

**Black Women's Experiences with Mental Illness, Help-Seeking &
Coping in the Halifax Regional Municipality:
A Study Conducted to Inform NSHA's *Nova Scotia Sisterhood
Initiative***

Principal Investigator & Author

**Dr. Ingrid Waldron, Ph.D.
Associate Professor
School of Nursing
Faculty of Health
Dalhousie University**

Email: iwaldron@dal.ca

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Acknowledgments

Principal Investigator & Author

Dr. Ingrid Waldron, Ph.D.
Associate Professor
School of Nursing, Faculty of Health
&
Flagship Project Co-Lead, Improving the Health of People of African Descent, Healthy
Populations Institute
Dalhousie University, 5869 University Avenue, Halifax, B3H 4R2

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Participants

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Research Assistants

- Jasmine Moreash
- Tolu Oladogba

NSHA's Nova Scotia Sisterhood Advisory Committee

- Gary O'Toole, Senior Director, Population & Public Health, Nova Scotia Health Authority (NSHA)
- Graeme Kohler, Director, Primary Health Care, Chronic Disease Management and Family Practice - Northern Zone
- Ashley Harnish, Manager, Nova Scotia Brotherhood Initiative (NSBI), Primary Health Care, NSHA, Central Zone
- Maria Alexiadis, Head, Department of Family Practice, NSHA, Central Zone
- Sharon Davis-Murdoch, Co-President, Health Association of African Canadians (HAAC)
- Mario Rolle, Wellness Navigator, NSBI, Primary Health Care, NSHA, Central Zone
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The Strong Black Woman is Dead...

On August 15, 1999, at 11:55 p.m., while struggling with the reality of being a human instead of a myth, the strong Black woman passed away. Medical sources say she died of natural causes, but those who knew her know she died from being silent when she should have been screaming, milling when she should have been raging, from being sick and not wanting anyone to know because her pain might inconvenience them. She died from an overdose of other people clinging to her when she didn't even have energy for herself. She died from loving men who didn't love themselves and could only offer her a crippled reflection. She died from raising children alone and for not being able to do a complete job. She died from the lies her grandmother told her mother and her mother told her about life, men and racism. She died from being sexually abused as a child and having to take that truth everywhere she went every day of her life, exchanging the humiliation for guilt and back again. She died from being battered by someone who claimed to love her and she allowed the battering to go on to show she loved him too. She died from asphyxiation, coughing up blood from secrets she kept trying to burn away instead of allowing herself the kind of nervous breakdown she was entitled to, but only white girls could afford. She died from being responsible, because she was the last rung on the ladder and there was no one under her she could dump on.

The strong Black woman is dead. She died from the multiple births of children she never really wanted but was forced to have by the strangling morality of those around her. She died from being a mother at fifteen and a grandmother at thirty and an ancestor at forty-five. She died from being dragged down and sat upon by un-evolved women posing as sisters. She died from pretending the life she was living was a Kodak moment instead of a 20th century, post-slavery nightmare! She died from tolerating Mr. Pitiful, just to have a man around the house. She died from lack of orgasms because she never learned what made her body happy and no one took the time to teach her and sometimes, when she found arms that were tender, she died because they belonged to the same gender. She died from sacrificing herself for everybody and everything when what she really wanted to do was be a singer, a dancer, or some magnificent other. She died from lies of omission because she didn't want to bring the Black man down. She died from race memories of being snatched and raped and snatched and sold and snatched and bred and snatched and whipped and snatched and worked to death. She died from tributes from her counterparts who should have been matching her efforts instead of showering her with dead words and empty songs. She died from myths that would not allow her to show weakness without being chastised by the lazy and hazy. She died from hiding her real feelings until they became hard and bitter enough to invade her womb and breasts like angry tumours. She died from always lifting something from heavy boxes to refrigerators.

The strong Black woman is dead. She died from the punishments received from being honest about life, racism and men. She died from being called a bitch for being verbal, a dyke for being assertive and a whore for picking her own lovers. She died from never being enough of what men wanted, or being too much for the men she wanted. She died from being too Black and died again for not being Black enuff. She died from castration every time somebody thought of her as only a woman, or treated her like less than a man. She died from being misinformed about her mind, her body and the extent of her royal capabilities. She died from knees pressed too close together because respect was never part of the foreplay that was being shoved at her. She died from loneliness in birthing rooms and aloneness in abortion centres. She died of shock in

courtrooms where she sat, alone, watching her children being legally lynched. She died in bathrooms with her veins busting open with self-hatred and neglect. She died in her mind, fighting life, racism, and men, while her body was carted away and stashed in a human warehouse for the spiritually mutilated. And, sometimes when she refused to die, when she just refused to give in she was killed by the lethal images of blonde hair, blue eyes, and flat butts, rejected by the O.J.'s, the Quincy's, & the Poitiers. Sometimes, she was stomped to death by racism and sexism, executed by hi-tech ignorance while she carried the family in her belly, the community on her head, and the race on her back!

The strong silent, talking Black woman is dead!

Written by Laini Mataka, author of the book *Bein' a strong Black woman can get U killed!!* (2000).

Executive Summary

Study Purpose

- The purpose of this study, which began in June 2019 and concluded at the end of May 2020 was to collect qualitative data on the mental health issues affecting diverse Black women in the Halifax Regional Municipality (HRM) to inform the *Nova Scotia Sisterhood Initiative*, a proposed health initiative for Black women at Nova Scotia Health Authority (NSHA).

Study Objectives

The study had four main objectives:

- To examine Black women’s experiences with mental illness, including how their experiences related to race, culture, gender identity, sexual orientation, socio-economic status, citizenship, disability, and age impact their mental well-being.
- To examine Black women’s beliefs about the causes of mental illness and how one should seek help for it.
- To examine Black women’s help seeking behaviours and coping methods to address mental illness.
- To obtain Black women’s suggestions for how the *Nova Scotia Sisterhood Initiative* can address Black women’s mental health needs.

Study Rationale

The rationale for the study was three-fold:

- There is a lack of research data on Black women’s experiences with mental illness in Nova Scotia.
- There are few, if any, mental health services that address the specific needs of Black women in the HRM and in Nova Scotia more broadly.
- These gaps will be addressed by conducting a study that will inform mental health services at the proposed *Nova Scotia Sisterhood Initiative* at NSHA.

Conceptual Framework

- The study uses a Black Feminist Analysis to examine how Black women’s multiple identities and the simultaneous oppressions they experience impact their mental well-being and influence their approaches to help-seeking and coping. Black feminism holds that Black women’s experiences must be understood as an outcome of their structural positions in relation to racism, sexism, homophobia, transphobia, class oppression, and other “isms”, and that Black women are positioned within structures of power in different ways than white women.

Methodology

Sample

- A total of 25 Black women living in the HRM were recruited to participate in this study. Participants were required to be 18 years of age and older and currently dealing with mental illness. Participants were diverse based on age, birthplace, culture, gender identity, sexual orientation, socio-economic status, and ability/disability.

Data Collection

- Data collection in the form of one-hour audio-recorded in-depth interviews with each participant were conducted using an interview guide.

Recommendations

The following is a summary of recommendations that outlines how the proposed *Nova Scotia Sisterhood Initiative* at NSHA can effectively address Black women's mental health needs. For the full list of recommendations, please see page 44.

Recommendation 1: Hiring Black Health & Mental Health Professionals with Diverse Educational & Professional Backgrounds

- Hire a Black manager who understands the importance of hiring a team of Black mental health professionals who are diverse based on culture (African Nova Scotian, Caribbean, African), sexual orientation, gender identity, and educational background and professional training.
- Ensure that health and mental health professionals and other service providers represent a wide spectrum of educational background and professional training, including general practitioners, nurses, recreation therapists, social workers, psychologists, psychiatrists, nutritionists, clergy with counselling experience, therapists, counsellors (including youth counsellors), and outreach workers who are connected to grassroots community initiatives and leaders.

Recommendation 2: Offering Holistic Community-Driven Trauma-Informed Services

- Provide holistic community-driven trauma-informed services that combine “western”, “alternative”, and self-care/self-healing approaches and that consider and address the intersecting personal, social, economic, community, and physical health needs of Black women.
- Acknowledge the personal, social, economic, community level, and structural barriers Black women face seeking help for mental illness, including the stigma around mental illness in Black communities, stereotypes of Black women as strong and not needing mental health care, a fear among Black women that they will be seen as weak if they

access mental health services and that their privacy will be compromised, and the cost of seeking help from a mental health professional.

Recommendation 3: Providing Accessible Services

- Locate *Sisterhood* services directly in multiple Black communities (including a centralized zone) and near a bus route to ensure that it is accessible to people who have childcare responsibilities and who are working part-time or doing shift work.
- Offer services with flexible hours and that are available from the early morning to late evening.
- Offer a free childcare service or a space where children can play.

Recommendation 4: Conducting Community Outreach to Increase Access to Services

- Develop relationships with Black female community leaders and other key community leaders who can spread the word about the services within their own communities and through their networks.
- Deliver presentations and workshops on *Sisterhood* services at spaces where Black women congregate, including recreation centers, hospitals, churches, social work conferences and other conferences, and Black community organizations, such as the East Preston Lions, the East Preston Ratepayers Association, the North Preston Ratepayers Association, the Black Educators Association, the Association of Black Social Workers, African Nova Scotian Affairs, and the African Diaspora Association of the Maritimes.

Recommendation 5: Creating Awareness About the Nova Scotia Sisterhood & its Services

- Share promotional material on the *Sisterhood* by email and on social media (e.g. Facebook, Instagram, Twitter, the African Nova Scotian Directory, library apps).
- Share promotional material about the *Sisterhood* with Black community organizations, libraries, and government departments and agencies, and ask them to share the information on their social media platforms and websites, through their email listserves, and at their organizations.

Study Description

Study Purpose

The purpose of this study, which began in June 2019, with various outreach strategies to recruit participants, and concluded at the end of May 2020 with the release of this study report, was to collect qualitative data on the mental health issues affecting diverse Black women in the Halifax Regional Municipality (HRM) to inform the *Nova Scotia Sisterhood Initiative*, a proposed health initiative for Black women at Nova Scotia Health Authority (NSHA). The study uses a Black feminist analysis to examine how multiple social identities shape Black women's lived experiences, struggles with mental illness, and coping and help-seeking approaches.

Study Objectives

The study had four main objectives:

- To examine Black women's experiences with mental illness, including how their experiences related to race, culture, gender identity, sexual orientation, socio-economic status, citizenship, disability, and age impact their mental well-being.
- To examine Black women's beliefs about the causes of mental illness and how one should seek help for it.
- To examine Black women's help seeking behaviours and coping methods to address mental illness.
- To obtain Black women's suggestions for how the *Nova Scotia Sisterhood Initiative* can address Black women's mental health needs.

Study Rationale

In March 2019, the principal investigator for this study and author of this report was approached by Mario Rolle, Wellness Navigator at NSHA's Nova Scotia Brotherhood Initiative (NSBI) and Dr. Ron Milne, a physician at NSBI, about meeting to discuss the possibility of the author conducting a study on mental health issues affecting Black women that would inform a new health initiative for Black women at NSHA, which would be tentatively called the *Nova Scotia Sisterhood Initiative* and would follow the NSBI model. NSBI is a free program for Black men to access health care in the community to improve overall health and wellbeing. A team of health care professionals provide culturally appropriate primary medical care, as well as health and wellness services for men of African descent across the HRM. These include primary medical care; health promotion and wellness education; chronic disease management; navigation to community resources; and a variety of free health and wellness programs. The proposed new "sisterhood" initiative for Black women would build on NSBI's successful model by providing health care to Black women directly in their communities.

During the author's meeting with Mr. Rolle and Dr. Milne, they indicated that Black women often attend their program with their partners and share the mental health struggles they are experiencing resulting from relationship and family conflicts, intimate partner violence, discrimination and other factors. However, since NSBI's mandate is to provide health care to Black men only, it does not have the capacity to provide health care to Black women. This

highlighted a need to address a gap in the health system by developing a health initiative for Black women and conducting a study that would focus specifically on Black women's experiences with mental illness and help-seeking. Therefore, the rationale for conducting this study was three-fold:

- There is a lack of research data on Black women's experiences with mental illness in Nova Scotia.
- There are few, if any, mental health services that address the specific needs of Black women in the HRM and in Nova Scotia more broadly.
- These gaps will be addressed by conducting a study that will inform mental health services at the proposed *Nova Scotia Sisterhood Initiative* at NSHA.

Context & Background: A Review of the Literature

At the end of the nineteenth century, a popular topic up for debate was the apparent relative absence of "madness" among African, Asian, and Native American people. As cited by Suman Fernando in his book *Mental Health, Race and Culture* (1991), the following comment by the clinical director of Georgia State Sanitarium about the apparent rarity of depression among Black people in the American South is typical of the general views among psychiatrists at the time:

It appears that the Negro mind does not dwell upon unpleasant subjects, he is irresponsible, unthinking, easily aroused to happiness, and his unhappiness is transitory, disappearing as a child's when other interests attract his attention ... Depression is rarely encountered even under circumstances where a white person would be overwhelmed (p. 39)

Over the last several decades studies have emerged to challenge notions about Black people's imperviousness to physical and emotional pain. Harriet A. Washington examines pathologizing myths about the Black body during the colonial era in her ground-breaking book *Medical Apartheid: The Dark History of Medical Experimentation on Black Americans from Colonial Times to the Present* (2007). In her book, she observes that slaves were exploited and abused by physicians by way of ad hoc experimentation in medications, dosages, and spontaneous surgical experiments. The powerlessness and legal invisibility of slaves enabled their neglect and abuse by a court system that had little concern for their safety and health. Real (skin colour, hair texture etc.) and imagined (elongated penises, distended labia, etc.) physical differences between Blacks and whites during the colonial era contributed to ideologies of Black biological primitivism and, consequently, led to the pathologization of Black bodies. According to Washington, physicians advanced theories about the greater immunity of Black people to malaria and yellow fever during the colonial era, although there was no evidence that they had an innate, absolute resistance to these diseases. Scientists also made claims at that time that the primitive nervous systems of Black people made them immune to physical and emotional pain and to mental illness. These and other stereotypes highlighted contradictions about the Black body in two main ways during the colonial era: 1) theories about real and perceived physical differences between Blacks and whites were developed and 2) myths about the Black body as inherently stronger, more resilient, or impervious to most illnesses were generated (Washington 2007).

Looking specifically at the intersections of socially constructed notions of Black femininity and mental illness, several studies observe that societal stereotypes of Black women as nurturing, strong, self-sufficient, assertive, resilient, and invulnerable “superwomen” have contributed to persistent myths that Black women don’t experience mental illness (Bing & Reid, 1996; Carrington, 1980; Collins, 1990; Moynihan, 1965; Mullings, 1992; Waldron, 2002, 2019). These myths are damaging not only because they ignore the racialized physical and mental trauma that Black women have long had to endure, but also because they are internalized by Black women, resulting in their tendency to minimize, ignore or deny the mental health challenges they experience. As the author of this study report observes in her article “Archetypes of Black womanhood: Implications for mental health, coping, and help-seeking” (Waldron, 2019), Black women’s structural location at the intersection of race, gender, class and other identities also contributed to representations of Black women as Jezebels, Mammies, Matriarchs, Superwomen, Angry Sapphires, and Welfare Mothers in pop culture and in society. These controlling images of Black women originated during slavery as a way for slave owners to justify their maltreatment, abuse, and oppression. The image of the Mammy is one that has persisted in popular culture and which portrays Black women as asexual, religious or spiritual, faithful, nurturing and subservient. The Black Matriarch stereotype is rooted in Black women’s disproportionate role as breadwinners in single parent households. This image obscures, however, the ways in which racism within education, employment, and the criminal justice system has severely limited Black men’s economic viability in their families and in society. The Welfare Mother stereotype is one that characterizes Black women as breeders who have a proclivity for giving birth to too many children and who rely on welfare. The Jezebel trope portrays Black women as hypersexual, promiscuous, and immoral. The Angry Black Mother or Sapphire stereotype depicts Black women as hostile, assertive and embittered. Finally, the Black Superwomen portrays Black women as resilient, strong, invulnerable, and having superior physical and psychological strength (Copeland, 1982; Stanton, Jerald, Ward & Avery, 2017; Waldron, 2002; Waldron, 2019).

Taken together, these six main controlling images characterize Black women as inherently and naturally built to endure life’s hardships, leading to unrealistic expectations from Black family members, the Black community, and the broader society that Black women should never show “weakness”. This has resulted in a strong devotion to non-disclosure among Black women facing personal crisis and, consequently, the underutilization of mental health services (Carrington 1980; hooks 1993; Mays, Caldwell & Jackson 1996; Schreiber, Noerager & Wilson 1998, 2000; Waldron, 2002, 2003, 2005, 2019). A fear of being stereotyped and misunderstood by therapists who will view their behaviours as pathological rather than as legitimate survival responses are some of the other reasons Black women avoid therapy (Boyd, 1990; Waldron, 2005). Black women’s experiences must be contextualized, then, within their structural location at the intersection of race, gender, class, sexual orientation, and other social oppressions, as Mirza (1997) observes:

Black women inhabit a space which, because it overlaps the margins of race, gender, and class discourse and occupies the empty spaces in between, exists in a vacuum of erasure and contradiction. It is a space maintained by the polarization of the world into Blacks on one side and women on the other (p. 4).

Black women's structural locations resulting from their multiple and intersecting identities and oppressions also offer an opportunity to contextualize Black women's experiences within an intergenerational trauma lens (Martin, Boadi, Fernandes, Watt & Robinson-Wood, 2013). The concept of intergenerational trauma provides an opportunity to examine how state-sanctioned violence (Alimahomed-Wilson Williams, 2016; Menjivar, 2016; Pellow, 2016) in the form of colonialism, slavery and intergenerational structural inequities continue to harm Black communities socially, economically, and politically. For immigrants and refugees from African countries, trauma has also come in the form of war and violence, political instability and persecution, ethnic/ religious/sectoral rivalries, territorial disputes, separation from family members, and rape (Yohani & Okeke-Ihejirika, 2018). These harms create an enduring burden on the physical, spiritual, emotional, mental and psychological well-being of Black communities, resulting in stress and stress-related diseases such as cardiovascular disease, diabetes, depression, suicide, substance abuse, hypertension, cancer and obesity (McGibbon, Waldron & Jackson, 2013).

It is within this context that it is important to understand Black women's emotional and psychological histories as not simply outcomes of hereditary and genetic factors, but also as outcomes of state-sanctioned forms of violence that systematically disadvantage Black and racialized women, preventing them from meeting their basic needs and rights related to employment, income, justice, housing, food security, and other resources. In the following sections, I delve deeper into the studies that have emerged over the past few years on Black women's experiences with mental illness and their approaches to help-seeking and coping.

Mental Health Outcomes Experienced by Black Women

Over the last few years, a body of research has been emerging that is examining the many causal factors for Black women's mental illness, including genetic factors, state violence and other structural inequities and oppressions based on race, gender identity, sexual orientation, citizenship, socio-economic status and other identities. They provide evidence that Black women's structural location at the intersection of those identities and oppressions are often experienced as trauma and, therefore, puts them at an increased risk for mental illness. For Black women, trauma is specifically experienced through their exposure to race and gender-based violence, including the violence of homophobia and transphobia in 1) their relationship to the state and social structures and in 2) their intimate and other personal relationships. For example, Okeke-Ihejirika, Salami and Karimi (2019) found that African immigrant women in Alberta experience specific stressors that impact their mental health that are related to the challenges they face transitioning and integrating into Canadian culture. Contributing to these stressors are the lack of support in Canada that were present in their home countries, language barriers, the devaluation of their credentials, job inequalities, economic insecurity, lack of access to social networks, changes to traditional gender roles that put these women at increased risk for IPV, and the lack of culturally-appropriate mental health services. The authors note that the lack of support systems these women have access to contribute to higher rates of depression they experience compared to their male counterpart. African immigrant women's experiences with pre-migration traumatic events in their home countries, including gender-based violence (GBV), have a significant impact on their mental health post-migration. Mental illnesses such as post-traumatic stress disorder (PTSD), anxiety disorders, mood disorders and stress, as well as

physical illnesses such as chronic pain and other somatic disease conditions are outcomes of conflict-related sexual violence they experienced in their home countries.

African American women are also at an increased risk of experiencing symptoms of PTSD compared to their counterparts from other ethnic groups, according to a study conducted by Hauff, Fry-McComish and Chiodo (2017). There is a prevalence of infant mortality among African American women, which has been attributed to cumulative traumatic experiences, which can be described as the lifetime exposure of an individual to multiple and repeated traumatic experiences of varying intensity and duration. Personal trauma, natural disasters, and PTSD in pregnancy contribute to African American women's experiences of cumulative trauma. A significant relationship was found to exist between cumulative trauma, partner conflict, and PTSD in the post-partum period among African American women.

Martin, Boadi, Fernandes and Watt, and Robinson-Wood (2013) found that Black women's experiences of depression are caused by systemic racism, microaggressions, poverty, cultural socialization, obesity, diabetes, and exposure to interpersonal and community violence. The study notes that Black women often mask their sadness because of the pressures they and others impose on them to persevere in the face of adversity and to maintain high levels of productivity, social engagement and service to others. Depression among low-income Black mothers is also linked to several social, economic, and physical health problems, including single parenthood, employment status, social support, self-esteem, negative thoughts, history of abuse, housing/shelter, substance abuse, child behaviour problems, the stress of caring for children, loneliness, post-partum depression, traumatic childhood experiences, stressful living conditions, chronic disease conditions, ineffective strategies for coping with stress, limitations in physical abilities, dealing with grief at an early age, and financial constraints (Atkins, Luo, Wunnenberg, Ayres, Lipman, Pena-Cardinali, Hayes & Deatrck, 2020).

Poor mental health outcomes among African American women such as depression and anxiety disorders were found to be associated with social and environmental factors in a study conducted by Lacey, Parnell, Mouzon, Matusko, Head, Abelson and Jackson (2015). These social and environmental factors include housing quality, financial resources, social isolation and community violence. Perceived racial discrimination, as well as experiences of IPV were also correlated with anxiety disorder, eating disorder and other mental health disorders. The likelihood of having a mental health condition was found to decrease as African American women age. African American women who were married were less likely to have mental health problems than those who were single, separated, divorced, or widowed. The study also found that less educated African American women were less likely to develop anxiety, substance abuse, suicidal ideation or other mental health disorders.

Studies that have emerged over the last several years point to discrimination, stigma and other structural factors for poor health outcomes experienced by Black and other racialized people in the LGBTQ community. For example, depression was found to be significantly more prevalent among transgender women than in the general population in the United States in a study conducted by Bukowski, Hampton, Escobar-Viera, Sang, Chandler and Henderson (2019). However, depression was even higher among Black transgender women (BTW) and associated with suicidal ideation and attempts. The factors that were found to be significantly correlated with symptoms of depression for BTW included IPV, physical and verbal violence, social support, gender identity, sex work, level of education, employment status, relationship status, and homelessness in the previous year. BTW were found to be at a higher risk for IPV resulting from their intersecting identities, limited economic opportunities due to discrimination and

stigma, and financial dependency on their partner. Social support acts as a mediator or moderator in the relationship between symptoms of depression and IPV and was found to play a significant role in the overall health of BTW.

Similarly, Sutter and Perrin (2016) found that there is an increased prevalence of anxiety, depression, mood disorders, and substance abuse among the LGBTQ individuals in their study, which examined the relationship between discrimination, suicidal ideation, mental health, and intersectional identities of LGBTQ individuals and racialized people. The researchers found that Black and Latino people are at a higher risk for depression than their white counterparts, and that their depression is often more severe. This can be attributed to their intersectional identities and experiences with both racism and LGBTQ-based discrimination. While the study found that racism was a significant predictor of psychological distress, it was not a predictor of suicidal ideation.

Bostwick, Hughes, Steffen, Veldhuis, and Wilsnack (2018) examined the relationship between lifetime depression and victimization among Black, white and Latino lesbian and bisexual women in the Greater Chicago Metropolitan Area. An increased prevalence of mental health disorders and poor mental health outcomes (lifetime depressive disorders, anxiety disorders, frequent mental distress, suicidal ideation and attempts) was observed for women who identify as bisexual and lesbian. While Black bisexual and lesbian women reported higher levels of victimization in the form of childhood victimization, childhood physical abuse and IPV, they were less likely to report or meet the criteria for lifetime depression. White bisexual and white lesbian were the most likely to meet the criteria for depression. The findings contradict the double or triple jeopardy framework that has long argued that the multiple oppressions arising from Black and other racialized women's multiple identities lead to poorer health outcomes. The researchers suggest, however, that the Strong Black Woman myth may be playing a role in these contradictory findings since Black women are often perceived as individuals who are self-sufficient, who gain strength from hardship, and who care for others at their own expense. The researchers also observe that various protective factors may ward off the mental health impacts of minority stressors, including strong racial identities, strong social support, and engagement in religious and other community events.

Factors such as low income, low levels of education, cultural barriers, institutional and social barriers, stigma, mistrust of providers, traumatic experiences, exposure to violence and racial discrimination also put African American women at significantly higher risk for depression and psychological distress, according to another study conducted by Woods-Giscombe, Robinson, Carthon, Devane-Johnson and Corbie-Smith (2016). A study conducted by Nowak, Giurgescu, Templin, Dailey and Misra (2020) found that compared to white women, African American women were more likely to have a higher prevalence of perinatal depression. They found that 50% of African American women experience symptoms of depression during pregnancy and that this was associated with adverse birth outcomes, low birth weight infants, poor infant development, impaired maternal-infant bonding, maternal hospitalization, and suicide. Several neighbourhood factors were linked to an increase in symptoms of depression, including residence in neighbourhoods with high levels of social disorder characterized by vacant housing, littered environments, drug dealing, drinking problems, noise, and vandalism.

Whittle, Sheira, Wolfe et al (2019) explore the relationship between food insecurity, anxiety, PTSD, and self-perceived stress among African American women living with or at risk for HIV, and found that food insecurity was observed to be strongly correlated with anxiety disorders, stress and PTSD among women at risk of HIV, Findings also indicate that the

probability of experiencing IPV increases among African American women if they are affected by food insecurity. Social-structural factors, socioeconomic status, and race were also identified as predisposing factors for anxiety, stress, and PTSD among these women.

Bernard, Lige, Willis, Sosoo, and Neblett (2017) determined the extent to which gender and racial discrimination moderate the association between feelings of intellectual incompetence—referred to as impostor phenomenon (IP)—and mental health among African American college students attending a predominantly White institution. The study suggests that mental health outcomes are influenced by the interaction among IP, gender, and racial discrimination experiences. IP is characterized by feelings of alienation, isolation, and anxiety related to academic perceptions and performance when attending predominantly White institutions. While societal gender inequality and gender socialization differences may increase the susceptibility of the development and psychological impact of IP for women, it is difficult to determine the extent to which gender influences the association between IP and mental health, especially among African American students. African American women who experienced lower levels of distress resulting from racial discrimination were found to be most vulnerable to negative mental health outcomes, particularly at higher levels of IP. Young African American women reporting higher levels of discrimination were most vulnerable to the negative mental health impacts of IP.

Black Women’s Experiences Seeking Help for & Coping with Mental Illness

Over the last several decades, studies in Canada (Schreiber et al, 1998; Waldron, 2003, 2005, 2010, 2019) have observed that Black women’s help-seeking and coping are significantly influenced by personal and culturally-determined beliefs they hold about the causes of mental illness, the stigma of mental illness in their communities, internalized beliefs about Black women’s strength, opportunities to access Black or culturally competent mental health professionals, and a general mistrust towards the health care system, including a fear of being stereotyped and misunderstood by mental health professionals who may perceive their cultural behaviours as pathological rather than legitimate survival responses. Therefore, a strong devotion to non-disclosure has characterized Black women’s response to the mental health issues they face, which has silenced Black women in personal crisis, resulting in their underutilization of mental health services (Waldron, 2003, 2005, 2019). Black Canadian women are more likely to address mental health problems through informal support networks and a reliance on religion, spirituality, and a higher power (Waldron, 2003, 2005, 2019).

In a study conducted by the author (Waldron, 2002), she observed that Black Canadian women of Caribbean and African heritages combine western and “alternative” approaches to address their mental health issues, including psychiatry, psychoanalysis, yoga, solitude, social support networks, spirituality, meditation, herbal remedies and diet regulation. She also found that help-seeking among Black Canadian women is influenced by social factors such as age, socioeconomic status, language, education, culture and beliefs about the causes of mental illness. Black Canadian women with higher socioeconomic status and educational levels were more likely to seek out western medical approaches than Black Canadian women with lower socioeconomic status and educational levels. Younger Black Canadian women were also more likely to use western approaches to treatment than their elderly counterparts. Some differences exist in the help-seeking behaviours of Black Canadian women who were of African and Caribbean

heritages, with women from African countries less likely to adopt western approaches and more likely to use traditional African approaches (such as a reliance on spirituality, religion and faith healers) and Caribbean women more likely to use Western modalities.

Taylor and Kuo (2019) found that stigma and double stigma are significant factors influencing help-seeking behaviours for mental illness among African Americans, and that in both the United States and Canada, Black communities hold three main culturally-determined beliefs about mental illness: 1) Black people are not affected by mental illnesses; 2) Black people must always show strength, regardless of the circumstances; and 3) people who seek help from mental health professionals lack faith in God. Similar to Black Canadians, many African Americans rely on religion and spiritual institutions to address their mental health issues, which is partly attributed to a fear that they will be perceived by others in their community as lacking faith in God or as spiritually weak. Black Nova Scotians also believed that they could be healed of their mental illness through their faith in God. Other factors influencing help-seeking behaviours among African Americans were cultural mistrust, underrepresentation of Black mental health professionals, and negative experiences with and perceptions of psychological help-seeking behaviours. Williams, Pickard, and Johnson (2019) examined the relationship between spirituality/religion and substance use among African American women and found that these women were more likely to experience psychopathologies such as depression, PTSD and anti-social personality disorders if they were addicted to multiple substances. They were also more likely to engage in religious or spiritual practices than women who had no addiction or only one addiction. The factors that were found to predispose African American women to substance use include racism, sexism, housing segregation, economic oppression, community violence, discrimination, and traumatic experiences.

In a review of the literature, Redmond, Smith and Collins (2020) observed that the barriers to mental health treatment among African American women include treatment readiness, such as fear of guilt or shame from seeking treatment, as well as a belief that treatment was not needed and lack of motivation for treatment. Barriers to treatment also included interpersonal or social support factors, such as lack of available childcare, responsibilities as a wife or mother, and fear that they may lose custody of their children as a result of being managed for substance abuse. African American women also faced barriers accessing treatment facilities and services due to inadequate treatment facilities in the community, lack of transportation, and financial constraints to pay for treatment services. The lack of culturally competent service providers, dissatisfaction with available treatment services, inadequate training of staff and mistrust in the health and social service systems were some of the treatment-related barriers they experience. Several other factors can be attributed to the underutilization of mental health services among African American women, including perceived stigma and judgement from family, friends, and community, and challenges with appropriate housing facilities among low-income African American women, especially women who were no longer in recovery.

Stigma and lack of trust in mental health service providers are some of the most common reasons why African American women underutilize mental health services, according to a study conducted by Woods-Giscombe, Robinson, Carthon, Devane-Johnson and Corbie-Smith (2016). Compared to non-Hispanic white Americans, African American women were also more likely to have unmet mental health needs. As has been observed in other studies, these women were most likely to use religion, spirituality, and resilience to deal with mental health issues. The authors determined the extent to which the Superwoman Schema (SWS) influenced the use of mental health services among African American women using five characteristics of SWS. These

include a perceived obligation to present an image of strength, perceived obligation to suppress emotions, fortitude to succeed despite limited resources, prioritization of care for others over self-care, and resistance to being vulnerable or depending on others for help. Many of these women equated help-seeking with weakness and shared that they would prefer to suffer with mental health issues than access mental health services if it meant they could maintain an image of strength or cope with the issues by relying on religion and spirituality. Some of the other reasons these women were reluctant to utilize mental health services include cultural expectations that they suppress emotional distress, concerns related to miscommunication between themselves and mental health professionals, and limited access to mental health service providers who were culturally sensitive and compassionate, and who understood the challenges they face and how the SWS concept contributed to those challenges.

Brenick, Romano, Kegler and Eaton (2017) explored the relationship between sexual orientation stigma and race-based stigma among Black women who have sex with women (BWSW), as well as the psychosocial obstacles to engagement in care among these women. They found that BWSW's racial background and sexual orientation resulted in higher rates of stigmatization related to multiple psychosocial barriers, higher levels of mistrust in health care services, and lower rates of engagement in care, including a reduction in physical examination engagement. There was an increase in engagement in physical examinations by health care providers among women who had reported low experiences of race-based stigma, sexual orientation stigma, and race-based distrust in healthcare services.

A study conducted in Toronto by Logie, Lacombe-Duncan, Lee-Foon, Ryan and Ramsay (2016) is one of few studies that address the gap in the Canadian literature on the experiences of African and Caribbean LGBT newcomers and refugees as they relate to the perceived benefits of social support groups in reducing health disparities and its impact on mental health outcomes. In looking at intersecting stigmas experienced by newcomers to Toronto, the researchers found that these individuals not only left behind experiences of oppression, imprisonment, sexual stigma, and the threat of execution in their home countries, but were also at high risk for intersecting stigmas associated with their gender, sexuality, race, class, and immigration status in their new home. These stigmas led to several challenges in addressing the social determinants of health following immigration that resulted in health disparities between them and the general population, including inadequate housing facilities, employment difficulties, lack of social support, disappointment and stress from unmet expectations before relocating to Canada, and post-migration experiences of sexual-orientation-based and race-based discrimination and stigma in Canada. Social support groups were identified by the researchers as having a positive impact on the mental health of these newcomers and refugees because they were viewed as an effective coping mechanism for LGBT newcomers and refugees of African origin. Findings indicate that the mental health of most of the participants improved after they began attending support group meetings because it raised their level of hope, provided them with the tools to address their challenges, provided them with opportunities to share their experiences with depression with others, reduced their feelings of isolation, and increased their sense of belonging and self-acceptance of their LGBT identity and rights. Structural benefits associated with support groups were also identified, including access to information on available resources and opportunities related to social determinants of health, such as housing rights, employment opportunities, health care costs and services, and assistance with the immigration process and resettlement in Canada.

According to a study conducted by Sullivan, Weiss, Price, Pugh, and Hansen (2018), the coping strategies that were most common among African American women who experienced

IPV and high rates of PTSD were social support, avoidance, religion, and substance use. Despite the stigma and shame that is often directed at them by their ethnic and religious communities, Yohani and Okeke-Ihejirika (2018) observed that African immigrant and refugee women who are survivors of sexualized violence often access psychosocial supports to address survival needs related to housing, financial security, employment, education, and medical assistance. They also coped in several ways, including keeping silent about their experience, accessing community supports, and reaching out for assistance with parenting and educational attainment (Yohani & Okeke-Ihejirika, 2018).

Black women's coping styles were the focus of studies conducted by West, Donovan and Roemer, (2010) and Atkins (2016). According to West et al, Black women use problem-focused coping and avoidant coping to deal with mental health problems associated with perceived discrimination. For Black women who used low levels of problem-focused coping, their experiences of perceived racial discrimination were positively associated with symptoms of depression. Black women who used high levels of problem-focused coping, findings indicate that their lifetime experiences of perceived racial discrimination was negatively correlated with symptoms of depression. Among Black women with high levels of avoidant coping strategy, a positive association existed between recent and lifetime experiences of perceived racial discrimination and symptoms of depression. However, among Black women with low levels of avoidant coping, a negative relationship was observed to exist between perceived racial discrimination and symptoms of depression. Atkins (2016) found that African Americans experience symptoms of depression at higher rates than their white counterparts but are less likely to seek mental health treatment or services. Single African American mothers were more likely to use the escape-avoidance emotion-focused coping style to address mental health problems. Some of the most common coping strategies they use include eating, shopping, reaching out to their social support networks, praying and attending church, sleeping, listening to music, dancing or engaging with their children. Very few of these women sought professional help for their mental health problems and were more likely to engage in emotion-avoidance strategies that included the denial or suppression of their emotions.

In conclusion, recent studies over the last several years indicate that Black women's mental health outcomes are impacted by personal, community-level, and structural factors, and that these factors are shaped by Black women's structural location at the intersections of race, culture, gender identity, sexual orientation, socio-economic status, citizenship, disability and age. Therefore, in order to fully grapple with the complexities of Black women's lives and their mental well-being, I have chosen to use a Black feminist analysis to unpack and conceptualize the nuances and contradictions of Black women's spiritual, emotional, and psychological lives.

Conceptual Framework

Race and gender-based violence against Black women takes many forms, including state violence, IPV, and structural inequities within labour, employment, immigration, health care, criminal justice, and media. The author's decision to use a **Black Feminist Analysis** (Carby, 1982; Crenshaw, 1989, 1991; Hill Collins 1990; King 1988) to interpret the study data was based on her recognition that it would provide her with the necessary tools to articulate how Black women's multiple identities and the simultaneous oppressions they experience impact their mental well-being and influence their approaches to help-seeking and coping. A Black feminist

analysis allows for an articulation of Black women's unique and shared experiences compared to both non-Black women and other Black women, thereby, highlighting the specific ways in which advantage and disadvantage are experienced among Black women. In other words, a Black feminist analysis points to the ways in which intersecting forms of domination produce both oppression and opportunity for white women, as well as for Black women vis-à-vis other Black women based on where they are positioned on the hierarchies of class, gender identity, sexual orientation, citizenship, disability and other identities.

Black feminism holds that Black women's experiences must be understood as an outcome of their structural positions in relation to racism, sexism, homophobia, transphobia, class oppression, and other "isms", and that Black women are positioned within structures of power in different ways than white women. Therefore, Black feminism emerged as a challenge to the gender essentialism of (white) feminist theory, which had failed to acknowledge intersectionality (Carby, 1982; Crenshaw, 1989, 1991; Hill Collins 1990; King 1988). The term intersectionality was first coined by Black legal scholar Kimberle Crenshaw in 1989 in her article "Demarginalizing The Intersection of Race and Sex: A Black Feminist Critique of Anti-Discrimination Doctrine, Feminist Theory, and Anti-Racism Politics". Crenshaw criticized both feminist and anti-racist theory and practice for neglecting to consider the interaction of gender and race, which led to a focus on white women or Black men, and resulted in the absence of Black women in analysis of either gender oppression or racism. In discussing the "matrix of domination", Patricia Hill Collins (1990) observes that several fundamental systems of oppression operate with and through each other, and that one's structural location in the structures of race, class, gender, and sexuality will lead to differences in how women experience themselves as gendered, raced, classed and sexualized.

More recently, the term *misogynoir* has been used by Black feminists to examine specific forms of race and gender-based violence experienced by Black women. It was created by queer Black feminist Moya Bailey in 2010 to characterize Black women's experiences of anti-Black sexism and to address misogyny directed toward Black women in American visual and popular culture (Anyangwe, 2015; Bailey, 2014; Macias, 2015; VERVE Team, 2018). The term is grounded in intersectionality theory and was initially used to discuss misogyny toward Black women in hip hop music (Bailey, 2014, Macias, 2015). The term *transmisogynoir* was created by Trudy, who runs the *Gradient Lair* website (Trudy, 2015) to describe the oppression of Black trans women whose experiences are situated at the intersection between transphobia, misogyny, and antiblackness, and to highlight the greater risk for violence that trans women of colour face (Wodda & Panfil, 2015). *Misogynoir* focuses primarily on the misogyny committed against Black women by Black men but can be perpetrated by anyone. Similar to earlier forms of Black feminist analyses, the term is used to call attention to the erasure of Black women in discussions on state violence in America, as well as to critique the many tropes imposed upon Black women that ignore the race and gender-based physical and mental trauma they have long endured, and that perpetuate the myth that Black women can handle these experiences (Boom, 2015).

Therefore, the intersectional analytical framework within which Black feminist analysis and *misogynoir* are grounded provide the tools to examine the processes through which inequalities are produced and reproduced within our social structures, and to question the power, privilege, and dominance that are outcomes of unequal relations between people and between people and social structures. It is a challenge to essentialist analyses that tend to homogenize difference or complexity by separating race from socio-economic status, citizenship, gender, sexual orientation, and other identities as discrete, rather than mutually constitutive concepts. It also

rejects analyses that present race, citizenship, gender and other social identities merely as characteristics of individuals rather than as social relations shaped by hierarchies of power and that, consequently, disconnect those social identities from the historical, social and political processes from which they emerge and shape the experiences of individuals and communities.

In highlighting sexism, racism, classism, homophobia, and transphobia, Black feminist analysis offers a framework that rejects narrow-minded thinking about identity and oppression (especially as they relate to Black women's lives) and that unpacks the ways in which Black women are affected in gender and race-specific ways as Jezebels, Mammies, Matriarchs, Superwomen, Angry Sapphires, and Welfare Mothers. As was mentioned earlier in this report, these damaging myths about Black womanhood ultimately affect and influence their interactions with social structures and their propensity to access various resources, such as health and mental health care.

Methodology

An interpretive, **Narrative Methodology** (Polkinghorne, 1988; 1995) was used in this study to collect and analyze data. This methodology enables participants to articulate and give meaning to their experiences and recognizes humans as self-interpreting beings whose interpretation of phenomena is embodied in social, cultural and linguistic practices. In other words, the methods in this research were designed to examine participants' "multiple truths", lived experiences, worldviews and perspectives, rather than to confirm any hypothesis. Polkinghorne (1988) observes that narratives are the "primary scheme by means of which human existence is rendered meaningful" (p.11). Narrative inquiry is not a mere retelling or description of another's story, but a dynamic process of interpretation that alters and contributes to the meaning of the story. Therefore, the importance of individual experience to reality is a key feature of an interpretive approach to narrative inquiry because it provides an opportunity for people to come to know themselves and others through stories and storytelling (Polkinghorne, 1988).

Recruitment Methods & Sample

Recruitment

Participant recruitment for this study was supported by the research assistant and began in June 2019 and continued throughout the project, with the final participant recruited in March 2020. The recruitment approaches used included sharing the recruitment poster through the author's social media platforms and email listserves, as well as sending it by email to leaders from African Nova Scotian and Black community-based organizations, who agreed to post it on their social media platforms and share it through their listservs. These organizations included the Black Educators Association, the Association of Black Social Workers, and African Nova Scotian Affairs. Recruitment was also facilitated by Mario Rolle and Dr. Ron Milne at the Nova Scotia Brotherhood Initiative, who discussed the study with their clients. Dr. Waldron also discussed the study on CBC Radio's Information Morning, the Sheldon MacLeod Show, and Global News Halifax.

Sample

A total of 25 Black women living in the HRM were recruited for this study. It is important to point out that participants who self-identified as biracial (born to Black and White parents or Black and Indigenous parents) were included in this study. Participants were required to be at least 18 years of age and currently dealing with mental illness. The study was successful in recruiting Black women who were diverse based on age, birthplace, culture, gender identity, sexual orientation, socio-economic status, and ability/disability. The participants identified themselves culturally in the following ways: African Nova Scotian; Black Nova Scotian; Afro-Caribbean and Canadian; Black Caribbean; African Caribbean; African American; African Canadian of Nigerian culture; and Nova Scotian. Some of the women stated that they did not identify with any specific cultural heritage, had never been immersed in their culture and, therefore, knew little about their culture. Study participants were also diverse based on sexual orientation and gender identity, identifying as straight, bisexual, pan-sexual, queer, and cisgender. Finally, the study also included women who were living with diverse kinds of disabilities, including hearing impairment, mobility issues, rheumatoid arthritis, chronic debilitating pain, attention deficit hyperactivity disorder (ADHD), other learning disabilities that were not identified by the participants, and obsessive compulsive disorder (OCD).

Data Collection

Data collection in the form of one-hour audio-recorded in-depth **Interviews** were conducted using an interview guide. Participants received an honorarium to compensate them for their participation in the study. The audio interviews were later transcribed verbatim. Each woman had the opportunity to review her transcript after her interview and to share any concerns she/they had with the information they provided or to let me know if they wanted any of the information they shared to be removed for reasons related to privacy and confidentiality.

Data Analysis

In keeping with the narrative methodology, the process of analysis for this study was guided by Polkinghorne's (1995) theory of narrative emplotment. The analytical process of narrative emplotment involves reading through the transcripts in their entirety alongside the field notes to gain a sense of the whole story. The transcripts were re-read by the principal investigator (Dr. Waldron) while listening to the audiotape to ensure that all details were captured. The principal investigator then developed initial narrative themes pertaining to participants' experiences related to the study topic and objectives. She then examined the data for narrative descriptions. Similarities and exceptions in relation to people's experiences of and priorities across the data were subsequently identified. Finally, statements were interpreted to provide a meaningful account of participants' experiences. Narrative methodology is inherently inductive by nature (Bryman & Burgess, 1994; Jain & Ogden, 1999). In inductive analysis the patterns, themes and categories of analysis emerge out of the data rather than being imposed upon them prior to data collection and analysis. A theme can be defined as a statement of meaning that runs through all or most of the pertinent data or is one in the minority that carries heavy emotional or factual impact. Themes typically reflect the questions posed during an interview, focus group, or

consultation, and reflect the project objectives used to develop the interview, focus group or consultation questions. There are several components to an inductive approach. First, data analysis is determined by both the research objectives (deductive) and interpretations of the raw data (inductive). Second, categories are developed from the raw data into a framework that captures key themes and processes. Finally, the findings emerge from multiple interpretations made by participants and from the raw data. These interpretations involve the researcher/principal investigator making decisions about what is more and less important in the data.

Findings

The findings documented in this section are based on my interviews with participants, who discussed 1) their beliefs about the factors that cause mental illness, and how these beliefs have been shaped by their cultural background and the broader society; 2) their beliefs about help-seeking and coping, and how these beliefs have been shaped by their cultural background and the broader society; 3) their experiences seeking help for and coping with mental illness in the HRM; and 4) their perspectives on the types of services that should be offered by NSHAs *Nova Scotia Sisterhood Initiative* to address Black women's lived experiences and mental health struggles.

Those “Home Truths”: Black Women’s Narratives of Struggle, Distress & Trauma

Participants shared their experiences with mental illness, including their views on the multi-causal factors that underlie their mental illness. Many of the participants used the term “trauma” to describe their experiences and challenges with mental illness. Findings indicate that the main factors underlying their mental illness include racism, sexism, homophobia, disability, income insecurity, sexual exploitation (through sex trafficking), sexual molestation and abuse, intimate partner violence, parental abandonment, unstable neighbourhood and family environments, family and relationship conflicts, and genetic or hereditary factors. The most common mental health problems participants suffer from are stress, anxiety, PTSD, depression, schizophrenia, and bipolar disorder. For example, one of the participants believes that the depression and anxiety she suffers from today are a result of hereditary/genetic factors, growing up with a depressed mother, and living in neighbourhoods where substance use was the norm:

Depression is something that I have struggled with all of my life. It is a part of my family history. My mother was clinically depressed as a result of having a fibroid issue that went undiagnosed for...until she was in her late 30s. So, I grew up with a depressed mother who was in bed all day long, crying, praying. And she was a single mom too. So, I grew up witnessing her deal with the pressures and stresses of life by sleeping and going to church. I just saw my mother crying and sleeping and praying and going unsupported as a single mom with three kids on social assistance and public housing...Because what I grew up in, what I saw was addictions. Like serious addictions. It was back in the '80s and '90s where crack was like rampant. Because anxiety is something that I've struggled with more recently.

Depression and grief resulting from an abusive relationship and her son's suicide are issues that another participant has been struggling with, and which she attributes to a history and cycle of abuse in her family:

I recently fled from a very abusive relationship. Very unsupportive partner.... While I was pregnant, he busted my window because I wouldn't let him in. I had to then deal with my son's suicide shortly after my daughter was born...I finally received some extensive counselling. However, my symptoms don't fade. The depression itself, it's oppressive and it's hard to deal with. Sometimes it's dark. Sometimes I feel hopeless and like I don't belong here. My grandmother kidnapped me. Her boyfriend was sexually abusive. And she was physically abusive. I guess I keep seeing the same guy with a different name. It's hard to break those cycles and those patterns because honestly when you've learned survival tactics, most of them are poisonous.

The lack of a meaningful relationship with a man is at the root of this participant's deep loneliness, sadness, and depression:

I think moving...migrating here to Canada, I've become more aware of some emotional issues that I have. And I think they have come to the surface more. So even though earlier I described having great relationships, they still do not fill the gap that I still have, where I'm single. There will be the stresses of work and of school. And even the simplest thing of a hug from a partner, I will crave for but I don't have that...And I don't really have that many persons physically here that I feel comfortable to relate back to. So oftentimes I feel myself going into a state of depression. Not so much where like it manifests itself in a way where I would have to seek professional help but the emotions get so much where I cry, I can't explain...or not that I can't explain but it's so hard to verbalize. And I just want to just wallow in that feeling. There was one time in particular where it was the very first time I said I can see why people commit suicide. I said it to my friend. I said I will never do it but I can see because I've come to a point where it would be just easy to end it right then and there because you think it's just too much.

Trauma from the loss of a parent, as well as secondary trauma she experiences through her job has resulted in stress and anxiety for this participant:

Within my profession and in my full-time work, I'm exposed to quite a bit of trauma and other people's trauma and secondary trauma. I feel like I have a lot of symptoms that I have been traumatized from the work that I do on a daily basis. I have a lot of stress and anxiety that comes from the work that I do. As well as like on a personal level, I am a very anxious and am very stressed the majority of the time. A lot of the daily anxiety and stress comes from like I worry a lot about clients. So, the clients that I work with are clients that are at severe risk of being harmed or killed by their intimate partners. So, I feel like I am not good at leaving that at work. And my mother passed away like very suddenly from... She was diagnosed with cancer, and she passed away within four months of being diagnosed. So, there wasn't like a lot of time to prepare like as a family, as much as you can prepare for losing a parent. And afterwards my dad really relied on

me for support and to help him navigate all the paperwork and everything that comes with somebody passing away.

Relationship issues, sexual violence, physical health issues, a physical disability and issues with self-confidence are at the root of another participant's anxiety and other mental health problems:

Well, my father's not in my life right now. Well, ever. I had trouble... I find I have trouble with that. I was sexually assaulted probably about over 10 years ago by somebody that I was with. I went to the police, and nothing ever happened. Just recently in the last three years, I've had a hard time with health issues. Like I have a blood disorder. With that came rheumatoid arthritis. Like three years ago I was not walking at all. Like I had canes, I was in a wheelchair. So now I'm actually doing much better. But I just feel like there's nowhere to go to talk to anybody about anything. And it's definitely hard. I feel like I always second-guess myself. Like can I do this? Or what if I don't do it right? Like even if I'm with...like if I have a partner, if I have a boyfriend or anything, I wonder to myself am I doing something wrong in a relationship all the time? I feel like I don't know how I'm supposed to be treated because he...my father didn't teach me that, right.

Her biracial (Black and white) and bicultural (Caribbean and Nova Scotian) identities, experience being sexually assaulted, family conflicts, and her menstrual cycle have all contributed to her anxiety, depression, ADHD, and PTSD, according to another participant:

So, I guess the underlying sort of illness or afflictions or conditions have been depression and anxiety. So, I do have very low episodes and I have in the past, particularly after having children. I had extreme postpartum. But I do see it's related to my menstrual cycle. I was hypersensitive as a child. And I believe that comes from sort of being a mix of two very different cultures. I think I was a little bit more sensitive than my siblings where I was really searching for identity. And I had a hard time finding it here in Nova Scotia. Because even though everyone was telling me I was Black, I really wasn't accepted by the Nova Scotian community here. I have extreme phobias with public speaking and meeting new people and speaking in front of groups. And I've made decisions and impulsive decisions, you know, because of that it has led to, I think depression. Which is comorbid. But one of the things that recently just got diagnosed was ADHD in my adult years. Another sort of mental illness is I think I struggle with is PTSD. I was sexually assaulted when I was younger. It was a family friend.

Another participant discussed how intergenerational trauma, childhood sexual abuse, and workplace harassment have impacted her mental health over the years:

I was diagnosed with PTSD, I think a social phobia, social anxiety and major depression several years ago. Several years ago, as a result of childhood sexual abuse. And yeah, so over the years I think I struggled with that. It bounces back and goes. So, I would say connecting with service providers has been a huge issue. Connecting family understanding. But family of origin being the cause of those issues. If that makes sense. I think I question people's motives. So, it causes me to struggle in relationships. It's the

intergenerational trauma...I've dealt with harassment in the workplace... Or just belittled, ridiculed, isolated in the workplace.

Anxiety, PTSD, and depression are also some of the mental health issues another participant struggles with, and that have led to anger and her propensity to sexualize herself as way to get validation:

I've been diagnosed with anxiety, I've been diagnosed with PTSD, I've been diagnosed with depression. I had a lot of anger and resentment...it's like the anger from the past would kind of roll with the anger of the present. Yes, a lot of anger because I felt like I brought it upon myself. Because growing up, they always told me, "Oh, you're too free, you're too this, you're too expressive." So, I felt like because I acted in that particular way, it drew men to me in a sexualized way. And because I was an already developed child, I already had like a lot of features that would I guess would attract men. And because of that, coupled with the way I acted in the kind of wild way that they sensed from me, kind of brought it on to me. And it kind of manifested in my life for many people who were way older than me, particularly Black men who were sexually interested in me when they shouldn't have been. Like I became very manic. Like whenever I disassociated myself from my body, it was very easy to...like hyper happiness, hyper joy, like hyper success, I guess. Yeah, so a lot of loneliness, a lot of isolation, a lot of just kind of becoming a hermit. A lot of sexualizing myself. And then therefore using men as a way to confirm...I don't know, like to feel something that I felt like I needed. There was a lot of like looking for validation from them, looking for something, some type of I'm worthy from them. It's like because I was so traumatized from Black men, seeing Black men was... So I was like leaning towards white people, and looking for white people for something. And then eventually when I became more aware about race and my identity, and how I fit in the world, I took a step back from that. I was no longer interested in the white world. And then tried to come back to the Black community. And realized I had so much trauma and so much issues and identity crisis. I didn't know how to even interact with Black people. And Black women and Black men.

The traumatizing effects of childhood molestation and emotional abuse from an alcoholic parent, as well as systemic racism has led to clinically diagnosed depression for another participant:

Well, I deal with trauma. I was molested when I was 11. And so that's always with me. And I've also dealt with so much racism in the workplace that, you know, I got depressed, my nerves. And I was diagnosed as depressed. But I left that job. Because of the racism, the hostility. It was so toxic that I eventually had to leave. My mom was very, very difficult. She was, you know, alcoholic because she was dealing with a whole bunch of stuff. And so she used to be very cruel – very cruel to me. She would say to me, "[Participant], I love you, but I don't like you." She would say to me... You know, we'd be sitting around saying what we wanted to do when we grow up. I said I wanted to be a teacher. She said, "Oh, shut up. You're so naïve. You're just going to have a bunch of kids and go on welfare." She was so cruel to me. She really was...I mean there's certain things I'm afraid of. I'm afraid of the dark. I have to have a light on. And then there's some other anxiety things I have which are really ridiculous...I think my mom had

mental issues. I really do. And she would block it with alcohol. You know, I'd come home and she would be passed out, and she'd have a cigarette hanging out of her, and then the mattress would be burning where the cigarette was hanging. You know what I mean?

Experiences with microaggressions during her university education and at her workplace, as well as the internalization of racism have impacted the mental health of this participant:

And then on my team, I am the only one that I identifies with being Black or African-Nova Scotian. Everyone else is white. And I find that often I'm dealing with a lot of like microaggressions or I'm often singled out as, "Oh, this is a Black issue so let's ask [participant]." And it's like I cannot speak for an entire community....But I find that the stress of being the kind of go-to Black person at work for issues or for clients that want to talk to somebody who looks like them adds another layer of like stress to an already very stressful job. But all of that combined, like that is something that I think as Black people in Nova Scotia, we are internalizing and dealing with on our own.

Similarly, this participant shared that racism has made her vigilant about how she interacts with others, and has created significant stress in her life:

Racism. Just being a racialized person in this world is a big, big contributor to this...But then being aware that there was a world where I was being racialized and having to always constantly be vigilant and aware that people are going to see me racialized and see me in a particular way is a stressor. It's a big stressor. Because I can't just be myself. I have to constantly be aware, okay, well, is myself being perceived in a particular way? Is this person thinking about this about me because they have this perceived idea of what Black people are, and Black woman are in particular? And I guess coming to the conclusion that that's the truth. That this is something that I'm going to have to encounter almost from everybody, including even Black people themselves, it's hard.

Another participant discussed how discrimination directed at her by other Black women triggered her anxiety and depression:

When I was organizing a festival celebrating Black heritage, I crossed paths with some African Canadian women who told me to my face that they did not really want to be seen as Black. That sort of really blindsided me....to cross paths with women who look like me, who the whole point of this celebration was to honour us and our history, and then to have them say...several of them, "I don't want to participate.". I had another woman who I interviewed who was very like suspicious of me as a Black woman. Like she talked to me, but it was sort of like, "Well, I'm not trusting you, this Black woman, to do this." I don't know if it was because, you know, I'm not Canadian. That blindsided me...And the mass, the societal mass prevents Black women from not seeing each other as worthy and having to battle that.....I wouldn't say that I have the sense that happiness is out of grasp. But like the illusion of permanent happiness is sort of non-existent in my life.

Although she has never been clinically diagnosed, this participant has been seeing a therapist for trauma-induced depression resulting from childhood trauma and IPV:

I've been actually recommended to see a trauma therapist, like a specialist. So, I haven't done that yet. I thought it was just because of a relationship. You always find that stuff goes a lot deeper. And after those sessions, just recently I was told that I need to see a trauma specialist because a lot of it has been since childhood. Things I picked up, norms and ways that I've picked up. Kind of like I've decided this is how I am and this is how I should be that have been directly impacting my relationships and everything now. I was married for over 20 years and just recently getting divorced. As a Black Christian woman, we're taught to be the pillars of the church and the pillars of our household, and to be quiet and supportive of our husbands at all times. So after like decades of emotional abuse and all that, I was exactly what I was taught to be. Because as a Christian, you pray about it and work it out. Just ended up being almost like a slave. From that to being submissive and then totally submissive, to where my husband had complete control. Where he refers to me sometimes as I was his slave. I mean I didn't know it was depression. You just have sadness. It's like you always want to cry. But I've trained myself not... It's numbing, basically. You become numb. Because it's too many emotions to handle at one time. So the only way for me to cope with it was to become numb.

She went on to describe how the Strong Black Woman myth and a belief that one should hand their burdens over to God, has been internalized by women in her family and has led to her unwillingness to show vulnerability in the face of despair:

We know our moms and other women in our family have been through some ugly stuff. We hear about that uncle that did such and such and such but you've never seen them cry. You've always seen them cook and put on the family benefits and the church stuff. You always see... And especially in the black churches, it's always women. But have you ever seen anybody cry outside of maybe when they were praying? So, you see them praying, you see them praising God, and you see tears coming. But that's associated with praising God. Nobody ever says they're crying because when they get home, they just found out that blah, blah, blah. You never find that out. So, I've always been taught that Black women are supposed to suck it up. That's what we do. Because you know what, whether it's a movie or whatever, it's suck it up because nobody's going to do anything about this. So, you can cry all you want and nothing's going to come about it. All of our little sayings, our little, you know, churchy sayings – too blessed to be stressed, and all that nonsense – is basically the same thing. Is that, you know what, that means suck it up.

Parental abandonment issues are at the heart of several participants' mental health issues. For example, one participant discussed how the absence of her mother during the early part of her life has impacted her mental health today:

Well, I think one significant thing that happened is my mom and my dad separated when I was really little. She went to another Caribbean island to make a good life. And then she came back with somebody else's baby. So that ended there. So anyways, my dad decided

that he was going to raise us, and my mom moved back to her grandmother's or whatever. And so I didn't really grow up with my mom. And I think to this day I struggle with it. And I do believe that sense of abandonment trickles out into my personal life because I always fear someone's going to leave me. Even if it's just a friend or a partner, I always have this issue, like not to be abandoned. So no, I've never had a diagnosed medical or mental illness diagnosed because I've been able to function in my life day-to-day.

Another participant discussed how abandonment by her father, a genetic predisposition to anxiety and depression, as well as IPV have contributed to her depression, anxiety, ADD and Obsessive-Compulsive Disorder (OCD):

My father left when I was like two...And then we were taken away from our mother. And just kind of like with friends always leaving throughout your life and everything, it's just... I don't know if it's just like the two parents leaving or what, but I ended up with huge abandonment issues. Yeah, because then we got more attached to my mother, and then she left after we were taken away from her. I find it hard to make and keep friends because I come off very strong where I'm afraid of them...or I'm afraid of losing people. So, it's a little hard. Or it makes me too afraid to try. My ex...we broke up around six months ago. He was very emotionally abusive during the relationship, and like mildly physically abusive. So, it's very stressful. My mom had anxiety and depression. My sister has anxiety and depression. The ADD, it's...I always found it very, very hard to focus and process things the way some other people would. I find the OCD can make my anxiety way worse.

Food and alcohol addiction, depression, and bipolar disorder are some of the mental health problems experienced by another participant, who has also dealt with abandonment by her father and sexual abuse by another family member:

People say, "oh, your father left". But it felt deeper than that. It did feel like abandonment. And so yeah, so I'll say that there were mental health issues that came out of that in that was the first time that I pretended there was nothing wrong. Being given a male role model who happened to be a white brother-in-law who sexually abused me for years. And he was supposed to be the trusted male influence in the family. So then all sorts of mental health issues stemmed from that. Food was my first let's say process addiction that I went to. And then growing into different addictions to cope with different things. Dysfunctions in relationships and what I ended up then acting out in relationships with people. My relationship still with food, with alcohol. And then as an adult, seeking help from professionals because I knew something was off, and being clinically diagnosed first actually as a child as having chronic depression. I was labelled that. And then as an adult, twice. The first time it was called manic depression, and then a decade later, a different one – it was bipolar. And I've also used exercise in extreme ways. And that's where the manic has taken place.

Another participant's experiences in the workplace, the stressors that come with completing a graduate degree, and the violence she witnessed as a child triggered some of the mental health issues she suffers from today:

I guess I'll start with employment experience. So, my first major job out of university ...there was a lot of politics that went on in that place. It was a very challenging, unhealthy work environment...And as I was working there, I was also pursuing my Master of Arts degree. So, I was doing that, and I was working. I received an envelope telegraph saying that my employment had been terminated for reasons unknown. I graduated from my program in the same year. And I think part of the reason why I was fired is because I could have applied for the executive director position at my workplace, being African Canadian. And I think that intimidated the social worker who was acting as the executive director. I think with everything going on, and then the firing from the job, I took that quite hard. I was thinking people were looking at me funny. I was feeling like telepathic experiences. Like feeling like my mind could be read. Feeling like I was having a conversation with people on the television. There have been things that I've been working with my psychiatrist that are sort of bubbling to the surface. So when I was a kid... one day my little friend came running to my dad asking for help because her dad was beating her mom. And so we would see them periodically throughout our lives...And there was this family that moved beside us –And all of a sudden I heard, "Help, help," and banging on the walls. And mom was home. And I told her. And at first she said, "That's none of our business," that kind of thing. But I persuaded her to call 911....And then I don't know what compelled her but after she hung up, she opened the door and he (the neighbour) was standing there with a knife, a bloody knife...So, the woman I was working with in private practice during a session revealed that she had been sexually abused by a family member. So those things definitely impacted my mental health.

For another participant, stress and depression are linked to the eczema she has been dealing with since she was five years old:

Ever since I was five, I've had eczema. So that affected my mental health a lot just because of it was very...it got really severe when I started university. It was really bad on my face. I was hospitalized. So, I really had some confidence issues. I really wasn't in tune with loving myself. My best friend had kind of told me that she felt like I was depressed. And I think after reflecting on it and after talking about it, I was depressed but I wasn't aware of it until someone told me. So then there was also the stress about stressing because I know it flares up under stress too. And just for years and years not...like being told by doctors that they don't know why it's getting worse, so they don't know what's causing it, there's no treatment, that also took an effect on me mentally too.

Family dysfunction and intergenerational trauma in the form of drug and alcohol addiction and criminal behaviour have impacted the mental health of another participant:

So emotionally I feel like I do have a lot of dysfunction in my family that I try to like manage. So, I'm learning to build boundaries around them because they don't respect

boundaries. And I think it's kind of intergenerational trauma that's passed down. So like, you know, there's people who are involved in crime and drugs and stuff like that in my extended family. And I try to put walls around them. But also, you know, my parents not always knowing how to be appropriate or not always putting my needs first. You know, it's always about what they need and what's important to them always has to come first. And I'm learning how to cope with that... And I guess I feel inadequate a lot of the time because I feel like, you know, other people have more stable family backgrounds and I don't. When I was an undergrad, I was having some difficulty coping with being in a new environment. I went away for school. And so that was really tough for me. And I started to drink too much. And alcoholism runs in my family. So, I'm like, hey, maybe I need to get some help with this. So, I was able to address that before I became an alcoholic.

Summary:

In this section, participants discussed the specific mental illnesses they suffer from, which are listed below in Table 1. They also attributed their mental illness to genetic/hereditary, social, economic, workplace, family, community and health factors, which are listed below in Table 2.

Table 1: Common Mental Illnesses Experienced by Black Women in the HRM
Stress
Anxiety
Depression
Bipolar disorder
Schizophrenia
PTSD
ADHD
OCD
Substance dependence
Food addiction

Table 2: Personal, Social, Economic, Community & Physical Factors Impacting Black Women's Mental Health
Family history of mental illness
Intergenerational trauma, as well as the trauma experienced from systemic racism, sexism, homophobia, microaggressions, and income insecurity
Workplace harassment and racism
Internalized racism
Family dysfunction and conflict
Parental abandonment
Relationship issues
Unstable neighbourhood environments

Witnessing violence
IPV and other experiences of violence and abuse, such as childhood molestation, and emotional, mental and psychological abuse
Loneliness and isolation
Identity struggles related to biracial and bicultural identities
Death of a parent
Physical health issues
Challenges with physical disabilities

Cultural Beliefs About Mental Illness & Help-Seeking in Black Communities

Participants discussed the various beliefs held in the Black community and in their families about the causes of mental illness and how one should seek help for it. For example, one participant noted that mental illness is a taboo in the Black community:

It is taboo. You don't want to discuss it, you don't want to talk to anybody about it. Like I mean I have plenty of friends that will talk to me, or I'll talk to them. But you can't go to I'll say the older family members. Do you know what I mean? It's not like the younger people, it's the older generation that you cannot talk to you because they're just set in their ways.

According to another participant, some people in her community believe that mental illness is a sign of weakness:

Because you're weak. I still struggle with that. That you're weak-minded. You know what I mean? Like again, it's internal, right. The causes are internal. You're weak, you can't handle it. You can't handle the stress. I don't know about you, but I grew up with Black women that could handle a lot. My mother went through fucking hell. My grandmother went through hell. All the women around me still that I know that are Black live through hell and huge amounts of responsibility. And then that pressure to be, "Well, you're weak. It's something in you." Or you need Jesus.

Another participant echoed these sentiments, stating that there is a general belief in the Black community and in her family that mental illness is a weakness, and that people should be able to address their mental health struggles on their own:

I think it keeps circling back to that idea that, you know, you're strong and you're smart, and you should just be able to like work it out. Just work it out, just push through it. Tomorrow's a better day. And I think that when we do that, things build up and it gets worse. And it's not helpful when people say that to you. And so, I think as a community, we are not helping one another to talk about the things that are happening that we need to talk about. Instead we are more or less encouraging people to suppress what's happening. Well, because you'll be seen as weak, right? It was like this idea that if you have a mental health problem or an emotional issue, that they're going to put you on some sort of medication that's ineffective and is going to make you dumb...Even my family was

like, “You’re scary.” If you have a mental illness, you’re scary, you’re unpredictable, you might hurt somebody, including yourself. It’s made it really, really hard to even get to the point to ask for help. Do you know how many times my father told me that I shouldn’t be going to see counsellors and psychiatrists and stuff like that because it’s going to come back and bite me in my ass and my career? And as a Black woman, you can’t be Black and mentally ill. You’re scary. You know what I mean? Because if you’re Black and crazy, you’re extra dangerous. Right? We’re not scared of the white boys that shoot up the high schools. But we’re scared of angry Black women who are on medication.

For some members of the community, there is a lack of understanding and education about the genetic/hereditary factors underlying mental illness and, therefore, a general perception that people who are mentally ill are simply “off”, as one participant explained:

My grandmother has severe mental illness and has had it her entire life. And it’s never really acknowledged as... Like she’s been diagnosed with schizophrenia. But it’s never been acknowledged that that’s why she is the way that she is. It’s just kind of like, “Oh, something’s off with Gram.” And I’m like, well, not something’s off with her, she’s clinically dealing with schizophrenia on a daily basis and trying to manage that... For me, I am very privileged in the fact that I was able to go to university. Many of my family members have never been to university, have not completed high school. So I feel like before university, that was my understanding. Is that some people were just “off” or acted weird, and that’s just kind of like how it is, and that’s just kind of how they are. But then as I became more aware of like no, like there’s biologically something going on in which somebody is unable to function at a “normal” level, when I got that awareness.

Another participant observed that there is a difference between the younger and older generations in their beliefs about how mental illness should be addressed:

At least in my circle of colleagues, all of us Black women are really into like mental health or like essential oils or whatever healing shit you’ve got to do. Yoga, meditation, blah, blah, blah. Versus like my mom and my aunties are not willing to go to therapy. When like they definitely need it.

The general belief in Nigerian culture that prayer is the only way to address mental illness is not one that this participant of Nigerian background shares:

Nigerians culturally are very religious. So, for them they’re like, “I’m going to pray about it.” And I respect that but, I’m not going to pray about it. So, my solution is to take care of it like I would an injury. And that’s why I say to people if you hurt your foot, if you bumped it against the door and you sprained it, you wouldn’t just let it sit there and fester. You’d go to the hospital immediately. So why would you let your head fester? I don’t understand. It just doesn’t make sense to me.

Similarly, another participant indicated that mental illness is not taken seriously by her family members, who view people with mental illness as having lost their way and needing to pray it away:

Every now and again we'll hear stories of like family... Like we have family in the States, family in the UK, family in Canada. And sometimes they'll share their problems with other people, and we hear the story. And sometimes it just feels like people have just lost their way. But sometimes I think it might be a little bit deeper than that. But if no one's taking it seriously then they might still be in that state unless somebody actually realizes they need help...they shouldn't be ignored. And I feel like when I hear the stories, it makes me feel like people don't take them seriously. They just kind of use it as a reference that yes, there's illness in our family. But they just assume that they'll heal themselves somehow. And that's the other thing, it's like super taboo. To talk about mental health just in general. Because it's like, "oh, you can't possibly have like a mental health issue". Like you're Christian. You're supposed to be perfect or fine. And when you have a problem, you pray it away, you work on it, and it will go away.

According to another participant, her personal beliefs about the causes of mental illness come from her own life experiences and include growing up and living in environments where there is considerable poverty, despair, instability and loss of hope:

Yeah, there's a strong indication that somebody will experience mental illness if their parents did. Like whether that be, you know, biological genetic or environmental, I don't know how much...I watched people jump off balconies out of despair and mental illness and drug use. I knew even then that I was surrounded by despair, mental illness, addiction, lots of people...refugees coming from East Africa at that time. So, I was surrounded by despair and depression. I believe that there is a biological component. And that yeah, some people just have less serotonin than others. Or there's a chemical imbalance that makes their moods go like this. Or hormonal balance, in my case. But I don't think that that is necessarily the cause. I really believe that... I think for some people it's that pure – biological. But I think for most people it's a combination of biology that is then shaped by our environment. So, for me, I can talk from my example, is I mean of course, I was born into a family with a history of--along my maternal line—of depression. I was born into poverty, despair. I was surrounded by drug addicts. And refugees running from, you know, war-torn countries. And yeah, alcoholics. Of course that's going to shape me and my sense of hope in the world, my sense of possibility. And I think for so many Black children, it's like that is what is at the root, is a sense of hopelessness and like no sense of possibility, no way of actually seeing yourself doing any better than what you see around you.

According to another participant, internalized oppression and racism have been at the root of the mental health issues experienced in the Black community intergenerationally:

I strongly believe that a lot of mental health issues within the Black community stem from internalized oppression and racism and prejudice and stereotypes, and everything that goes along with that. And I think that we see that in generations, right. Like it continues to show up in generations moving forward. So I think that as a community, on some level we all understand that that is a root cause. But there also is this expectation that that's just how it is, and you have to continue to like push through it and just deal with it. Yeah, we know that it's shitty and racism exists, and you have to deal with it on

an everyday basis on some level. But you're also expected to just push through it. And that women in particular are expected to push through it as a Black person but also as a mother, a daughter, a woman on all of these other layers and expectations that come with being a woman. So, you have like these multiple layers that you're trying to carry on your back as you like navigate the world in your everyday life. And no wonder people have anxiety and depression and stress and trauma and are dealing with grief.

The myth of the Strong Black Woman was identified by a participant as playing a role in the mental health problems experienced by Black women, and in the ways Black women's struggles tend to be dismissed:

But I think intergenerational trauma has a lot to do with mental illness. And, specifically for I guess Black people living in Canada, part of our mental illness is the fact that the world tells us that you're crazy, that you're imagining things. And like poverty and like trying to like work twice as hard to get half as much, and like working too much. Just kind of everything in society wasn't built for us....You know, even like the stereotypes that follow us, right. Like oh, the strong Black woman. It's like okay, you face all these like horrible toxic elements in society, but then, you know, you're heralded as like, "Oh, well, you're so strong and independent". And, it's like meanwhile you're not taking care of yourself and your body's kind of like rotting from the inside out. I think it's trash because it allows people to dismiss all the barriers that we face, and all the suffering that we have. And it invalidates us because we're stronger. And we're not horses, we're people. So, it's like you can't just treat me like crap because I'm strong. I don't have to be strong all the time.

A lack of access to resources and other social determinants of health, as well as abuse play a role in mental illness experienced by Black women, according to this participant:

I believe that abuse, sometimes lack of resources, and sometimes they're inherent, sometimes you're born with it. Lack of resources. Being homeless, not having proper nutrition, those are other things that I mean by lack of resources. And all of those things I believe can cause or exacerbate mental unwellness. Because I mean sometimes it is an illness and doesn't go away. Mental unwellness is more a temporary thing and it can be fixed. Mental illness doesn't go away...Oh, in the instance of overt child abuse, even if it's not physical. Because that psychological abuse, that verbal abuse is having an impact on the mental health and wellbeing of that child, and it's overflowing into other areas of their lives. I've experienced all that and have been overlooked. So, I feel and I know that this is indeed true.

Another participant observed that parental abandonment, broken families, and systemic racism are significant factors impacting mental health in Black communities:

Abandonment. My mother, father. I think that goes back to the original not having a secure base. It was not secure. Because I was raised by my sister and her husband. So when the secure foundation is not there, then you've got trauma after trauma on top, that's what comes. I think it's family breakdown. I think it's systemic racism in there.

You look at like being part of an oppressed people. You just can't send your kids to school because you've got to deal with...you've got to fight the system there. And so, I think there's so much systemic racism in all the different systems - in our healthcare system, in our education system, in our justice system, in the finance systems. And there's all that we've got to deal with.... I think all those factors impact our mental health.

Stress was also identified by many participants as one of the many causal factors for mental illness, as one participant observed:

Well, the stresses of life. If you've got a job, you hate it. Or poverty. All the different things. If you have a medical mental issue, or any kind of mental health issue, it's going to make it worse. A lot of Black women are overweight. A lot of that's probably associated with the fact that we eat our stress. I have men in my family that are addicted to different types of drugs. I know a lot of that has to do with stress.

Another participant stated that Black people's propensity to evaluate their success based on a white, straight, male model underlies some of the mental health problems the Black community struggles with:

I think that, you know, sort of the world dominated or appears to be dominated from the media, that what we see is a world dominated by white men, white straight men, Western, you know, straight men, affluent, you know, straight, white men. And that they're greedy. And I think that it is really challenging when you look at that as like the model of success or power, and you feel like you are ineffective to do anything to change that. To say look at me, I'm a Black woman. And we don't have to live that way. Like why can't I and my people like be the model?

While one of the participants did not believe that mental illness was an outcome of demonic factors such as evil spirits, she does believe it results from a kind of "spiritual sickness":

Well, for me, it's definitely influenced by African culture. I don't really believe it's like demonic but I do think it is a spiritual type of disease. It's a sickness that comes from not taking also care of your spiritual self and what you believe. And you know, nurturing your soul and nurturing...not just nurturing your body but your soul as well. You know, getting back to your ancestors, getting back to I guess the spirits that exist in this world.

Summary:

In this section, participants discussed long-held beliefs in their culture and family about the causes of mental illness and how it should be addressed, which are listed below in the Table 3.

**Table 3:
Cultural Beliefs About Mental Illness & Help-Seeking**

Taboo
Sign of weakness
People who have lost their way
Spiritual sickness
Hereditary/genetic/biological factors
Living in environments where there is considerable poverty, despair, instability, and loss of hope
Systemic racism
Internalized oppression
Parental abandonment
Broken families
Abuse
Lack of access to resources and other social determinants of health
Stress
Evaluating one's success based on a white, straight, male model
Prayer is the only way to address mental illness
People should be able to address their mental health struggles on their own

Help-Seeking, Coping & Healing: Black Women's Journeys to Wellness

Participants discussed their own experiences seeking help for and coping with mental illness, which includes a combination of western and “alternative” approaches. These include accessing services from a mental health professional (such as a psychiatrist, psychologist, therapist and social worker), yoga, meditation, mindfulness, acupuncture, reaching out to friendship networks, self-reliance, reliance on religion, spirituality, and a belief in a higher power, church, spiritual healers, and solitude. For example, a participant shared that although her self-reliant nature makes it difficult for her to reach out for help, she uses multiple approaches to address her mental health concerns, including exercise, spirituality, and attending church:

:

I am a self-reliant type person. So, I find reaching out very challenging because I worry so much about what people will think and say of me. But my folks, I respect and trust them very much. So, if they're noticing something then that means that it's true and that I should highly consider doing whatever it is they're suggesting I do. Definitely exercise, trying to eat right, spirituality. I'm connected to a church, and I have a church family now. So I'm not isolating as much. Well, I've been doing a lot of praying.

Therapy, spirituality, and crying to release stress are the ways in which this participant copes with her mental health problems:

I think maybe a therapist. Because the one friend that I call on, she's not always available. But I don't want someone to tell me something that I want to hear. I want somebody who can give me the tools...I find that I try to rely on my spirituality as well.

And I also try not to keep it bottled inside. Because if I feel... If I keep it inside, especially the moments when I...Crying for me is a way of relief. It's releasing. When I keep it together, I become so stressed. There's a tightness in my chest. I feel like a tension headache. I try not to view crying as being a sign of weakness or negativity, I try to just see it as a way of releasing.

Another participant stated that she addresses her mental health problems through spirituality, music, and, sharing her struggles with others:

Music, definitely. If I listen to some gospel or a choir, that does things to me. Hearing people's stories does things to me. So, I commune that way, and I restore that way. Church definitely has done that for me many times. But it's... You know, I'm not an avid church goer. But I do believe in a higher power, and that there's a power in when people connect on that level of all wanting to be there and sharing that experience and be a part of something bigger than themselves.

For another participant both western and alternative methods, medication, alcohol, and travel have been effective in helping her cope with and address her mental health issues. She also shared that although she has made efforts to seek out therapy, she has had little success finding a culturally competent counsellor who understands the role that race plays in her mental health struggles:

Yeah, drink and do yoga. Still two of my major coping mechanisms. And then so I saw an Employee Assistance Program (EAP) counsellor because it was the first time that I had a full-time job. And she was another white woman and didn't bring race at all into it. It was all cognitive behavioural therapy. I didn't connect with it. I didn't connect with all the sheets of paper that she was giving me to fill out. And in the end, I ended up quitting my job. And my coping at that time was just to get out of that job. And I wanted... I knew I needed fun and lightness and something that was less serious than listening to stories of violence against women and supporting women who have endured horrific violence. So I went travelling for several months. And again, that was wonderful for my mental health. And it just put my life into perspective, and my privilege into perspective. And it also sort of activated in me an outward look at helping other people...I tried antidepressant medication because I was having such a hard time getting through school, getting my assignments completed because of depression...The other thing that was helpful but that wasn't necessarily culturally appropriate, I did a mindfulness group for depression. And that was helpful. Mindfulness is more about just sitting with what is, not getting caught up in the past, not getting caught up in the future. So that has and continues to be a good tool for me. I started to do somatic experiencing work. So, stuff that taps into the body and the understanding that the body keeps the score of our traumas and our history. And that trauma cycles need to be completed. So, the idea of like going back but being resourced in your body, being able to keep your nervous system in a calm state, looking back at what has happened, and then releasing that in some sort of physical way. Whether it be through voice, screaming, shouting, kicking, stomping, being held while you cry. But the idea that you're completing a trauma cycle. Because there's some

trauma theory that says that that's what happens. It doesn't get complete... Our bodies hold onto it. And that we need a somatic release. So that's where I've been leaning more.

Another participant learned about deep breathing and meditation from a counsellor she was seeing:

I'm not fully sure what I did before I started seeking help. But I went to like a free youth counsellor, I think, for a little bit. And she was teaching me about the deep breathing and like meditation. And that helped. So that really got me into deep breathing. Which I don't always find works at all. Sometimes I feel like when I try to deep breathe, I feel like I can't breathe. And that just makes me feel more panicked.

Acupuncture and biomeridian testing were methods that another participant used to determine if there was a relationship between her hormones and her mental health struggles:

And I kind of figured like maybe that might hint that there's like an off-balance with my body. Like hormonally that could be triggering anything. I mean that was expensive too. And that's the other thing. She just suggested I take three different types of medication to try to deal with the specific digestive issues that she discovered that I didn't know. Like I knew that I was having some issues, I just don't know what's physically causing them. But yeah, so I went through that. It was a lot different than I thought it would be but I still decided I'll just...it's not the worst thing in the world. It's someone just trying to tell you what your body's going through.

Therapy, meditation, reading the bible and other books, prayer, connecting with friends, solitude, and taking a mental health day from work are some of the methods this participant uses to cope with her mental health issues:

Yeah, changing the way you think, understanding and then... Yeah, I think it was cognitive behavioural therapy that my counsellor used when I look at what's been out there. But she also just...she was someone I could sit and talk to without feeling judged. I do an inventory of myself – how am I doing, where are my thoughts at, what am I focusing on? I do prayer. I do meditations in the sense that's prayer. I get reading the bible. I read books. Sometimes I just go out and have a coffee with a friend. Yeah, spend time with other people. Sometimes I just need to just chill and spend time on myself. Sometimes I just need to take a mental health day at work. Phone in, call in sick. I don't need to give an explanation. I just take my mental health day. Or just, yeah, take time off of work and, you know... So I try to get the focus off of me and my hole – whatever hole I'm in. So, I try to look at where am I going. Sometimes pursuing other things. Reminding myself of where I'm going in life and just having a bigger vision for life sometimes. Sometimes that overachievement helps too. I've got to go do this, go do that. So yeah, there's a variety of things.

Similarly, for another participant, maximizing her resources by engaging in multiple approaches to cope with and address her mental health issues has been effective for her:

Mindfulness practice. I learned how to do it in the hospital. I contacted spiritual care specialists while I was hospitalized, and they taught me about mindfulness practice. I think spiritual care is a biggie. I really do. And that the paradigm that is used within spiritual care needs to be culturally contextualized. Because I think that if there's more access to spiritual care that will sort of...that it goes hand in hand nicely with more like structured medical care. I go to church, right, on Sundays, and there's hundreds of people praying or being asked to pray. I finally got to a place where I'm stable. I've been doing good ever since. I'm the type of person to maximize many resources in order to maintain my overall wellness. So, whatever it is that I'm not getting from my psychiatrist, I'm getting through other resources. The psychiatrist focuses more on medication. My psychologist that I work with uses cognitive behavioural therapy approaches, which I've found helpful.

According to one participant, while she has sought help from psychiatrists, psychologists, licensed clinical social workers, and medical physicians, exercise has been the most effective approach in helping her cope with her depression:

And, also part of my like healing ritual, that I always knew that exercise is good for depression. So, I just walked more, I started taking a seniors yoga class, and I learned how to swim for the first time ever. So, that's how I dealt with it. I think that there's something like within my psyche, my way of being that has always moved forward. And a part of me that believes that while there are the racist barriers and whatever, I have like a core belief that most people in the helping professions really do want to help. And that my experience has sort of taught me that they want to have jobs, careers, interactions that are fulfilling for them. And the feedback that I have gotten from healthcare providers that I've been engaged with is that they found me and my issues really interesting, Yeah, I would say mainly exercise. You know, I take an aerobics class. We don't own a car. So, I either walk or take public transportation. I try to engage in all of the free stuff that happens here at the library or concerts or whatever. Music. We go to the symphony. I go to the dance concerts.

In addition to spirituality, attending church, relying on friendship networks and receiving services from a psychologist, a participant shared her experiences receiving services from a spiritual healer:

Spiritual healers: The ones I've gone to, you have someone that is a prayer warrior, that believes that prayer works, and knows that there's also a practical side to it. So, I've sat with healers that, you know, you sit and they actually have like word of scripture for you. But they're also praying with you. But then they're also saying, "okay, well, let's talk about what's going on with you, how you're feeling". So, I've had a healer that sat with me and said... was teaching me how to keep things in perspective. He taught me this thing about the elephant in the room. He would always say, "So you're trying not to focus on the elephant in the room. But that means that everything, your entire focus is on

the elephant. Because in order to not focus on the elephant, you have to focus a part of your mind on the elephant. Which means that you're never 100% complete. You're never present”.

Another participant stated that she started seeing a psychologist when she was six years old and currently receives services from a counsellor, which has been helpful in breaking the patterns that have prevented her from moving forward in overcoming her struggles:

I've been kind of doing ongoing therapy for the past eight years now. Yeah, different counsellors. I don't think I've seen like a formal psychologist. Mostly counsellors. But at one point my family doctor did give me anxiety medication because I was feeling really stressed about like...: I think for me going through therapy for a long time, I think the first part was kind of discovering what my negative patterns are. Just kind of getting out like what my trauma was. Like I just needed to like let it all out, talk about how crazy my family is, and like have some affirmation that it is not just me. And then I guess the past two, three years has really been me actually learning how to overcome it, I guess. Not just cope with it, like how to actually address it and correct the patterns. For the most part going to therapy has been really positive for me. I have had some good therapists, bad therapists. I think it is nice if you can have a person of colour. If they're not a person of colour, I think they really have to be aware of like specific issues that face people of colour and women of colour, and queer women of colour in particular. I've had one really terrible therapy experience with this white woman. And you know, I came in, it was our first session. This is what I want to address throughout our time together. And she says, “You know what, I don't want to deal with all those Black issues. I think you should go see someone else.” And I said here's my response – “Me either, actually. I also don't want to deal with the Black issues. But here we are.”

For another participant, counselling has been effective in helping her address her fractured relationship with her father, as well as her experiences with depression, social anxiety, PTSD, selective mutism, and sexual exploitation and physical abuse at the hands of a former boyfriend/ She is currently receiving counselling support from a white social worker who has helped her to express her feelings, which has reduced her anxiety and depression:

Earlier on, one of the other reasons why I stopped seeking counselling... Like I knew I had it through my insurance like access to counselling money. But it was back then I had to drive all the way to Burnside in order to get reimbursed from the health card place or whatever it was – MSI or something. And that was just inconvenient. And that's the reason why I probably didn't just seek someone else after the first man. It wasn't until it was fully free that I kind of committed to it and started like seeking... I found in the winter... Like I find I have seasonal depression a bit too. And the winter is just harder for me to get out of bed and do things and concentrate. But in terms of ongoing, it's not that bad like since I've been able to get things off my chest. It's when it's built up and I have no one to talk to and it's built up for years and years that... Like counsellors have described me as like a highly sensitive person. So, I cry easily like from triggers. I don't know if that's part of depression.

Drinking alcohol, smoking marijuana, listening to music, swimming, crying, and traveling have all been coping mechanisms for this participant:

Like I guess the weed thing is more of a calming mechanism. So it's not like it all goes away. But for that very short amount of time, I feel like I can get my life together and things are going to be okay. I'm a very high-strung person. Like very type A. And so sometimes I need to just be type A. Like I will sit or I'll go for a swim. Swimming for some reason is very helpful for me. I'll sit and listen to music. I'll just sit and cry. Sometimes I just have that break and just sit and cry. And then I'll get it together and I'm good. But yeah, that's about it. It's clearly time to go travel. It's clearly time to go to Europe. It's clearly time to go to anywhere. Anywhere and everywhere, I will go. And it's that short very long whatever break that I'm not me. I'm a whole different person. Nobody where I am knows who I am. Nobody knows... I don't have to think about anything. There's no stress. I don't care. I have to worry about where the next bar is typically. But it's just my time to be away from like my family, my friends.

Several participants shared that the services they have received from (mostly white) mental health professionals have not been culturally competent and that there is a dearth of Black mental health professionals in the HRM. Many of these participants were not receiving services from a mental health professional due to past negative experiences accessing services or because they did not know how to find a mental health professional who could meet their specific needs as Black woman with diverse identities related to culture and sexual orientation. One participant observed that while she believes that counselling is an important way to address mental health struggles, she has had challenges connecting with counsellors over the years:

I know that it's important to share it and to talk about it and to discuss it with other people. So that's why I think I've been really trying to like find that counselling piece that is going to work...I did really like the idea of a grief group and sharing as a group. I really liked that idea. And I think that that's why I kept trying to go back and make it work. But like I said, like I couldn't connect with anybody there because everyone was white. They all lived in the country. I was trying to connect with these people and I wasn't able to find ways to connect with them. But I kept going back because I liked the idea of being in a group with other people that have this shared experience of loss.

Several participants discussed the importance of being able to access services from Black or racialized mental health professionals and, failing that, culturally competent mental health professionals who could empathize with Black women's lived realities. For example, one participant observed that it can be difficult for white mental health professionals to resonate with Black patients since they don't share or understand their experiences as racialized people:

They've got a lot of white people working with Black patients. There's a cultural significance there. And it is such a great divide that it makes it difficult for the Black person to feel comfortable and understood enough to tell those home truths that will get them to the bottom of what's really ailing them. It is home truths. Because when you really, really resonate with somebody, that person should look and have some of the same background experience as you. They can't come from a whole other different social,

societal construct, and have a firm understanding of what's the ground you're standing on. It's not possible.

These sentiments were shared by another participant, who said she felt understood by her doctor, who was a racialized woman, and dismissed by white mental health professionals:

Yeah, so the East Indian woman was my doctor. Like my MD. And I think... You know, if you're a woman, you understand what it's like to be a woman. If you're a woman of colour, that's another dynamic you understand. And she just understood. When I said things, she'd be like, "I understand." "Thank you for acknowledging," right. So, I think it was a matter of...it was feeling validated by somebody and having somebody who had shared experience. Where the woman I had fired, our experiences were so...there was so much of a gap between the two of us, nothing I said to her made any sense. But the woman I fired, when I explained to her what I thought, I said, you know, I'm feeling judged and feeling this and feeling that, she was like, "Well, why? Like what's the big deal? Like who cares?" And I felt very dismissed by her. And that's why I had to fire her. Because it was like you are not going to understand my experience. And that's okay. So, when I moved, I sought out another professional who was in my network, within my healthcare. And I ended up, for lack of better words, firing this person because I tried to explain to her... When I explained to her what I was feeling, what struggles I was having with identity, she was very dismissive of the idea. And she was older, probably 70, Caucasian woman. And it's like you're never going to know what I'm talking about. Like our lives couldn't be any more different. And I didn't fault her for it. But when I did eventually say to her like I feel like we're not connecting, you're not really understanding me, she sort of like laughed on my voicemail, and was like, "Okay, well, you know, good luck." And I basically rolled my eyes and just like enough of you, and I was done with her, and I fired her. So, I found another therapist, a psychologist, who was a Black female. So now that I'm back in Canada, I've been trying to find a mental health professional. Moving home has been a bit of a reverse culture shock. And readjusting to what it's like to be in Canada, in Nova Scotia and Halifax, I'm having a hard time finding a Black therapist.

Another participant indicated that she is still receiving services from the therapist of colour she was seeing when she was living in another city because she has found it difficult to find a Black therapist in Halifax, and because many therapists in Halifax use behavioural cognitive therapy, which she doesn't believe adequately addresses her issues:

Yeah, huge, long wait lists for mental health help. They're huge wait lists. And then, as I said, you get through all these hoops and then you're sitting in front of a 24-year old white social worker. Do you think I want to talk to her? Do you think she can hold me? You've heard some of my story. They don't even know where to begin. They can't hold my elbow. Yes. I have a therapist... I have a talk therapist of colour who's a social worker. And I found her in another city. And I still see her on Zoom because there's nobody here still. I mean the only reason I see my talk therapist now through Zoom is because she gives me a sliding scale. And because I'm off work, I get a decent disability payment. Because it's through my work, it's not through social assistance. But if I was

on social assistance, I would have to go through the public health system. And I know it wouldn't be helpful. For one, I'd probably know the social worker on the other side of the room. And, two, they're most likely white. And three, they're over-worked and they're forced to do cognitive behavioural therapy. Like I want to talk about me and the wholeness of my experience. Not just within a cognitive behavioural therapy framework. It's not enough.

The value of being able to receive services from a mental health professional who shares your racial background and, consequently, understands your experience was not lost on another participant:

When I talked to mom about it, she had set me up with a clinical therapist who was Black... Honestly, I think I was very lucky to have her. I don't think I ever went through the mental health system in any other way. Like to address my mental health, I would just go see this lady. We have similar values and beliefs.... For me it was very helpful because this was someone who had experienced some of my struggles with their life experiences and probably more.

Summary:

Study participants discussed the multiple approaches they are using to address their mental health struggles, as well as the challenges they have experienced finding Black or culturally competent mental health professionals, which are outlined in Table 4 below.

Table 4: Experiences Seeking Help For & Coping with Mental Illness
Maximizing resources by engaging in multiple approaches to cope with and address mental health issues, including “alternative” modalities, self-healing and self-care approaches and “western” approaches.
Using “alternative”, self-healing, and self-care approaches to address mental health issues, including: <ul style="list-style-type: none"> • Solitude • Exercise • Eating well • Medication • Alcohol • Marijuana • Travel • Music • Yoga • Meditation • Deep breathing

<ul style="list-style-type: none"> • Mindfulness • Acupuncture • Biomeridian testing • Reaching out to friendship networks • Self-reliance • Spirituality and reliance on religion and a belief in a higher power • Reading the bible • Spiritual healers
Accessing diverse mental health professionals, including psychiatrists, psychologists, therapists, counsellors, social workers and physicians.
Not currently receiving services from a mental health professional due to past negative experiences accessing services.
Lack of awareness about how to find a mental health professional that can address Black women's specific needs.
Challenges finding culturally competent counsellors who understand the role that race, gender, sexual orientation and other identities play in Black women's mental health struggles.
Inability of white mental health professionals to resonate with Black patients since they don't share their experiences as racialized people.
Negative experiences receiving services from white mental health professionals who were dismissive.
Positive experience receiving services from a white social worker who helped the participant to express her feelings, which reduced her anxiety and depression.
Positive experiences receiving services from racialized health and mental health professionals who made the participant feel understood

Recommendations

Based on their own experiences with mental illness and help-seeking, participants shared their perspectives on how the proposed *Nova Scotia Sisterhood Initiative* at NSHA can effectively address Black women's mental health needs. Recommendations in five main areas will now be discussed based on these perspectives:

- Hiring Black health and mental health professionals with diverse educational and professional backgrounds.
- Offering holistic community-driven trauma-informed services.
- Providing accessible services.
- Conducting community outreach to increase access to services.
- Creating awareness about the *Nova Scotia Sisterhood* and its services

Recommendation 1: Hiring Black Health & Mental Health Professionals with Diverse Educational & Professional Backgrounds

- Hire a Black manager who understands the importance of hiring a team of Black mental health professionals who are diverse based on culture (African Nova Scotian, Caribbean, African), sexual orientation, gender identity, and educational backgrounds and professional training.
- Ensure that health and mental health professionals and other service providers represent a wide spectrum of educational and professional backgrounds, including general practitioners, nurses, recreation therapists, social workers, psychologists, psychiatrists, nutritionists, clergy with counselling experience, therapists, counsellors (including youth counsellors), and outreach workers who are connected to grassroots community initiatives.
- Hire mental health professionals who have expertise in trauma-informed counselling and can support Black women in addressing their trauma histories resulting from intergenerational trauma; systemic discrimination and micro-aggressions related to racism, homophobia, and transphobia; race and gender-based violence; and family and relationship conflicts.

Recommendation 2: Offering Holistic Community-Driven Trauma-Informed Services (see Table 5 for more details)

- Provide holistic community-driven trauma-informed services that combine “western”, “alternative”, and self-care/self-healing approaches and that consider and address the intersecting personal, social, economic, community, and physical health needs of Black women. These services are listed below in Table 5.
- Acknowledge the personal, social, economic, community level, and structural barriers Black women face seeking help for mental illness, including the stigma around mental illness in the Black community, stereotypes of Black women as strong and not needing mental health care, a fear among Black women that they will be seen as weak if they access mental health services and that their privacy will be compromised, and the cost of seeking help from a mental health professional.
- Ensure that mental health services offer a safe space for Black women from the LGBTQ community.
- Recognize the unique and specific service needs of Black women of diverse professional and socio-economic backgrounds, diverse cultural identities (African Nova Scotian, Caribbean, African, Black), and who live in diverse geographical areas (East Preston, North Preston, Lake Loon, Cherrybrook, Halifax, etc.).

Table 5: Holistic Services Proposed for NSHA’s <i>Nova Scotia Sisterhood Initiative</i>
One-on-one counselling
Drop-in service where you can receive counselling support without an appointment
Peer support groups
Crisis hotline
Health services where you can get a pap test and other health services
Meditation
Deep breathing
Reiki
Yoga
Mindfulness
Emotional Freedom Technique (EFT)
Acupuncture
Sharing circles with food
Healing circles
Sound baths
Essential oils workshops
Dancing
Music therapy
Art therapy
Book club
Swimming
Room with a punching bag where clients can release anger
Mentorship program for young women
Parenting programs
Employment counselling
Financial management workshops
Childcare or a space for children to play

Recommendation 3: Providing Accessible Services

- Locate *Sisterhood* services directly in multiple Black communities (including a centralized zone) and near a bus route to ensure that it is accessible to people who have childcare responsibilities and who are working part-time or doing shift work.
- Offer services with flexible hours and that are available throughout the morning, afternoon and late evening.
- Provide bus fare to women who are dealing with financial insecurity to ensure their access to services.
- Ensure that all services are offered at no cost or are covered by insurance.
- Offer a free crisis hotline that is available 24 hours a day, seven days a week.
- Offer services through voice video chat for clients who are unable to attend services in person because of work, childcare and other responsibilities.

- Offer a free childcare service or a space where children can play.

Recommendation 4: Conducting Community Outreach to Increase Access to Services

- Develop relationships with Black female community leaders and other key community leaders who can spread the word about the services within their own communities and through their networks.
- Develop relationships with Black women at Black churches through the women's ministry and bible study classes.
- Develop relationships with Black women through their children's school.
- Develop relationships with Black women through universities.
- Organize an open house with refreshments or a summer barbecue to share information on the services, provide an opportunity for Black women to share their concerns and ideas, and to develop relationships with Black women in an informal setting.
- Deliver presentations and workshops on *Sisterhood* services at spaces where Black women congregate, including recreation centers, hospitals, churches, social work conferences and other conferences, and Black community organizations, such as the East Preston Lions, the East Preston Ratepayers Association, the North Preston Ratepayers Association, the Black Educators Association, the Association of Black Social Workers, African Nova Scotian Affairs, and the African Diaspora Association of the Maritimes.

Recommendation 5: Creating Awareness About the Nova Scotia Sisterhood & its Services

- Organize a launch party to introduce the Black community and Black women to the *Sisterhood* and to listen to their concerns and suggestions about how it address their priorities and needs.
- Share promotional material on the *Sisterhood* by email and on social media (e.g. Facebook, Instagram, Twitter, the African Nova Scotian Directory, library apps).
- Ensure that the material used to promote the *Sisterhood* includes images of Black women of diverse age groups.
- Discuss the *Sisterhood* in radio, television and print interviews, including CBC and CKDU (which is targeted to a younger demographic).
- Post information about the *Sisterhood* on bulletin boards at churches and other religious institutions, Black community organizations, women's shelters, hair salons, and fast food restaurants.
- Share promotional material about the *Sisterhood* with Black community organizations, libraries, and government departments and agencies, and ask them to share the information on their social media platforms and websites, through their email listserves, and at their organizations.
- Hold information sessions and workshops in the community to share information about the *Sisterhood*.

Last Words

Study findings indicate that mental health services in the HRM do not adequately meet the needs of Black women, and that the proposed *Nova Scotia Sisterhood Initiative* should offer community-driven holistic trauma-informed services that understand Black women's personal, social, economic, and community experiences and how these shape their experiences with mental illness and help-seeking and coping behaviours. Black women hold diverse beliefs about the causes of mental illness and how it should be treated - beliefs that are grounded in their culture, the broader society, personal experiences, and their educational background and training. Therefore, it is important that a wide range of services be made available to Black women through the *Sisterhood Initiative*. The findings also indicate that personal social, economic and community factors should also be considered in determining the factors that will increase Black women's access services in HRM, inform how outreach should be conducted, and to create awareness about the services available through the *Sisterhood*.

Participants shared similar sentiments about the difficulties they have experienced finding Black mental health professionals in the HRM, and about the need to hire more Black female mental health professionals who have diverse educational, training, and professional backgrounds. Participants indicated that they combined "western" (general practitioners, psychiatrists, social workers, psychologists, counsellors), "alternative" (Reiki, yoga, acupuncture, mindfulness, EFT, etc.), and self-care/self-healing (prayer, reading, exercise, dancing, etc.) modalities to address their mental health issues.

While some of the participants acknowledged that genetic/hereditary factors play some role in mental illness, most participants believe that trauma is at the root of the mental illnesses we see in Black communities in Nova Scotia, whether it be intergenerational trauma stemming from colonialism, every day and systemic forms of racism, sexism, homophobia, and transphobia, or the trauma of race and gender-based violence, including sexual abuse and molestation, sex trafficking and IPV. As indicated throughout this report, Black women's structural location at the intersection of race, culture, gender identity, sexual orientation, socio-economic status, citizenship, disability, and age puts them at an increased risk for mental illness, resulting from experiences of trauma. Therefore, this study seeks to extend conventional notions of "trauma" in Canada to include not just the kinds of state violence that refugees experience, for example, but also the traumatizing aftereffects of slavery and colonialism, as well as structural forms of violence that Black people and Black women are exposed to every day in Nova Scotia and Canada.

In an interview with clinician Resmaa Menakem, the author of *My Grandmother's Hands: Racialized Trauma and the Pathways to Mending our Hearts and Bodies* (2017), journalist Kristin Moe (2020) examines how trauma resulting from the racial violences of the past and present becomes embedded within the body and the approaches that can be used to heal those wounds. Menakem calls attention to the ways in which racial violence is intertwined with the collective history, identities, and cultures of Black people, and how emotion, memory, and trauma come to reside in both the mind and the body. Building on the field of epigenetics, which focuses on how trauma gets passed down through generations, Menaken "contextualizes his clinical work within historical and collective trauma that is passed on from one generation to another through our very DNA" (Moe), or what is often referred to as intergenerational trauma. When similar traumas are shared by a people in this way, as it is for Black people in Nova Scotia, Canada and globally, the strategies they use to cope with trauma will also look similar. Menaken refers to this as *traumatic*

retention (Moe). In his book *My Grandmother's Hands*, Menaken observes that trauma manifests in the body and influences our behaviour, often in ways that have detrimental and harmful effects. It reminds us that racism is not simply an idea but is also visceral in the way it is stored as sensation, tension, and pain (Moe). For Black people, specifically, trauma is rooted in the structural apparatus that imposes a “white body supremacy” in which Black people are expected to live up to a white European ideal or standard (Moe). Menaken argues that if these and other conflicts inside the Black body are not resolved, “racial violence will remain an unhealed wound” (Moe). He also takes issue with the term post-traumatic stress disorder (PTSD), arguing that “post” is about trauma in the past. Rather, he suggests that Black people have *persistent*-traumatic stress disorder that remains an ongoing threat (Moe).

The central role that trauma plays in Black women’s emotional lives suggests that Trauma Informed Care (TIC) may be an effective approach for helping Black women work through multiple and intersecting types of trauma that contribute to their mental health struggles. TIC is a strength-based approach that understands and responds to the impact of trauma on individuals and communities, and that emphasizes physical, psychological, and emotional safety for both health professionals and patients (Hopper, Bassuk, & Olivet, 2010). It recognizes that trauma results from experiences that impact an individual’s capacity to cope with such issues as abuse and neglect; family conflict; poverty; life-threatening illness; undergoing repeated and/or painful medical interventions; accidents; witnessing acts of violence; experiencing war; intergenerational events; and grief and loss. Slavery, colonization, racism, loss of culture, forcible removal from family/community, and genocide are forms of intergenerational trauma that have been passed down through generations and that have had enduring impacts on the emotional, psychological, and cultural well-being of Black people in Nova Scotia. Being trauma informed is about acknowledging the many ways in which trauma manifests, building welcoming and safe physical and emotional environments, promoting safety, trust, and respect, and ensuring positive social interactions with clients, families, staff, and volunteers.

Cultural and historical awareness are principles of TIC and refer to the ability to understand trauma as an outcome of culture, historical events, and/or being part of a marginalized group. Therefore, trauma-informed services must be structurally and culturally competent (IWK, n.d.). TIC also highlights why a colour-blind (or race blind) approach is ineffective for addressing the mental health issues experienced by Black women. A colour-blind approach enables white mental health professionals to deny or ignore their own racial bias and the racial bias in the wider society. And, while many mental health professionals have been trained to be culturally competent, this training has tended to “culturalize racism” by masking issues of race and racism in favour of a focus on culture. Therefore, when mental health professionals provide services to Black and other racialized patients as if they were colour-less, they obscure, ignore, and undermine the significant impact of racism on the mental health and well-being of racialized peoples. Therefore, as Fernando (1991) points out in referring to the profession of psychiatry:

“To ignore culture in psychiatric practice is a mistake; to ignore race is racist” (p. 143).

It is imperative, then, that the *Nova Scotia Sisterhood Initiative* and any other health and mental health service that seeks to respond to the challenge of diversity and difference be concerned not only with the question of representation or the need to have a multiplicity of voices and perspectives entrenched as part of health and mental health knowledge and practice,

but also with healing the trauma that resides in Black women's bodies as a result of historically rooted and present-day structural inequities.

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