations to present struggles and the experience of adversity to build resiliency in African youth is consistent with other research (Theron & Theron, 2013; Lothe & Heggen, 2013). Here, it is important to note that although comparing struggles can help bolster resilience in African immigrant youth, it can also serve as a double-edged sword that becomes a barrier to seeking help for mental health issues. If there is an expectation for a person to always have hope and be strong in the face of adversity, there may be a fear of being looked down upon if they were to show signs of helplessness or defeat. This can prevent them from opening up about mental health challenges, and in turn, prevent them from seeking help.

The socio-economic conditions in some countries on the continent of Africa can unfortunately be poor at times. Hunger, internal conflicts, poverty and illnesses can be a source of trauma or adversity for people (Amuyunzu-Nyamongo, 2013; Guruge & Alem, 2000). Witnessing, hearing stories, or experiencing any of these situations can either make one believe they are able to overcome any situation, or give up in defeat. The capacity for individuals to be resilient is dependent on their individual capacity, the quality of the relationships with their family, friends and community, and the resources available to support them (Liebenberg, Ungar & Vijver, 2012). Liebenberg et al. (2012) explain that while some aspects of resilience may be universal for youth, contextual differences exist due to race, gender, ethnicity and culture. This holds true for African immigrant youth. I believe that it is important to pay particular attention to how the participants in this study described what mental health and a mentally healthy person means to them. They used phrases such as “cope and maintain a certain level of functioning, despite whatever troubles may come their way”; “able to face or overcome life’s challenges”;

“being able to deal with everything you struggle with, the situations of life...being able to go through life well and be strong”. These phrases are descriptors of a resilient human being. They do not deny or minimize the presence of trauma or adversity, but in the face of adversity, they are able to bounce back and maintain a certain level of functioning. This was the case for several of the participants, such as Dami, who lost a job for his co-op semester that he believed was secured. He stated that although this situation affected his mental health, he found positivity in improving his interview skills as he went job hunting a second time. It can be said that resiliency serves as a protective factor for mental health challenges in youth (Johnston et al., 2018; Khanlou, et al., 2008; Khanlou, et al., 2014).

Religion as a protective factor. Hope is an important factor that aids in resilience for African immigrant youth. This hope is closely tied to religion and spirituality, as one of the participants, Felicia mentioned: “I’ll also say that because of religion being so strong, I feel like Nigerians always have hope as well. I don’t think that even if people are going through somethings, as Nigerians, that anybody is truly suicidal”. Bunmi stated that as a Christian, prayer was one of the reasons she was able to overcome her mental health challenges. African immigrant youth who are religious use their religion as a source of hope and strength during difficult times. Dami mentioned that in his family, if anyone was to experience a mental health crisis, the first response would be “a spiritual response...they’d probably have like a prayer meeting about them first, before anything else happens”. Prayer can almost be seen as first-aid for Africans who are in crisis. Because of this response, seeking help from medical professionals may be discouraged, and youth may be more willing to seek help from religious leaders when experiencing mental health challenges. The relationship between mental health, resiliency and religion/spirituality is consistent with other research findings (Adekeye et al., 2014; Fenta et al.,

2006; Lothe & Heggen, 2013; Khanlou et al., 2014; Shakya, Khanlou & Gonsalves, 2010; Ziaian, de Anstiss, Antoniou, Baghurst & Sawyer, 2012). It begs the question about what happens when youth seek mental health assistance from religious leaders. Are they directed to mental health professionals? Are they provided with counselling? Or if these religious leaders are from their community, are they discouraged from speaking about mental health challenges? These and similar questions could be explored in further studies on the role religion plays in African immigrant youth mental health.

Spirituality and religion in Africa predates the introduction of Western religions such as Christianity and Islam by colonialism. African indigenous religions, which spread across the continent, are based in the belief that supernatural beings/spirits are the explanation for all things that happen in life (Igboin, 2011). Though the influence of Western religion is strong in Africa, the presence of indigenous and traditional beliefs has not disappeared entirely, as stories of spiritual deities tend to be passed down through generations (Daniel, 2010; Igboin, 2011). Africa has deep spiritual roots, be it traditional beliefs, or modern religion. Religion serves as a moral compass for contemporary African people and they hold God and the spirits as the highest level of a hierarchal structure that forms the “forces of life” (Daniel, 2010; Igboin, 2011). There is also a concept of good versus evil that exists in traditional African religions, and perhaps this could explain why Christianity and Islam were retained by Africans post-colonialism.

When discussing mental health in an African context, the influence of religion and spirituality in the discourse cannot be overlooked. Dami and Sarah both acknowledged that mental illnesses were attributed to “spiritual forces” and “the devil”. Bunmi and Felicia noted the strong influence of religion in their home countries and how that affected people’s perception of mental health challenges. It is important to examine not only the positive influence, but also the

negative influence spirituality and religion could have on the mental health of African immigrant youth. While religion is a source of hope for individuals, it can also reinforce the stigma faced by those who are experiencing mental health challenges. Bunmi stated that in her experience, religion and God are put above all else, and once you have belief in God, “you should be grateful”. She stated that there is no room for one’s feelings in this situation because there is the perception that “as long as you have Jesus, you’re ok”. Notwithstanding, one’s faith can be truly tested when experiencing a mental health challenge. This is especially true if one is made to believe that all they need to do is pray a little harder to overcome their challenges. Sarah mentioned that “there’s this idea that if you pray, everything is going to be ok”. Those who do pray harder and are still experiencing mental health challenges, are no weaker than others who are able to overcome their mental health challenges. However, if their community believes in only in faith-based methods of tackling mental health issues, it can be a catalyst to drive them away from the church, mosque or any other religious institution. And once they are away from their religious community, they lose a much-needed source of support

Hypermasculinity. African males might be particularly susceptible to mental health challenges because of the intersectionality of their race, culture and gender. David touched on the expectations put on a Black man, and the relationship between Black men and women. He stated that Black men go through unique experiences that build them to be strong. He used the examples of working twice as hard as others in a classroom or workplace setting in order to be recognized or having to be the best at a sport because of his Blackness. He stated that although these experiences can build people to be strong, it can also affect their mental health, because it begs the question, “why be weak?”. This ties into the expectation of being able to overcome anything that comes a person’s way. He went further by stating that he had noticed Black men being called

“weak” by Black women in some relationships and because of this, some men do all they can to maintain the role of “the strong Black man”. Culture also plays a role in this: as Felicia mentioned, because of her experiences and her cultural norms, she has always expected men to “always be strong; to never cry, or never really open up too much”. Sarah and Dami also mentioned that in their experience, men do not really speak up much about their mental health. This could be because opening up to someone requires a level of vulnerability. For one to be vulnerable means that they are “capable of being physically or emotionally wounded” (Merriam-Webster, 2018). For Black men, this could translate as being put in a position of weakness that they have been working so hard to avoid. In order to protect against this state of weakness, they may exhibit hypermasculinity, an exaggerated form of masculinity, in which they display a stereotypical “gendered display of power and consequent suppression of signs of vulnerability” (Spencer, Fegley, Harpalani & Seaton, 2004, p. 234). On the part of women, the expectation of men to be strong and stoic, can cause men to fear being emasculated if they open up about their emotional health. Hypermasculinity can then become a coping mechanism for them if they feel they are at risk of being emasculated by women or even other men. Although it may protect them from the immediate fear or threat of weakness, in the long run, the internalization of hypermasculinity places them in a particularly vulnerable state because they may be suffering in silence (Barker, Ricardo, Nascimento, Olukoya & Santos, 2010; Spencer et al., 2004; Watkins & Neighbors, 2007). Although there was research to support this in Black men, I was unable to find research specific to African immigrant males. Perhaps this could be an area for research development in the future, as cultural nuances do need to be considered.

Immigration Experiences of African Immigrant Youth

Support system. Immigration circumstances and experiences differed for participants in this study. Five out of eight of the participants immigrated to Canada with family between the ages of 5 and 15, while the other three came to Canada alone when they were teenagers, as students. For those who came with family, family proved to be a source of support when they were going through difficult times. Thandi mentioned that when she moved to Canada, her family got much closer because they only had each other. Miriam also reported getting closer to her family. Bunmi mentioned that although she had her immediate family with her in Canada, the move was still difficult because of the lack of extended family members. She stated that not having her grandparents and her cousins here could have affected the way she felt about herself, because she did not have a support system. This is important, because a support system could mean different things to individuals. For some, like Felicia, immediate family could be sufficient as a support system, but for others, it may need to include extended family members and friends. Moreover, service providers and those receiving services may have different definitions of a support system. The definition of a support system is evidently multidimensional and individual (Makwarimba et al., 2010; Simich, Beiser, Stewart & Mwakarimba, 2005; Stewart et al., 2008). Thus, when considering the impact of a support system on the mental health of individuals, it is important to take into consideration the individual's perspective of what a support system means to them in order to provide the best possible care.

Amongst participants who came to Canada pursue studies, two came without any family and one came with her siblings. Sarah found the move to Canada particularly difficult because she did not "have that support". Not having her parents with her significantly impacted her mental health, and she "fell into...almost a depression and [she] didn't do well after that". She

eventually had to seek out help and ended up seeing a counsellor in school. Dami on the other hand, had a positive experience moving to Canada for school. He said that although not having his parents here with him was stressful, “everything just worked well”. He stated that having a community of friends in the boarding school he attended helped him because he “very rarely felt lonely”. Although these two experiences are contrasts, they both support research showing the importance of a support system for one’s mental health (Makwarimba et al., 2010; Stewart et al., 2008). The presence of a support system can improve mental health outcomes, as it did for Dami, while the lack of support system can impact one’s mental health negatively. As mentioned above, the definition of a support system is very subjective and individual based. This reflects an important foundational underpinning of interpretive description, in which multiple, possibly contradictory realities exist in the world of human experiences, thus, there is no singular truth to be achieved (Thorne, 2016). Experiences are individualized and meanings are subjective. It is important to turn the focus on how the diversity of individuals’ experiences and the meanings they ascribe to concepts can put them at a disadvantage for poor mental health outcomes.

Role changes. Although David moved here with family, his father remained back home in Nigeria working to support the family. David, being the oldest experienced this transition to Canada as challenging, because he had to take on new roles to support his mother and his younger siblings. He stated that he had to be somewhat of a “fatherly figure” and that he tried his best to make his mother happy, knowing that she did not have “much support in a new country”. This was despite his tender age of 12 years upon arrival. Socially constructed gender norms could have demanded that his role as the oldest child and a male required him to step up to fill his father’s shoes. This can be a lot to demand from a young person struggling to adjust to a new society, while also trying to help others in his family adjust as well. Although David said that his

situation brought out a sense of maturity in him, going through it wasn't easy, as it led to him having anxiety and a fear of not meeting up to expectations. It is important to acknowledge how gender norms and the power dynamics between men and women could leave young African boys vulnerable to mental health challenges. Furthermore, the intersection of cultural norms and social class combined with gendered expectations may be a source of pressure for African immigrant males and can impact mental health outcomes (Barker et al., 2010). There is limited research that explores culture-gender intersections and gender differences in immigration experience for African immigrant youth and its effects on mental health. More research needs to be developed on this topic, as it is worth exploring.

For some participants who came to Canada with their family, financial difficulty or instability was seen in family role changes. For example, David stated, "I'm coming from a country where I didn't need to do chores. My family has people doing it for us. Then all of a sudden, you come to a country where you cannot afford that, you know starting off". Miriam also stated, "I know there was economic challenges because when we lived in Gambia, my mom never worked because my dad always worked in England, so he lived like outside Gambia. But when we came to Canada, my mom ended up getting a job too". Role changes due to financial instability can cause a disruption in family dynamics, which can lead to poor mental health outcomes, or can build resilience in individuals (Hansson et al., 2010; Robert & Gilkinson, 2012; Stewart et al., 2008). For these participants, they describe a process of becoming resilient and dealing with the challenges that they encountered. The need to do domestic chores may not seem like an important role change, but for someone like David who for 12 years had someone else perform these things for him, it is a role disruption.

This chapter focused on the interpretation of my findings from the study. Participants' transition through different life stages, geographical locations and subsequently identity, proved to have an effect on their mental health. The process of moving from childhood to adulthood came with unexpected trials such as academic strains and employment challenges. It also brought out a sense of maturity in some participants, along with self-awareness. Migration also came with its own set of challenges, as it brings with it a culture shock, dealing with the stigma of mental health/illness in communities and changes in parental styles that affected some youth.

Participants described experiences of perceived discrimination and othering, which contributed to an identity crisis and the feeling of being stuck in the middle of two differing cultures.

Protective factors such as resilience, religion and hypermasculinity proved to be a double-edged sword that on one hand helped protect youth from mental health challenges, while also reinforcing the stigma associated with mental health/illness in their community. Lastly, the different immigration experiences of youth such as the presence or non-presence of a support system and role changes led to different mental health outcomes. The different interpretations present in this chapter were shaped by the theoretical framework of critical theory and intersectionality and offered explanations for why African immigrant youth have certain experiences.

Chapter Six: Discussion

In this chapter, I will discuss the significance of my findings and what Thorne (2016) terms the “so what” of the study. I chose to approach this study from a critical theory and intersectionality perspective because it aligned with interpretive description, my research methodology; as such the discussion will be undertaken with a critical lens. Interpretive description research places importance on examining how historical, social, structural and cultural factors are powerful influences on the human experience and how those experiences are played out in individual situations (Thorne, 2016). I will begin by discussing how the theoretical perspectives of critical theory and transcultural nursing aided in formulating my research questions, the role they played in the interpretation of my findings and my thoughts on reflexivity and the research process. I will also explore the reasons why Leininger’s transcultural nursing theory was not incorporated in my analysis of the data and interpretation of the findings. I will then discuss practice implications, such as the benefits of moving from the notion of culturally competent nursing into cultural humility. Lastly, I will discuss areas for further study.

Theoretical Considerations and Discoveries

Formulation of research questions. Leininger’s (1995, 2002) Transcultural Nursing theory initially served as a theoretical perspective when I started my preliminary research on the topic of mental health perceptions in African immigrant youth. Along with critical theory, it informed development of my research questions, and subsequently, my interview questions. According to Leininger (2007), the theory is holistic in that it seeks to discover “culturally based care that promotes and/or maintains the health and well-being of individuals, families, or groups” (p. 9). It also incorporates social factors such as religion, gender, values, beliefs, politics and ways of living as “potential influencers of culture care phenomena” (Leininger, 2007, p. 9).

Based on this description by Leininger, I sought to find out the attitudes and beliefs that influenced African immigrants' views of mental health. I also employed Leininger's theory to understand the origins of these beliefs and their influence on the mental health practices of African immigrant youth. I had an understanding that culture was not limited to ethnic background and race but incorporated other factors such as religion, gender, sexual orientation, social behaviors of groups and more. Even further, there was the understanding that health care behaviors were not strictly based on individual choices, but also on societal categories of difference that oppress groups of people and cause health disparities. I decided to use critical theory and an intersectional framework to supplement my inquiry based on this understanding of culture. I felt that the addition of these two theoretical perspectives would allow me to inquire beyond the role culture plays in the mental health of African immigrant youth. Critical theory served as the basis of my question on other factors that influence the mental health of African immigrant youth. These theoretical perspectives also influenced the development of both my demographic form and my interview questions. The questions I asked were supported by research I found during my literature review supporting the role socio-economic and political factors play in the mental health of immigrant youth (Guruge & Butt, 2015; Hansson et al., 2010; Makwarimba et al., 2008; Shakya et al., 2010; Viruell-Fuentes et al., 2012).

Transcultural nursing: Is it enough? Thorne, Kirkham and O'Flynn-Magee (2004) state that interpretive description research allows the researcher to engage in a "dialectic between theory and the data... in the quest for a coherent rich interpretation that allows a priori theory to be changed by the logic of the data" (p. 6). This methodology allows the researcher to depart from the preliminary theoretical perspectives, as alternative information arises from the data (Thorne, 2016; Thorne et al., 2004). As I conducted the study and started my interpretive

process, I realized that Leininger's theory was not sufficient as a theoretical foundation for the analysis of my data. This came to light when I began analyzing the complex issue of African-Canadian immigrant youths' experiences in view of protective factors, migration and identity development. I found myself leaning more towards interpretation mainly from a critical theory and Intersectional perspective. I discovered that although Leininger's theory was a good start to understanding differences between groups of people, it might not be inquisitive enough.

Although the theory acknowledges that there are cultural differences and commonalities amongst groups of people (Leininger, 2002, 2007), it does not fully consider the social categories of difference and power imbalances that influence health care behaviors in people (Campesino, 2008). There have been various criticisms that Leininger's theory views culture as static, since many people do not choose to follow cultural practices. Also, it does not take into consideration the impact of immigration and the merging or loss of one's cultural practices on individuals (Campesino, 2008; Williamson & Harrison, 2010). Leininger's (2007) emphasis on the Ethnonursing research approach to care, in which researchers and healthcare providers enter participants' and care recipients' world to discover the "covert culture care beliefs, values and practices" (Leininger, p. 11), can be seen as paternalistic and colonizing. Culture isn't meant to be discovered, as it already exists. Rather than a focus on discovering culture, there should be a shift in focus to simply understanding. This is especially important, as Leininger uses the concept of the Western vs. non-Western world when referring to culture (Leininger 2002, 2007), which can posit "Western" or Whiteness as the norm. Campesino (2008) describes this as "essentialism", which is a "process of attributing particular characteristics as inherent to all members of a group of people" (p. 302). Essentialism fails to recognize that dominant structures create representations of groups of people, such as the Western and non-Western world

(Campesino, 2008). This creation of representations of people tends to be largely homogenous, and people are typically lumped in the same category, such as “Black people”, despite differing origins, values, perspectives and characteristics (Alcott, 2006; Campesino, 2008; Khanlou, 2010). More often than not in the Western world, racial categorization trumps people’s cultural, national, ethnic or religious identity (Alcott, 2006). For this reason, it was important for me to focus specifically on youth of African origin within the Black community, as their mental health needs may differ from Black youth of other origins. I recognize that even within youth of African origin, differences exist, as there are thousands of cultural groups on the continent.

During my analysis, I realized that Leininger’s theory could not adequately explain the impact migration has on individuals and their subsequent health outcomes. As evident in my findings, migration can change an individual’s concept or idea of culture, as they work to merge their heritage culture and their host culture together. This can result in a culture clash and an identity crisis for individuals. Race and ethnicity are not enough to describe one’s culture, as these can change depending on a person’s geographic location. Campesino (2008) describes ethnicity as “the expression of a particular cultural heritage in the context of multiple and distinct social groups” (p. 301). For example, back in their country of origin, African immigrants’ ethnicity would be their self-identified ethnic background. But moving to Canada creates a different ethnic identity, “African”, that differs from the dominant culture. They are also assigned a racial category of “Black” that they may not have identified with previously. Leininger’s theory fails to recognize that conceptualizing culture is quite difficult and complex.

The role of critical theory in the interpretation of findings. Critical inquiry requires one to go beyond the superficial level of data provided and dig deeper for meanings that are connected to the impact of social, economic, cultural and political factors on health (Mosqueda-

Diaz et al., 2014). I was able to draw on the concept of intersectionality to make vital connections between participants' experiences and their mental health outcomes that may not have come to light without examining the data from a critical perspective. Utilizing critical theory also guided me to look for the "why" in the findings which led to further examination of the literature in search for help with interpretation. In my findings on identity, critical theory guided my interpretation of how race and geographic location played a role in the formulation of one's cultural identity.

For example, when examining hypermasculinity in Black men based on some of my participants' views, I went further than simply acknowledging that it exists. Instead, I sought to examine the reasons why it exists and the potential consequences of this phenomenon. Although men are represented in research on mental health and are a target population for health services, they are underrepresented compared to women and they are often looked at as the "oppressors", not as complex beings whose health behaviors are influenced by gender and social norms (Barker et al., 2009; Watkins & Neighbors, 2007). Furthermore, Black men are under-studied in mental health research, though research has shown that Black men may be more likely to take on traditional attitudes about masculinity, thus leading to more mental and physical health consequences (Fragoso & Kashubeck, 2000; Watkins & Neighbors, 2007).

When men take on gender roles and norms that are constructed by society, this only seeks to reinforce a patriarchal society that seeks male dominance and female subordination (Hunnicut, 2009). Unfortunately, even within this system that is designed to uphold and promote male dominance, African immigrant Black men are at a disadvantage and can fall victim to this system. When their maleness is combined with their race, ethnicity, immigrant status and cultural expectations, we see men who are at a higher risk for poor mental health outcomes. Like the

participants in the study mentioned, the cultural expectation to always maintain strength in the face of adversity and to let go of all signs of weakness, such as crying, can lead them to be even more vulnerable to mental health challenges. The stigma of African immigrant men speaking about mental health and help seeking in their communities, along with the expectations of the women in their lives perhaps warrant deeper examination of their mental health outcomes. Programs and services that cater to men's mental health also need to consider how intersections of men's identities place them at higher risks of mental health challenges and these should be reflected in how they deliver care to African immigrant youth.

Reflexivity and the research process. Reflexivity was a key aspect of this study because of the insider view I held and my prior experience and knowledge of the topic at hand. I discussed earlier that I found it difficult at times to separate myself from the data especially when hearing experiences from participants that were so similar to mine. As I went on to formulate an interpretation of the data, I found myself constantly writing reflective notes on why I decided to go with certain links or patterns. At that time, I referred back to Thorne's (2016) notes that the researcher or inquirer and the "object of inquiry" are inseparable, and this interaction will no doubt influence the research process (p.82). I realized that the goal of reflexivity is not to maintain an objective outlook on the data, but to acknowledge whatever impact, however unintended the researcher may have on the gathering and interpretation of data. I was essentially concerned with developing the trustworthiness of the study with respect to ensuring confirmability. I wanted to make sure that my biases and perspectives did not overshadow that of the participants. Interpretive description proved to be the best methodology for this study, because it recognizes that the data will be influenced by the researcher's theoretical stance, their disciplinary knowledge, and their prior experience (Thorne, 2016). However, it also calls for the

researcher to be mindful and aware of how these factors can influence the data and the final product. Reflexivity ensured that the participants' voices were put ahead of my own biases and prior experiences. Thorne (2016) recommended that in order to avoid an "over-inscription of self" in the data, the researcher (myself) needs to step back from time to time in order to create some distance from the research process (p.196). I was able to do this every few weeks, and the time away from the study allowed me to look at it with fresh eyes, challenge the links that were forming, and formulate new connections and patterns in the data. This allowed me to not be completely wrapped up in the data, though I was still very much engaged with it.

Practice Implications

These findings can benefit the health care system at large, organizations that offer mental health services, and nursing and other healthcare professionals whose service groups include African immigrant youth. This study takes into consideration demographic differences amongst immigrant groups, with its focus on African immigrant youth and it provides the opportunity to understand the different beliefs, mental health practices and contributing factors to mental health specific to this population. It encourages health care providers to move beyond a cultural competence framework when delivering care into a more appropriate model called cultural humility. Practice implications also include the benefits of using critical inquiry in closing the health equity gap.

Cultural humility: The way forward. Although cultural competency has been beneficial in nursing, it may actually further stereotyping and othering. In literature about cultural competency, culture is broadly defined and typically refers to ethnicity and race, without regard for other intersections of a person's identity (Alcoff, 2006; Kumas-Tan, Beagan, Loppie, MacLeod & Frank, 2007; Yeager & Wu, 2013). Culture is a complex and multifaceted concept

that is intertwined with one's class, gender, race, ethnicity, sexuality and more, and culture can be expressed differently between individuals. With cultural competency, there is also a focus on the "other," and it assumes that culture is something that only the "other" possesses, while also seeking to study or be aware of cultural differences from the "other" (Kumas-Tan et al., 2007). It does little to address systemic issues that are the root cause of health disparities and does not always acknowledge the power imbalances that occur in the nurse-client relationship (Kumas-Tan et al., 2007; Ortega & Faller, 2011; Tervalon & Murray-Garcia, 1998; Yeager & Wu, 2013). In order to consider these factors missing from cultural competency, the term "cultural humility" (Tervalon & Murray-Garcia, 1998) was coined.

According to Tervalon and Murray-Garcia (1998), cultural humility is a life-long process that involves the health care provider (HCP) engaging in self-reflection and self-critique and requires them to be humble and flexible enough to assess each encounter with a client as individual and new. These authors encourage HCPs to go beyond the previous knowledge on culture that they may have received, to a relationship focused on the client in relation to the cultural identity the client may consider important to them (Tervalon & Murray-Garcia, 1998; Hook, Davis, Owen, Worthington, & Utsey, 2013). Cultural competency may infer that once a nurse is competent in cultural training, they are bringing a level of expertise into the HCP-client relationship, when in reality, the client is always the expert in their cultural care. Cultural humility on the other hand does not assume that there is a level of cultural competency to be attained. It goes beyond attaining knowledge in culture, and HCPs do not assume that they are competent in their client's idea of culture (Hook et al., 2013). Whenever cultural differences are apparent in the HCP-client relationship, cultural humility allows HCPs to express respect, and there is no demonstration of superiority; rather, they are conscious of the power dynamics that

are in play in that relationship (Hook et al., 2013). Cultural humility posits the HCP as a learner in the HCP-client relationship as opposed to the dominant holder of knowledge in that relationship, as the client possesses the knowledge on their expression of culture (Hook et al., 2013; Ortega & Faller, 2011). Cultural humility is beneficial for both the health care provider and the client, as it leads to mutual respect, empowerment, lifelong learning, and optimal care, and furthers the goals of social justice (Foronda, Baptiste, Reinholdt & Ousman, 2016; Hook et al., 2013; Tervalon & Murray-Garcia, 1998). Health care providers should treat the HCP-client relationship like a partnership, and they need to understand and explore the patient's background, rather than only making assumptions based on previously acquired knowledge on one's culture. The knowledge that HCPs possess should be used in conjuncture with humility when working with clients (Hook et al., 2013). Research done on minority populations should be used as a guide in practice, but not in a prescriptive manner, as individuals may not subscribe to cultural norms.

In the same way, this research conducted on African immigrant youth should serve only as a guide when interacting with this population. Not everyone exhibits the expressions of culture described by the participants in this study, and that should be taken into consideration when interacting with them. Some participants in this study mentioned that they would prefer interacting with mental health care providers who were of the same or similar background, while others said they would like someone who can understand their experiences. Cultural humility serves to bridge this gap. While working to increase the number of mental health care practitioners from minority backgrounds in the field, those who are already practicing can utilize cultural humility in their practice to further strengthen the therapeutic relationship they have with their clients who happen to be African immigrant youth. While practicing cultural humility, it is

important to understand why each immigrant group must have services tailored to them. Not all immigrant groups experience the same challenges. There are differences in immigration experience, differences in perceived discrimination experiences, and differences in health behaviors. Even within immigrant groups from similar backgrounds, differences still exist. For example, immigrants of African background might identify as Black, White, Arab, Indian, etcetera. While White African immigrants maintain their racial status when they immigrate, Arab Africans may be assigned a White racial status, but not the National status of the receiving country, so they may not reap the full benefits that Whiteness affords (Viruell-Fuentes et al., 2012). Research has shown that for immigrants of color, their experiences of immigration may be worse than those of their White counterparts, especially when interacting with the healthcare system (Fenta, et al., 2006; Hansson et al., 2010; Makwarimba et al., 2010). Their different experiences deserve to be acknowledged and researched, hence the need for this study. They also have a belief that they are different from the general Canadian population, so mental health promotion and treatment strategies should acknowledge these differences. Although studies have shown similar mental health experiences with immigrant youth (Shakya et al., 2010), their mental health outcomes and how they respond to care is based on the intersections of their different cultural experiences, religion, social situation and other intersecting experiences. These nuances need to be taken into consideration when caring for clients who are African immigrant youth. Immigrant sub-populations deserve to be studied independently, and perhaps future studies could also further break down mental health in different groups of African immigrants. Not all Africans identify as Black, so their experiences with immigration and their mental health perceptions could differ based on this racial difference. Also, regional differences could exist, as cultures and cultural experiences differ across Africa.

Social justice. Critical inquiry aligns with the goals of social justice and health equity. We cannot close the health equity gap without a critical examination of why those gaps exist in the first place. We also cannot understand health behaviors and mental health outcomes without the reasons behind them. For example, immigrant youth from racialized backgrounds have been shown to be highly resilient persons when faced with challenges, which can help with coping and lead to positive mental health outcomes (Johnston et al., 2018; Khanlou et al., 2008). For African immigrant youth, their resiliency may be connected to the social and political conditions in which they were raised, historical accounts of their ancestors, their religion, and their individual households. Critical inquiry allows for structural examinations to take place to get an understanding of mental health outcomes. As mentioned previously and as research has shown, cultural explanations of immigrant mental health are limited and do not take into consideration other social categories such as race, gender, class, religion and more in their outcomes (Viruell-Fuentes et al., 2012). Immigration status as well should be taken into consideration, as demonstrated by participants in the study who came with their families as landed immigrants and those who came as students. Their experiences differed based on the citizenship status, their perception of a support system, the presence of said support system, and their differing experiences of racism or discrimination. Critical theory was used to challenge the status quo of mental health care delivery methods, such as cultural competence training. It was also used to examine the power dynamics in the healthcare provider-client relationship and to provide options to balance out the relationship.

A critique of Transcultural Nursing Theory that has practice and policy implications is that the narrative of equity that is largely missing. Gustafson (2005) noted that Transcultural nursing theory attempts to emphasize the uniqueness of each individual and the commonalities of

differences that exist between individuals. While it is important to acknowledge that no two people are the same, this point of view ignores the social categories that actually make a difference in health outcomes for groups of people. In the nurse-client relationship, this can be problematic, as nurses can assume that everyone begins from the same social location, which renders invisible the systems of power that work to oppress certain groups (Gustafson, 2005; Campesino, 2008). This can result in equal treatment of patients, rather than equitable treatment. While equal treatment might seem appropriate, equitable treatment is more desirable, because some patients' needs may require more attention due to those social categories of difference. Furthermore, the lack of discourse on equity can result in complete disregard of systems of oppression such as discriminatory practices in immigration and health care, and does not advocate for the dismantling of these structures. Leininger's theory focuses on direct care between the nurse and individuals/groups but does not focus on necessary systemic and policy changes that can influence health outcomes.

Areas for Further Study

This study brought up a multitude of questions that I believe warrant further study in the future. Of importance is examining the rate of mental health service utilization amongst African immigrant youth. Given the stigma associated with help seeking in this community, it begs the question of how many people seek out mental health services when needed. In this study, three out of eight participants were in contact with a mental health professional. It may be beneficial to explore on a larger scale how many African immigrant youth seek help. And for those who do seek help, it would be beneficial to explore their experiences with the mental health care services provided. Breaking this down further, one could explore if there is a gendered difference in mental health care service utilization amongst African immigrant youth. Based on the results of

this study, in which both men and women acknowledged that men are more resistant to opening up about their mental health, and also based on their vulnerability, it would be helpful to study this difference. Although not deeply explored in this study, some participants alluded to the process of becoming “Black” (racialization) when they moved to Canada, based on their experiences of discrimination. It would be interesting to explore in depth the identity shift and the process of “becoming Black” that immigrant youth experience in their host country. Blackness carries a weight as members of this group face racial injustices that have negative physical and mental health consequences (Carter, 2007; National Collaborating Centre for the Determinants of Health, 2017). Another area worth exploring is that of African immigrant youth place of residence when they first arrive. Some of the participants mentioned that they faced some sort of discrimination when they moved into a White neighborhood. It would be interesting to explore the experiences of those raised in high immigrant neighborhoods. Perhaps they may not have faced discrimination from their neighbors, but they could have experienced some sort of structural discrimination that residential segregation carries (Viruell-Fuentes, 2012).

Limitations

This study has some limitations. A possible limitation to this study could be that data are those I deemed relevant to collect and interpret due to my prior knowledge. In order to minimize this, I strived to participate in reflexivity as much as possible. I wrote down any prior thoughts I had before entering the field, and I questioned how I came to the interpretation of my study. I also participated in member checking, by sending a summary of my findings and interpretation to the participants, though only four participants responded. Another limitation is the small sample size of the study. There were two male and six female participants, which is not representative of the African immigrant youth demographic. Although the findings may not be

generalizable to the whole African immigrant youth population in Canada, they did provide some insight into the topic.

Dissemination of Findings

The findings from this study will also add to the body of research on mental health amongst immigrant groups, and more specifically, African youth. I will seek to present any findings at conferences or forums that cater to mental health nursing, in order to support the importance of diversity and cultural competence in mental health nursing research and practice. I also hope to publish my findings in a research journal for the academic community.

Chapter Seven: Conclusion

The “So, What”? of it All

This study sought to explore the attitudes and beliefs African immigrant youth in Canada held towards mental health and their origins, along with the ways these beliefs influenced their mental health practices. The mental health practices of African immigrant youth were also explored as well as factors that affected their mental health. Eight participants were interviewed to gain their perspectives on this topic. The findings from the study showed that African immigrant youth held generally positive views on mental health even though the topic is stigmatized in their community. Their personal experiences with mental health challenges, along with parental influence and observations of cultural norms were the origins of these beliefs. Participants endorsed that although speaking up about mental health was looked down upon, they found the strength to seek help when it was needed. Gender differences were also acknowledged by participants; men were discouraged from speaking up about mental health than women. Transitioning proved to be difficult for participants, as they grew into adulthood, moved locations, switched identities. Factors such as resilience, religion and hypermasculinity proved to be protective for their mental health, while also serving as a double-edged sword. Immigration experiences also differed for participants that shaped their mental health outcomes.

This study provides an understanding as to why some mental health service providers may not necessarily see many members from this demographic accessing their services. Based on the findings of this study, it is recommended that mental health promotion and treatment services be brought to African immigrant youth, rather than waiting for them to access their services. The stigma of mental illness and help seeking in the African immigrant youth community shows there is a need for mental health literacy in the African immigrant community.

It would be beneficial if those providing the education were from the African diaspora community, as participants in the study stated that they would be more likely to connect with them. It may also be beneficial to hold mental health education sessions in religious institutions, as African immigrant youth may be more likely to access faith-based organizations before formal mental health services. For students, African student associations in universities and colleges could serve as a hub for mental health promotion services.

This study urges nurses to look beyond the surface of the client or patient that they're presented to consider the intersecting socio-political-economic factors that affects their health. This encourages health care professionals to break down barriers to care for members of this group who want to seek help for mental health challenges or mental illness. The knowledge gained from this study can help nurses advocate effectively for patients who are African immigrant youth.

Finally, this study highlights the importance of cultural humility in the care of African immigrant youth. Services that are aimed towards promoting mental health and preventing mental illness can use the information from this study as a guide, in conjunction with the knowledge of their client, when working with African immigrant youth. African immigrant youth should serve as care partners in the working relationship and they should have a voice in their treatment options. Services that are to be delivered to this demographic should have their input, as they are the experts in their care. The consideration of cultural humility in care delivery serves the overall goal of social justice which will subsequently work to reduce health inequalities.

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Appendix 1

LET'S TALK



Participants needed for a MScN thesis study on the views of African immigrant youth on mental health

Are You Eligible?

- African immigrant youth between the ages of 18 and 25
- Born in an African country
- Came to Canada during grade school years
- Currently living in Canada

If you meet the criteria listed above, please feel free to contact me.

You will be asked to participate in a sit-down interview for approximately 45 minutes on your views on mental health.

For more information or to volunteer, please reach out to Lola Olawo

Please note that participation is completely voluntary and your confidentiality will be protected.

Appendix 2 Interview Guide

1. Can you describe what mental health means to you?
2. How would you describe someone who is mentally healthy?
3. What do you believe is the cause of mental illness?
4. How is mental health viewed in your culture?
5. How has your cultural background influenced how you view mental health?
6. What situations or experiences have influenced your views on mental health?
7. Talk to me about your thoughts on immigration and how it affects youth mental health?
 - a. What challenges did you experience when you moved to Canada? (For example, some people experience economic challenges, discrimination [race/ethnicity, gender, sexual orientation] etc.) Did you experience any of these? If so, how did you cope with these?
8. How would you describe your mental health?
9. Have you experienced any mental health issues or challenges? (Some may not recognize symptoms of mental health issues, so I will use probes such as: For example, feeling sad for a long time, trouble sleeping, or concentrating, irritability)
 - a. If yes, how did you deal with it?
 - b. If no, can you share some ideas on how you would possibly deal with a mental health crisis? Or how you would encourage others who are dealing with a mental health crisis?
10. What services do you think would be helpful to African immigrant youth who are experiencing a mental health crisis?
11. Is there anything else about mental health you would like to add that you think is important but didn't come up in the questions I asked?

Appendix 3
Demographic Form

What country were you born in? _____

What is your current age? _____

At what age did you move to Canada? _____

What gender do you identify with? Male Female Other

What is your identified race? _____ What is your ethnicity? _____

What is your primary language? English French Other _____

On a scale of 0-10, how would you rate how financially stable you and your family were when you moved to Canada (where 0 = none at all and 10 = the most possible)?

0 1 2 3 4 5 6 7 8 9 10

What is the highest education level you have completed?

- Some high school
- High school graduate
- Some college/University
- Bachelor's degree
- Master's or professional degree
- Other _____

Please leave a contact number in case we need to reach you _____

Appendix 4 Informed Consent Form

Study Name:

Exploring the Attitudes, Beliefs and Practices Concerning Mental Health Amongst African Immigrant Youth Living in Canada: An Interpretive Description Study

Researcher:

Omolola Olawo, RN, MScN candidate, York University

Purpose of the research:

The purpose of this study is to enhance understanding about the attitudes, beliefs and practices concerning mental health amongst African immigrant youth living in Canada. The study will seek to examine how these youth view mental health and the social and cultural factors that influence these views.

What you will be asked to do in the research:

You will be asked to complete a demographic sheet. This quick questionnaire will ask your age, gender, country of origin, family financial stability growing up and education level. You will also be asked to have a face-to-face interview with the researcher. The interview can take from 45 minutes to an hour or more, depending on how much information you choose to share. During this interview, you will be asked questions that relate to mental health, your cultural background and social experiences post immigration. This interview will be audio taped and you will be asked permission for this before the interview begins. At the end of the study, you will also be asked to participate in a group interview with other participants in order for the researcher to share findings of the study. This follow up interview will take approximately an hour. You will be asked as a collective whether or not the researcher's interpretations align with your perspective.

Risks and discomforts:

The discussion of mental health and mental illness could be a sensitive topic to some. I am committed to creating a supportive environment and a safe space where each participant will be able to request a break if needed or request the interview to stop if they are upset. Referral to mental health services that provide culturally congruent care for African youth will be available upon request, and if participants were to disclose a mental health challenge.

Benefits of the research and benefits to you:

There is no direct benefit to you. However, participants will have the opportunity to share their thoughts and experiences concerning mental health with a researcher who is genuinely interested in listening to them. You will be offered a \$10 cash gift as a token of appreciation for your participation. The findings of this study will add to the limited body of research on mental health and African immigrant youth. The knowledge gained could potentially help reduce the stigma of discussing mental health amongst African youth. It can also aid in supporting the need for culturally adapted mental health services and programs.

Voluntary participation:

Your participation in the study is completely voluntary and you may choose to stop participating

at any time. The incentive offered will not be revoked if you wish to withdraw from the study. Should you decide not to volunteer this will not influence the relationship you may have with the researcher or with York University either now, or in the future.

Withdrawal from the study:

You can stop participating in the study at any time, for any reason, if you so decide. Your decision to stop participating, or to refuse to answer particular questions, will not affect your relationship with the researcher, York University, or any other group associated with this project. In the event you withdraw from the study, all associated data collected from you will be immediately destroyed wherever possible.

Confidentiality:

All notes and audiotapes from this study will be stored in a locked cabinet accessible only to the researcher. Electronic copies will be stored on a flash drive that will be kept with the notes and audiotapes. They will not be destroyed at the end of the study. The data will be kept safely for a period of two years. All data will then be destroyed two years after completion of the study. The researcher will ensure your confidentiality to the fullest extent possible by law.

Questions about the research?

If you have any questions about the research or your role, feel free to contact the researcher listed above. You may also wish to contact my supervisor, Dr. Beryl Pilkington. You may also wish to contact the graduate program of nursing. They can be reached at gradnurs@yorku.ca. This research has been reviewed and approved by the Human Participants Review Sub-Committee, 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 Exploring the Attitudes, Beliefs and Practices Concerning Mental Health Amongst African Immigrant Youth Living in Canada: An Interpretive Description conducted by Omolola Olawo. I have understood the nature of this project and wish to participate. I am not waiving any of my legal rights by signing this form. My signature below indicates my consent.

I agree to be audio-recorded during the course of this study

Signature _____
Participant: (named above)

Date _____

Signature _____
Principal Investigator: Omolola Olawo

Date _____

Appendix 5

Summary of findings and interpretation

Attitudes and Beliefs about mental health

- Participants hold a positive view towards mental health
- Those who viewed it negatively previously have changed their minds due to personal experience or interaction with those experiencing mental health challenges
- Meanings attributed to mental health: coping, dealing with life's struggles, meeting goals and expectations, self-care, acknowledging one's feelings
- It's not talked about openly in African culture. Stigma surrounds the discussion of mental health
- Physical manifestation needed to believe someone is experiencing a mental health crisis
- Mental health challenges are usually denied or dismissed
- Guys are not as open discussing mental health as girls are. Men are supposed to be strong and not show emotions that can be seen as "weak"
- Guys relate mental health more to goal achievement
- In general, Africans are meant to be strong and they are supposed to be able to overcome anything.
- Spiritual beliefs closely tied to mental health beliefs. There is the belief that prayer is supposed to overcome everything. If someone is mentally ill, perhaps the devil has something to do with it. Spiritual beliefs can make one delay seeking medical treatment when issues arise

Origin of Beliefs

- Personal experiences with mental health challenges
 - School, employment issues, parental pressure, immigration, and other stressors
- Exposure to cultural beliefs through parents (parents are not open to discussing mental health), and community at large; observation of cultural norms- culture of denial and dismissal, religious experiences
- Education and awareness: lack of this leads to ignorance on mental health, but when people receive the education, they are more open to discussing and accepting the existence of mental health issues

Influence of Beliefs on Mental Health Practices

- Denial: some participants explained that because of the way they were raised and what they observed, it was easier to deny their symptoms than seek help. Because one doesn't see others experiencing mental health challenges around them, they believe it can't happen to them. Others feel like their feelings may not be valid because there may be people experiencing worse. There is also the feeling of embarrassment when it comes to help seeking.

- Lack of trust: for some participants, the lack of trust they felt for others made it difficult to open up about mental health challenges to people. The lack of trust could come from cultural norms or previous experience where trust had been betrayed
- Dismissal of feelings: when people speak up, feelings are easily dismissed. There is the fear that people will call others “crazy”, or attribute mental illness to something only White people experience. There is that fear of how people will react. They may be told to pray about it, but those they are disclosing to might not acknowledge their feelings
- Easier to talk to immediate family members than those outside of the family, again due to trust issues, fear of feelings being dismissed

Practices African Immigrant Youth follow to protect their Mental Health

- Self-care: eating well, going for walks, working out
- Finding a community where one belongs, friends, family, etc.
- Acknowledgement of feelings.
- Speaking up and seeking help
- Removing stressors from life
- Meeting goals and expectations set out for self
- Men need to be encouraged a lot more because they are resistant to speaking up about mental health

Factors Influencing the Mental Health of African Immigrant Youth

- Parenting: authoritative parenting can sometimes have a negative effect on one’s mental health. Heavy parental expectations and pressure can also lead to mental health challenges. Parental support can have a positive effect on one’s mental health; the ability to speak openly with one’s parents
- School: stress of coming into university from high school, going to school in a different country, academic pressure
- Culturally competent mental health care practitioners: Having a therapist or counsellor who one can relate to can build the therapeutic relationship. These practitioners may be of similar background, or have a deep understanding of the unique issues African immigrant youth experience
- Immigration: not having a support system could negatively impact one’s mental health; different experiences of immigration affect participants on different levels, could be experienced as bullying, microaggressions, etc.; identity issues and culture shock was reported by some participants- this happens when you come into a country and you become the minority, trying to fit in with Canadian culture, while also maintaining African identity. It can be hard to find the balance.
- Employment: searching for employment or losing a job can have an impact on one’s mental health
- Overcoming challenges: for those who experienced challenges, overcoming them gave them a positive outlook and had a positive impact on their mental health.

Interpretation

- The main themes that emerged in the findings were around transitioning between life phases, the different experiences of immigration and resilience and protective factors that serve as a “double edged sword”
- **Transitioning- the unknown**
 - Emerging Adulthood: Unfamiliar Territory
 - This phase brings about a new set of challenges, priorities and responsibilities one may not be familiar with
 - Transitioning from high school to university, looking for a job and being financially independent
 - It can be difficult to cope in this phase of life that one is unfamiliar with.
 - This transition also brings about maturity and self-awareness
 - Migration: Where am I?
 - Difficulties may arise when trying to adjust to a new country with different sets of laws, rules and cultural norms
 - Culture shock
 - Lack of social support for some can be trying on their mental health. For those who find a community, it is difficult to disclose mental health challenges because of the stigma that exists. People would want to do anything to keep this community close, including denying mental health symptoms and delaying help seeking.
 - The lack of representation of those who are experiencing mental health challenges in that community can also lead to self-stigma and denial. People may feel like they are the “abnormal” one out of others.
 - For those who felt like their parents were overprotective when they moved to Canada, this again can be linked back to the lack of a support system. There aren’t a lot of people that parents can trust. This is especially true if they live in a low income neighborhood. There is the instinct to want to hold a child close in order to protect them. Parents may not want their kids to mix with other children born in Canada, in order to maintain their culture and traditions.
 - Identity: Stuck in the Middle
 - Youth come into a culture that they do not necessarily understand. They feel like they are different from the general Canadian population. For African youth, their identity is closely tied to their culture, which is multilayered and multidimensional. Culture for them includes their unique experiences of race, gender, religion and shared group behavior.
 - There is the pressure felt by some to either identify with the Canadian culture or their heritage culture. If they didn’t fit into the Canadian culture,

due to their accent, and all around “difference”, they may be bullied or discriminated against

- On the other hand, if they try to fit into the Canadian culture, there is the risk of being looked down upon by others in their heritage culture for being “too Canadian”. This creates a feeling of being stuck in the middle of two contrasting identities. A culture clash of some sort exists. Integrating two cultures can be confusing and distressing for youth. This can take a toll on one’s mental health
- Discrimination in Canada can be due to the negative perception of Africa in media outlets.

- **Protective Factors**

- Resilience: Glass half full
 - Being able to bounce back from challenges serves as a way to protect African immigrant youth’s mental health
 - Participants mentioned that they were able to tap into their internal strength, utilize religion, a support system and looking forward to the future as a way to bounce back from challenging situations
 - Knowledge of African history and the turmoil the continent has faced builds one to be strong and encourages them to be able to overcome challenges they face. When comparing their situation to others, they seem to tap into an internal strength that holds them up.
 - Although this can help build resilience, it can serve as a barrier to seeking help because they believe they should be able to overcome it all.
- Religion as a Protective Factor
 - Hope and strength closely tied to religion and spirituality
 - African immigrant youth who are religious use their religion as a source of hope and strength during difficult times
 - Prayer may be seen as first aid for those who are in crisis. Seeking professional help may be discouraged and youth may be encouraged to pray or seek out religious leaders instead
 - Strong influence of religion can affect people’s perception of mental health. While religion is a source of hope for individuals, it can also reinforce the stigma faced by those who are experiencing mental health challenges

- **Immigration Experiences of African Immigrant Youth**

- Support System
 - Definition of a support system differs between individuals. Can mean immediate family, extended family or friends

- For some, the presence of their defined support system when they came to Canada provided them a positive experience. Those who did not have a support system noted a negative impact on their mental health
- Role Changes
 - When one moves, their role in the family may change depending on immigration circumstances.
 - Males may have to take on a father figure role if their father did not make the move with them. This can be demanding for young people who are struggling to adjust to a new society while also trying to help their family settle in as well. Gender norms, cultural norms and power dynamics can leave young African boys vulnerable to mental health challenges
 - Mothers who did not work back home may need to find employment, if financial challenges exist.
 - Youth who move by themselves take on the role of being independent, which may be a disruption to the role they previously had back home
- Gender
 - For males, there may be the need to be hyper-masculine because of gender and cultural norms
 - This can make them susceptible to mental health challenges because they may be resistant to discussing their mental health openly
 - Although they may be encouraged to open up and be vulnerable, they might associate vulnerability with being weak, which in turn causes them to retreat even further
 - There may be expectations from females of how they believe males are supposed to act- strong and non-emotional. If males start to show emotions, there may be a fear of being emasculated by females