The psychological literature on mental health has shown that oppressions such as racism, sexism and classism can be extremely stressful. Thus individuals' identities, such as race, gender, and socioeconomic status, and the oppression these can lead to have clinical implications. The current research sought to investigate the intersection of Black Canadian women's identities and how it contributes to their unique experience of depression and coping. The aim of this study was to identify significant experiences of depression and coping of this population in order to develop a theory of healing.

The current literature on Black female depression is dominated by Black American and Black British women’s experiences. Black Canadian women’s experiences resemble those of these groups in terms of marginalization, discrimination, and unequal access. However, patterns of migration and the specifics of race relations and diversity issues differ between these countries. To address this gap in the literature, this study specifically explored Black Canadian women's experiences of depression and how they cope.

The participants in the study were 20 Black Canadian women who self-diagnosed with depression. This research employed a qualitative methodology of constructivist grounded theory to provide a detailed description of the participants’ journeys through depression, coping, and
healing. The findings suggest that there are distinct and unique ways of experiencing and coping with depression among Black Canadian women. Healing was revealed to be a relational phenomenon involving self, family, and community.

A theoretical framework of healing was developed from the interconnections of the multiple complex layers of the healing process. Isolating the themes of the Strong Black Woman, mother-daughter relationships, and transgenerational trauma/resilience transmission provided a means to illustrate their paradoxical influences on depression. These themes illustrate the reality of Black Canadian women’s lives dealing with depression. Understanding the role that the stereotype of the Strong Black Woman and intergenerational relations play in depression and recognizing the importance of community engagement and self-definition puts Black Canadian women on the road to healing.
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In line with the popular African proverb, “It takes a village to raise a child,” I say that it takes a village to produce a dissertation (Timothy, 2007). There are so many (living and non-living) beings that held me close and supported me. So many blessings I received to make this dissertation possible.

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Chapter One
Introduction

Rationale and Background for the Study

To treat all Canadians who struggle with depression and coping the same way is to ignore the variability of human beings. There is no one way of being depressed, and there is no single way of coping; rather there are numerous ways of manifesting mental illness and of coping with it. Black Canadian women have a unique way of seeing their world. Their experiences and way of seeing influence their expression of depression and methods of coping. By acknowledging the diversity of human beings we can develop a best practice model for the treatment of depression and healing for Black Canadian women.

The *Diagnostic and Statistical Manual of Mental Disorders IV* (DSM-IV) is being challenged as an effective tool for measuring Black Canadian women’s depression on the basis that there is no one-size-fits-all method of diagnosing depression. It has been found that there are “fundamental racial, ethnic and cultural differences in the experience and manifestation of depression” (Cardemil, 2006, p. 151). Keyes, Barnes, and Bates (2011) questioned its suitability for the Black population:

The present DSM nosology may not accurately tap Black psychological responses to their unique stress exposures, and therefore DSM-IV depression as currently defined may not be the appropriate outcome to fully understand racial differences in depressive mood states. Support for this theory can be drawn from the multiple studies showing that Blacks report lower levels of wellbeing, higher levels of distress and higher depressive scores when measured on non-DSM instruments. (p. 658)

Yet, practitioners rely heavily on the DSM-IV for diagnosis.
Variations in coping styles also need to be recognized. No particular way of coping is universal. However, the literature is heavily biased toward the notion that coping mechanisms can be described with just two categories: approach/avoidance and problem-focused/emotion-focused (Roesch, 2006, p. 111). This does not take into account that coping patterns are subject to the unique ethnic, gendered, and socioeconomic identities of individuals. Roesch (2006) explains: “these patterns are not equivalent across all people” (p. 112). It seems likely then that the distinctive form for coping that Black Canadian women display may not be prevalent in the mainstream white population.

The challenge for practitioners is to be flexible and responsive to the distinctive needs of their clients. The philosophy of multicultural counselling recognizes that practitioners need to be aware of the specific requirements of their clients: particularly the requirements of clients who are of a different culture from them. For instance, Jibeen and Khalid (2010) suggest that in order to meet the psychological needs of the Canadian population, mental health services need to be offered in clients’ native languages. The Canadian census of 2011 reported that 20.6% of Canadians speak a language other than one of the official languages, English and French, in their homes (Statistics Canada, 2011). This is something that mental health services in Canada need to take into account. This approach is in line with Buhin’s (2006) definition of multicultural counselling competencies: “gaining knowledge, increasing awareness, and obtaining skills for effective and ethical work with culturally different clients” (p. 311). Understanding the complexity of the needs and challenges of a diverse community is critical to the mental health of Canadians.

Canadians pride themselves on their multicultural society. Throughout Canadian history, Canada's population growth has largely been a result of immigration. Statistics Canada (2012a)
estimated that as of January 1, 2013, the population of Canada was 35,056,100. The Canadian population includes people who have migrated to Canada from all over the world. Canada is one of the most ethnically diverse countries in the world. Its population is made up of people of ethnicities and cultures from across the globe. Statistics Canada (2013a) states that the largest visible minority groups are South Asian, Chinese, and Black. Therefore mental health practitioners in Canada need to be able to respond to the psychological needs of a culturally diverse population (Dyck & Hardy, 2013; Jibeen & Khalid, 2010).

It is important to note that the Canadian Black population is not a homogeneous group. The families of some Blacks have been in Canada since the 1600s (Beagan, Etowa, & Bernard, 2012; Sadlier, 2010), others are first- or second-generation citizens of immigrant parents from the Caribbean, while still others are recent immigrants from Africa. Black migration to Canada has occurred in a number of phases. The first Black person was documented in the territory that is now known as Canada in 1605: Mathieu Da Costa, who served as an interpreter for the French explorer Samuel de Champlain (Milan & Tran, 2004; Sadlier, 2010). From 1628 until the early 1800s, Africans were brought to Canada as slaves (Milan & Tran, 2004; Sadlier, 2010). Slavery in Canada officially ended in 1833. The elimination of slavery in Canada inspired Blacks from the United States of America to risk their lives to come to the country via the Underground Railroad (Sadlier, 2010). Many more Blacks came to Canada in the 19th century. These were often Black Loyalists who had been promised land in return for their support of the British during the American Revolution. Black Loyalists settled in Nova Scotia, Ontario, and later in Western Canada (Milan & Tran, 2004). From the beginning of the 20th century Black women migrated to Canada as labourers from the Caribbean (Brand, 1993). In the 1960s and 1970s, Black Caribbean women came to Canada as domestic workers. From July 1975 to June 1976,
44.8% of all entrants to Canada’s foreign domestic program were women from the Caribbean (Crawford, 2004). Many of these women came with hopes and dreams for a better economic future for themselves and their families (Massaquoi, 2004). The 1980s saw many children of Caribbean immigrant women, who had been left behind in their countries of origin join their mothers in Canada (Smith, Lalonde, & Johnson, 2004). In the late 1960s and early 1970s, Blacks also arrived in Canada from different parts of Africa (Ruprecht, 1998). After the Nigerian Civil War, from 1967 to 1970, a large number of Nigerians settled in Toronto. Following the revolution in Ethiopia in 1974, refugees fled to neighbouring African countries and many of these eventually immigrated to Canada. In the late 1980s, refugees from Eritrea came to Canada. In addition, many Somali refugees have made Canada their home. Black people in Canada are a diverse group who have come from all parts of the world and travelled along many different paths to Canada to raise their children and make it their home.

Black people have entered Canada in different ways and have come from different places, but they report a shared experience of racism due to the colour of their skin (Beagan & Etowa, 2009; Bernard, 2002; Reitz & Banerjee, 2007; Sadlier, 2010). Many Black Canadians have reported experiencing stress due to racism (Beagan & Etowa, 2009; Reitz & Banerjee, 2007). Harrell and Sloan-Pena (2006) defined racism as: “A system of oppression based on racial/ethnic group designation in which a pervasive ideology of racial superiority and inferiority provides the foundation for structural inequalities, intergroup conflict, discrimination and prejudice” (p. 396). In the Canadian context, racism has a specific expression. Rosemary Sadlier (2010) defined racism in Canada in the following way:

Canada does not have a significant incidence of lynching, race riots, or mass destruction of several communities. It does have continuous episodes of racial discrimination which have resulted in the deaths of Black people at the hands of
other community members or the police. The continuous nature of the discrimination, combined with their marginalized experience educationally, economically and culturally, creates the distinct experience of “Black” Canadians. However, the racist definition is not only a measure of the frequency, intensity and duration of racist acts, nor is it only connected to acts of violence—it is a definition that is related to race-based differential treatment involving notions of superiority and inferiority of one race over others enforced by power. That being the case, Canada is a racist country according to the UN definition, and the work of countless researchers, given its founding as a slave society. (p. 38)

An awareness of widespread racism in Canada led researchers Reitz and Banerjee (2007) to inquire about the phenomenon in their study “Racial Inequality, Social Cohesion, and Policy Issues.” They asked 40,000 Canadians if they had experienced discrimination in the past 5 years. Sixty percent of second-generation Black Canadians responded that they had, while only 10% of white Canadians responded affirmatively. The researchers concluded that visible minorities such as Black Canadians perceive racism as part of their lives (Beagan & Etowa, 2009; Reitz & Banerjee, 2007). In response to racism, some Black Canadians in Toronto advocated for an Afrocentric school that would address the specific needs of Black students. In 2009, the Toronto District School Board (TDSB) finally responded by creating such a school in the Greater Toronto Area (GTA) (Gordon & Zinda, 2012). This supports the concept that one approach does not fit all. The TDSB acknowledged the need to tailor their approach in order to meet the needs of a particular population. It is argued from this study that the mental health system in Canada needs to follow suit.

Commonplace racism contributes to the distinctive experiences of Black Canadians and how they educate their children to survive racism (Beagan & Etowa, 2009). Negative interpersonal interactions and derogatory verbal and non-verbal exchanges inflict emotional pain and/or reinforce racial stereotyping, which is a subtle form of racism prevalent in Canada. The effects of racial stereotyping are so insidious that it is difficult to describe them fully. Sue et al.
(2007) have defined this phenomenon as *racial microaggressions*: “Brief and commonplace daily verbal, behavioural, or environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative racial slights to people of colour” (p. 271). This insidious kind of racism not only affects Black adults but their children as well. The subtle but harmful effects of racism are similar to those of sexism as it is manifested in Canadian society.

Sexism is an insidious form of oppression that is also prevalent in Canadian society. It marginalizes Canadian women with the result that Black women experience depression differently from their male counterparts. McMullen and Stoppard (2006) report Canadian women’s vulnerability to depression can be attributed to their position in society. As in the case of racism in Canada, women most often experience a subtle form of sexism that Becker and Wright (2011) refer to as “benevolent sexism” (p. 1). This can take the form of references to women that appear positive but in reality further marginalize them. For instance, the notions that women should be protected by men and that women are more morally sound than men are subtle forms of sexism that easily go unnoticed. At first glance, these two ideas appear to be positive, yet they undermine women's ability to function independently in society. As Becker and Wright (2011) explain: “Portraying women as wonderful but childlike, incompetent, needing men to protect them, and therefore best suited for low-status roles . . . justifies gender inequality” (p. 62).

Lemus, Spears, Bukowski, Moya, and Lupianez (2013) stated that women have a vested interest in challenging gender stereotypes, but these “stereotypical social roles are predominant in society, making it difficult to contest them” (p. 109). For instance mothers who relinquish custody of their children to the father may be seen as immoral while the same behaviour demonstrated by fathers is seen as normal.
In Canada this inequality can also be seen in the differences in economic stability between the genders. The notion that women work for supplementary income in the family leaves women more subject to economic hardship. For instance, it is sometimes expected that women’s careers and or jobs be compromised when responsibility for nursing a sick child at home become viewed as the mothers’ role and not fathers’ responsibilities. Hence, women report filling more part-time and contractual positions compared to their male counterparts (Statistics Canada, 2012a). And they continue to be overrepresented in the service industry, which consistently pays lower wages than other sectors (Statistics Canada, 2012a).

Being Black and female in Canada often means being poor (Galabuzi, 2006). According to the 2006 census, 8.4% of visible minority women aged 25–54 were unemployed, compared to 6.2% of visible minority men and 5% of non-visible minority women (Statistics Canada, 2012c). The Canadian Association of Social Workers’ document, *Income of Black Women in Canada*, reported that 34.5% of Black women in families were below the low-income cut-off of Statistics Canada—the unofficial poverty line (Bruhier & Drover, 2005). The incidence of Black women in families who are poor is two-and-a-half times higher than that of other women in families (13.7%) and almost three times higher than of men in families (12.0%) (Bruhier & Drover, 2005). Poverty is a reality for many Black Canadian women (Galabuzi, 2006). Many are among the working poor at the bottom of the ladder in Canada’s capitalist society. This phenomenon makes their experience of depression and coping different than that of others.

Racism, sexism, and classism are all oppressions that afflict Black Canadian women on a daily basis. Thus Black Canadian women face a triple jeopardy, and these “isms” are not separate entities, but intertwined in the reality of their lives (Rosenfield, 2012). Researchers
(Everett, Hall, & Hamilton-Mason, 2010; Greer, 2011; Hamilton-Mason, Hall, & Everett, 2009) have argued that Black women who occupy a lower rung in the social hierarchy because of their racial and sexual identities may suffer from greater psychological distress. The stress emanating from the intersecting oppressions of racism, sexism, and classism has been linked to depression. Therefore, one may conclude that Black women have a particular understanding of depression and coping because of their experience of the intersection of racism, sexism, and classism.

The relationship between the oppression of Black women’s identities and mental health has become the subject of critical discussion in the literature of counselling and psychology. For instance, the women in Edge and Rogers’s (2005) study, “Dealing with It: Black Caribbean Women’s Response to Adversity and Psychological Distress Associated with Pregnancy, Childbirth and Early Motherhood,” were reluctant to consult the medical system for their depressive symptoms for fear of being further oppressed:

Based on their experience of negative contact with health professionals, but more importantly, on perceptions of discriminatory and coercive treatment of Black people by mental health services, some women resisted consulting their GPs. (p. 21)

Black women’s historical distrust of the medical profession due to the treatment they received and their ancestors received may be an explanation for this group’s low attendance of therapy. For instance, researchers Keyes et al. (2011) have questioned the methodological approach used to measure depression among Black women that has led to these conclusions. Distrust of the medical field and routine misdiagnosis by health care providers may also explain why Black women are less likely to attend therapy. Hence, there is a need to investigate whether Black Canadian women experience and interpret their depression and coping in ways that may not be recognized by traditional Western medicine. Understanding Black Canadian women’s experience
of depression can help improve the current mental health system. In the next section, I discuss this study’s problem statement.

Statement of the Problem

Despite the long history of Black women living in Canada, their needs have gone almost unnoticed in the field of mental health. For instance, only a small number of researchers (for example: Etowa, Keddy, Edgeyemi, & Eghan, 2007; Schreiber et al., 2000) have investigated depression in Black Canadian women. The researchers who have examined this group report that Black Canadian women are routinely ignored or misdiagnosed by mental health practitioners (Martin, Boadi, Fernandes, Watt, & Robinson-Wood, 2013). One documented explanation for this phenomenon is that health care providers routinely dismiss Black women’s accounts of their own depressive symptoms (McKnight-Eily, 2009). In the British and American literature it is claimed that some practitioners believe that Black women can handle extreme emotional challenges well and therefore do not investigate whether British and American female Black clients are experiencing depression (Edge & Rogers, 2005; Jones & Shorter-Gooden, 2003; Waite & Killian, 2008).

It is noteworthy that the literature has shown that Black women have internalized the belief that they are “emotionally strong” (Edge & Rogers, 2005; Jones & Shorter-Gooden, 2003). Many Black women have used this belief to cope with their lower social status resulting from the multiple oppressions of race and gender (Schreiber et al., 2000). Glass’s (2012) study discovered that Black American women's perception of a resilient self interfered with their ability to seek and accept emotional help from others. Hence, being “emotionally strong” has become a double-edged sword for Black women. On the one hand, it is a form of resistance to an oppressive
environment, but on the other, it has denied Black women their own feelings of despair and sadness (Edge & Rogers, 2005; Jones & Shorter-Gooden, 2003).

The relationship between depression and Black women’s capacity to cope is a complex one (West, Donovan, & Roemer, 2010). This study aims to investigate Black Canadian women’s living through depression by documenting their unique ways of experiencing their emotions and of coping. Next, I discuss the theoretical framework I use to examine Black Canadian women’s depression and coping.

**Theoretical Framework**

When studying Black Canadian women it is important to use a theoretical framework that recognizes race, gender, socioeconomic status, sexual orientation, age, (dis)ability, and religion/spirituality. That is, it is important to use a theoretical framework that allows an in-depth exploration of the intersection of identities that shapes Black Canadian women's lives because individuals understand who they are through the intersection of identities over time and in relation to social interactions and context (Cheshire, 2013). I have thus chosen to use an intersectional framework, which recognizes the multiple identities of Black Canadian women, and at the same time recognizes the multiple intersecting oppressive systems in which they live. Intersectionality is a theory accepted in women's studies and in feminist thinking (Phoenix & Pattynama, 2006). For instance, Black feminist literature draws on the theoretical perspective of intersectionality in discussions of Black women's lives (Bowleg, 2008). In Collins (2000), Greene (2005), hooks (1993), Moodley (2011), Wane (2009), and Williams (2004), narratives are based on the connections among race, gender, socioeconomic status, sexual orientation, (dis)ability, and religion/spirituality. This study uses the concept of intersectionality borrowed
from feminist discourse and particularly from Black feminist theory to investigate the mental well-being of Black Canadian women.

Critical race theorist Kimberlé Crenshaw (1991) is credited with originating the term *intersectionality*:

The experiences Black women face are not subsumed within the traditional boundaries of race or gender discrimination as these boundaries are currently understood, and the intersection of racism and sexism factors into Black women's lives in ways that cannot be captured wholly by looking at the race or gender dimensions of those experiences separately. (p. 1244)

Crenshaw (1991) highlights the complexity of intersectionality. An individual's identity as a Black woman includes race and gender, but it also encompasses socioeconomic status, sexual orientation, age, (dis)ability, and religion/spirituality. These social identities are interdependent and mutually constructed. According to intersectional ideology as explained by Crenshaw (1991), Black women’s experience of oppression is multidimensional. Bowleg (2008) reminds us that Black women are not just Black in the sense in which race is understood in reference to the experience of Black men. They are not just women in the way that being a woman is understood in the literature on white women's experiences. Hence Black women’s experiences are only minimally addressed in critical race analyses and in feminist discourse. An intersectional perspective acknowledges Black Canadian women's realities as they relate to how Black women express and negotiate identities commonly oppressed in Western society. It is a theory that provides a richer and more complex ontological approach to looking at Black women’s lives. For instance, Black women are continuously subjected to racism and sexism simultaneously. They are immersed in a double jeopardy (Foynes, Shipherd, & Harrington, 2013; Jackson, 1998) of racism and sexism, and in some cases, in a triple jeopardy because of their socioeconomic status (Hall, Everett, & Hamilton-Mason, 2012; Habarth, Grahan-Bermann, & Bermann, 2009;
Rosenfield, 2012). For still others, oppression also results from sexual orientation, spirituality, age, and/or (dis)ability, which affect the position in which they find themselves. The theory of intersectionality can also give added insight into the complex nature of Black women's mental health. Mental health practitioners are in fact beginning to use it as a clinical construct when working with Black female clients (Braun Williams, 2005).

For practitioners in the field of mental health, intersectionality theory offers useful tools for working with individuals holding strongly multilayered identities. Cheshire (2013) stated:

There appears to be a shift taking place in the field of counselling and psychotherapy that is calling for counsellors to adopt more complex models of social identities in their work. (p. 8)

Intersectionality is committed to addressing multiple simultaneous social identities that are subject to oppression in order to capture all of the factors that may influence Black women’s sense of mental health. As Jackson (1998) claimed, the concept of self is based on multiple identities that are socially constructed and that exist in a historical context:

The discarding of the individual categories would be to deny the real life experiences of these women. Rather we need to explore more carefully and critically the ways these categories do come to define who we are and how the relationship between such categories results in complex identities and definitions of self. (p. 181)

The multiple identities of Black women inform how others see them and how they see themselves. Intersectionality theory provides an in-depth understanding of the different social positions Black women occupy and how these are interactive, rather than isolated, factors in women's lives. Taking Audre Lorde’s (1984) lead on how our understanding of Black women's literature can benefit from an acknowledgement of the multiple identities of Black women, I
argue that mental health practitioners can use this approach to further enrich their sessions and therapeutic alliances with their Black female clients:

To examine Black women's literature effectively requires that we be seen as whole people in our actual complexities—as individuals, as women, as human—rather than as one of those problematic but familiar stereotypes provided in this society in place of genuine images of Black women. (p. 3)

Lorde’s (1984) notion of how one should relate to and interact with Black women is important advice for the mental health profession.

Yet some critics of the theory of intersectionality argue that the approach essentializes Black women’s experiences. Intersectionality has been criticized for its potential to marginalize and further silence Black women, rather than leading, as intended, to a greater understanding of Black women's unique experiences of marginalization. Alexander-Floyd (2012) makes the point that some Black women hold privileged identities. After all, some Black females are not on the lower end of the socioeconomic scale, are in heterosexual relationships, and practice a mainstream religion. This observation reveals that although intersectionality has mostly been theorized from the standpoint of those who experience multiple dimensions of disadvantage, this framework can also clarify the identities of members of privileged groups. Intersectionality theory, originally intended to examine Black women’s experiences of oppression, can thus be used to ignore oppressed Black women and to support mainstream ideologies. As Alexander-Floyd asserted in 2012, intersectionality can serve to analyse anyone’s identity and neglect the specific needs of Black women therefore it cannot prevent the elision of the Black women whose interests it was designed to promote. In Alexander-Floyd’s (2012) perspective, intersectionality can therefore end up supporting everybody else’s causes and leaving out Black women, thus re-marginalizing them.
Discussing how intersectionality can end up benefiting everyone but Black women, Lorde (1984) advised: “we must recognize differences among women who are our equals, neither inferior nor superior, and devise ways to use each others' differences to enrich our visions and our joint struggles” (p. 6). When comparing Black women with respect to their different relationships to the hierarchy of oppressions, one must remember that allies can also be found among privileged groups. However, regardless of socioeconomic status, all Black women are subject to racism and sexism in Canadian society.

It has also been argued that intersectionality has been overused in academia. Fine and Burns (2003), for example, referred to intersectionality as an academic mantra. They argued that it has been used so often by feminist scholars to give the appearance of inclusivity that it has lost the essence of Black women's everyday reality of managing multiple identities that have been historically subject to oppression and continue to be today. Canadian Aboriginal feminist Jessica Yee (2011) agrees that intersectionality is not a panacea:

Western notions of polite discourse are not the norm for all of us and just because we've got some new hot language like “intersectionality” to use in our path it doesn't necessary make things change in our walk. (p. 11)

The deconstruction of intersectionality is important so that we do not lose its true intent of making Black women’s lives visible in feminist discourse. But to continue to investigate depression in isolation based on separate identities will not get to the heart of the uniqueness of Black women's experiences. Intersectionality theory at least acknowledges Black women as whole beings. Phoenix and Pattynama (2006) reminded us: “no concept is perfect and none can ever accomplish the understanding and explanation of all that needs to be understood and explained within the field of women's studies” (p. 187).
Depression and coping cannot be looked at in isolation. Just as Black women have intersecting identities so do the concepts of depression and coping. There is not just one way of manifesting depression. Depression comes in many forms and each individual uniquely manifests the experience. Coping varies as well. As the research question speaks about the unique experience of Black Canadian women’s depression and coping, it is important to bear in mind that there is no one unique way of being a Black Canadian woman. However for the sake of the study the manifestation of Black Canadian women’s depression and coping will be looked at as a group phenomenon to identify commonalities.

Intersectionality theory is critical to understanding Black Canadian women's depression and ways of coping. The various identities of Black Canadian women—such as race, gender, socioeconomic status, sexual orientation, (dis)ability, and religion/spirituality—help explain Black women’s perceptions and articulations of their mental well-being. However, due to the limitations of this thesis, I will be investigating only three of the group of seven identities separately: race, gender, and socioeconomic status. These identities are dissected individually as they are presently treated in the literature to give an in-depth analysis of the part each play in an individual’s experience of depression and ways of coping. Subsequently, I discuss these identities at the intersection at which they are experienced in the day-to-day reality of Black women’s lives. I conclude that in order to fully discuss Black Canadian women's depression and coping these identities need to be considered together. In the next section, I discuss the objectives and goals of this study on Black Canadian women’s experiences of depression and coping.
Objectives and Goals

My objective in the present study is to advance our understanding of depression and coping by acknowledging the intersection of race, gender, and socioeconomic status and its effects on Black Canadian women. I seek to address the treatment gap by engaging in qualitative research into the experiences of Black Canadian women who have struggled with depression. It is my hope that this research will provide tools for mental health practitioners to assist Black women in their journey from depression to a healing space. The ultimate goal of the study is to develop a theory of healing.

The research was directed by three basic objectives as follows:

1. To examine what it means for Black Canadian women to be depressed.

2. To address the embodiment of the intersection of the oppressions of racism, sexism, and classism to which Black Canadian women are vulnerable, due to their race, gender, and in some cases poverty, and how this contributes to their rate of depression.

3. To investigate the narratives of Black Canadian women’s experience of depression, a turning point (the awareness that a change has occurred and the move from a place of depression to coping has begun) and coping in Black Canadian women’s search for mental well-being.

These objectives have led to the development of a particular research question.
The Research Question

How do Black Canadian women in the GTA who have had or currently have depression experience their depression, and how do they cope with it? This is my leading research question. The following three subquestions are central to the research:

1. How do Black Canadian women experience depression?
2. How do Black Canadian women cope with depression?
3. How do Black Canadian women heal?

These questions give rise to some implications. I discuss these in the next section.

Study Implications

Acquiring greater knowledge of Black Canadian women’s experience of depression and about their unique ways of coping opens up the possibility that expressions of depression and coping styles may not be monolithic. This would challenge the current notion of a one-dimensional experience of depression that is valid across all cultures. My investigation suggests that different subgroups in the Canadian population experience and demonstrate depression in unique and distinct manners. That is, one subset of the Canadian population may experience depression quite differently than another. I am therefore suggesting a paradigm shift in how the mental health field approaches depression in a diverse society.

As Canada is a multicultural country, there is a need for a diversified perspective on mental illness. This study challenges mental health practitioners to allow the cultural experience and subjective perception of illness and treatment guide and inform the healing process. To show how this will be established, I outline a road map to this study in the next section.
Road Map of the Thesis

This thesis is structured in the following manner: Chapter One offers a brief history of Black Canadian women designed to give an understanding of the background and context in which these women live. It also introduces the theoretical perspective of the intersectionality of identities that is used to investigate the experiences of Black Canadian women throughout the study. Chapter Two provides a detailed literature review highlighting studies that explore depression. Chapter Three continues the literature review by investigating the concept of coping. Chapter Four moves the discussion forward by addressing the research design and methodology. It elaborates the choice of a constructivist grounded theory methodology as a tool for both data collection and data analysis. Chapter Five focuses on the results and findings of the study. It draws on the data generated from the interviews of 20 Black Canada women who self-identified as having had depression at some point in their lives. The findings illustrate aspects of the participants’ experience of depression, their sense of a turning point, and their ways of coping. Chapter Six explores the theoretical model that was generated from the results. It discusses the framework of Black Canadian women’s experiences of mental health that moves from depression, to a turning point, to coping, and, eventually, to a healing space. Chapter Seven concludes the thesis by identifying the implications, strengths, and limitations of the study and offers recommendations for future research.

Summary

The 2006 Canadian census data reports that approximately 696,800 Blacks, and within that number 363,265 Black women, call Canada home, making Black people the third largest visible minority group in the country (Statistics Canada, 2011). Black Canadians names a diverse group. Some Black people’s ancestors have been in Canada since slavery while others are recent
immigrants from the Caribbean and Africa. Black Canadian women have reported experiencing racism and sexism, and some also carry the additional burden of poverty.

Most in the mental health field agree that oppression is extremely stressful. Researchers Hamilton-Mason et al. (2009) have stated that Black women are more susceptible to depression because of the intersection of identities commonly subject to oppression, such as race, gender, and socioeconomic status. For instance, Jones and Shorter-Gooden (2003) found that the oppressions Black women face because of being Black, female, and poor can result in depression.

The literature has also shown that Black women manifest depression differently than the mainstream Western population with the result that their symptoms are often dismissed or misdiagnosed by clinicians (Kleinman, 2004; Martin et al., 2013). The failure to acknowledge how Black women manifest depression has affected the relationship between Black women and the mental health system.

A conference held in Alberta, Canada, on October 17, 2008, entitled “How to Improve Prevention, Diagnosis, and Treatment,” called for new approaches to the treatment of depression that recognize that patients are people first (Kirby et al., 2008). Focusing on the concerns of Canadian Black women's mental well-being, particularly on how they experience and cope with depression is an answer to this call.

There is much that we can learn about depression by looking at it through the lenses of marginalized communities. Black Canadian women who are marginalized in Canadian society and have experienced depression possess a wealth of information that can inform the mental
health community about what it means to be a Black Canadian woman struggling with depression. This study presents that information using an intersectional framework.
Chapter Two
Literature Review:
Depression and Black Women

Studying Black Canadian women’s experience of depression has particular challenges. Black women are not a homogeneous group; they are diverse, particularly across nations. The literature for example consists predominantly of investigations into the experiences of Black American women (Glass, 2012; Hamilton-Mason et al., 2009; Heller, Viken, & Swindle, 2013; Waite & Killian, 2007, 2008, 2009) and Black British women (Brown et al., 2011; Edge, 2013, Edge & Rogers, 2005). There has, however, been very little investigation into the experiences of Black Canadian women with depression (Ali & Toner, 2001; Etowa et al., 2007; Schreiber et al., 2000). Issues faced by Black American women, Black British women, and Black Canadian women may be similar in terms of marginalization, discrimination, and unequal access; but migration, race relations, and diversity issues differ among these countries. Hence, there is a need to fill the gap in the literature by addressing the particular unique experiences of Black Canadian women with depression.

Though I concede that depression is experienced by individuals of all racial, ethnic, gender, and socioeconomic backgrounds (Jackson, 2006; Kleinman, 2004), I insist that narratives of depression are unique to particular groups in society. Whereas some scholars are convinced that there are universal characteristics of depression as outlined in DSM-IV (American Psychiatric Association, 2000), I maintain that depression presents differently in the lives of Black Canadian women than it does in the mainstream Western population (Shorter-Gooden, 2004; Waite & Killian, 2007). When it is assumed that the manifestation of depression is the same across cultures, genders, and socioeconomic levels. Black Canadian women become
vulnerable to misdiagnosis or to having their symptoms ignored altogether by their mental health practitioners (Kleinman, 2004; Martin et al., 2013; Waldron, 2003). Those unfamiliar with the school of thought that there is diversity in depression may be interested to know that it basically boils down to understanding that Black women have unique experiences which provide insight into the barriers they face when it comes to their care (Goodman, Dimidjian, & Williams (2013).

I argue throughout this chapter that Black Canadian women show particular symptoms of depression that differ from those shown by members of other groups. I insist that there is no one particular or universal experience of depression, but instead multiple ones, and that Black Canadian women express their distress in distinctive ways. This literature review looks at the diversity of expression and experience of depression and, in particular, at the features that are unique to Black Canadian women's descriptions of their own depression. I am conscious of the diversity that exists among Black Canadian women: I understand that not all Black Canadian women experience depression in the same way. However, for the sake of this investigation, I look at the commonalities of Black Canadian women's descriptions of depression and at how the pathology manifests in a unique form distinguishable from its manifestation among members of other groups. To provide an in-depth investigation into the area of depression among Black Canadian women the chapter is divided into seven sections, each representing a theme in the area of the study of depression. First, I define depression as it is understood in the mainstream Western approach. Second, I offer a discourse on depression and culture. Third, I engage in a conversation on depression and race and racism. Fourth, I explore depression and gender and sexism. Fifth, I examine depression and socioeconomic status and classism. Sixth, I discuss depression and intersectionality. And last, I engage the question of the unique features and experiences of depression among Black Canadian women. A review of depression using the
above themes is critical at this time in counselling psychology as multicultural counselling is becoming increasingly necessary given the increasing diversity of the Canadian population, and given that depression is one of the fastest growing diagnoses in Canada, the U.S., and the world (Canadian Institute for Health Information, 2008). According to the World Health Organization (2012), “Globally, more than 350 million people of all ages suffer from depression.” The intent of this discussion is to raise the awareness of scholars and practitioners and to take stock of what is known about Black Canadian women’s depression so that we might understand where to go in future research in this field.

**Depression: A Mainstream Approach**

Depression is a serious mental health disorder that has grown into a worldwide epidemic. The World Health Organization (2012) stated that depression is the leading cause of disability worldwide. I agree that depression is a major health concern for all Canadians, a point that needs emphasizing since use of the word *depression* has become so widespread that it has entered casual conversation in English-speaking Western countries. For instance, some Canadians will say that they feel depressed meaning that they are having a “down day.” However, such a remark will be interpreted differently depending on who is doing the interpretation. In the mental health field, depression is a mental disorder that involves much more than feeling down or temporarily sad. It has physical symptoms, affects cognitive functioning, lowers one’s self-esteem, and, at its worst, can lead to suicidal behaviours (American Psychiatric Association, 2000).

Depression is experienced around the world (Kleinman, 2004), but mental health practitioners everywhere commonly use Western diagnostic tools to measure depressive symptoms in their clients. I think this is a mistake because it assumes that all individuals articulate their experience of depression in the same way that is, in a Western way. These
Western tools rely on individual narratives of depression. The *Diagnostic and Statistical Manual of Mental Disorders* (DSM-V) (American Psychiatric Association, 2000) is a tool used worldwide by the medical profession to identify depressed individuals. The DSM-IV diagnostic method involves inquiry into a range of areas in one’s life (American Psychiatric Association, 2000), such as physiological, social, and cognitive issues as well as self-esteem. Recently, as of May 2013, the Fifth Edition of the DSM was released. The Coding for depression in the DSM V is similar to the DSM IV. I will be referring through the document reference to depression according to the DSM IV.

1 The current official diagnosis of depression is based on the criteria laid down by the *Diagnostic and Statistical Manual of Mental Disorders*, 4th ed., text revision (DSM-IV-TR; American Psychiatric Association, 2000). To diagnose a person with a major depressive episode, five or more of the following nine symptoms must be present:

1. Depressed mood most of the day, nearly every day, as indicated by either subjective report or observation made by others (in children and adolescents it can be irritable mood).
2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (based on self-report or observation made by others).
3. Significant weight loss (not due to dieting), or decrease or increase in appetite nearly every day.
4. Insomnia or hypersomnia nearly every day.
5. Psychomotor agitation or retardation nearly every day (self-report corroborated by others).
6. Fatigue or loss of energy nearly every day.
7. Feelings of worthlessness or excessive or inappropriate guilt nearly every day.
8. Diminished ability to think or concentrate, or indecisiveness, nearly every day (self-report or observed by others).
9. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

The symptoms must have been present during the same 2-week period. This must represent a change from previous functioning and at least one of the symptoms ought to be either depressed mood (symptom 1) or loss of interest or pleasure (symptom 2).

In addition, the symptoms should cause clinically significant distress or impairment in social, occupational, or other important areas of functioning and should not meet criteria for a “mixed episode” (manic and depressive symptoms), and they should not be due to the direct physiological effects of a substance, or accounted for by bereavement (adapted from DSM-IV-TR; American Psychiatric Association, p. 356, as cited in Alladin, 2013, pp. 251–252).
Other instruments are also used for rating depression. Some clinicians use the Beck Depression Inventory (BDI) (Beck, Steer, & Brown, 1996), a self-report measure of depressive symptoms that uses a symptom checklist and rating scale. The Hamilton Rating Scale (Hamilton, 1960), another measure used, is similar to the BDI and the DSM-IV.

Any one of these three Western scales is employed to decipher clients' diverse expressions of their distress. Practitioners must attempt to interpret clients’ subjective narratives to make them fit the scale they are using in order to assess whether the individual is depressed. The score is based on clients' reflections on and articulation of what is happening to them, which means that the onus is on the client to speak the language of the mental health professional in order to receive an accurate assessment. By viewing clients through the lens of Western understanding of depression, clinicians overlook the deep problem that cultural differences might affect the interpretation and expression of depression of the individual client.

**Depression and Culture**

The nature of the relationship between depression and culture has sparked much discussion in the literature (Black, Gitlin, & Burke, 2011; Kleinman, 2004; Moodley, 2003; Ussher, 2010). Mental health discourse has been criticized for its essentialist approach to the understanding and treatment of depression. For instance, Ussher (2010) has argued that members of different cultures around the world articulate their symptoms of depression in unique and specific ways:

[S]uffering is signified by bodily or psychological complaints as varied as chest pains (China), burning on the soles of the feet (Sri Lanka), semen loss (India),

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2 The BDI comprises 21 items such as “Sadness: 0 = I do not feel sad, 1 = I feel sad, 2 = I am sad all the time and I can’t snap out of it, 3 = I am so sad or unhappy that I can’t stand it.” Scores are derived by summing the responses to each of the 21 items. Scores of 14–19 generally indicate mild depression, 20–28 indicate moderate depression, and 29–63 indicate severe depression.
ants crawling inside the head (Nigeria), or soul-loss (Hmong). (p. 10)

Members of different cultures describe their depression differently.

Because culture influences the understanding, presentation, and disclosure of symptoms of depression practitioners need to be aware of the differences among cultures. Kleinman (2004) is surely right that each culture, and, for that matter, each individual has its distinctive way of communicating feelings of depression, and each has its own notions about potential cures for psychological difficulties. Brown et al.’s (2011) study concurred with Kleinman (2004). Brown et al. (2011) found that Black British women have a different understanding and perception of depression than do white British women. Overall they concluded that Black British women did not take their symptoms of depression as seriously as did their white counterparts. Black British women viewed their symptoms as the result of dealing with social issues that needed to be ignored, while white British women saw their symptoms as something that needed to be addressed and treated. This research supports the claim that mental health practitioners need to be aware of clients’ different understandings of their symptoms. If practitioners are not aware of the diverse interpretations and subjective meanings of clients' depressive symptoms, useful clinical interventions can be missed, which makes for poor treatment. Researchers (Brown et al., 2011; Martin et al., 2013; Moodley, 2003) have suggested that practitioners’ lack of sensitivity to individuals' cultural differences when it comes to manifestations of mental health problems can have serious implications. As Donnelly et al. (2011) stated:

Barriers such as differing cultural values and perspectives, enforcement of dominant values onto clients, common clichés that only offer short-sighted help, and lack of sufficient time spent with clients may result in mistrust that hinders development of the therapeutic relationship between healthcare providers and clients. (p. 287)
The therapeutic alliance fails to develop if practitioners are not culturally sensitive to their clients' needs. Clients become vulnerable to practitioners' labelling their interpretations of their experiences as pathological, resulting in misdiagnoses or inappropriate treatments (Alladin, 2013). For instance if the practitioner fails to understand the client’s expression of her symptoms adequately the client might be diagnosed with some other pathology that she does not actually suffer from. I agree that different articulations of depression should not be seen as a sign that one is unable to express distress because of one’s culture (Raguram, Weiss, Channabasavanna, & Devins, 1996), but simply as cultural differences in the expression of a universal mental illness.

I am adamant that awareness of cultural differences in the communication of depression is important. Yet I am mindful the possibility that this could lead to the development of stereotypes of cultural groups. Beiser (2005) encouraged scholars and practitioners not to use cultural differences in the manifestation or expression of distress as the basis for stereotyping and unifying experiences of depression inappropriately. According to Beiser (2005), such investigations have gone as far as suggesting that, for example, members of Asian communities lack the vocabulary to express psychological symptoms in virtue of their shared culture, which is not the case. For instance, some Asian individuals may use somatic symptoms to describe their distress, while others may not. It is vital to be aware of the diversity of expression among individuals within a culture. For example, as some researchers (Jacob, Bhugra, Llyod, & Mann, 1998) have shown, Indian British women view depression as a result of a social problem or as an emotional reaction, rather than as a medical problem. However, this observation does not mean that all Indian British women view depression this way. There are various subjective expressions of depression within each cultural group. Multiple expressions of depression can also be found among all Canadians.
Canadian practitioners define depression based on the DSM-IV (*Diagnostic and Statistical Manual of Mental Disorders, 4th ed*) (Alladin, 2013). Yet, Alladin (2013) has argued that no clear definition of depression exists. What constitutes depression among Canadians appears to be to some extent shaped by the different presuppositions of practitioners. Alladin (2013) has explained:

> The debate illustrates the division in opinions of what constitutes depression and this has significant implications for diagnosis and treatment. For example, the practitioners who believe in the medical model of depression are more likely to take a medical approach to diagnosing and treating depression. On the other hand, practitioners who ascribe to a non-biological model of depression are more likely to advocate for a non-pharmacological approach to treatment. (p. 253)

Alladin (2013) is surely correct that the mental illness of depression is understood and treated according to the paradigm under which the practitioner operates. This has consequences for the care and treatment clients receive. For example, psychiatrists regard depression as a biomedical problem and may therefore treat it with prescription medication, while a psychologist is more likely to recommend treatment in the form of talk therapy. The variations in approaches suggest that there are multiple ways of treating depression hence their multiple ways of expressing depression.

Practitioners equipped with cultural knowledge about the conception and expressions of depression are important as well for their clients. However, according to Charmaine Williams (2006, as cited in Williams, 2010) training in cultural competence among Canadian practitioners has proven to be inadequate:

> The cultural content that has been used to educate service providers is often based on static representations of culture that either reinforce stereotypes or dominant group experience, not taking into account within-group diversity or dynamic transformation in culture that accompany changes in environment. (p. 55)
Training in cultural competence is suspect because of the potential that it will end up reproducing the perspective of the dominant culture on minority cultural groups. I concur with Williams’ (2010) argument that cultural competency training is inadequate in Canada. There is a need to “discourage students in the field of mental health that ‘the delivery of services in ‘one-size-fits-all’ packages – cannot address the diversity of the needs within a cultural group’” (Williams, 2010, p. 56). Kayali and Iqbal (2012) argued that there is much to be gained from taking into account clients' subjective perception, as their subjective accounts are important to the understanding of depression and treatment. Taking these into account allows for the diagnosis of the mental distress and an understanding of its meaning in the life of the client. If the subjective perceptions of clients are not taken into account, practitioners run the risk of misunderstanding, pathologizing, and offering inappropriate treatment to their clients. One group that has been historically pathologized and misunderstood by the mental health system is the Black population (Nelson, 2006). In the next section, I explore the relationship between depression, race, and racism in the lives of Black women.

**Depression, Race, and Racism in the Lives of Black Women**

I am of two minds about race and its implications for depression. On the one hand, I agree that one’s race, such as being of the Black race, affects how prone one is to depression (Brackend & Reintjes, 2010; Foynes et al., 2013; Jager, 2011; Matthews, Hammond, Nuru-Jeter, Cole-Lewis, & Melvin, 2013). But I’m not sure Blacks have a higher incidence of depression than whites (Nelson, 2006; Taylor & Turner, 2002). I think what is missing in the debate is the notion that the category of being “Black” is socially constructed and it is the particular experiences of individuals from this group that influences their tendency to depression.
I argue that it is not race per se that makes one more or less prone to depression; rather, it is the discrimination individuals face based on race that puts them at risk for depression (Jager, 2011). Race is socially constructed based on specific histories and geopolitical experiences of groups of people (Moodley & Curling, 2006). What is “the most useful way to work with race is to explore the power relations that intersect between the personal and the social level to produce racism and misogyny” (Moodley & Curling, 2006, p. 385). Black people, due to the social ideas associated with their race, are more likely than others to face racial discrimination (Beagan & Etowa, 2009; Foynes et al., 2013). For instance, African people’s history of enslavement in the West has played a significant role in determining the meaning associated with skin colour. White skin has been historically favoured over Black skin to justify the cruelty of slavery that was inflicted on Black people, and this is the root cause of racism (Wilder, 2010). A growing number of studies have documented the relationship between racism and depression (Edge & Rogers, 2005; Foynes et al., 2013). Thus, the fact that people of African descent living in Western societies have experienced a legacy of racism and oppression makes them more susceptible to depression and influences how they express depressive symptoms.

When looking at the care Blacks have received for their depression, researchers have reported it may be difficult to diagnosis because they tend to accept the symptoms as normal responses to difficult challenges (Etowa et al., 2007). Studies have shown that Black Americans are significantly less likely than whites to receive good care for their depression. There is a history of mistreatment of Blacks by the mental health community and this has discouraged Black people’s open articulation and expression of depression.

In the early 20th century, the psychiatric literature commonly reported that Black people do not suffer from depression due to their “primitive nature,” and thus providers did not deal
with Black people’s mental health issues. Suman Fernando (1988), in his research into the
history of Black people and mental health, described the attitude practitioners held towards their
Black clients, then referred to as “Negroes”:

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 in which a White person would be
overwhelmed. (p. 39)

The view that Black people do not suffer from depression illustrates the neglect and
misdiagnoses that Black people have historically received from the mental health system. It
therefore is unsurprising that Blacks do not trust the mental health system (Nicolaidis et al.,
2010) and hence convey their depression in coded form.

In fact it is not one’s race that makes one voice depression in a particular way; it is one’s
susceptibility to racism that influences communication of depressive symptoms. Researchers
have reported that racist behaviour has changed in the past 60 years from being overt to being
covert (Sue et al., 2007; West et al., 2010), in other words that Black people are still vulnerable
to racism. Racism today is exemplified by such things as the denial of housing (Curtis &
Lawson, 2000), disparities in health care (Nicolaidis et al., 2010), and gaps in income (West et
al., 2010). These subtle forms of racism can be extremely detrimental to one's mental well being
Sue et al. (2007) defined them as “microaggressions . . . brief, everyday exchanges that send
denigrating messages to people of color because they belong to a racial minority group” (p. 273).
These experiences contribute to Black people’s unique experience of depression.

Because racism has become increasingly covert in nature (Sue et al., 2007; Sue et al.,
2008) it is more difficult to identify, and, for some, this in itself gives rise to psychological
consequences. It is important to note that individuals’ perceptions that an event or situation is racist affect their mental health. Racism has been recognized as a social determinant of health, which addresses the reality that particular groups, such as Black people, are denied full access to appropriate health care and educational opportunities and are more likely to be living in poverty. That racism is a social determinant of health influences Black people’s unique experience of depression.

Researchers Mair (2010) and Seaton, Caldwell, Sellers, and Jackson (2010) explained that when individuals experience prejudice they look for ways to explain it. For example, their explanations of racism may be based on external reasoning, that is, the event’s cause is located outside the self, or internal reasoning, that is, the cause of the event is something inside the self. This is also the case with experiencing depression. Seaton et al.’s (2010) study found a correlation between perceived discrimination and negative indicators of psychological well-being. Their results showed that, based on their sample of 810 African American and 360 Caribbean Black adolescents, perceived discrimination was linked to an increase in depressive symptoms, decreased self-esteem, and low life satisfaction. Perception is the key factor in one’s mental state. As Ida and Christie-Mizell (2012) discovered in their study, positive racial group identity is correlated with good mental health among Blacks in the United States (see also Branscomb, Schmitt, & Harvey, 1999). However, an individual may have a positive racial group identity when witnessing a member of their race being discriminated. For example, a Black person, who is a bystander to racism, may internalize the feelings of sadness, hopelessness and depression when witnessing an individual of their race being confronted by oppression. This does not only occur in racial groups but as well in gender groups. In the next section, I look at the literature on the relationship between depression and gender.
Depression and Gender and Sexism in the Lives of Black Women

It is true that women suffer from depression much more frequently than men do (Marcus, Yasamy, van Ommeren, Chisholm, & Saxena, 2012; Ussher, 2010). Western accounts of the causes of depression have varied considerably during the 20th century, with explanations ranging from biological (e.g., genetic or hormonal), to psychological (e.g., personality traits), to social (e.g., life circumstances), to multifactoral (e.g., psychosocial) (McMullen & Stoppard, 2006). However there is general agreement that, on average, twice as many women as men experience depression (Marcus et al., 2012). Explanations of this are based on the assumption that certain traits (biological, psychological, or social) thought to be more typical of women (e.g., so-called feminine traits such as emotional expressiveness, concern for others, lack of competitiveness) increase their susceptibility to depression. But does this mean that women experience depression differently than men?

Taking a feminist perspective helps shed insight into the distinctive experience of female depression. Feminists critic the argument that women are prone to depression due to their high need for support and approval is misogynistic. Although these traits are often understood to arise from gender-specific socialization practices, or as taking place within a gender-specific behavioural context (e.g., Jack, 1991), this explanation, like biological explanations, is rooted in the essentialist view that something about female personality development lies at the heart of women’s depression (McMullen & Stoppard, 2006). I agree with McMullen and Stoppard’s (2006) argument that such an explanation diverts attention from the oppressive economic and political conditions in which women around the world find themselves. This is a point that needs to be emphasized since so many Westerner practitioners believe that female depression is mainly
a result of female biology (Hammarström & Phillips, 2012) and do not consider the social
determinants of health affecting women.

The concept of social determinant of health is very useful for coming to a better
understanding of Black women’s lives. Social determinants of health are the circumstances in
which individuals are born, raised, labour, and age. Context shapes their access to money, power,
and resources, and this affects their health. Hammarström and Phillips (2012) are correct that:

Such avoidable determinants are often analysed in relation to socioeconomic
position, they are rarely considered in relation to gender differences in depression.
Thus there is a need for more focus on gendered social and avoidable
determinants of depressive disorder. (p. 746)

I would go further to add that there is a need to also include the intersecting racial and gendered
social determinants of depressive disorder to fully understand Black Canadian women’s
distinctive experience of depression. Individuals’ identities of race and gender can affect where
they live and work, which has consequences for their access to appropriate health care. For
instance, according to data gathered by the World Health Organization (2013), poverty tends to
place a higher burden on women’s health compared to men. And there is much research that
links low economic status and depression (Mawani, 2008; Siefert, Finlayson, Williams, Delva, &
Ismail, 2007; Todd & Worell, 2000). Looking at the economic situations of men and women,
women lag far behind. Hunn and Craig (2009) described poverty as a form of trauma inflicted on
women that leaves them more susceptible to depression.

Another social factor that contributes to women's vulnerability to depression is the
normative role of being a woman. Feminist scholars such as Beauboeuf-Lafontant (2007), Jack
(1991), and Schreiber (2001) have talked about the burden of the expectation that one be a
“perfect” woman, wife, or mother. While it is often understood that these expectations are
unrealistic, women still strive to fulfill them, and their failure to do so may result in symptoms of depression. These expectations around ideal womanhood can be seen, in one form or another, throughout the world. However, Colla, Buka, Harrington, and Murphy (2006) found that this phenomenon is extremely prevalent in North America, and that the expectations put on women are directly linked to depression in Canadian and American women. I agree with Colla et al. (2006) study and a recent study conducted by Hopcroft and McLaughlin (2012) that looked at depression among people around the world. They found that women from countries with greater gender equality, such as Canada and the United States, had the highest incidences of depression compared to the men in those countries and to the women and men of countries with less gender equality. The study concluded that the expectations placed on women in countries with greater gender equality were excessively demanding: that is, women in these countries are expected to be able to negotiate and manage simultaneously the demands of work, partners, and children (Hopcroft & McLaughlin, 2012). The construction of gender roles and the expectations placed on women that are linked to depression are further discussed by Ussher (2010):

Examining the construction and treatment of depression also provides insight into the cultural construction of what it means to be “woman” where diagnosis with pathology is an ever present spectre, whether we accept or reject archetypal feminine roles. (p. 25)

I would add into the discussion race, specifically in reference to Black women, to provide insight into the cultural construction of what it means to be a “Black woman.” This highlights the expectations placed exclusively on Black women. For instance, Beauboeuf-Lafontant (2005) argued that being a Black woman means being entwined in the societal expectation that one is emotionally strong, which becomes limiting rather than empowering. As Beauboeuf-Lafontant (2005) wrote: “Construction of Black femininity . . . rewards women for a stoicism that draws
attention away from the inequalities they face in their community and the larger society” (p. 104).

I have always believed that the overwhelming demands placed on women to manage work, family, and self simultaneously can lead to depression. For instance Health Canada (2009) reported that Canadian women between the ages of 35 and 44 have the highest incidence of depression compared to other women or to men. Health Canada (2009) further correlated family status and stress: 41% of Canadian women aged 35 to 44 who were single parents reported the highest level of stress, compared with 38% of those living alone, and 28% living with a spouse and children. These findings suggest that the social expectations that are placed on Canadian women, single parents in particular, that they should be able to juggle work, home, and children successfully is a reason why more women report being depressed than men.

Another interesting finding is that a specific subset of the female Canadian population is more likely to seek medical treatment for depression. Even though depression is considered a treatable disorder (World Health Organization, 2012), white, middle-class Canadian women are more likely to seek out help for their condition than other Canadian women (Hunn & Craig, 2009; Nicolaidis et al., 2010). This suggests that one’s race may play a significant role in how one experience, expectations and understands depression. Another factor that has been linked to depression is low socioeconomic status. In the next section, I look at the literature on the relationship between depression and socioeconomic status.

**Depression and Socioeconomic Status in the Lives of Black Women**

The research has shown that having a low socioeconomic status may put one at risk for depression (Ali, Hawkins, & Chambers, 2010; Etowa et al., 2007; Kinyanda et al., 2011).
If Etowa et al. (2007) are correct that depression occurs in Black women in a social context that is detrimental to their overall health, as I think they are, then we need to emphasize that there is no one way to experience depression. Depression is a socioeconomic problem, and poverty has been cited as one of the social determinants of health (World Health Organization, 2012). A lack of adequate shelter and food compared affects one’s experience of depression. Ali et al.’s (2010) study discovered that when their participants received economic support, their depressive symptoms declined and they showed high rates of recovery. Heflin and Iceland (2009), however, remind us that it may not be the poverty that caused depression among their participants, but hardships due to poverty that made them susceptible. For instance, their research revealed that difficulties such as struggling to pay bills made participants increasingly prone to depression. Therefore poverty and all that goes with it may have significant effects on how some participants experience depression and how they cope.

It is true that Brown, Brody, and Stoneman (2000) reported that there is a link between Black women's vulnerability to depression and their socioeconomic status, where low socioeconomic status is the result of limited education, low income, and unemployment. Kinyanda et al. (2011) conducted a study in Uganda and found that poverty, being separated or widowed, being a single parent, lack of formal education, and unemployment were indicators of an increased risk of depression among their participants. But we already knew that. Studies need to move deeper by focusing not only on what makes one vulnerable to depression, but also how individuals experience their depression.

Although I agree with Santiago, Wadsworth, and Stump’s (2011) finding that poverty-related stress is directly linked to depression, I think they need to call out attention to their findings that living in poverty psychologically affects not only the individual members of a
family but also the family as a whole: it has a trickle-down effect from the parents to the children. This indicates that individuals that experience poverty and depression experience it in a particular way as it affects not only themselves but also their offspring.

I support the position that there is a correlation between poverty and depression, but I find the literature does not go far enough. It overlooks that poverty shapes one’s perception of self, and can influence how one understands one’s depression. In the next section, I discuss the connection between depression and race/racism, gender/sexism—the intersectionality of identities contributes to a specific experience of depression.

Depression and Intersectionality in the Lives of Black Women

Currently, the literature provides a remarkable amount of information on the effects of depression and its links to social factors such as race (Bowleg, Malebranche, & Tschann, 2013; Foynes et al., 2013; Hopcroft & McLaughlin, 2012; Kayali & Iqbal, 2012; Ussher, 2010), gender (Beauboeuf-Lafontant, 2007; Jones & Shorter-Gooden, 2003), and poverty (Ali et al., 2010; Etowa et al., 2007; Khosla, 2008). However, it is the intersecting identities of being Black, female and of a low socioeconomic status that makes Black Canadian women’s experience of depression distinct. I however move the discussion further to include that it is not only the particular experienced of a individualist approach to intersectionality but rather a community approach that illustrates Black Women’s unique experience of depression.

Recently there has been an increase in scholarship focused on the multidimensional aspects of an individual’s psychology and the importance of applying multiple contextual factors to mental health issues (Daley, Costa, & Ross, 2012; Mair, 2010; Moodley 2011; Remedios, Chasteen, & Pack, 2011; Rosenfield, 2012). Taking into account the intersectionality of Black
women’s identities means recognizing all identities of an individual, such as race, gender, and socioeconomic status and looking at how they correlate with depression. In much of the psychological literature (Mair, 2010; Remedios et al., 2011; Rosenfield, 2012) there is a debate about whether their socially constructed identities affect Black women’s vulnerability to depression, or whether Black women’s internal belief systems regarding their identity cause it. However what is missing is discussion at a new level based on the assumption that having multiple identities (such as being Black, female and/ or low social economic status) does not make one vulnerable to depression, instead it influences how one understands and undergoes depression from an individual experience to a group experience of depression. For instance Rosenfield (2012) stated:

Self-salience schemas about the importance of the self and others arise from multiple sources such as gender and racial socialization, which affect mental health by forming subjective status hierarchies that are alternatives to larger societal stratification systems. (p. 1798)

This finding then supports the notion that self-salience is what drives the articulation and understanding of depression. However, I contend that for Black women’s self salience is not only experience of their individual multiple identities of being Black, female and their social economic status but they are also connected to their membership of being from a particular of community of Black females from a particular social class.

Mair’s (2010) study also illustrated Rosenfield (2012) position of self-salience in their investigation Asian Canadian women’s reactions to racism and sexism and ignores the how the individual perception is also attached to the group identity. Mair (2010) found that Asian Canadian women experience the effects of depression more when confronted with racism than with sexism due to their internalized reaction to racism. The Asian Canadian women in the study
felt that the racist incidents were directed at them personally (internalized) rather than at them as members of a group (everyone is rejected), which contributed to their depression. This finding has important consequences for the broader domain of the conceptualization of the kinds of experiences affecting depression, as the key factor here was the participants' perceptions of their experiences. The belief that they are devalued individuals due to their race caused by racism makes one experience depression in a specific way. However I debate that when the conceptualization that ‘everyone is rejected’ is also included in a personal (internal) rejection for the individual. For instance, Thomas, Hacker, and Hoxha (2011) discovered in their study of 17 young African American women (aged 15–21) that the participants’ experiences reflected a combination of race and gender. For these participants, race and gender simultaneously influenced their perceptions of themselves. Self-perception that endorsed the negative stereotypes associated with being both Black and female contributed to some participants’ poor mental health, while participants who did not subscribe to the negative stereotypes of this particular group did not suffer as much. It is important to note that both groups reported emotional distress but their self-perceptions of how they interpreted the group (Black women) influenced their mental health. I contend that it is the personal internal affiliation of being a member of a group that captures Black women’s specific experience of depression. All the women in Thoma et al. (2011) study reported that they needed to overcome the stereotypes to engage in self-determination. I maintain that they needed to overcome the stereotype that is inflicted on all Black women to engage in self-determination. Studies such as the ones mentioned emphasize that clinicians should not only be mindful of the intersectionality of their clients’ identities, but I contend that it is also, more critical to be mindful of the clients’ understanding and affiliation to their group identity that when a member of the group suffer it impacts the
mental well being of each individual in the group. For instance when one reads the news that a Black child is shot by police all Black mothers feel the pain of that particular mothers’ loss.

As depression is becoming increasingly associated with social factors arising from multidimensional identities, it is critical to include in the discussion how specific multiple intersecting identities contribute to distinctive experiences of depression. In the case of Black Canadian women this is always an important consideration. In the next section, I focus on this group.

**Depression and Black Canadian Women**

I argue that the investigation of Black Canadian women's depression begins with an examination of the interplay of identities such as race, gender, and class. West et al. (2010) discovered that Black women's experience of mental health is complicated by their position at the intersection of racial, gender, and class oppressions. For example, studies have shown that experiences resulting from sexism (Woods-Giscombé, 2010) and class (Kraus, Adler, & Chen, 2013), in conjunction with experiences of racism, likely affect Black women's well-being differently than they do white women’s and Black men’s (West et al., 2010). The intersection of race and gender creates a unique experience for Black women suffering from depression compared to white women with depression in terms of their manifestation of the disorder.

As the social context of women's depression is paramount to an understanding of their mental state, it is important to look at Black Canadian women's depression from this standpoint. As argued by hooks (1993), the behaviours of Black women are adaptations to a complex set of gender, generational, chronic, and extreme life stressors, and they should be viewed in terms of the psychosocial and cultural factors unique to them. For instance, sexism and racism have
shaped the way Black women view themselves, and they have also influenced the way in which others value and interact with them (Townsend, Thomas, Neilands, & Jackson, 2010). Stereotypes such as the sharp-tongued Sapphire, the prevailing Mammy, or the strong, resilient matriarch Jemima (Townsend et al., 2010) are used as excuses for the ill treatment Black women receive from others and/or the derogation that Black women inflict on themselves (Beauboeuf-Lafontant, 2007; Greene, 2005; Jones & Shorter-Gooden, 2003). The controlling stereotypical images of Black women just mentioned emerged from the transatlantic slave trade in which Black women, seen as chattel and abused as field workers, domestics, and surrogate mothers to white families, were dehumanized. As a result, Black women have been perceived as able to withstand stress and trauma, as independent, and as naturally suited to the lowest paid and most menial jobs (Adkison-Bradley, Maynard, Johnson, & Carter, 2009)—thus they do not suffer from depression.

Many scholars working within and outside the Canadian perspective have suggested that such images of Black womanhood explain why they so often experience misdiagnosis, have their symptoms ignored, and themselves deny their emotional distress (Adkison-Bradley et al., 2009; Beauboeuf-Lafontant, 2007; Collins, 2000; Townsend et al., 2010). Black Canadian women have similar experiences as their histories and experiences of discrimination and oppression are comparable to those of Black British women and Black American women. As Beauboeuf-Lafontant (2007) has stated, African American women address Black women's depression in the framework of the sociocultural engagement of the Strong Black Woman, which makes one vulnerable not only for depression but also for its denial, not only in the Black community and the larger society but among Black women themselves. The experiences of Black Canadian women are similar. Black women’s perception of themselves as being emotionally strong may
explain why Lawlor, Johnson, Cole, and Howard (2012) found that Black American women are less likely to refer themselves to a mental health institution in a crisis. Black women's perception that they are emotionally strong distinguishes them from others. Brown et al. (2011) discovered a difference in the perception of depression between Black and white British women. They found that Black British women were more likely to perceive depression as less serious; to be associated with fewer symptoms; to be less chronic; and to be less amenable to treatment. And the Black women in the study more frequently attributed depression to social factors compared to their white female counterparts. Black women's perception of mental health issues and their manifestation contributes to the relationship they have with their health care providers. Brown et al. (2011) concluded that the differences they found between the perceptions and experiences of Black women and white women explain the low detection rates of depression among Black British women. It also contributes to the explanation of ethnic differences in help seeking behaviour.

Researchers (Adkison-Bradley et al., 2009; Hunn & Craig, 2009) have suggested that the controlling image of the Strong Black Woman has particular implications for the diagnosis of depression in Black women (Beauboeuf-Lafontant, 2007). This theory is extremely useful as it sheds light on the challenge to explain that Black Canadian women’s experience and manifestation of depression is unique compared to other groups. For instance, Black women are often misdiagnosed and left untreated for depression because of the general stereotype that Black women are strong-willed and independent (Beauboeuf-Lafontant, 2007). According to Shorter-Gooden (2004), Black women’s depression is not typical of the depression for which the Western diagnostic assessment tools are designed. Black women may express their depression in behaviours such as working hard and keeping extremely busy, or taking care of everyone else’s
needs while being disconnected from their own. Black women's “busyness” has been seen as problematic for them, yet clinicians' evaluation of depression is mostly based on the traditional symptoms as outlined in the DSM-IV: these do not include busyness, a show of strong will, or independence. Therefore Black women are at risk for underdiagnosis or complete lack of treatment (Adkison-Bradley et al., 2009).

Black women also hesitate to speak to their physicians about emotional distress for fear of being prescribed medication. In their research, Kozhimannil, Trinacty, Busch, Huskamp, and Adams (2011) found that among postnatal patients, Black women were least likely to demand medication for postpartum depression compared to whites and Latinas. The research suggests that this may be due to “stigma, communication problems and logistical issues including insurance coverage, time constraints, child care and transportation” (Kozhimannil et al., 2011, p. 620). I agree with the above findings and Brown et al. (2011) also found that Black British women had a stronger anti-medication bias than white British women. It cannot be overemphasized that Black women’s perception of depression can contribute to the form of care they are open to and receive.

Another major barrier to effective treatment for Black women is the cultural attitude to the notion of “having a problem” (Adkison-Bradley et al., 2009). The stigma attached to counselling among Black women has been well documented. Seeking counselling is often seen as a sign of weakness or as confirmation that an individual is “crazy” or out of control. Yet, this view blames women for not trusting a system that historically has not understood them or considered their worldview valuable. Research has repeatedly documented racism occurring in the context of Black women's mental health care. Racist ideas about Black women have become a central part of the ideologies and practices found in mental health institutions (Adkison-
Bradley et al., 2009; Edge & Rogers, 2005; Etowa et al., 2007). For instance, during slavery women of African descent were defined as hypersexual and subhuman in comparison to white women. African female slaves were used to “breed” slaves to increase the slave owner’s profits (Adkison-Bradley et al., 2009). Failure to recognize the depth and complexity of these stereotypes and how they affect society's current beliefs about Black women is a form of gendered racism. Etowa et al.’s (2007) study concluded the following:

There are social and environmental factors that influence the chain of events that are associated with depression among midlife African Canadian women. Depression can be difficult to diagnosis in African Canadian women because they tend to accept the symptoms as normal responses to everyday stressors, thus they tend to ignore these symptoms and the circumstances associated with them. Denial and lack of knowledge of common symptoms of depression may also pose a challenge in diagnosing the condition in this population. (p. 211)

For those unfamiliar with Etowa et al.’s (2007) view, it basically boils down to the idea that a failure of the mental health care provider to acknowledge a client’s subjective understanding of mental well-being can have diagnostic implications. Edge and Rogers (2005) explained that influences affecting the process of diagnosis, such as subtle language differences and racism, have skewed diagnoses for Black women. Their study showed that the unequal and inappropriate treatment of Black people by mental health services has created a lack of trust in Black women for the medical field. Black women are apprehensive about accessing a system that has historically been racist and sexist. However, Pickard, Inoue, Chadiha, and Johnson (2011) found that Black female caregivers in the context of religious organizations help build trust between Black women and Western health care services. Pickard et al. (2011) caregivers are unpaid and informal support helpers of elderly African Americans. Pickard et al. ’s findings suggest that the trust individuals have in other members of their church may help break down the barriers to mental health care.
The effects of slavery and continued discrimination have led Black women to distrust mental health services, and in that they differ from white women and even from Black men in Canadian society. Black women experience more unfair treatment, are more disadvantaged, and have always been placed at the bottom of the hierarchy in terms of race, sex, and socioeconomic status (Hunn & Craig, 2009). Even with equal socioeconomic status, Black women are still often viewed as inferior to their white counterparts. Racism is part of the daily existence of Black women (Thomas, Witherspoon, & Speight, 2008). Part of understanding Black women's depression is recognizing the social context in which they live (Nicolaidis et al., 2010).

Depression in Black Canadian women is not understood fully, in part because of the limited information about Black Canadian women's experience of depression in the literature. Issues related to race, gender, and socioeconomic status influence Black Canadian women's experiences. Much more research into Black Canadian women's depression based on an understanding of their unique ways of expressing their emotional distress is needed.

**Summary**

I argue that the term *depression* is ambiguous. It is often used to denote a syndrome, but it may also refer to a mood disorder or to a mood state lacking clinical significance. Individuals’ attempts to convey their experience may or may not result in a clinical diagnosis of depression as the diagnosis is based on a single set of symptoms described by the DSM-IV.

Various clinical instruments have been used to rate individuals’ depression. These tools take into account an individual’s physical and emotional state and aspects of the individual’s life circumstances. Information gathered by the clinician is measured based on how well the individual’s description matches the criteria used by common diagnostic tools. Yet, if depression
is an illness affecting individuals worldwide, the meaning of depression in particular cultural contexts needs to be considered, especially since most non-Western cultures do not have a word for the condition (Ussher, 2010). Depression can mean different things to different people. Moodley (2003) has suggested that depression has, in the context of Western medicine, a universal definition separate from cultural and historical expression. Hence, there needs to be a cultural critique of this definition of depression.

I concede of course that depression is experienced by people throughout the planet (World Health Organization, 2012). Nevertheless it is apparent that culture needs to be central in our understanding of this mental disorder. In other words, as Odell, Surtees, Wainwright, Commander, and Sashidharan (1997) have suggested, problems of diagnosis may also reflect that there are “different ways of expressing mental distress and different health beliefs” (p. 540). This is consistent with recent research of Alladin (2013), which examined how beliefs influence the mental health practitioners’ conceptualization of care for individuals struggling with depression. A cultural critique of the concept of depression is central to developing a better understanding of mental illness. For instance race, gender, and socioeconomic status are three cultural identities that influence how one understands one’s depression.

I argue throughout this chapter that race, gender and socioeconomic status influences Black Canadian women’s experience of depression. I contend that this is not an individual experience for Black women but also a group experience as they connect with the self as being a Black female at the same time their affiliation being a member of a particular race, gender and social economic class. Hence, Race is central component to understanding Black people’s distinctive experience of depression. Their expression of depression is unique due to the experience of racism that shapes their perception of self and others. Sexism is another variable
involved in the distinctive expression of depression among women. Women’s experience of depression is based on their social position and the expectations placed on them as women. Added to the mix is low socioeconomic status, which also affects how one experiences depression. Not having access to basic resources such as reliable employment, adequate shelter, and appropriate food creates also affects the experience of depression. In short the presentation and manifestation of depression occurs in the landscape of the intersection of an individual's race, gender, and socioeconomic status.

My conclusion then is that depression for Black Canadian women is shaped by the intersectionality of multiple cultural identities such as race, gender, and socioeconomic status. Black women have a particular way of experiencing themselves and the world around them due to the intersection of identities that is unique to them. However, the mental health profession continues to use intervention models that are designed to “meet the needs of all” based on Eurocentric experiences, assumptions, and values. This is counterproductive and can only increase the marginalization of Black women. Moodley (2003) suggested that the “lack of critical understanding . . . has led to gross generalisation about specific mental (ill) health issues relevant to particular individuals” (p. 115). Hence, Western psychotherapy that professes to be medically objective and clinically subjective can be experienced as oppressive and limiting to Black women of lower socioeconomic status.

It is critical to understand that what sets Black women apart from members of other groups in society is their specific intersecting identities of being Black and female and, for some, being of a lower socioeconomic status. Theses identities are subjected to discrimination and
oppression that in turn can influence how Black women experience depression. As Hall et al. (2012) stated:

Black women's experiences with racism and sexism are complicated by their position at the intersection of race and gender oppression . . . as a result future studies should examine the roles of racism, sexism and classism on Black women to better understand the “triple burden.” (p. 220)

Hence, intersecting race, gender, and class oppression is an important concept in the investigation of how Black Canadian women experience and communicate their experience of depression. Consequently, this research addresses the multiple and intersecting features of race, gender, and class that influence Black Canadian women’s depression and how an understanding of this perspective is an essential component of the therapeutic setting.
Chapter Three

Literature Review:

Coping and Black Women

The purpose of this chapter is to explore the literature on how Black women cope with depression. To explore the reality of Black women's coping mechanisms, I discuss in detail the intersectionality of their multiple identities by first recognizing that Black women do not experience their identities separately, but in unison. However, for the purpose of this investigation, I focus on three particular identities: gender, race, and socioeconomic status. I first dissect each identity to fully explicate its role, and then I bring them together to look at how they intersect in Black women's lives and lead to their unique way of coping.

This review addresses Black Canadian women's mental well-being as dependent on a coping style that is different from that of members of other groups in society due to their uniquely intersecting identities. It is the intention of this study to inspire a paradigm shift in the psychological thinking about coping by developing an intersectional approach that acknowledges the multiplicity of identities in Black Canadian women.

As it is imperative to acknowledge each of the relevant identities, this chapter seeks to demonstrate that there is a need for a discussion on coping that takes into account the everyday experiences of Black Canadian women. That is, the discussion must take into account the intersectionality of their embodied reality by incorporating considerations of race, gender, and socioeconomic status. I first offer a definition of coping based on the current research; second, I discuss how coping and culture are significant in the discussion of Black Canadian women's coping styles; third, I further the discourse to include the concept of gender; fourth, I look at the
racial aspects of coping; fifth, I discuss coping and socioeconomic status; sixth, I focus the discussion by making the case that Black Canadian women's coping styles are unique and need to be looked at not in the context of separate aspects of identity but in the context of interlocking concepts that include sexual orientation, spirituality, age, and (dis)ability. As there is very little literature on Black Canadian women's coping styles relative to the intersection of their identities, this chapter demonstrates the urgency of investigating Black women's coping from this particular angle.

The research on coping itself is extensive (Everett et al., 2010; Kuo, 2011, 2012; Lazarus, 2000; Lazarus & Folkman, 1987). Pioneer researcher Richard Lazarus (2000) has argued that the study of coping throughout the years has matured. He asserts that coping is not static, based on an individual's personality, but instead must be viewed as an approach to managing the demands placed on an individual's resources (Lazarus, 2000). However, the literature on coping has not matured to the point that it includes a discussion of the intersectionality of identities such as the one that shapes Black Canadian women's realities making their ways of coping distinctive compared to other groups.

Researchers such as Kuo (2011), Everett et al. (2010), and West et al. (2010), recognizing that race, gender, social economic status, sexuality, and (dis)ability may contribute to one’s coping strategies, have looked at specific subgroups and their unique forms of coping. Prevailing research has identified a number of factors that affect coping, such as culture (Joseph & Kuo, 2009; Kuo, 2012), race (Adams & Roberts, 2010; Krause, 2010; Utsey, Bolden, Lanier, & Williams, 2007), gender (Donnelly et al., 2011; Glass, 2012; Hall et al., 2012; Woods-Giscombé, 2010), socioeconomic status (Everett et al., 2010; Habarth et al., 2009; Henry, 2004), sexual orientation (Duarte-Velez, Bernal, & Bunilla, 2010; Levitt, Puckett, Ippolito, & Horn, 2012), age
(Barusch & Wilby, 2010; Black et al., 2011), spirituality (Beagan & Etowa, 2011; Beagan et al., 2012; Jarvis, Kirmayer, Weinfield, & Lasry, 2005; Krause, 2010; Sharpe & Boyas, 2011; Utsey, Bolden, Williams, et al., 2007), and (dis)ability (Parmelee, Harralson, McPherron, DeCoster, & Schumacher, 2012). How the identities of race, gender, and socioeconomic status intersect with one another and affect coping style will be addressed in the section on intersectionality and coping later in this chapter. The findings regarding these identities are critical to the development of the literature on coping, but they are limited in their usefulness because of their compartmentalization of identities. They do not address the reality that identities are intersectional. It is imperative that this issue be addressed, as it is central to, for example, understanding Black Canadian women's way of coping. Extant research does not address the different oppressions in Black Canadian women's lives and tends to be based on the lives of African American women (Beauboeuf-Lafontant, 2005, 2007, 2008; Everett et al., 2010; Hall et al., 2012). Although there are similarities between these women's coping mechanisms, the experiences of African American women also differ significantly, particularly with respect to the immigration experience. Therefore, it is necessary to investigate Black Canadian women's experiences specifically.

**Coping: A Mainstream Approach**

There has been growing interest in the field of coping (Barush & Wilby, 2010; Kuo, 2011). Because of its broad implications for human well-being and for adaptive abilities (Aldwin, 2007) coping is one of the most intensively studied areas in health, social, and psychological research.

The literature grounded in the mainstream medical model on treatment modalities for depression shows that a combination of medication and psychotherapy, such as cognitive
behavioural therapy (CBT) or interpersonal therapy (IPT), proves highly effective in dealing with, and treating depression (Hollander, 2013; Siddique, Brown, Chung, & Miranda, 2012). Antidepressants such as selective serotonin reuptake inhibitors (SSRI) are usually the first choice of psychiatrists for the treatment of depression (Olfson & Klerman, 1993, as cited in Siddique et al., 2012) as they have been shown to be effective in the initial stages of depression. There is also evidence that CBT and IPT are highly effective treatment modalities for helping clients manage their depression (Siddique et al., 2012). David Dozois (2013) adds that evidence-based research supports the view that CBT and IPT interventions help people manage depression. McKenzie, Khenti, and Vidal (2011) adapted the mainstream treatment CBT for use with the English-speaking Caribbean population in Canada. They created CA-CBT (culturally adapted cognitive behavioural therapy), which is similar to conventional CBT. In their framework they extended the normally short-term intervention by offering space and time for clients to feel comfortable with the therapeutic intervention and to address issues of trust, safety and power in order to build a strong working alliance with the therapist.

The mainstream medical treatment of depression involves one or the other or both drug therapy and psychotherapy suggests that there is no single way to resolve depression, just as there is no single typical coping style that is effective in dealing with depression. Hence it is important to investigate the whole range of effective coping styles.

Much of the coping research undertaken in the 21st century has been built on Lazarus's (1993, 2000; Lazarus & Folkman, 1987) coping theory. Under Lazarus’s framework, coping is a process. Lazarus (1993) stated:

My own analysis and research emphasized coping as a process—a person’s ongoing efforts in thought and action to manage specific demands appraised as taxing or overwhelming. Although stable coping styles do exist and are important,
coping is highly contextual, since to be effective it must change over time and across diverse stressful encounters. (p. 8)

_Coping_, therefore, refers to the various ways in which an individual manages demands that, at first glance, appear to be overwhelming.

Lazarus (1993) divided coping as a stress reaction into two main categories:

First, if a person’s relationship with the environment is changed by coping actions the conditions of psychological stress may also be changed for the better. My colleagues and I called this _problem-focused coping_. If we persuade our neighbor to prevent his tree from dropping leaves on our grass, we overcame the original basis of whatever harm or threat their dropping caused us. Other coping processes, which we called _emotion-focused coping_, change only the way we attend to or interpret what is happening. A threat that we successfully avoid thinking about, even if only temporarily, doesn’t bother us. Likewise, reappraisal of a threat in nonthreatening terms removes the cognitive basis of the stress reaction. For example, if a person can reinterpret a demeaning comment by his/her spouse as the unintended result of personal illness or job stress, the appraisal basis for reactive anger will dissipate. Denial and distancing are powerful techniques in the control of psychological stress because they enable a person to appraise an encounter as more benign. (p. 8)

Based on Lazarus’s (1993) theory of coping, problem-focused and emotion-focused coping are widely recognized in mainstream research as coping styles used by all individuals. Scholars have also reported that coping style is subject to cultural expression (Utsey, Bolden, Lanier, et al., 2007). For instance, Kocot and Goodman (2003) investigated coping and social support and their relationship to battered African American women's mental health and found that problem-focused coping was not always proved to be empowering for poor African American battered women as is assumed in the mainstream culture. The study discovered that coping was referenced to participants’ relationships to their social supports. The African American women in the study were involved in the criminal prosecution of their batterers and were forced to testify incidents of their abuse. This resulted in the women being put in a position of alienate themselves from their support of their friends and family members. The researchers concluded
that problem focused coping such as testifying against the perpetrator was not always empowering but rather increased mental health difficulties. The key finding I believe from this study is that coping is complex and needs to be understood from a cultural approach. For instance, Black people’s culture is based on a collectivist approach therefore coping needs to be positioned in how it affects the individuals’ social support. Hence, Kocot and Goodman’s (2003) study demonstrates the complex nature of coping and its impact on mental health.

Research suggests that the manner in which individuals cope with adversities can help predict mental health outcomes. However, whether emotion- and/or problem-focused coping is used to manage a stressor, mental health outcomes are difficult to predict without considering the social and cultural context in which the stressor occurs. This calls into question Lazarus and Folkman’s (1987) coping theory, which limits coping to the mastery of stressful demands and the overcoming of a stressful situation.

The management of stressful situations is based on the assessment of perceived and available resources that will aid in the coping process and help facilitate positive outcomes. In other words, if there are limited resources available, or a person perceives the resources as unavailable, there is an increased likelihood of a negative effect on mental health (Sharpe & Boyas, 2011). When working with disenfranchised populations, such as Black Canadian women, whose access to resources has been affected by their multiple, intersecting identities, this situation needs to be taken into account when looking at how they cope. Therefore, coping needs to be investigated from a structural and cultural perspective in order to understand the nuances of coping in diverse populations. In the next section, I discuss the effects of culture on coping.
Coping and Culture

Coping is a universal experience of all individuals regardless of culture, ethnicity, race, socioeconomic status, or gender; however, members of different groups might perceive and respond to stressors using different coping goals and strategies, and they might experience different outcomes (Kuo, 2011). Despite this, relatively little is currently known about the relationship between culture and coping: specifically, little is known about the relation between the universal and the culturally specific dimensions of the coping process (Kuo, 2011). Cross-cultural coping has been subject to relatively limited research (Bardi & Guerra, 2011; Joseph & Kuo, 2009; Kuo, 2012). Researchers on the topic such as Kuo (2012) have criticized mainstream coping theory for its monocultural perspective. They have argued that mainstream theory is entrenched in Western ideology and an individualist perspective, and ignores the community perspective highly valued by African, Caribbean, Asian, and South Asian communities, which are noted for being more collectivist. As Hashim (2003) has claimed, individualist cultures appear to prefer problem-focused coping while collectivist cultures are more likely to use emotion-focused coping. These two coping styles have also been valued differently in the literature. Individualist styles are valued more highly than collectivist styles. This is seen in the emphasis placed on personal control, agency, and direct action in the major coping theories, and in the neglect of culture as a fundamental context of coping (Chun, Moos, & Cronkite, 2006). Consequently, culture has not been adequately examined in the coping literature (Kuo, 2011).

Scholars have recently advocated for critical cultural and multicultural perspectives on coping and have developed cultural and contextual theoretical models of coping (Chun et al., 2006; Hobfoll & Schrober, 2001). The four theoretical models of coping that take culture into account identified for this review are the resource-congruence model (Wong, 1993; Wong &
Ujimoto, 1998); the multiaxial model (Hobfoll, 2001); the transactional model (Chun et al.,
2006); and the sociocultural model (Aldwin, 2007).

The resource-congruence model (Wong, 1993; Wong & Ujimoto, 1998) is derived from
Lazarus and Folkman’s (1987) cognitive-relational theory of stress and coping. According to this
model, adaptive coping is based on attaining “congruence” with one's coping sources, and coping
responses that match the demands of the stressor. Similarity occurs when one’s coping responses
are in line with one's cultural values and practices (Wong, Reker, & Peacock, 2006). Wong
(1993) suggested that cultural context is the basis for stressors faced by individuals and
subsequently shapes their perception of stressors, resources, and their selection of coping
strategies. The result of this determines how helpful the coping strategy adopted will be. Culture
affects the stress-coping process by (a) defining stress; (b) influencing individuals to respond to
stress in a culturally determined way; (c) defining the nature and the range of resources
employed (d) delivering cultural information for culturally appropriate coping responses to a
given stressor; and (e) stating the indicators of the coping results (Wong & Ujimoto, 1998).

The second model is Hobfoll's (2001) multiaxial model of coping. This model is
grounded in a socioanthropological perspective on stress. It assumes a social, collective
framework for individuals’ stress-coping experiences. It focuses on the “communal” aspects of
stress coping. Coping is determined by the needs of individuals to ensure collective survival in a
tribal society. As such, Hobfoll’s (2001) model stresses the importance of viewing individuals'
coping processes in the context of the community. Coping is based on a sociocultural context
that influences one’s relationships with family, religious institution, place of work,
neighbourhood, and ethnic group. This model emphasizes that individuals’ coping is understood
within a social context.
The third model is the transactional model of cultural stress and coping (Chun et al., 2006). This model proposes a dynamic, operation-based framework to illustrate a culture's interaction with how individuals cope with stress. The transactional model asserts that culture surrounds the entire stress-coping process and affects five sequentially arranged but interactive systems or panels (Chun et al., 2006). The model underscores collectivism and individualism as the end points for cultural and psychological dimensions along which diverse cross-cultural coping experiences are organized. Chun et al. (2006) posit that the “transactions” among culture, context, and stress coping produce distinct consequences within and across five specific domains or panels. Panel I takes into consideration the environmental system (e.g., social climate, stressor, and resources in family and work). Panel II pays attention to the personal system (cognitive abilities, personality traits, and social competence). Panel III focuses on transitory conditions or stressors (life events and changes). Panel IV focuses on cognitive appraisal and coping skills (approach or avoidance coping). Panel V describes the health and well-being of the individual (Kuo, 2011).

The theory hypothesizes that the environment and personal factors in Panels I and II, respectively, interact to foreshadow transitory life events in Panel III (the intermediate phase). An individual's stress appraisal and coping, Panel IV (coping responses), interact with and assess the extent to which the prior three systems can meet the demand of the stressors. The end result determines the health and well-being of the person as represented in Panel V (the outcome) (Kuo, 2011).

The transactional model attempts to address the direct and indirect links between collectivism/individualism and stress coping. Chun et al. (2006) have argued that coping methods aimed at confronting and modifying external stressors, such as problem-focused
methods, work better in individualist societies. The emphasis on personal autonomy in such
societies is conducive to this approach, while emotion-focused coping strategies are more
effective in collectivist cultures due to their dependence on the values of social interdependence
and harmony.

The fourth theory, the sociocultural model of stress, coping, and adaptation (Aldwin, 2007), hypothesizes a sociocultural conceptualization of stress coping that emphasizes the
“social context.” This framework views coping as a function of individuals' stress assessment,
coping resources, social support, resources afforded by their culture, and the reaction of others in
their social context. According to the theory, individuals' experiences with cultural expectations
and resources affect their perception of the demands of a stressor and of the resources available
to meet the demand; this in turn affects their stress appraisal. At the same time, the model also
assumes that broad cultural beliefs and values shape an individual's beliefs and values, and
others' reaction to the individual’s perception of the stressor. In the meantime, individuals' social
support and coping efforts serve to negotiate the effects of coping, which affect not only the
person involved but also his or her environment, resulting in cultural, social, situational,
psychological, and physiological consequences (Kuo, 2011).

Aldwin (2007) described the pathways through which culture affects the entire stress and
coping process. In essence, the model requires that culture determines (a) the characteristics of the
cultural context that forms the stressors typically met by members of the same culture; (b) the
degree of tension and stress aroused by a stressor; (c) the range of a coping approach for a
particular stressful event; and (d) the various institutional methods (e.g., social support,
psychotherapy, etc.) by which people cope with stress. Similar to the transactional model in its
relatively concise nature, the sociocultural model should serve as an example to future cultural
coping research due to their deep understanding that stress and coping is culturally influenced (Kuo, 2011).

The models described here have not all been validated by empirical evidence (Kuo, 2012). Nevertheless, they add to our understanding of how coping can be conceptualized. I do agree that each approach provides insight into coping. Although Black Canadian women live in an individualist society, their ancestors lived in collectivist communities. Hence, both the individualistic and collective coping models can provide insight into how Black Canadian women view their world. Nonetheless, I find them simplistic. How an individual copes with stress is not determined entirely by whether they adhere to individualism or communalism; issues of race and racism, gender and sexism, and class and classism needs to be included, which suggests that how a coping method comes to be chosen is a complex matter. Next, I review the empirical evidence on variations in coping by race.

**Coping and Racism**

There has been some movement in coping research toward identifying the culturally specific coping preferences of different racial groups (Joseph & Kuo, 2009). Some scholars (Adams & Roberts, 2010) have taken on the task of comparing racial groups to determine if differences exist among their coping styles. Adams and Roberts’ (2010) study on chronic health issues among those living in congregate housing compared the coping behaviours of African American and white residents. The study found that African American and white participants in general reported similar coping strategies. However, African Americans relied more on spiritual coping than white residents did. Researchers (e.g., Beagan & Etowa, 2011) have reported that spirituality is a common form of coping for people of African descent. Cummings, Neff, and
Husaini’s (2003) study found that religion was a greater buffer to the effects of functional impairment for African American than for white participants.

Investigations into the coping styles of people of African descent from a cultural perspective are quite scarce (Joseph & Kuo, 2009; Utsey, Adams, & Bolden, 2000; Utsey, Bolden, Lanier, et al., 2007). Much of the research surrounding the coping styles of people of African descent examines their coping responses to racial discrimination due to their position in society as members of a minority group that is significantly more likely to have to deal with race-related stressors than members of the majority culture (Utsey, Hook, & Stanard, 2007).

Utsey, Bolden, Lanier, et al. (2007) suggest that responses to incidents of racial discrimination by African Americans are influenced by the context in which the event occurs. One coping mechanism that Pittman (2011) looked at among people of African descent was anger. Pittman (2011) revealed that using anger to cope with racial discrimination negatively affected the general and psychological well-being of African Americans. This finding raises concerns about the effectiveness of anger as a coping mechanism for dealing with racism given the toxic effects it can have on African Americans’ mental health.

Utsey et al. (2000) documented other culturally specific coping behaviours shown by people of African descent during stressful encounters, termed in the study “Africultural coping.” According to Utsey et al. (2000), Africultural coping behaviours can be described along four primary dimensions: (a) cognitive/emotional debriefing (e.g., hoping for things to get better); (b) spiritual-based coping, which refers to behaviours that reflect a spiritual sensibility (e.g., praying that things will work out); (c) collective coping, that is, a reliance on the group to manage stressful situations (e.g., resolution and comfort sought from others); and (d) ritual-based coping, which involves African cultural practices (e.g., burning incense for strength or guidance.
in dealing with a problem) in response to stressors. Utsey et al. (2000) found that African Americans cope with racial discrimination in race-specific ways. They use debriefing, religious and spiritual practices, and the support of community (Shorter-Gooden, 2004) to deal with the stress of racism. These results might easily be misunderstood to mean that Black people’s coping style is passive in response to racism. On the contrary, Joseph and Kuo’s (2009) study shows that Black Canadians do not use only one way of coping with racial discrimination; instead, they use a wide spectrum of coping strategies, including problem-solving, cognitive/emotional debriefing, and spiritual-based, collective, and ritual-based methods. Joseph and Kuo’s (2009) research helps clarify the findings of research on coping with racial discrimination by people of African descent that did not take culture into account. It appears that Black Canadians possess a variety of psychological resources, many of which are deeply rooted in African cultural traditions, customs, and practices.

Joseph and Kuo’s (2009) results demonstrate that Black Canadians’ selection of coping strategies varies according to the nature of the racial discrimination experienced. The characteristics of the coping profile points to a hierarchy of context-dependent preferences for coping strategies among Black Canadians in response to racial discrimination. All five coping strategies assessed by the study (problem-solving, spiritual-based, ritual-based, collective coping, and cognitive/emotional debriefing) were used for the various kinds of racial discrimination encountered (interpersonal, institutional, and cultural discrimination). The results of the profile analysis indicate clear preferences for some strategies over others depending on the nature of the discrimination. In particular, the results show that Black Canadians are least likely to adopt problem-focused coping when confronted with interpersonal discrimination and are most likely to adopt this kind of strategy in response to cultural discrimination (Joseph & Kuo, 2009).
While these studies took into account the relationship between race and coping, they ignored gender and how it contributes to one’s coping style. The coping literature speaks to the complexity and diversity of coping methods used by people of African descent. It further underscores the importance of employing a cultural framework when studying the stress-coping strategies of members of ethnic minorities, including strategies specific to race-related stressors (Joseph & Kuo, 2009; Kuo 2011, 2012; Utsey, Bolden, Lanier, et al., 2007). Next I discuss the literature on gender in relation to coping.

**Coping and Gender and Sexism in the Lives of Black Women**

In this section I discuss how being female can influence one’s particular coping style. As gender has been associated with depression, namely, females are reported to experience depression more than males, it would be interesting to see whether women use to manage their depression differently.

Few researchers are investigating coping strategies relative to gender (Donnelly et al., 2011; Glass, 2012; Hall et al., 2012) even though women have a higher rate of depression than men. Investigations into the role that gender plays in coping strategies may offer some insight into the factors that contribute to women’s mental well-being. When comparing women’s coping behaviour to the traditional coping responses of men, previous studies have described women’s behaviour as “inferior” and sometimes as “dysfunctional” (Folkman & Moskowitz, 2004).

The literature on stress has shown differences between how men and women cope. With respect to social support seeking, women are more likely to seek support than men (Day & Livingstone, 2003); women’s coping strategies are more firmly rooted in the social context; they are more strongly influenced by interpersonal relationships (Krajewski & Goffin, 2005); and
they engage in more verbalization to others (Tamres, Janicki, & Helgeson, 2002). In contrast to these findings, when status, power, and job type are controlled for, few gender differences are found in direct-action coping (Korabik & Van Kampen, 1995). As feminist researchers have argued, there is a direct relation between gender expectations and roles and depression in women (Beauboeuf-Lafontant, 2007; McMullen & Stoppard, 2006; Schreiber, 2001); therefore, women’s coping is subject to the same influences. Hence, the expectations of and attitudes toward each gender shapes the coping behaviour of women and men in society.

In Western cultures, masculinity implies technical competence, competitiveness, aggressiveness, and rationality, whereas femininity implies emotionality, nurturance, passivity, and an emphasis on relationships (Nelson & Burke, 2002). Accordingly, the problem-focused coping style can be seen as masculine because it relies on competence and rationality. And the coping style of seeking social support, due to its focus on relationships and the expression of emotions, is usually associated with femininity. The latter type of coping is commonly referred to as emotion-focused coping. The coping-gender match hypothesis (González-Morales, Rodriguez, & Peiro, 2010) suggests that the effectiveness of the coping strategy chosen may depend on one’s gender. González-Morales et al. (2010) have argued that the tendency of each person to choose coping strategies that are in agreement with his or her socialized gender role may lead to the selection of the most effective strategies.

Sontag and Graber's (2010) study looked at differences in the coping responses of adolescent males and females. They found that their female participants engaged more in what they called engagement coping (e.g., emotional expression, seeking social support, and problem-solving) than their male participants. Sontag and Graber (2010) concluded that engagement coping is more socially acceptable for girls, while talking about their problems and expressing
emotions may be frowned upon among boys. González-Morales et al.’s (2010) longitudinal study of coping and gender in the female-dominated occupation of teacher found that female teachers are more likely to use social support than male teachers. These results support the literature on coping differences that shows that women use social support more than men do (González-Morales et al., 2010; Tamres et al., 2002). However, women do not use problem-focused coping less than men do when structural variables are controlled for (Korabik & Van Kampen, 1995). But it has been found that problem-focused coping is less effective for women. Korabik and Van Kampen (1995) confirmed that the most effective type of coping for each gender is the one for which the members of that gender are socialized. They predicted that women would benefit more in terms of reduced exhaustion than men when social support was high.

The un-match coping is not beneficial at all for the subjects of the gender who mismatch the coping strategy [problem-focused coping in women] and it can even be harmful [social-support seeking in men]. (González-Morales et al., 2010, p. 40)

The socially accepted coping style, determined by the individual’s gender, was found to be more effective because the behaviour is socially acceptable by the community.

Calvete, Camara, Estevez, and Villardon (2011) examined the role of coping with social stressors and gender differences in the development of depressive symptoms. The study participants were 978 Spanish adolescents (aged 14–18 years) who completed measures of social stressors, coping responses, and depressive symptoms at the beginning of the study and measures of depressive symptoms at a 6-month follow-up. The study suggested that the high incidence of girls suffering from depression compared to boys was a result of the tendency of the female participants to engage in disengagement coping strategies, which they described as rejecting and ignoring problems, which can lead to depression. Calvete et al. (2011) explained:
The results suggest that adolescent girls are more likely to experience depressive symptoms because they perceive stressful social events as more severe and because they use more disengagement coping strategies, such as avoidance and denial. (p. 401)

These findings are consistent with those of Sontag and Graber (2010) and of González-Morales et al. (2010), which also reveal that gender and social norms play a vital role in coping strategies. These factors influence how females cope: emotional expression, disengagement and seeking support are emotionally more acceptable for females and are more commonly used by women than by men. Yet, this does not seem to be the case for Black women.

Much of the literature (Beauboeuf-Lafontant, 2007; Woods-Giscombe, 2010) on Black women’s coping reveals that it is not socially acceptable for Black women to openly express emotions or reach out for support. Consequently, Black women’s experience becomes invisible to mainstream research. These studies’ results support view that there is a need for more targeted prevention and intervention programming appropriate for this group. Socioeconomic status is another variable that plays a role in one’s coping strategies; I explore this issue next.

**Coping and Socioeconomic Status in the Lives of Black Women**

There has recently been an increase in literature focusing on low socioeconomic status and coping (Everett et al., 2010). Some researchers have suggested that a better income results in better coping, such as Ali (2002), who found that among Canadian immigrants, an increase in income resulted in a proportionate decrease in depression and increase in mental well-being. However, Jagannathan, Camasso, and Sambamoorth (2010) claimed that the situation was more complex. How one interprets one’s self-worth with respect to one’s multiple identities contributes to how well one copes. For instance, Jackson, Twenge, Souza, Chiang, and Goodman (2011) found that individuals who perceive their race, gender, and socioeconomic status to be of
lower status tended to use a ruminative coping style, which is linked to ill health. Ruminative coping style is worrying about the distress and bad feelings one is experiencing and not focusing on a solution.

One source of ruminative coping is the perception of oneself as relatively low in social hierarchy . . . imagining oneself as low in the social hierarchy caused participants to ruminate more than if they imagined themselves at the top of it. (Jackson et al., 2011, p. 2449)

Hence individuals’ perceptions of their identities with respect to race, gender, and socioeconomic status must be taken into account when trying to understand the relationship between coping and socioeconomic status.

Habarth et al. (2009) stated that the identities of Black women identities as Black and as women play an integral role in their socioeconomic status, as these two identities have been identified as barriers to upward mobility (Everett et al., 2010). Hence coping with poverty is not an isolated phenomenon but can be perceived to be a result of being Black and female. Being Black and female makes one vulnerable to being unable to find adequate employment because of racism and sexism. As a result, Black women are more likely to find themselves in the tight quarters of poverty. But poverty is not what makes them susceptible to depression; rather it is the systemic structure in which racism and sexism play themselves out that can lead to depression. For instance, Hall et al. (2012) have argued that:

The usual stressor of the working environment may be unbearable because Black women can be easily singled out and treated differently than their colleagues. Discrimination in the workplace on the basis of race and gender is a chronic stressor for Black women. (p. 209)

Coping with depression due to lower socioeconomic status is intertwined with coping with the intersection of racial and gendered identities. Everett et al. (2010) and Smith-McKeever,
Row, and Goa (2012) challenge Ali et al.’s (2010) finding that an increase in income can reduce the rate of depression. Everett et al. (2010) discovered that better education and an increase in socioeconomic status did not protect their participants from racism and sexism. Smith-McKeever et al. (2012) found that increased income was more strongly associated with lower depression rates among white mothers than among African American mothers. They also found that social interaction was more valued among Black women as a form of coping than increased wealth. Smith-McKeever et al. (2012) concluded that the reason for the differences was that increases in income do not eliminate racism which contributes to the lack of well-being among Black women. Therefore, for African American mothers, coping with the stressors of poverty are compounded with the need to cope with racism and sexism.

Black women's coping style is unique for they must contend not with one isolated stressor, such as poverty, but with the stress of multiple oppressions. Habarth et al. (2009) reported that African American women of low socioeconomic status cannot rely on a single coping style, but rather use both avoidance and emotion-focused coping. The intersection of these two coping styles helps African American women to deal with poverty, which also involves dealing with racism and sexism, which are factors affecting their socioeconomic status.

An examination of coping and lower socioeconomic status on its own does not get at the heart of how Black women manage their well-being. Effective coping strategies for Black women need to acknowledge their intersecting identities.

Coping and Intersectionality in the Lives of Black Women

Black women’s ability to cope is based on their understanding of the interconnected effects of race, gender, socioeconomic status, sexuality, spirituality, age, and (dis)ability. Black
women are unique in that their experience cannot be explained solely through one or another of race, gender, or social class, an so on (Everett et al., 2010). However, they are not in the only group that experiences intersecting oppressions (Bowleg et al., 2013). Patricia Hills Collins (1991) first identified intersecting identities that extend beyond race and gender. Psychological researchers are now incorporating questions of how intersectionality contributes to individuals’ mental well-being in their research on, for instance, Black men (Bowleg et al., 2013), lesbian, gay, bisexual, and transgender populations (Meyers, 2003), immigrants (Viruell-Fuentes, Miranda, & Abdulrahim, 2012), certain age groups (Ecklund, 2012), and people with disabilities (Shuttleworth, Wedgewood, &Wilson, 2012).

For Black women specifically, managing the interconnected effects of racism and sexism is a core theme in their daily lives. It has been documented that the triangulation of race, gender, and socioeconomic status affects the psychological health of African American women (Everett et al., 2010). Racism and sexism are contextual factors that directly affect the socioeconomic status of Black women, their access to resources, their opportunities for self-actualization, and the manner in which they cope with stress (Hall et al., 2012).

Researchers have argued that the intersectionality of Black women’s identities and how it manifests in their coping mechanisms is demonstrated through “controlling images” (Collins, 2000). One such image that has received attention in the past 30 years is that of the “Strong Black Woman” (Beauboeuf-Lafontant, 2007); an image that affects the views of both the Black community and mainstream society (hooks, 1981). Beauboeuf-Lafontant (2007) explained:

The idea of strength is typically viewed as an honourable alternative amid the denigrating stereotypes generated by the larger society . . . Foreground Black women's survival of enslavement and continued socioeconomic marginalization, the strength discourse gathers its authority not from empirical investigation but contrasting Black women to normatively feminine white, middle-class women.
According to Townsend et al. (2010), the Superwoman image that portrays African American women as being capable of doing and having it all, similar to the icon of the Strong Black Woman, was not a choice but adopted out of necessity for the survival of Black women after the end of slavery. Black women needed to become mothers, nurturers, and breadwinners in response to Black men’s inability to attain economic stability and provide emotional support to their partners and families.

Black women who have managed to personify the image have been praised for their resilience in the face of social and personal challenges; however, this has become a liability (Beauboeuf-Lafontant, 2007). A number of studies have suggested that Black women have embraced the oppressive, iconic image of the Strong Black Woman in order to cope (Black & Woods-Giscombé, 2012; Etowa et al., 2007; Schreiber, Stern, & Wilson, 1998; Woods-Giscombé, 2010). But embracing “being strong” for Black women is paradoxical. It provides many Black women with strength, but the Strong Black Woman idealization eventually limits Black women rather than empowering them (Waite & Killian, 2009). Black feminist theory provides a critical examination of the development of this image. The work of writers such as Collins (2000), Beauboeuf-Lafontant (2007), hooks (1993), and Shorter-Goode (2004) are part of a rich discourse about the dangerous repercussions of the Strong Black Woman ideal on the interpersonal, social, and emotional well-being of Black women. Beauboeuf-Lafontant (2007) maintains that this image is problematic because it reflects the stereotype that Black women are naturally strong and, therefore, less oppressed due to their gender than white women. To believe that Black women are liberated from the social oppressions that white women face while Black women continue to experience poverty, violence, and illness at rates that exceed those of white
women is to deny the intersectional oppressions Black women experience on a daily basis. Collins (2000) has declared that the intersection of the oppressions of race, gender, and class depicted in the controlling image of the Strong Black Woman was used to justify the oppression of Black women in the past and continues to justify it today.

In the article “You have to show strength,” Beauboeuf-Lafontant (2007) argued that image of the Strong Black Woman leads Black women to care for others before themselves, and that the stress and pressure of this responsibility can take a toll on their health. Black women's well-being is being compromised: their caring for themselves and their families while dealing with discrimination of various kinds on a daily basis gives them the strength to struggle through, but at the same time it depletes their physical and emotional resources. Etowa et al. (2007) have pointed out that some Black women feel a sense of failure once they are unable live up to the ideal of the Strong Black Woman. This makes them even more vulnerable to depression. Therefore the Strong Black Woman is not an effective coping strategy. Greene (2005) has argued that Black women are taught not to challenge the image of the Strong Black Woman, but rather to take in how others have defined them and to make it their own. They eventually embody this image of themselves and come to believe that they must endure hardship. They accept mistreatment and believe that they deserve what happens to them and/or that they are not worthy of care. The personification of the Strong Black Woman becomes Black women's straitjacket of depression. It bars them from experiencing the ontological process of their own well-being. In the next section, I review the literature that has documented Black Canadian women's distinctive ways of coping.
Coping and Black Canadian Women

There is a scarcity of literature dealing specifically with the coping styles and strategies of Black Canadian women. There has been little research into Black Canadian women’s ways of coping that takes into account the intersectionality of their identities. The research done addresses certain subsets of this population. For instance, Jarvis et al. (2005) addressed the relationship between ethnicity, religious practice, and psychological distress among immigrants in Quebec. The study found that Black Caribbean Canadian women received greater benefits from participating in religious practices than Black Caribbean Canadian men. However, Jarvis et al.’s (2005) description of how Black Caribbean Canadian women cope was limited because their study population included a variety of visible minority groups. Also, while their research took into account gender and race, it did not look at socioeconomic status (Jarvis et al., 2005).

James (2010) also found spirituality to be a major form of coping for Black Canadian women. This spirituality varied from going to church every Sunday to talking with ancestors. Beagan and Etowa’s (2011) study found that spirituality constituted a major coping mechanism among the Black women living in Nova Scotia who were their study participants. In a racist and sexist context, communion with spiritual communities and ancestors allowed a connection to time-honoured traditions used by generations to survive adversity and make meaning from suffering (Beagan & Etowa, 2011). The study revealed the importance of emotion-focused coping among Black Canadian women. The connection with others in a spiritual community, that is, a connection with others who shared their values and morals, constituted a significant part of their coping strategy and a source of support and assistance in difficult times. James’s (2010) study participants said that they made sense of their struggles through their belief in a larger purpose. They came to understand their struggles as given by a supreme spiritual being for their
growth. For instance, prayer, reading sacred texts, and even private devotions were means to make sense of racism. Beagan and Etowa’s (2011) study also found that spirituality enabled Black women to cope with racism by giving them the perspective that adversities such as racism were trials they could triumph over in this world with their creator's support. Although Beagan and Etowa’s (2011) study provides significant insight into Black Canadian women’s coping, it lacks the intersectional perspective needed for a full discussion.

Wane (2009) used an intersectional lens to investigate how Black Canadian women cope in academia. Using Black Canadian feminist theory that recognizes the multidimensional nature of Black Canadian women’s identities, she concluded that Black Canadian women have a unique way of coping. Coping for Black Canadian women is rooted in traditions passed down through the generations (e.g., through spirituality). Coping for Black Canadian women constitutes an organic process that involves the ancestral spirit attending to their physical well-being. To centre ancestral spirituality in the coping strategies used by Black Canadian women is to acknowledge spiritual practices that have survived colonial, gendered, classist, and racist oppressions (Wane, 2007). Similarly, Waldron (2012) stated that the relationship between the living and non-living is important in Black Canadian women’s spiritual coping:

> It is also premised on the interrelationship between the living and the nonliving, natural and the supernatural elements and the material and immaterial. The emphasis on spiritual phenomena is an important aspect of this world view, particularly the belief that deceased individuals transform into invisible ancestral spirits and involve themselves in all aspects of life. (p. 41)

According to Wane (2007), coping for Black Canadian women is the sharing of stories of adversity. The objective is to clear the path for the next generation to help assume responsibility for uniting, learning from each other's strength, sharing knowledge and skills, and gaining wisdom. Many Black Canadian women have formed sisterhoods through this process. The
psychological survival skills that Black women living in Canada have embraced so successfully are skills that are known as “our blood memory” (Wane, 2007). These are the memories of the ancestors.

The question of what type of effective coping strategies is employed by Black women has received limited attention in the literature. Researchers who have begun investigating Black women’s coping styles have categorized their strategies based on the problem-focused and emotion-focused coping strategies theorized by Lazarus and Folkman (1987) and by Hall et al. (2012). Throughout the coping literature, problem-focused strategies have continued to be seen as a superior to emotion-focused strategies (Hall et al., 2012). Although it has been documented that Black women use both coping styles, it seems that Black women rely more on emotion-focused than on problem-focused coping. On this basis, Hall et al. (2012) have argued that while both forms of coping strategies are relevant; the one that is used is determined by the individual’s comfort level with a style and the situation encountered.

Bowen-Reid and Harrell (2002) discovered that women rely on both types of coping strategies: problem-focused and emotion-focused. For instance, Hall et al. (2012) reported that the problem-focused coping styles used by African American women were education and self-care (e.g., date nights and exercise). Hall et al. (2012) also found that the emotion-focused style that the Black women in their study used was an effective response for avoiding the negative consequences that the participants recognized stress had on their health. Collins (2000) noted that social support and spirituality are common coping responses for Black women. Shorter-Gooden (2004) adds to the conversation by pointing out the multiple ways in which African American women resist oppression. She provided seven strategies of both emotion-focused and problem-focused styles. Examples of emotion-focused strategies were prayer and spirituality; drawing
strength from African ancestors; sustaining a positive self-image; relying on social support; altering their outward behaviour or presentation; and avoiding certain people and situations. An example of a problem-focused strategy was directly challenging the source of the problem (Shorter-Gooden, 2004). Although Shorter-Gooden (2004) and Hall et al. (2012) reported that Black women used both coping styles, they found that Black women rely more heavily on emotion-focused strategies. As well, in their study that looked at how African Americans cope with the stress of racism, Utsey et al. (2000) found that women were more likely than men to use emotion-focused strategies in response to institutional or cultural racism. They also found that Black women were significantly more likely than Black men to use social support to cope with racism.

Thomas et al. (2011) reported that age plays a role in how women respond to stress. In their study, which looked at Black women aged 15–22, participants reported that inner strength helped them feel positive. This sense of inner strength is connected to the spirituality the Black community values (Thomas et al., 2011). Dawn Edge (2013) also found that coping strategies involving spirituality were prevalent, particularly among Black British Caribbean women. These results highlight the importance of spirituality as a form of coping for Black women.

Summary

Coping is organic and constantly changing based on how well individuals manage particular adversities at a given time (Lazarus, 1996). The mainstream psychological literature focuses on two styles of coping strategies: emotion-focused and problem-focused as outlined by Lazarus (1996).
Looking at coping from a cultural perspective gives deeper insight into the particular ways in which an individual copes (Kuo, 2012), because how one copes can depend on one’s culture. Individualist coping styles favoured in the West differ from the collectivist coping styles (Hobfoll, 2001) favoured elsewhere. Black Canadian women’s ancestors came from collectivist societies, which may influence their coping styles today. Joseph and Kuo (2009) have stated that Black people's coping styles are rooted in African cultural traditions. But gender expectations also influence coping mechanisms (Nelson & Burke, 2002).

Contrary to the assertion of Shorter-Gooden (2004) and Hall et al. (2012), Black women tend to use both problem-focused and emotion-focused coping styles that are both associated with individualist and collectivist societies: rather than favouring one over the other, they draw on the strength of both, depending on the particular situation (see also Joseph & Kuo, 2009).

The coping research is extensive and acknowledges that there is no one way of coping, rather there are several different approaches. The intersection of identities of Black women such as race, gender and socioeconomic status influences their coping to make it distinct from that of other groups.
Chapter Four
Methodology

The main objective of this chapter is to discuss the research methodology used in the study: the research questions, procedures for the recruitment of participants, data collection, interpretation of the data, and data analysis. In this qualitative study, I used a constructivist grounded theory methodology (Charmaz, 2005, 2006, 2011) to investigate Black Canadian women's depression and the ways they cope. Janice Morse (2012) defines qualitative health research as follows:

Qualitative health research is an inductive research approach used for exploring health and illness. It considers the perspective of the people themselves, rather than the researcher's perspective. Researchers use qualitative inquiry to elicit emotions and perspectives, beliefs and values, and actions and behaviors for the purpose of understanding the participants’ responses to health and illness, the meanings they construct about the experience and their subsequent actions. (p. 155)

Constructivist grounded theory methodology (Charmaz, 2005, 2006, 2011) builds on traditional grounded theory methodology (Glaser & Strauss, 2010) by increasing the flexibility of the traditional holistic and organic approach to planning the research, collecting the data, analyzing the data, and reporting the findings (Egan, 2002).

In this chapter, I begin by defining the classic approach to grounded theory and move into the development of the constructivist revision of this methodology. Second, I explore other research in counselling psychology that has used the grounded theory methodology. Third, I explain why constructivist grounded theory is the most appropriate method for my investigation into the depression and coping of Black Canadian women. Fourth, I outline how I used grounded theory and constructivist grounded theory in my research. Finally, I summarize the chapter by
revisiting some of the main challenges and concerns I had to consider in devising and carrying out this study.

**Grounded Theory**

Grounded theory is a methodology that develops a theory from data rather than seeking data to confirm or refute a hypothesis. In this case, the data are individuals' experiences. Using this methodology, the researcher takes, for example, the transcripts of interviews with participants and identifies common themes to explain a particular phenomenon. Through this process the theory unfolds as the researcher constantly refers back to the data to ensure it is grounded in the participants’ lived experiences. It approaches research by starting with the participants. Barney Glaser and Ansel Strauss (2010), the originators of the methodology, stated: “Our basic position is that generating grounded theory is a way of arriving at theory suited to its supposed uses” (Glaser & Strauss, 2010, p. 3). Grounded theory methodology is also described as an inductive approach to research. Glaser and Strauss (2010) argued that the investigation of a phenomenon should not begin with an initial hypothesis. Instead, grounded theory methodology considers a general understanding of the phenomenon under investigation sufficient for the initiation of this type of research. For example, while in the traditional approach a literature review is conducted at the beginning of the research, Glaser and Strauss (2010) suggest that this be done more fully at the end so as not to contaminate the theory emerging from the participants' accounts with previous theories. However, because in this study I employed a constructivist approach to grounded theory, a review the literature was conducted at the beginning of the study. According to Charmaz (2006):

> Delaying the literature review differs from writing a scanty one. Nor does delaying it excuse careless coverage. (p. 166)
Existing theories are not ignored, but rather that they are set aside for possible future application as the analysis progresses.

Theory is developed and grounded in a particular phenomenon. Glaser and Strauss (2010) emphasized that researchers must not work from an initial assumption about what is occurring but should instead pay special attention to the relationships between the categories as they emerge from data analysis.

Joint collection, coding and analysis of data is the underlying operation. The generation of theory, coupled with the motion of theory as process, requires that all three operations be done together as much as possible. They should blurred and intertwined continually, from the beginning of the investigation to its end. (Glaser & Strauss, 2010, p. 43)

This is how theory is developed. For example, the researcher allows emerging impressions to form the data, conceptualizes the data, and then analyzes the emerging relationships between concepts (Egan, 2002). Charmaz (2011) stated:

Our systematic scrutiny not only increases analytic precision but also keeps us close to the data and thus, strengthens our claims about it. (p. 361)

Theory begins to evolve during data collection and continues to evolve through a continuous interplay between data collection and analysis. “A discovered, grounded theory, then, will tend to combine mostly concepts and hypotheses that have emerged from the data with some existing ones that are clearly useful” (Glaser & Strauss, 2010, p. 46). However, according to Charmaz (2005, 2006, 2011), constructivist grounded theory acknowledges that the finding of a particular occurrence is influenced by time, space, and the state of the researcher and the participants. Instead of striving for theoretical overview (the goal of classical grounded theory), constructivist grounded theory aims for explanatory understanding (Charmaz, 2011).
Charmaz (2006) argued that constructivist grounded theory does not produce prescriptions but rather an interpretive representation of the studied phenomenon. Charmaz (2005, 2006, 2011) described constructivist grounded theory as the evolution of grounded theory methodology that incorporates the rooted principles of grounded theory but integrates relativity and reflexivity throughout the research process, bringing the researcher's position and actions into view.

Constructivist grounded theory uses methodological strategies developed by Barney Glaser, the spokesperson for objectivist grounded theory, yet builds on the social construction inherent in Anselm Strauss's symbolic interactionist perspective. (Charmaz, 2011, p. 365)

Constructivist grounded theory has revolutionized classical grounded theory by incorporating the following six principles: It

1. rejects claims of objectivity;
2. locates researchers' generalizations
3. considers researchers' and participants' relative positions and standpoints;
4. emphasizes reflexivity;
5. adopts sensitivity concepts such as power, privilege, equity, and oppression; and
6. remains alert to variation and differences. (see Charmaz, 2011, p. 360)

The data throughout this study were collected and analyzed in a comprehensive process that followed the methodological principles of constructivist grounded theory (Charmaz, 2005, 2006, 2011).

**Rationale for Using Constructivist Grounded Theory Methodology**

I specifically chose a constructivist grounded theory methodology for this research because it is designed to generate theory from the lived experiences of participants who are actively engaged in the research. Participants are viewed as experiential experts on the
phenomenon studied. Constructivist grounded theory also allows the large amount of information coming in the form of participants' stories to be sorted, compared, questioned, put into relationships, and developed into concepts that address a particular phenomenon. It provides a road map to navigate the enormous quantity of data generated by the interviews to facilitate the organization and analysis of that data. Since constructivist grounded theory is based on the principles of traditional grounded theory, it has frequently been used to analyze narrative data in the area of mental health.

Grounded theory has traditionally been the qualitative method of choice for researchers in the counselling field. Studies by Schreiber et al. (2000), and Waite and Killian (2007) had great success using traditional grounded theory methodology to investigate Black women's depression.

Schreiber et al.’s (2000) study, *Being Strong: How Black West-Indian Canadian Women Manage Depression and its Stigma*, used grounded theory to research the contexts for managing depression, and its stigma among Black West Indian Canadian women. The study investigated the strategies used by 12 Black West Indian Canadian women to manage their depression through the use of interviews. Schreiber et al. (2000) stated that using grounded theory methodology allowed them to discover that the concept of being strong had meaning for their participants in the overlapping areas of three social contexts: the cultural stigma of depression, male and female roles and relationships, and belief in Christian doctrine. Schreiber et al. (2000) expressed their confidence in the results that were generated from the data because the grounded theory methodology allowed for validation and confirmation by the participants throughout the process. The theory that emerged was consistent with the experiences of the women.

Waite and Killian’s (2007) study, *Perspectives about depression: explanatory models among African American women*, also used grounded theory methodology to much success. The
researchers used focus groups to gather their data. Waite and Killian (2007) concluded that the way African American women shaped their views and communicated their feelings of depression was influenced by their social and cultural experiences, values, and knowledge about depression. Waite and Killian (2007) stated that they valued this methodological approach because it allowed the participants’ voices to be heard and also to be central to the findings.

Participants' voices are central in the methodology because it recognizes that study participants are not mere subjects but are also knowledge makers. According to Maguire (1987):

Knowledge must be put to use for emancipatory purposes. The oppressed must have an equitable role in the production and utilization of knowledge. To consciously choose alternative paradigm research is not, then, a choice to validate only one form or source of knowledge. Instead, it is a choice to recognize a range of knowledge forms and inquiry systems which produce knowledge for the explicit purpose of human emancipation. (p. 28)

Grounded theory is a methodology that places participants’ voices at the centre of the investigation. It gathers knowledge from the participants by developing theory from participants’ lived experiences. Schreiber et al. (2000) and Waite and Killian (2007) made good use of grounded theory analysis to identify the main themes emerging from Black women's experience of depression.

Grounded theory methodology is a qualitative approach widely used in the social sciences, particularly in health research (McCreaddie & Payne, 2010). This is in part why I chose constructivist grounded theory methodology to explore in depth the subjective experiences of Black women's depression and their ways of coping. The methodology enables the development of a complex, holistic picture of the human phenomena of depression and of coping to be examined through thick, rich descriptive narratives within the context of Black Canadian women's realities (McCreaddie & Payne, 2010). Since the methodology allows theory to emerge
from data, it is ideal for research concerned with developing new theories and conceptualizations around issues of mental health (Egan, 2002). The openness of constructivist grounded theory methodology provided me with the flexibility and tools to uncover the often basic and unarticulated social problems facing Black Canadian women in the mental health system. According to Charmaz (2011), “grounded theory constitutes a useful toolkit to advance social justice inquiries” (p. 359).

Constructivist grounded theory methodology puts participants' voices in the centre by allowing participants to influence theory development. At the same time, it acknowledges the influence the researcher has in theory development. Charmaz (2011) states:

The quest for generalizations erases differences and obscures variation. For constructivists, generalizations remain partial, conditional and situated. (p. 366)

As such constructivist grounded theory methodology challenges positivist social science research, which promotes itself as the only valid form of knowledge making (Maguire, 1987). In the positivist paradigm, knowledge creation lies in the hands of minority elites, and it is assumed that the majority needs reality interpreted for them. Grounded theory, on the other hand, challenges the notion that knowledge is “top down,” and instead makes the claim that knowledge is everywhere (Glaser & Strauss, 2010). Hence it invites initiation and participation and provides possibilities for contribution to everything from the larger theory-building agenda to human resource development (Egan, 2002).

**Position of the Researcher**

Constructivist grounded theory methodology acknowledges that the researcher’s position influences the research findings. “Line by line, initial grounded theory coding with gerunds, is heuristic device to bring the researcher into the data, interact with it, and study each fragment of
it” (Charmaz, 2011, p. 368). The excavation of an ontological project investigating Black Canadian women’s experience of depression begins by locating the researcher within the research. I am a Black African Jamaican Canadian female researcher and therapist. My Blackness connects me to the group of people onto whom this term has been socially imposed. I have empowered the term to fight against racial oppression. My socially constructed gender identification is female. I was born in Canada of Jamaican parents whose ancestors came from Africa and Europe. My identity gives me a sense of belonging to a rich, vibrant, and proud Jamaican culture that has a long history of survivors. I see my African Jamaican heritage as made up of survivors of slavery, survivors of the economic hardship of living in a country labelled “third world,” and survivors of migration from Jamaica for greater economic opportunities and to raise their children in countries such as Canada, England, and the United States.

I aim to be sensitive to the fact that parts of my identity put me in a privileged place in Canadian society. These are my position as a professional therapist, a doctoral student at the University of Toronto, and the child of a middle-class family in Toronto, Canada. I am aware that I could easily reproduce a traditional positivist piece of research and in doing so produce knowledge that reaffirms the dominant culture’s ideas about Black Canadian women. Instead, I lean upon my epistemological and political position that knowledge is collaboratively produced, and on my understanding that Western knowledge has been used to colonize Black people (Smith, 2004). I continually need to be aware that I was “breastfed” by an oppressive society in which I, too, digested the stereotypes of the Black woman. I therefore continually challenge my own assumptions about my Black sisters and myself.
Because of my social location, I am what Collins (2000) describes as an “outsider within,” that is, we are all sometimes outsiders in any group, even in ones we are politically aligned with. Being a Black Canadian woman, for me, does not mean that I am exactly like every other Black Canadian woman. I am, for example, provided with specific privilege due to my placement on the “whiteness scale” (Collins, 2000) determined by the shade of my skin, the broadness of my nose, and the kinkiness of my hair. These features are judged based on the white standard of beauty and create distinctions and privilege within my race. My body is politicized: I am an able-bodied, middle-class, middle-aged, heterosexual, spiritual Black female therapist dealing with all forms of oppressions and privileges at the intersection of identities through which I negotiate my existence and my interactions with others. I can be seen as an outsider within my political affiliation to Black Canadian women, and I acknowledge that we are all individuals and all “outsiders within” (Collins, 2000).

My worldview or paradigm is influenced by my multiple identities. The privileges I receive based on some of my identities and the oppression I may be subjected to based on others all influence my research. I am aware that these influences weigh on the conceptual framework with which I engage the data. In the traditional approach to research, the goal is to limit researcher bias as much as possible so as not to contaminate the data. However, qualitative research recognizes that this is well nigh impossible. Maguire (1987) has stated: “…objectivity is an ‘illusion’ because it suggests that it is possible to separate the subject of knowledge, the knower, from the object, the known” (p. 19). It is therefore my intent in this study to develop a theory of Black Canadian women’s depression and coping while being conscious that I have an identity similar to that of the participants. Consistent with my theoretical framework and ethical stance as a therapist, a Black woman, and a researcher/ knowledge maker, I have used a
methodology that respects the principles of empowerment and acknowledges all forms of knowledge (Banks-Wallace, 1998; Charmaz, 2011; Maguire, 1987).

**Procedure**

Constructivist grounded theory incorporates many of the traditional stages of research, such as planning, data collection, analysis, and reporting (Charmaz, 2005, 2006, 2011; Corbin & Strauss, 2008; Glaser & Strauss, 2010). Yet, grounded theory methodology is not a linear process; it is holistic, naturalistic, and inductive (Egan, 2002).

The following steps were taken in this research:

1. establishment of the research question
2. participant selection
3. data collection and analysis
4. reporting

**The Research Question**

The questions to be asked during the interviews were given specific attention at this stage of the research process (see Appendix A). These questions are semi structured in nature and used as a prompt during the interview when participants needed clarification. Time was spent articulating the questions such that they would be clearly understood by prospective participants. The questions were designed to aid in the exploration of Black Canadian women’s experience of depression and coping. This took careful consideration because I had to consider how the research would be framed. A review of the literature on depression and coping helped guide the questions for my inquiry. My main research question was:
How do Black Canadian women in the Greater Toronto Area (GTA) who had or have depression experience their depression, and how do they cope with it?

**The Subquestions**

My intent was to generate questions that would elicit information on depression, coping, and on how mental health practitioners can best assist Black Canadian women. Questions were designed with the above framework in mind, yet they were flexible enough to support a semistructured interview. This allowed space for the further clarification of specific ideas. It also allowed the conversation with the participants to move in whatever direction the discussion of these issues naturally took them.

In addition, consideration was given to the context of the research, that is, to factors such as cultural, social, and interpersonal influences. Throughout this process I had to remain open to the possibility that the research focus would shift as a result of the study participants’ active involvement. This is what Corbin and Strauss (2008) call *theoretical sensitivity*. In the interviews I probed further into a topic by asking when, who, where, what, how, and why questions. For example, when asked how depression informed the participant about herself, some participants commented that depression enabled them to have a deeper understanding of who they were as individuals. This sparked my interest, so I probed further by asking subsequent participants whether they felt there were any benefits to depression. The technique of theoretical sensitivity allowed assumptions about depression to be turned upside down and opened up other possible avenues for the research to follow. The goal was for rich questioning to take place that moved the discussion away from the standard ways of thinking and allowed the exploration of other avenues of thought and insights into depression.
Data Selection

The founders of grounded theory research emphasized that data selection should be a flexible and dialectic process (Corbin & Strauss, 2008; Egan, 2002; Glaser & Strauss, 2010). They insisted that “theoretical sampling” involves data collection shaped by the budding analysis. For example, Glaser and Strauss (2010) stated:

Theoretical sampling is the process of data collection for generating theory whereby the analyst jointly collects, codes and analyzes his [sic] data and decides what data to collect next and where to find them, in order to develop his [sic] theory as it emerges. This process of data collection is controlled by the emerging theory. (p. 45)

In grounded theory research, ongoing sampling adjustments are possible and expected. For instance, incorporating a diverse sample and broad array of experiences allows for interesting and important variation in comparisons associated with the phenomenon of Black Canadian women’s depression and their ways of coping.

Recruitment

The aim of the recruitment process was to obtain a study population representative of the diversity of Black Canadian women with respect to class, sexuality, age, (dis)ability, religion/spirituality, and nationality. In order to achieve this, a focused and representative sampling strategy was adopted.

Participants were recruited in the Toronto area through flyers, self-referral, and e-mail networks. I also contacted community health centres and other community agencies that work closely with Black women. This initial contact occurred through a letter of intent (see Appendix B) addressed to the executive directors of the agencies outlining the research process and inviting
participants. A follow-up telephone call was made to answer questions and clarify the aims and objectives of the research.

A recruitment poster (see Appendix C) was designed that invited the participation of Black women who were interested in talking about their experience of depression. It was posted at locations throughout the Toronto area that Black women frequent (e.g., university and college campuses, hair salons, and community centres).

Word-of-mouth recruitment was used, as were e-mail networks. The latter produced the best response of the recruitment methods used. Once an interested potential participant had contacted me by phone or e-mail, I conducted a phone screening with her to determine whether she met the criteria for the study. The following were the criteria for participation in this study:

- self-identification as a Black female
- experience of depression
- residence in the GTA
- age between 18 and 65 years
- willing to disclose her socioeconomic status in the in person one on one interview.

These recruitment criteria were developed with the main research question in mind, and they assisted in the investigation of depression and coping for this particular group.

Once eligibility was confirmed, face-to-face contact was arranged and confidentiality, interview and research outcomes, and formal consent were discussed.
Consent Process

I booked time with each prospective participant to discuss the details of the study. A letter to potential participants was provided (see Appendix D). After receiving detailed information about the study, those who met the inclusion criteria and were interested in participating in the study were included in the consent process. They were further informed about the process and given the consent form (see Appendix E). If they needed more time to contemplate their involvement or to ask further questions, time was allotted. Once an individual felt comfortable about participating and was willing to sign the consent form, I signed as well to formalize my commitment to confidentiality. At this point the woman was invited to participate in the study. At the time of the interviews, I reminded the participants that participation in the research was completely voluntary and that they could withdraw at any time at their discretion. All participants were told that they would have access to the research results once a written version was available.

Twenty-two women were screened; one of them declined after the telephone interview, and another explained that it was her mother, not her, who had experienced depression, so she was not selected. Twenty women met the criteria for the study and were willing to participate.

Research Participants

Grounded theory emphasizes maximal variation in sampling (Corbin & Strauss, 2008; Glaser & Strauss, 2010); I was satisfied that the sample I had was an adequately diverse group of individuals who self-identified as Black Canadian women from 20 to 65 years of age who had suffered or were experiencing depression.
The 20 women who agreed to be part of the research identified as Canadian, Jamaican Canadian, Guyanese Canadian, African Canadian, Kenyan, Ghanaian, Somali, and Caribbean. However, all had lived in Canada for more than 5 years. Most participants were working: 7 had full-time positions, 2 identified as students, 1 was a stay-at-home mother, 3 were self-employed, 3 worked part-time, 1 was retired, and 3 were unemployed. The demographics of the participants can be found in Appendix F.

In addition to the demographic diversity, participants also had a variety of experiences with the mental health system. Nine of the participants were seeing or had seen psychotherapists, 1 was seeing or had seen a psychiatrist, 2 were seeing or had seen a combination of both, and 3 had had no experience with mental health practitioners.

I chose participants who were members of a community with which I, too, identify. This was intentional. When scholars research a social or cultural group with which they themselves identify, it is a way of rectifying the constant reproduction of the status quo (Mama, 1995). My decision to select participants from the Canadian Black community places this study within that frame. My choice to study this community using a participatory approach reflects my commitment to generating knowledge from a situation in which the researched are not subjugated to the researcher.

The Interviews

In-depth interviews are commonly used in qualitative studies when the researcher wants to gain a better understanding of individuals’ perceptions of a particular phenomenon (Krahn & Putman, 2003). Researchers that choose the interview process as a method of data collection respect participants’ worldview, wisdom, and conceptualization of a particular phenomenon. The
in-depth interviews permitted me to explore a few general topics on depression and coping. It also allowed for a deeper investigation into the participants’ understanding of a particular phenomenon by valuing their frames of reference and their social locations, both of which influenced their responses.

I conducted a one-on-one, in-depth interview with each participant. The interviews were approximately 90 minutes long and were audio-taped. All interviews were conducted face to face, either at a coffee shop or in the participant’s home. Proper precautions were taken to ensure privacy and the participant’s comfort in whatever venue was chosen. Transcriptions of each interview were made immediately after the conversation was completed.

The first question asked in the interviews was very broad: “What do you feel happens when an individual gets depressed?” Based on the response to this first question, further questions followed, such as, “What do you feel led up to your psychological distress?” and “Why did you think you were depressed?” In accordance with grounded theory, my focus changed as I analyzed the data. For example, some participants reported that their experiences with their mothers had taught them what depression looked like. As I developed hypotheses about the women’s understanding of depression, I explored issues arising from their relationships with their mothers in interviews with subsequent participants. This follows Corbin and Strauss (2008) theoretical sampling:

The process of data collection for generating theory whereby the analyst jointly collects, codes, and analyses his data and decides what data to collect next and where to find them, in order to develop his theory as it emerges (p. 45).
These hypotheses were then confirmed or disconfirmed by the other participants’ responses. The process of hypothesis generation and testing is further explained in the analysis section.

**Data Analysis**

I analyzed the interview data using Corbin and Strauss’s (2008) three levels of data analysis: open, axial, and selective coding, and Charmaz’s (2005, 2006, 2011) constructivist grounded theory approach. Open and axial coding techniques were used throughout the research process, from the first interview until the last. The results generated using these techniques also guided subsequent interviews as described above. Selective coding was used later in the research process, once the major categories had been developed and interlinked.

I used open coding on each transcript once it was complete. Through a careful examination of the text, I sorted the words, phrases, and ideas into a set of broad categories that incorporated several different properties characteristic of the category that might vary across situations. I then decompartmentalized these properties, that is, I placed them along a continuum of perspectives. For example, the participants gave a range of responses when asked what they did to cope with their depression. The category in this case would be coping strategies: the continuum of responses ranged from listening to music to shopping.

During this phase of analysis, I continually compared and contrasted data as new transcripts were coded. This method of constant comparison allowed increasingly complex and inclusive categories to emerge. As I compared data across interviews, I noticed potential contradictions in my understanding; these then became the basis for new clarifying questions in interviews with subsequent participants. That is, once a category was established, interviews
with subsequent participants included questions about the category. This process continued until saturation was reached, that is, until no new information was gained through new interviews.

In the next stage, I used axial coding to identify the relationships between categories within the phenomenon as a whole. The first step was to identify the central phenomenon or main issue in the study based on its centrality and inclusiveness in relation to all other categories, the frequency with which it occurred in the data, whether it was abstract enough to be used in a general theory, its explanatory power, and its capacity for maximal variation (Corbin & Strauss, 2008). In the process of identifying the core category, I was looking for a repeated pattern of events or behaviours the women exhibited in response to their depression. Once the central phenomenon was chosen, categories and subcategories were woven together to develop a coherent theory. Axial coding also involved identifying the intervening conditions that shaped the central phenomenon, as well as the strategies or routines related to it.

Finally, I used selective coding to integrate and refine the categories. This stage began only after all of the interviews were completed. I went back through the interview data and memos to check whether the model was internally consistent and to look for data that did not conform to the developing theory. When an outlier was discovered, I worked to identify the intervening variables or conditions that explained it. For example, one of the participants spoke about medication when asked about how she coped. Because no other participants had mentioned medication, I looked for possible intervening variables that might explain this outlier. In this case, the relevant variable seemed to be that, unlike most of the other participants, this participant was seeing a psychiatrist to manage her depression. This idea was then tested by going back to the subsequent interviews that were completed.
At this stage a theory began to emerge grounded in the experiences of the participants. According to Smith (2004), members of marginalized communities telling stories about their lives, their families, and the world around them constitute a powerful form of resistance. The results are not the researcher’s hypothesis being supported by the data, but rather the stories of participants’ lived experiences informing theory development. In constructivist grounded theory and traditional grounded theory allows the data to evolve creating a theory based on the participants’ lived experiences. Black Canadian women’s experiences of depression and their ways of coping were central in the development of the theory.

**Conducting Research**

In this section I discuss the rigour of the study, its benefits, risks, considerations of privacy and confidentiality, ethics, and the consultations with my supervisor to help identify and ameliorate researcher bias.

**Rigour**

In addition to the constant comparative method described above, I employed memo writing to ensure the data’s integrity and validity. I wrote memos consisting of questions and thoughts that arose as the data were coded. The idea behind memo writing is that it helps make the implicit or intuitive parts of coding explicit, allowing the researcher to go back and revisit the connections and processes used in categorizing the data (Charmaz, 2005, 2006). For example Charmaz (2006) stated: “comparative method lends you basic tools, yet myriad interactions occurring in multiple forms at various levels shape the content of your grounded theory” (p.179). This allowed me to record theories or hunches that arose during coding and to think about how the data related to existing literature. These theories were then compared to the existing data or
out to the field for verification. For example, one of the participants talked about education helping her rise above her depression. Because this was the first participant to describe education playing a role, I decided to explore this way of coping in interviews with subsequent participants, that is, I asked them for their thoughts about the effects of education.

**Benefits**

The potential benefits of participation in this research project included the opportunity for participants to engage in discussions exploring the dimensions of their mental health. Many of the participants said in their interview that it was the very first time they had the opportunity to share their personal experience with depression. They also said that they felt honoured to be part of a process that would begin the discussion around Black Canadian women’s depression and coping.

An added benefit is that this study will build and promote mechanisms for knowledge translation and exchange between researchers, policy-makers, service providers, service users, and community members.

**Risks**

Ethical concerns were identified and measures were taken to safeguard against any physical and/or psychological harm that could occur during the course of the study. Krahn and Putnam (2003) have warned of the ethical concerns that arise particularly in qualitative research stemming from the proximity of the researcher to the phenomenon under study and to the study participants. For instance, in this study, if a depressed Black woman disclosed a plan to harm herself, as a therapist I knew my duty would be to break confidentiality and take action to protect
her. Also as a therapist I am bound to comply with the ethical code of conduct established by my profession, which applies to any research study I conduct (Krahn & Putnam, 2003).

I acknowledge that discussions exploring the psychological, social, and cultural experiences of Black women with depression may have been emotionally distressing for some participants. When I sensed that this was the case, I asked the participant if she would like to stop the interview. Also, I provided all participants with list (see Appendix G) of distress centres, support groups, therapists, and other services that they might find useful during and/or after the research project.

**Privacy and Confidentiality**

Participants’ personal details and information were kept confidential and their anonymity was maintained. Participants’ names and other personal details that might identify them were not used in discussions of the research or in any written or visual form that the research took. In all cases pseudonyms were used.

To further ensure confidentiality, all data collected were stored in a locked filing cabinet and a password-protected computer.

**Ethics**

Before this research began a proposal was submitted for ethical approval to the University of Toronto Research Ethics Board (REB). Ethics forms were completed in accordance with the REB’s guidelines. The research was approved.

I am aware of the ethical principles guiding qualitative studies. The methods used to ensure the participants’ rights to self-determination, anonymity, and confidentiality were outlined
in the consent form signed by the participants. I am and was also aware of the complexity of ethical issues that can arise in participatory qualitative studies. All these issues were covered in the consent form and were discussed with the participants at the time of recruitment.

Consultation to Deal with Bias

My thesis supervisor, Dr. Roy Moodley, and I reviewed and analyzed the data repeatedly during a number of meetings and discussions to look for any bias I may have had in conducting the research. This approach assisted me to become more aware of my leanings in approaching the data. As a person who shares the same gender identification and culture as the participants, it was critical that I be conscious of my insider status (Collins, 2000). And I also needed to be conscious that, as a researcher, I was also an outsider (Collins, 2000). Throughout the research process, my thesis supervisor kept me conscious of my insider-outsider status to minimize bias as much as possible.

Summary

Constructivist grounded theory methodology has brought traditional grounded theory into the 21st century and has become a commonplace and acceptable scientific practice in psychological research (Morley, 2012). Hence the choice of constructivist grounded theory as a methodological approach to investigate Black Canadian women's experience of depression and coping is a sound one. Using this methodology, a theory was developed that revealed the process of healing for Black Canadian women. The process of data collection through interviews with 20 Black Canadian females living in the GTA who self-identified as suffering now or in the past from depression and analysis of the data using the chosen methodology was a comprehensive process. The flexibility of constructivist grounded theory allowed for lower-level categories,
mid-level themes, and higher-level themes to evolve until the saturation of the themes and a sufficient understanding of the roles of depression and coping had been reached. It allowed for the building of a comprehensive theory of healing based on the lived realities of Black Canadian women.
Chapter Five

Results

This chapter explores the participants’ intimate thoughts about their journey through depression and how they arrived at a place of healing. Throughout the discussions with the participants common themes emerged and were classified into three overriding key themes: Depression, Turning Point, and Coping (see Figure 1). From the interconnections between these key themes, subthemes, categories, and subcategories evolved. The study uncovered the participants’ collective experience of being depressed and revealed turning points that were reached through various coping strategies. Throughout this research I have endeavoured to do justice to the participants’ narratives in my outline of the paradigm shift they underwent on their particular journeys to well-being.
Figure 1. Overview of the interconnections between key themes, subthemes, categories, and subcategories.
Depression

The key theme Depression starts with the participants’ own understanding of what it means to be depressed. They demonstrated their understanding by sharing deep, personal stories. Their insights suggested four subthemes: Definitions and Descriptions of Depression; Causes of Depression; Silencing Depression; and Experiencing Depression.

Figure 2. Subthemes under Depression.

Definitions and Descriptions of Depression

This subtheme brings to light the participants’ comprehension of depression. Many stated that it was difficult to explain what they were experiencing. However, they provided graphic depictions of what it was like for them to feel depressed. Geraldine, for instance, referred to her body, spirit, and mind to illustrate her understanding of depression:

It’s like you are underwater. So you are alive, but you don’t feel present. You don’t feel present in your body and in your mind. It’s a blanket over your soul and you just feel sunken down and muted.

Many of the participants said that depression was something they felt throughout their entire being: it was a physical, spiritual, and cognitive experience. It was a feeling that, they said, was difficult to put into words. Many had trouble summing it up in a definitive way. Depression, for
the participants, ran throughout their bodies, spirits, and minds in a way that could not be separated but was experienced simultaneously. Thus, two categories emerged: “I Don’t Have the Words” and Body, Spirit, and Mind (see Figure 3)

<table>
<thead>
<tr>
<th>Definitions and Descriptions of Depression</th>
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<tbody>
<tr>
<td>“I Don’t Have the Words”</td>
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<tr>
<td>Body, Spirit, and Mind</td>
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Figure 3. Categories under Definitions and Descriptions of Depression.

“I Don’t Have the Words”

Throughout the interviews the participants expressed how challenging it was to define and describe depression. According to the participants, depression was a feeling of despair that words failed to capture. For instance, Sue struggled to find the right words to describe what was happening to her. Spoken language failed to capture the depth of her feelings: “It is more a behavioural . . . but also a very internal feeling that I can’t really explain. I don’t have the words to describe it.” Like Sue, Lynn tried to articulate what was occurring inside her by using a range of adjectives to describe her pain. “It is a dejected feeling, loss of energy. I feel really sad and negative.” However, according to Lynn, her description of her depression did not capture the true essence of what she was experiencing. Cher also tried to describe the sensations she experienced in order to offer a definition of depression. What she gave was a description of what happened to her when she was in a depressed state of mind:

Depression is that time I want to be alone . . . things are just overwhelming to a point of anxiety . . . then I just don’t want to do anything. I just want to be.
Depression was an event that took over their lives. It was difficult for Nalya to summarize her experience in a few words: “It didn’t seem like me. I felt that I was living someone else’s life.” Like Nalya, Diane said that depression took over her sense of self and that it frightened her:

When I think of depression the first thought is spiral. I envision a descent, and of course the terrible fear is that [descent] into madness, and I am going to just be so out of it.

Many of the participants described depression as an overpowering entity. They struggled to find the right words to describe what was happening to them. Each woman shared her personal experience with depression. Lynn said that she wanted to know what her depression was about:

I am trying to understand it and by understanding it I want to look at it from all angles and hopefully by looking at it I won’t get any worse.

**Body, Spirit, and Mind**

The category of body, spirit, and mind revealed the participants’ collective response to their depression. They articulated that depression affected their whole being; it took over their bodies, spirits, and minds. The data revealed that the participants' sensations of depression in body, spirit, and mind could not be separated—they were experienced simultaneously.

Participants described depression as physically, spiritually, and mentally painful. In Althea’s words: “I feel like a physical weight has been placed on my body.” Sandra also expressed that depression affected her physically: “I literally feel weak and beaten up.” Participants claimed that they were so depleted by their depression that they did not have the strength to stop it.
Depression entered their bodies and took over. Cher described her body as an informant who notified her that she was depressed:

Depression tells my body how much I can take and how much I should take. It defines that for me. . . . My mind is like a circuit overload: it tells me I don’t want to move anymore, I don’t want to think anymore.

The recurring theme in the participants’ descriptions is that depression is something that takes over their body, spirit, and mind. It affected Asha’s whole being so much that she did not have the energy to engage in her daily routine. Waking up in the morning and attending to her basic needs became so overwhelming that she could no longer take care of herself or her daughter:

I started staying at home, and after a while I started not waking up in the mornings, just staying in bed for long periods of time . . . not sleeping, but I am in bed . . . I had no energy . . . I was not eating . . . I did not have any appetite . . . I was not even cooking for my daughter.

Participants shared that it disturbed them that depression could be felt in their bodies and affected their behaviour to the point that mundane activities such as getting ready in the morning for a new day were seen as enormous tasks. However, what really proved challenging for most of the participants was that depression tried to dampen their spiritual being.

Lorraine said that when she was depressed, her spirit felt as though it was disconnected from her being. She said that she was no longer present within her spiritual self. Lorraine asserted that she became aware of her depression when her spirit became dormant:

You know my spirit is what carries me through my life . . . that is what takes me around, that is what keeps me happy. So when I become unhappy—well then, that
light that usually shines from my spirit diminishes.

Throughout the interviews many of the participants described themselves as spiritual beings. Depression tried to take away their spirit. Many participants reported that depression was so powerful that it separated them from their God. Lisa said: “When I am feeling low in my spirit, I don’t feel that connection with God.” They asserted that they were left isolated in their world, feeling spiritually disconnected. This was extremely troubling for many of the participants. Their connection with God was one thing, they said, they could rely on in difficult times. This was no longer the case when they became depressed. For instance, Geraldine referred to her depression as “the hibernation of the spirit.” Participants declared that when their bodies felt the pain of depression, their spirits became disconnected and negative thoughts engulfed their minds.

Althea reported that depression filled her with negative thoughts: “I can't think, everything is negative, and I just want to sleep. . . . Like it is also, oh, you kind of lose your soul to the point of not feeling.” Like Althea, Geraldine said that depression affected her mind so much that she began to become cynical:

My first reaction is usually pessimistic. Like I don’t really have much faith in people or hope in the world. . . . So there is always sadness, no matter what is going on in my life . . . my negative thoughts swell up. It is like a stream, but it turns into a river and swells, and it is always there.

Kim also noted that her thoughts became very negative: “My mental state is really negative . . . I don’t feel good about myself.”
According to the participants, when depression consumed their thoughts, it was the beginning of the end. Their cognition became so distorted that it frightened them. Yvonne stated that when she was consumed by negative thoughts, nothing mattered to her anymore. She became paralyzed by her thoughts:

I get to the point where it is more than just the blues, it is more than just that I am down. It is more of what I call immobilization; either I repeat the same thing over and over or I get so caught in my thinking that I am truly trapped, there is no way out. Because [it is] either the way I am talking about it in my mind or truly [the] way things present [themselves]. Sometimes there is no way out. That means I am immobilized. So I am stuck.

The participants all described depression as an entity that expressed itself throughout their bodies, minds, and spirits. They described depression as an overwhelming feeling of sadness engulfing them. Depression paralyzed their physical bodies, disconnected their spirits, and flooded their minds with negative thoughts. This all-encompassing pessimism was so strong yet elusive that it left them at a loss for words to describe it exactly. In the next section, I discuss what participants identified as the causes of their depression.
Causes of Depression

Causes of Depression pertain to the reasons participants gave for their depression. It is difficult to discuss this theme fully in isolation as the participants’ various experiences overlapped, interconnected, and occurred simultaneously. Diane said:

It’s not only one thing that leads to this horrible depression: the boyfriend and then the mother . . . the money and the loneliness—it just got to be where, in my mind, I would not think about one thing. There was always another thing that was terrifying or scary or confusing to add to the mix. So it built itself.

The participants’ responses in this subtheme were grouped according to three categories:

*Low Self-Esteem*, *Family Conflict*, and *Discrimination and Oppression* (see Figure 4).

**Figure 4. Categories under Causes of Depression.**

**Low Self-Esteem**

The category of low self-esteem explores participants’ internalization of the oppression they experienced living in Canadian society that resulted in them becoming depressed. Participants reported that they did not possess the qualities they needed to be considered a woman of value in Canadian society. They referred to themselves as “not possessing the power of beauty,” and as “not being good enough.” As Nalya pointed out:
Society has a picture about what I as a woman am supposed to be and, on top of it, what a Black woman should be and what she shouldn’t be. And it is a constant judgment.

Participants stated that they were constantly being scrutinized as Black women. The data revealed that the participants believed that they were not attractive enough to be powerful as women, which contributed to their feelings of low self-worth. The participants also expressed disappointment that they did not manage to be a “Strong Black Woman,” which also contributed to their depression. Hence two subcategories emerged from the participants’ narratives about their self-perceptions: Beauty is power: “I am already not considered beautiful” and Failing to be a Strong Black Woman (see Figure 5).

**Figure 5. Subcategories under Low Self-Esteem.**

*Beauty is power: “I am already not considered beautiful”*

This subcategory of the power of beauty refers to participants’ expression of their hatred of their physical selves and their negative perceptions of their own attractiveness compared to the dominant images of beauty in Western society. It further emphasizes how such feelings estrange Black women from each other. Ann argued that her Black female features were not valued in
Canadian society. “I am seen as invisible . . . having blonde hair and blue eyes has more value compared to the Black features that I possess.” Participants conveyed that the Western standard of beauty is based on the features of white women who possess fair skin, thin physiques, and straight blonde hair. It is the standard against which all beauty is measured.

Participants also claimed that in the Black community beauty is determined by how closely a woman’s features resemble those commonly associated with white women. For instance, if they are not considered “light-skinned,” they are not considered beautiful. According to the participants, this creates a division among Black women. The data reveal that participants who considered themselves “dark-skinned” felt inferior and unable to meet the standards of beauty. Participants, who identified as “light-skinned,” felt hatred and mistrust from their “dark-skinned” counterparts. According to many of the participants, this ideal contributed to their depression.

Throughout the interviews, participants asserted that how well they measured up to others determined their worth in society. Ann explained:

Beauty is power, and if, as a Black woman, I am already not found beautiful, I am outside of the loop. And I can feel completely depressed about not being a part of it.

Participants felt that they needed to possess some form of female attractiveness in order to feel like valued members of society. Not feeling valued stirred up feelings of deep sadness. For instance, Diane claimed that her attractiveness was measured according to the colour of her skin: the lighter her skin, the more beautiful she was considered to be in her own community. Diane said that her self-worth had been diminished since she was young because of this perception:
I was always told, “She looks good for a dark girl. She nice, she pretty even though she dark.” Right. So you know all of that growing up—that affects your ideas of beauty. I didn’t grow up thinking I was a beautiful person. I am OK for a dark girl!

Diane further explained that she never felt beautiful or worthy enough, which left her with feelings of low self-esteem.

Like Diane, Rose referred to the colour of her skin when discussing her sense of worthiness and her beauty. Her belief that she was not considered beautiful enough based on the colour of her skin triggered feelings of depression. “When I think about myself and how I look and how dark I am compared to other Black women, it goes downhill from there for me.”

For the participants, depression was commonly associated with not being “light” enough to be considered beautiful. For instance, Lisa also believed that she was not considered attractive, and this contributed to her depression. According to Leslie, her sense of self disintegrated when she grew to dislike and even reject her natural embodied self and fell into a state of depression: “It is always known that lighter is better. I am darker, so I guess I am not better . . . I guess I am not worth much . . . that really makes me feel depressed.” Leslie’s sense of self was tied to the value her skin colour had in society. For Leslie, having darker skin meant that she was not valued and therefore not beautiful. She stated that she felt like an outsider, which led to feelings of isolation and depression.

Participants described their perception that light-skinned Black women are thought to be beautiful and hence valued more highly in society. According to Diane, it is commonly known that there is a split between dark-skinned Black women and light-skinned Black women. Diane
said that light-skinned women are referred to as “browning” in her community. “Browning,” according to Diane, signified a particular value that she did not possess:

Buju Banton [a popular reggae singer] says it best: “I love my house, I love my car, I love my money and things/but most of all, above all other things, I love my browning.” The browning is the most prized possession. I know I am not a browning, therefore I could never aspire to the heights they enjoy.

Not being worthy of the term browning brought with it a sense of devaluation for Diane that contributed to her depression. Diane said that she felt as though she were treated as a second-class person because she is not a “browning.”

I remember walking through the mall one day and a security guard decided to show his appreciation for my body, and I did not take kindly to it. I was walking away [and] he says to me, “How you go on so nice? Like why are you acting like you are all that, after all, you not even brown.” I had no right to reject him because I was not brown. I had nothing. I should be honoured, like he was doing me a favour.

Diane claimed that the men in her community judged her based on her skin colour. Diane and many of the participants said that this left them feeling unvalued. The participants said that the lighter-skinned (“browning”) Black women were considered to be more attractive to men, while darker-skinned Black women held no value to Black men. They believed that Black men would not look at them if they were considered too dark.

Diane shared another experience that reinforced the notion of the greater power of light-skinned Black women: “In high school I remember a fellow student said to me, ‘I can get any man from you, any man,’ and she can get any man that I had because she was brown.” The divide between dark-skinned and light-skinned Black women, of which participants spoke in the
context of the discussion about their ability to attract men, left many of the participants feeling unworthy and depressed.

On the other side of the spectrum is Geraldine, a woman who identifies as a light-skinned Black woman. She spoke about the hostility she felt from Black women, which left her feeling isolated.

I would say, “Why is this woman looking at me in such a mean way?” with another Black woman. I am looking at her with a warm feeling and she looking at me with hate. My friend would be like, “[It’s] because you are light skin.” It is very weird to me and disturbing because it’s like, great, I have to sort of be wary of my own people because they may think that I think I am better than them because of how I look.

According to the participants, the perception that light skin is more attractive than dark skin creates a divide among Black women. Lynn discussed this divide among the Black women in her community:

I was called a half-caste because I am not too dark, but Black women wouldn’t talk to me because they thought I was better than them. I felt really sad and alone.

Both participants who identified as “light-skinned” and participants who identified as “dark-skinned” said they felt disconnected from each other based on this notion of value attached to skin colour. Regardless of the lightness or darkness of their skin, participants who claimed to feel disconnected from other Black women experienced feelings of isolation, low self-esteem, and depression as a result. In the next section, I discuss how the participants’ self-esteem was further diminished by their belief that they could not live up to the ideal of the Strong Black Woman.
**Failing to be a Strong Black Woman**

This subcategory of the Strong Black Woman explores participants’ feelings of being unworthy of being described as the Strong Black Woman. They described themselves as “weak” women compared to the archetype of the Strong Black Woman and expressed embarrassment at not living up to this icon. Rose said this lowered her self-esteem and eventually caused her to become depressed:

> I should be able to multitask, like work, come home, have the house spotless, [but] it is exhausting. I just get exhausted out of it . . . I can’t keep up with the pace, and then it is downhill from there. When things are overwhelming, it reminds me I am not good enough and I just get depressed.

The data reveal that participants saw themselves as inadequate because they believed that they did not possess the innate characteristics of resilience that they thought all Black women should. This belief lowered their self-worth and led them into a state of depression.

Participants repeatedly declared that the origin of their depression was their failed attempt to be a Strong Black Women. They expected that they “should” be able to manage everything and be “strong.” However, they discovered that they were unable to do it all and felt inadequate. Consequently, they became depressed. For instance, Cher remarked:

> You have work, you have children, you have your whole family, and your own stuff you have to think about, and it is just overwhelming to the point of anxiety and depression. I don’t know what is wrong with me, but I find it overwhelming.

Like Cher, Lisa pointed out that she found it difficult to manage everything in her life, which meant to her that she is unable to be a Strong Black Woman:

> Black women are known to be resilient. We are known to be strong . . . we are
known to weather the storm. I seem not to be able to do that. I don’t have the
strength. I just curl up at times and feel depressed about it.

Participants measured their worth by how they compared to the icon of the Strong Black
Woman. Like Lisa, Sue stated that she tried to emulate this icon but struggled. She was ashamed
and embarrassed when she felt overwhelmed; she said, “I should not be feeling this way. I should
be able to manage.” For many of the participants, feeling overwhelmed was troubling. It
indicated to them that they were emotionally weak. This lowered their self-esteem.

Nalya and Janet reported feeling ashamed knowing that their ancestors had survived
numerous catastrophes while they could not even handle their day-to-day lives. Nalya expressed
the following sentiment:

They [her ancestors] survived slavery, having children, taking care of their
families, dealing with racism. I should be able to handle my life.

Nalya expected herself to be able to handle adversity based on the strength shown by her
ancestors. Janet also had high expectations of herself, and she interpreted her “weak” behaviour
as disrespectful to her ancestors, which left her with feelings of shame:

I feel guilty. I am not fulfilling what my family and what my ancestors have
struggled for and that can feel like a lot of guilt. I just kind of get paralyzed by
that feeling.

Janet said that she would be so paralyzed by her feelings that she would become depressed and
unable to get out of bed.
Like Nalya and Janet, Lisa felt disgusted that she was not the woman she thought she
should be. According to Lisa, her ancestors made sacrifices for her to be strong, but “in return”
she was “weak:

I am not as strong as a Black woman should be, you know. I am not as resilient as
we are known to be, and it hurts.

Lisa’s negative self-image spiralled into depression.

Falling short of the expectation that one should be a Strong Black Woman was viewed by
many of the participants as a personal failure, which made them feel depressed. Participants
stated that they were not the women they intended to be and that they did not possess the Black
woman’s heritage of resilience. According to Diane, Black women are supposed to be able to
handle everything; therefore, she should be able to handle everything:

Black women are not allowed to have too much on their plates. The plate must
extend from her; if there is any of you left, there is something to give. I try to be
everything, but it is really hard. I am ashamed to say it is actually hard for me.

Not being able to handle “everything” was very upsetting for many participants. Like Diane, Rita
said that trying to live up to the Strong Black Woman added another layer to her depression:

I think just constantly having to prove myself and constantly having to see other
people who look like me have to prove themselves and how nicely I have
internalized that.

Yvonne believed that trying to live up to the Strong Black Woman image as a cause of
depression was a phenomenon unique to Black women:

I think it [the notion of being strong] is unique for Black women because the
weight of the world is on my shoulders and I should be OK with it. I don’t think white women have any of that burden on their shoulders when they get depressed. There is no comparison.

Participants’ vulnerability to depression increased when they felt they had failed to live up to the expectation that Black women are inherently resilient.

In the next section, I discuss what participants shared about the dynamics in their families and how their family relationships contributed to their depression.

*Family Conflict*

The category Family Conflict explores the idea that the participants associated their depression with their relationships with family members. Althea pointed out, “I usually get triggered around issues with my family.” The participants indicated that friction in their relationships with their mothers and their partners was a cause of their depression. Many described their relationships with their mothers as strained or nonexistent. Three subcategories emerged from the data: Absent mother, Surrounded by mother’s anger, and Getting a divorce (see Figure 6).

![Figure 6. Subcategories under Family Conflict.](image-url)
Absent mother

Participants claimed that their mothers’ absence from their lives during their childhood contributed to their depression in adulthood. For instance, Lorraine stated: “I have issues with my mother for not being there, and you figure at 42 you would get over your issues.” Seventy percent of the participants experienced feeling depressed because their mothers were absent for a long period of time during their childhoods, either because the participants were sent to live with members of their extended family when they were children or because their mother died when they were young. According to the participants these events contributed to their depression.

Geraldine, Kim, Sue, and several others reported that they had experienced some form of physical neglect by their mothers. Many reported that their mothers were not present to take care of them as young children and expressed feelings of deep sadness and unworthiness as a result. Geraldine shared:

At 3 my mother sent me to Jamaica for my aunt to take care of me. It was really hard, and coming back to Canada when I was 10 to rejoin my mother was even harder.

The separation from her mother that Geraldine experienced was emotionally troubling.

This was a theme repeated in many of the interviews: difficulties arising from not having their mothers present in their lives. Another participant, Kim, also spoke about her mother’s absence. “My mom gave me to my grandmother and aunt to live with and sometimes thinking about it can upset me.” Like Geraldine and Kim, Sue expressed feelings of loss and deep sadness because her mother was not present to care for her when she was young. She explained that she felt abandoned by her mother when her mother made the decision to immigrate to Canada and leave her and her siblings in the care of their father:
I can remember when I was a child growing up always feeling sad. It makes me feel really low just thinking about it and that gets me depressed.

Even though Sue was left in the care of her biological father, she still felt the need for her mother’s nurturing.

Many of the participants identified not having a real bond with their mothers as a reason for their depression. Not having her mother around in her early years was particularly difficult for Lorraine. She said that she struggled to come to terms with the fact that her mother had chosen to abandon her. When she speaks to other people about the difficult relationships they have with their mothers growing up, Lorraine is left feeling depressed, knowing that she does not have a relationship with her mother because of her mother’s decision to leave her:

I didn’t have my mother in my life and I hear about somebody else who had their mothers in their lives and they are pissed off at their mothers, like they have arguments with their mothers. . . . .But I compare my relationship with my mother to theirs. Let me see: have her piss me off and stay in my life or don’t have her . . . . but even though their mothers piss them off, at least she was there for them [tears]. Mine wasn’t there, and I am really pissed off.

Not only was Lorraine depressed by her mother’s failure to nurture her as a child, but she was also still angry. As is discussed in the next few paragraphs, a mother’s absence in childhood has powerful effects that continue to affect participants into adulthood.

Some participants reported that even though their mothers left them through no fault of their own, the children still felt abandoned. For instance, Rose’s, Nneka’s, and Lisa’s mothers died when they were children. According to all three women, their mothers’ early deaths had a profound effect on them, and shaped their current emotional state. They described experiencing
feelings of loss and despair due to the untimely deaths of their mothers. They believed that their mothers were supposed to be the one person they could go to for all the nurturing they needed, and they felt cheated out of that love by their mothers’ deaths. Nneka asserted: “My depression was tied into loss: loss of love and security and loss of future and loss of who I was because my mother had died.” Lisa reported that after her mother’s death she lost interest in her life; her world was not the same anymore: “When my mom died nothing mattered.”

For the participants who lost their mothers at an early age, their mothers' absence in their childhoods led to their depression in adulthood. They reported feeling unworthy and abandoned and that they experienced a loss of interest in their lives. The lack of a bond with their mothers became the basis for the participants’ depression. But death is not the only reason for a lack of bonding in the mother-daughter relationship that leads to depression. In the next section, I discuss how the unsettled relationships some of the participants had with their mothers also contributed to their depression.

**Surrounded by mother's anger**

This subcategory pertains to the turbulent relationships some of the participants reported having with their mothers. These participants claimed that their mothers’ behaviour towards them caused them to feel depressed. Althea described a very hostile relationship with her mother. “When I am going to talk to my mother, it is going to be combative.” These participants explained that their depression was caused by the lack of a nurturing relationship with their mothers.

Many of the participants reported growing up in an atmosphere created by their mothers’ anger. They described their childhoods with their mothers as violent and unsafe. Geraldine said:
“I remember just being surrounded by all this crap and violence and anger. It was just horrible.” These participants described their mothers’ treatment of them as horrific. Diane illustrated how her mother interacted with her: “My mother freaks out, like she explodes into, I don’t know, there are no words for what she becomes.” Many of the participants reported that they had been the target of their mothers’ anger growing up, which made it very difficult for them to be close to their mothers as adults.

Despite the friction between many of the participants and their mothers, they said that they yearned to be close to them. The distance between them caused them to feel depressed. Janet said:

She is my mom and I am her daughter and how much I love her, but for us to continue this way . . . I felt like really disengaging. . . . Our relationship is just hurtful and painful.

Eleven of the participants reported that they did not have a close relationship with their mothers. Nalya shared:

I remember when I was 12 wanting to run away from home because there was times when she would just get so mad and it would go out of control. It would put a strain on our relationship for a long time.

Participants said that they felt alone due to a lack of closeness with their mothers. The disconnection participants felt from their mothers came up repeatedly. They described their mothers as angry and not nurturing. Lorraine offered this description of her mother:

Bitch, bitch . . . I have so many stories of my heifer mom. She was never there for me, and it makes me sick thinking about the ways she relates to me.
Lorraine was angry about the relationship she had with her mother, and she believed it was the root cause of her depression. She has carried the disconnection she felt from the time she was a child to the present day.

In the next section, I discuss the relationships with male partners that participants also cited as playing a role in their depression.

**Getting a divorce**

This subcategory describes the emotional torment participants experienced in ending a marriage. Some of the participants claimed that the cause of their depression was the ending of a close, intimate relationship. Ann stated this plainly: “Getting divorced caused my depression.”

The participants’ intimate relationships had a profound effect on their mental well-being. They stated that when they were in conflict with their partners it was emotionally upsetting to the point where they felt unworthy, irritable, and depressed. Diane reported:

> Dealing with my husband is difficult. The idea that I say something and he responds with something negative, and then I can get caught in that dance of anger and resentment . . . that keeps feeding itself into my depression.

Disagreements in particular were painful. Participants related that major conflicts with their partners had a significant effect on their emotional well-being. Rose, for example, was devastated by events that occurred in her relationship. She said: “My whole life turned upside down. My husband wanted to get out of the marriage.” She said that it affected her to the point of depression.

The end of a close relationship, such as a marriage, was truly devastating for many of the participants. Sandra disclosed: “I feel like this whole divorce thing really had a profound effect
on me, you know, more so than I ever dreamt it would.” Participants were surprised by the emotional strain and extreme pain they felt when their marriages came to an end.

Participants expressed that what was most disturbing—indeed, terrifying—for them was the idea that getting a divorce meant a lifetime of loneliness. Divorce was not only the end of a close, intimate relationship, but it brought up feelings of unworthiness as well.

Race added another dimension, as two participants pointed out. Diane expressed that being a Black woman made it extremely difficult to find a man:

My husband recently left me. Oh gosh . . . I will never get a man because Black men are looking at white women or Asian women and white guys are not looking at me at all. [To] Asian men, I don’t even exist. I disappear like the night; I blend in. My hopes are shot. I must resign myself to a future of sexless martyrdom—not very appealing.

Rose agreed with Diane that it was particularly difficult for her to form intimate relationships with members of the opposite sex because of her belief that, as a Black woman, she is not the most desirable to men:

All the good men are taken and the ones out there [who aren’t] are not looking at me, being Black and female. I don't meet [the criteria for] what they are looking for.

Consequently, dealing with the end of a relationship for the participants also triggered feelings that no one would want them in the future because they were Black women. This made them feel unworthy, alone, and depressed.

In the next section, I explore the role of discrimination in mainstream society in the participants’ depression.
Discrimination and Oppression

All 20 participants referred to multiple adversities as major causes of their depression. Participants disclosed dealing with various oppressions on a daily basis, and they described racist, sexist, classist, and homophobic incidents. Rose said that dealing with the multiple oppressions of Western institutions contributed to her depression:

It is hard out there being a different race because I am faced with the whole racism and stereotypes that go along with not only being a woman but a Black woman.

Participants’ skin colour and gender made them targets of discrimination in mainstream society and thereby vulnerable to depression. The category of Discrimination and Oppression is explored in three subcategories: Broken promise of education, Living from paycheque to paycheque, and the Experience of being hated (see Figure 7). I discuss these subcategories in detail to show the complex relationship between them and the participants’ depression.

Figure 7. Subcategories under Discrimination and Oppression.
**Broken promise of education**

This subcategory refers to participants’ being told by their parents that education would shelter them from discrimination, and then discovering that this was not the case. In fact, they believed that education not only failed to shelter them from discrimination but instead put them in a position in which they were more vulnerable to harassment, which eventually led to depression. Yvonne stated: “Education just makes it worse.” The data reveal that educational institutions played a role in the women’s depression.

Geraldine said she was raised with the belief that education would set her free from discrimination and put her on a level playing field. Her family saw educational achievement and success as a defence against racism and sexism:

> I have that Jamaican culture [of] just being very, you know, ambitious. That is the family I come from as well—you should always be the best and do the best you can and be smart; that was always there. [If] you get 99% [on a test, they would say], well, what happened to the 1%? That perfectionism you have to be number one, you have to be on top, and especially for a Black person . . . you have to come up with more to make it. And that was what your parents thought.

Many of the participants claimed that they were raised to believe that education was crucial to their survival as a Black woman. Education was believed to be their best personal tool against oppression. They stated that they were expected to be “the smartest and the brightest.” It was not enough to be the same as white people; they had to be 10 times better to have a fighting chance of obtaining a good career.

Diane professed her belief that education was there to protect her: “I felt racism was external to me. My education, I felt, cushioned me from many of these concerns.” However, she
reported, she felt disillusioned when she found out that this was not the case. She was still confronted with racism and sexism on a daily basis. Diane shared an incident she regarded as racist and sexist that occurred when she was looking for a lawyer to advocate on her behalf in a dispute over the custody of her children:

When I walk into a lawyer’s office, he does not talk to me as a person with an advanced degree. He doesn’t ask me if I am married to this guy; he just assumes “well, [he’s] your baby daddy.” Who is he to talk to me about having a baby daddy? But that is how I am read. Whether I read myself that way or not, I have to acknowledge that I am dealing with people who will look at me as a person with a baby daddy and all of the things that come with that, and that adds a lot of stress.

Many of the participants were hurt to discover that despite their higher education they still had to deal with multiple forms of oppression. The promise that education would protect them from various kinds of oppressions did not hold true for them. Geraldine explained:

You’ve got a bigger uphill battle [to face]. It is not just getting your education; it is a lot more than that. It’s getting experience to get ahead; [But] there is nepotism, racism. There are places where people don’t like you.

The realization that education would not free her from oppression left Janet feeling depressed:

I have gone to school and I have gotten a degree and I am sitting on the dean’s honour roll and got accolades and stuff and I am still dealing with all this hate because of who I am.

Academic achievement did not provide the participants with the protection from discrimination that they were raised to believe it would. Just like Janet, many were left feeling disillusioned and depressed.
Participants also stated that their high academic achievement did not guarantee good jobs. They struggled to find satisfying work in their fields. This caused many to feel even more depressed. In the next section, I discuss living from paycheque to paycheque.

**Living from paycheque to paycheque**

This subcategory describes the participants’ struggles to find satisfying employment, which eventually contributed to their depression. Participants also reported that poverty was linked to their depression. Many of them described their day-to-day struggle with not having adequate economic resources as extremely stressful and said that this was a major contributor to their low mood. The data reveal that not having financial freedom caused participants to feel hopeless, irritable, and worthless. The combination of these emotions eventually triggered their depression.

Lorraine stated: “I am usually depressed over money.” Sandra said: “My financial situation is a big part of my burden right now.” Repeatedly, throughout the interviews, participants correlated financial instability with feelings of depression. Naomi revealed that her daily existence of living in poverty had a depressive effect on her:

I had my two kids in the daycare, but I needed the daycare to be subsidized, because paying that amount of money for the daycare would cut down on food, so the stress of it eventually made me get depressed.

The overwhelming stress of not being able to financially provide for her children upset Naomi. Like Naomi, Asha said that just trying to provide for the basic needs of her daughter had a profound effect on her mental well-being:

Not finding a job, not having money, not providing for my daughter, I was unable
to start my life, and I was unable to feed my daughter. It was depressing for me.

Poverty created limits for the participants that contributed to their depression. They were expected to provide for their families even though they did not have the money to do so. Lorraine shared:

I have a 17-year-old and he is lazy. He doesn’t want to work so he is in my pocket every day. And I got to feed him and you know he eats plenty—that brings on a lot of stress for me.

Many of the participants were the main breadwinners for their families. They tried their best to meet their financial obligations, and felt as though they were letting their family down by not being able to provide for them properly.

Participants claimed that they found it difficult to secure employment that would help them get out of poverty. Many lived on the economic edge, where they heavily depended on a paycheque each week, one that barely covered their expenses. Lorraine said: “I live from paycheque to paycheque, and I don’t want to live from paycheque to paycheque.” Despite possessing postsecondary education, 9 of the participants found it difficult to find adequate employment.

According to the participants, the Black community does not believe that work is a means of emotional fulfillment; rather, it is just a means to pay the rent. This notion irritated Lisa:

Having a career certainly is my goal, and I have heard this term all the time: “You got to do what you have to do.” It is like, why do I have to do what I have to do? I mean, why should I try? I hear that a lot!
Lisa wanted a job that not only allowed her to pay her bills but was also emotionally satisfying to her. But she felt pressured to settle and take whatever job was offered to her. The message that one should be grateful to obtain any form of employment left Lisa disillusioned.

Added to this message is the belief that racism is to blame for the barriers to obtaining suitable employment, which further upset all of the participants. Asha said:

You can try to apply, but they don’t want you [because] you don’t have the right skin colour. It can be oppressive living in this country.

For the participants, due to the barriers of racism, work became just what they had to do to barely pay their bills. It was much more of a challenge to find financially rewarding and emotionally satisfying careers. Naomi spoke about the racism she encountered in trying to secure employment in her profession. She came to Canada to find work in her field as a teacher, but was unsuccessful. “I was very angry because I was doing domestic work. I could not come to Canada as a teacher.” Participants were distressed by the difficulty of finding financially and emotionally rewarding careers.

Participants who secured employment in their field described their positions as very tenuous. For Rita, her workplace triggered deep feelings of disillusionment and unworthiness, and eventually depression:

When I think about my workplace and the types of people that we serve and how much effort we put into serving one group and not another—and I belong to that other group—and how that is OK, those are the kinds of things that hurt. You realize that maybe I am not valued or maybe the people that look like me are actually not valued as much as I thought in Toronto. That really saddens me.
The behaviour Rita witnessed in her place of employment lowered her self-esteem. She repeatedly saw incidents of other Black people being discriminated against by her employer. Lynn also claimed to have observed racism, which was extremely disturbing to her, in her workplace:

   If they have a Black person to look after, they don’t want to look after the Black person because they think they are not worth looking after. It is just things I have seen in my practice; it makes me sick.

It was difficult for Rita and Lynn to see other Black people being mistreated by their employers. Being a bystander to these occurrences left these participants feeling disillusioned, sad, and unworthy. Racism in the workplace created a stressful environment that led many participants to become depressed.

   Racism in society in general also presented problems for the participants. In the next, section I disclose how they dealt with racism in their lives.

   Experience of being hated

   This subcategory refers to participants’ experiences of being discriminated against in Canadian society, an experience that contributed to their depression. Participants gave numerous examples of incidents that left them feeling excluded from Canadian society based on their race, gender, class, and/or sexual orientation. Kim reported:

   I am always asked where am I from. I am not my grandparents. I was born here in Canada; my parents were born here as well. But that is their way of letting you know they don't want you here.
Participants reported that they felt as though they were outsiders in Canadian society. Feeling isolated and not included triggered feelings of sadness. The interviews revealed that dealing with multiple forms of oppression proved detrimental to the participants’ mental health.

Sharon reported that she had experienced discrimination since she was a child. She divulged that her childhood experiences of oppression were pivotal to her feelings of depression in adulthood:

In my early years I experienced being hated because of the colour of my skin, and being hated because I ate food that was different from my counterparts’, all of that stuff, and I know that has shaped who I am today.

Discrimination had a profound effect on the other participants as well. They reported that the hatred they experienced in childhood depleted them emotionally in their adult years.

Participants reported that being Black and female living in Canada made them targets of hate. The hate participants experienced from individuals in mainstream society affected them emotionally, and they linked the discrimination they faced to their feelings of depression. Yvonne put it simply: “In a sense, being Black put me in this situation of depression.” Geraldine said:

You know there are concrete things that back up my depression. There are situations in my life as a Black woman looking for a full-time employment, countering racism and countering sexism, getting a lot of obstacles—they are real, so that adds to the sadness.

Geraldine pointed out that the roots of her depression lay in being discriminated against because she was a Black woman living in a Western society. Her experiences and memories were linked to the oppression she endured, which manifested in depression. According to Althea, her
depression was based on being discriminated against not only because of her race and gender but also because of her sexual orientation and socioeconomic class. She, too, felt as though she was a target of hate due to living in what she describes as a racist, sexist, classist, and homophobic society:

I am a Black woman and I am a lesbian and of Caribbean background that grew up in public housing most of my life. I think oppression is part of depression. And I think that has really shaped, actually affected me; just my status—my social status—my gender, my sexual identity. Because what I have had to do is kind of depress or oppress how I feel about myself.

Participants said that dealing with oppression made them feel unworthy, disempowered, and, ultimately, depressed.

Participants reported that they felt depressed because of living in a society that marginalizes them. All spoke about not having equal opportunities and being turned away from various institutions based on the colour of their skin. Geraldine had to leave Canada to find suitable work in her field. She eventually came to the conclusion that racism is alive and well in Western society:

I did so much in Taiwan that I couldn’t do here in my own country, even though I was still qualified or whatever; then I realized that in Taiwan, yes, Canada is racist.

As Geraldine illustrated, depression emerged when participants did not feel included in their own country. Participants said that oppression disempowered them and prevented them from fully engaging in Canadian society. They claimed that white, heterosexual, middle-class men possessed privilege in society, something evidenced by them being offered better jobs, more
economic stability, and more freedom to express their sexuality. Participants pointed out that they did not have those entitlements, which contributed to their depression.

Participants reported that the hatred they were subject to had a long history. They believed they inherited the oppressions that their great-grandmothers, grandmothers, and mothers felt. Lorraine concluded that in Canada, “we [Black people] live a life of hell, as well as our forefathers lived a life of hell.” Participants shared not only their own stories of oppression but also those of their family members. Lynn reported that events occurring in her family also hurt her, to the point that she suffered from depression because of them:

I heard from my first daughter that she was subjected to so much racism. I was really shocked to know that she had to put up with a lot of negative things when she was so young. So I have no faith in people as a whole anymore because it is like [you have to] fight all the time, you can’t even relax for a minute, and you have to put a smile on your face even though you don’t feel like smiling.

Participants spoke about the psychological distress they experienced collectively and individually as a result of the history of oppression against Black people in Western society. Lorraine shared this:

My mother was here in Canada in the sixties and around those times she experienced her share of racism. . . . [I], too, experienced racism. . . . Someone on the train called me “nigger.” Yes, here in Canada, on the subway, a man called me a nigger. His exact words were “a Black Nazi nigger.” I was shaken up about it.

Participants maintained that the hate directed at their ancestors is the same kind of hate directed at their people today and will be directed at their children in the future. Being hated based on the colour of their skin was psychologically painful and contributed to the participants’ depression.
Silencing Depression

The subtheme *Silencing Depression* refers to the stereotypical belief that Black people, particularly Black women, do not suffer from depression. Participants described various incidents in which their feelings were silenced by themselves or by others. On several occasions, participants reported, they were discouraged from speaking openly about their feelings of hopelessness, sadness, and despair. The data reveal that participants had internalized the message that Black women do not get depressed: their mothers modeled emotional strength; friends championed the icon of the Strong Black Woman; the Black community encouraged stoic behaviour; and some of the mental health practitioners whom participants saw failed to acknowledge issues that were important to them. At some level, all of the participants themselves accepted the notion that Black women do not get depressed, which also had the effect of silencing them. Four categories related to silencing depression emerged: *The Self; Mothers; Friends and the Black Community;* and *Mental Health Professionals* (see Figure 8).

![Figure 8. Categories under Silencing Depression.](image)

**The Self**

This category describes participants themselves ignoring or silencing their depression. Participants explained that they were initially unaware that they had depression. For instance, Sue stated: “I really don’t even know what it is and I can’t really justify it.” Many of the
participants confessed that when they became aware that their recurring feelings of despair were an indication that they were depressed, they deliberately tried to repress their feelings. They believed that they had no right to be depressed. Therefore, two subcategories of self-silencing emerged: *Unaware of it* and *Deliberate* (see Figure 9).

![Figure 9. Subcategories under The Self.](image)

**Unaware of it**

This subcategory expresses the idea that some participants were not conscious of their depression. They disclosed that when looking back, they initially were not even aware that what was happening to them was called depression. Geraldine reported that she tried to normalize her feelings of despair. She told herself that life was a challenge and that one must fight. “You are taught that this is your lot in life; you have to push forward no matter what.” The interviews revealed that participants tried to push forward through life despite the challenges they faced, not recognizing that what was occurring in them was depression.

They revealed that they were initially perplexed about what was happening to them. This became the catalyst to their painful journey through depression. Asha, for instance, comprehended the challenges she faced as a new immigrant to Canada, but she felt bewildered by her own behaviour:
I did not know what was happening to me. I knew I didn’t have an appetite. I found out that I was losing weight. I knew that I had a lot of difficulty from the Ministry of Immigration. I knew that I wanted to work and I knew that I am in a new place and that I didn’t have money at that time. I became like someone who accepted whatever she was going through and ran from my problems by just sleeping and staying in bed. I was in a delirious state.

Asha did not have the words to describe what she was experiencing. This was true for several of the participants. For instance, Diane said:

I am sad, like my sister died, and I was sad. And then the next day I might be OK. But slowly more and more things added to that. It was just that the sad days were too many and I didn’t recognize it as depression at the time because I never experienced it before.

Participants recognized that they were not feeling like themselves. They were able to identify the problem that was creating their unsettled feelings, but they did not use the term depression to identify their experience.

Cher also did not know that what she was feeling was depression. All she knew was that her behaviour had changed:

First, I didn’t know what it was, to tell you the truth. But then I saw myself wanting to get away from things and I started getting an attitude. Little things started to affect me.

Participants reported that they recognized various changes in their behaviour and health that disturbed them. Nalya was oblivious to her depression. Her physician had to make the connection that what was happening in her body was a result of her being depressed:
I just recently went to the doctor’s and found out I was 157 pounds and I have high blood pressure. And I am 25. So I was like, “I need to get my ass in gear” [laughter]. Yeah, I was like, something is wrong; like, most people at 25 don’t have high blood pressure. It is scary, you know. He [her doctor] said, “is it because you are depressed?”

For Althea, depression was a foreign topic. Her family had never talked about depression, so she did not initially know what it was:

Being Caribbean, your parents will say, “Suck it up, what is wrong with you?” There is no “How are you feeling?” or “Are you sad? I see you sad like for a week, are you depressed?” There is no conversation like that.

Participants said they became aware of the label depression from other sources, such as physicians and the media.

Diane and Naomi reported that they learned about depression through the media. Diane said watching a particular television program provided her with information about what was going on:

I knew I was depressed because I watched Oprah; I was watching Oprah and she had a guest on talking about depression. I really related to what the person was saying because it sounded like the things she was experiencing, I was experiencing, too.

Like Diane, Naomi found a connection with an individual through the media that helped her give a label to what she was experiencing. Naomi said she learned more about depression from reading about other people’s experiences:

I learned about depression from Oprah, and she also opened up about her
experience of being abused. I kept reading and reading, and I was so happy when I read Maya Angelou’s *I Know Why the Caged Bird Sings*, and I realized it was not me alone.

Although participants found a label for their feeling through their physicians or the media, they felt that they could not justify being depressed and therefore deliberately silenced their feelings. In the next section I discuss participants’ deliberately keeping their feelings of depression quiet.

*Deliberate*

This subcategory describes participants purposely keeping their feelings of depression to themselves. They believed it inappropriate for them to be depressed and that they constantly needed to exhibit emotional strength. Rose explained what she would do when she felt depressed: “Block it out. Just ignore it and try to move forward. I have to deal with it, right? Just acknowledge that this is the way it is.”

Diane noted that Black women like her should not be depressed. Depression for her was inappropriate:

> It is not OK for me as a Black woman to be depressed. I have no right. I think, I do what I got to do and being depressed is not on the agenda. It is selfish; it is horrible for me to say I am not coping. To even look at myself and to say “I want,” there is no “I.” There are children, and there is work, and there are bills, and there are parents. I don’t have the luxury to be depressed.

Like Diane, Janet stated that depression was an indulgence and something that she should not take part in:
I usually think of depression as a luxury, so depression is something that I can’t get into. It is a condition of people who are affluent. So they can be depressed because they don’t have to go to work because they don’t have to take care of family. . . . Whereas I really don’t have the time or the energy or the capacity to not act . . . I really don’t have time to be depressed.

Participants’ professed the existence of an expectation that Black women will keep it all together. People count on them. Yvonne claimed that she needed to be strong:

I can’t act up. I cannot go crazy. I have a family that relies on me and I have businesses to run. I don’t have the luxury of screwing up, and so the burden is quite high.

Participants repeatedly expressed their need to silence their emotions and present themselves as strong Black women.

Participants kept their feelings to themselves and deliberately ignored their depression. They expected themselves to be emotionally strong: their families depended on them. Depression was inconsistent with who they believed they should be. Lynn said, “I find that depression is very self-indulgent; all you think about is yourself.” Participants did not feel comfortable with the emotions associated with depression: depression, according to them, was a self-absorbing illness. They believed that Black women should not focus on themselves but on others. This disease took them away from what was important in their lives: their families.

Participants, therefore, felt ashamed and humiliated by their depression and tried their best to hide their feelings. Rita said: “I wouldn't want anyone to know that I was feeling that low or that weak.” For Cher, depression was a secret that she did not want anyone to find out about. “Talking to someone about it is a definite no-no. It can make it worse.” Like Cher, Lynn feared
being judged and deliberately kept her feelings of hopelessness, unworthiness, and deep sadness to herself:

I don’t want to let anybody catch it; well, I know they won’t catch it, but I don’t want anybody to know about my sadness. So I cover it up.

Participants tried their best to keep their feelings tucked deep inside themselves so that no one could see them. Many argued that they needed to suppress their feelings at all costs. The risk associated with revealing their depression was too high. Geraldine said:

I have so much rage that I can’t vent it because I don’t want to look like a crazy Black person that needs to be shot by the police.

The pain the participants were feeling was so enormous that they feared there would be terrible repercussions if they expressed it. So they concealed their depression as best they could.

Masking their feelings was a challenge. Participants stated that they began to isolate themselves when they were experiencing an episode of depression. They did not want anyone to know about their internal struggles. Rose said: “I was kind of withdrawn from my friends who I am close with. I didn’t want them to see me like this.” Participants admitted that it was difficult at times to hide their depression, but they mustered the strength to rise above it. Nneka described this:

I don’t want to be functional. I don’t want to do anything, but I have commitments and I have obligations so I carry [them] out to the best of my functioning level. And then when the day is done, I crawl back into my hole and I fall into bed and I just stay there.
Participants reported that they tried their best to ignore their feelings, but sometimes the depression became so overwhelming that they could not fight it off. It was difficult for them to handle their depression, but they felt that they needed to silence it due to the expectations of them as Black women. In the next section, I discuss how their mothers contributed to the silencing of depression.

**Mothers**

This category pertains to the messages participants received from their mothers’ actions and to the advice their mothers gave them. Some of the participants suspected that their mothers were depressed but that they found various ways to conceal their depression. Participants claimed that their mothers did not tolerate feelings of depression, neither from themselves nor from their daughters. Hence two subcategories emerged: *Suspicion of mother’s depression* and “*Stop being sad*” (see Figure 10).

![Subcategories under Mothers.](image)

**Suspicion of mothers’ depression**

This subcategory pertains to the participants’ beliefs that their mothers may have been depressed. Janet thought her mother’s behaviour may have been the result of trying to block out her own feelings:
My mom has nightmares, awful dreams, and she suffers from serious sleep insomnia; I think it is because she does not want to dream. She doesn’t want to go into a deep sleep because she will dream horrible things that are haunting her and she would have to face all her emotional pain.

The participants’ mothers did not verbalize their depression. There was no discussion of depression between participants and their mothers. For example, Lynn said that no one really knew what was going on with her mother when she was taken to an institution.

My mother was sick, but they did not know what it was. My father thought it was something emotional, but she never got a diagnosis and we never spoke about it.

Lynn’s mother was put into a hospital but never actually knew what was wrong. However, through Lynn’s own experience and growing up watching her mother’s behaviour, she concluded that her mother must have been suffering from depression without knowing it: “I just remember she was always withdrawn, never interacting with us; she was just there, but not really there.” Sue came to the same conclusion about her mother: “Perhaps my mother suffered with depression. And I still think she has bouts of it.” Participants spoke openly about their suspicions that their mothers were depressed but never actually told them, and to their knowledge, their mothers were never officially diagnosed with depression.

Participants suspected that their mothers were depressed based on their behaviour. Nalya concluded that her mother’s depression manifested itself in her treatment of Nalya while she was growing up. “There were times where her depression showed in extreme ways, like the ways she would punish us.” Violence was cited by few of the participants as an indicator of their mothers’ depression. Geraldine said her mother never talked about being depressed but exhibited anger, resentment, and irritability:
She acted out her depression in different ways, like emotional eating or rage and anger, overspending, [being a] pack rat—an extreme pack rat. Never throws anything away, like crap; [she] would just keep it.

Participants believed that their mothers were oblivious to the fact that they were exhibiting signs of depression. Lorraine shared one interaction she had with her mother:

It is funny how she is the person to go, “Lorraine, you need to go to counselling,” and my question to her, in our heated arguments, “Yo heifer! When you go get some counselling about the shit that plagued you for you to treat me the way you have been treating me and continue to treat me all these years, then I will get some counselling for all the treatment that I had to put up with. You can’t tell me to go get counselling and treatment and you yourself has not stop to seek counselling and treatment for yourself.”

According to the participants, their mothers’ ignorance of their own depression caused tension between them. Participants claimed that they tried to confide in their mothers about their own struggles with depression but that their mothers did not want to hear it. In the next section, I discuss participants’ mothers’ reactions to their daughters’ disclosure of their depression.

“Stop being sad”

The subcategory pertains to the message participants received from their mothers when they confided in them about their emotional pain. The reaction participants received from their mothers was intolerance to depression. Diane said the advice her mother gave her was, “Stop it! Stop being sad!” Participants said that their mothers felt a need to teach them to be emotionally strong and that therefore there was no room for depression. They quickly learned from their mothers to silence their depression.
Asha said her mother raised her to be an emotionally strong woman. Her mother did not cater to feelings of hopelessness, sadness, and unworthiness. She taught her to be strong, not emotionally weak:

It is kind of how I was raised; my mother, she used to tell us, “Keep your head up and keep your dignity and don’t put yourself down . . . there is no time for all that nonsense.” That is what she always told me.

Like Asha, Geraldine explained that she was raised to survive. It was important for her to be able to live up to her mother’s standards:

My mother taught me to be strong in order to survive. So I just ignore it [the depression] so much that I just become thicker skinned and I have to keep going.

As described most notably in the category *Discrimination and Oppression* and in the subcategory *Failing to be a Strong Black woman*, participants believed that the requirement to be strong stemmed from the oppression they faced in society and the hurdles their ancestors overcame. Silencing one’s depression was seen as a survival tool. Nalya explained that since her foremothers survived slavery by being emotionally strong, she, too, had to learn to be emotionally strong to survive oppression. Nalya provided a historical account to explain why her mother needed her to stop being depressed:

Apparently there is this slave owner who wanted a foolproof way of keeping the slaves in check, and he did this by putting fear in the Black woman. He spoke about taking the Black husband and tying his legs or his arms to two horses and making them go. Having the Black woman watch that with her children. Now she has the fear [that] “he can be taken away, he is not going to be here to protect me, what am I going to do.” Now it is up to her to raise her family. She has to be the mother and father. She is now going to teach her daughters to be emotionally
strong. That is what my mother is doing, being strong, which teaches me to be strong and not succumb to depression.

According to the participants, this survival skill of silencing their feelings and being emotionally strong was passed down from one generation to the next. Kim remembered that as a young child her mother taught her to be strong. “She would instil in me . . . since I was about 2, she would say, you are Black, and I would be, like, proud. She would say that to me all the time.” It was important for the participants to be strong, and any signs of depression threatened their survival as a people against the oppression in Western society.

Diane also grew up knowing that she had to be emotionally strong. There was no mention of the word depression. When she brought up her depression to her mother, the latter would not tolerate it:

The response she [her mother] had for me, and I heard from even Africans in Canada is, “What do you have to be depressed about? There is nothing in your life, like you have food and shelter. There is nothing to be depressed about.”

Diane said she understood very quickly that she would be alone with her feelings of depression; her mother would not allow any discussion of it.

Janet observed her mother’s emotional strength growing up. She said she believed that her mother needed to be strong to continue their ancestors’ fight against oppression:

I never talk to my mother about how I was feeling because I don’t want to disturb the castle that she has built, her castle of strength. I know she is hurting, but she covers it up so well. I don’t think she can take hearing about my sadness because it may reflect on her own sadness.
Participants understood that their mothers’ advice to “stop being sad” came from a concern for their survival. They believed that their mothers, in their own ways, were teaching them that they must be emotionally strong to survive oppression. The participants felt that they had to move forward. They had greater things to do than focus on their emotions.

The advice to silence their depression did not only come from the participants’ mothers. In the next section, I discuss how their friends and community silenced depression as well.

**Friends and the Black Community**

This category refers to what the participants described as a prevalent notion that Black women do not get depressed. The participants’ attitudes towards their own depression were strongly influenced by the beliefs of their inner circle of friends and of the larger Black community. Nneka pointed out that depression is seen as a threat to the future and well-being of her community. She claimed that members of her community would not entertain any discussion of depression; hence depression was silenced among her friends and peers:

A lot of people resisted me being honest about my depression because it is like a mirror for them that they don’t want to see. . . . So I learned to keep it quiet.

According to the participants, depression was stigmatized among their friends and community. They confessed that they tried to bury their pain so as not to be ostracized. Participants claimed that the community's stance that Black women do not get depressed estranged them from their friends and the rest of their community. Hence this category can be divided into two subcategories *Black women do not get depressed* and *Stigma*. 
Black women do not get depressed

This subcategory reflects the attitude that participants claimed their friends and community had towards Black women. The participants brought to light that their friends and members of the Black community believed that to say that a woman was Black and depressed is an oxymoron. This attitude contributed to Sue staying silent about her feelings of depression: “I think there is an expectation among West Indians that depression is not a Black person’s condition or disease, so I cannot justify my depression.” According to the participants, it was imperative that they silence their emotional suffering in order to live up to their friends’ and families’ expectations.

Some participants said that they did not even feel comfortable opening up to their closest friends about their feelings. Nalya believed that her friends would not understand what she was going through: “I have my girlfriends that I love, but there are certain things that I do not necessarily feel comfortable telling them.” Like Nalya, Althea concealed her emotions. She preferred to keep them to herself:

When I was going through a lot of depression, I didn’t really have that many people I could talk to. Or if I had, they would look at me with a blank stare, so I
could not speak to them about these issues. I would just keep it to myself.

Participants concealed their pain to avoid the embarrassment of being a seen as a weak Black woman. According to Sue, her friends and the Black community would not stand for her to be depressed. She was expected to be emotionally “strong.” She said that her ancestors’ resilience was the reason that her community would reject her depression. She claimed that it was commonly said that she was expected to be resilient because of her foreparents. Her ancestors were strong enough to survive slavery; therefore, she should be inherently resilient:

I am expected to be strong. It is because of the hardships that we have to go through, and as Black people, you are supposed to bounce back; you better get on your feet and get over it, move on. I am lucky because sometimes I eventually bounce back.

Naomi also felt the pressure to be emotionally strong. She shared the response she received from her friend when she was admitted to hospital for her depression.

She said to me, “Naomi, I don’t understand. When I had my problems you could always help me, and now you can’t help yourself!”

Participants reported that their friends and their community were perplexed when they found out about their depression. Sharon said no one really understood what she was going through. Furthermore, her friends and members of the Black community did not understand what it meant for a Black woman to be depressed; they felt that depression was not a Black woman’s disease:

There isn’t the acknowledgment that I am a Black woman who could experience heartfelt pain. It is always, “OK, get up and fix yourself up and you can be on your way.”
Participants said that they felt socially isolated by their pain and sadness. Others did not recognize their despair. If participants revealed their depression publicly they faced the consequence of being ostracized. In this way, the stigma of depression is maintained.

In the next section, I discuss how depression is stigmatized among the participants’ friends and in the Black community.

**Stigma**

This subcategory refers to the disgrace associated with depression. Participants pointed out that, in their community, depression is an illness surrounded by shame. Lynn said: “When you are depressed people just shun you.” Participants revealed that they kept their feelings of depression to themselves because they feared repercussions from their friends and the community.

Nalya revealed that she would be disgraced in the eyes of her friends and community if she disclosed any sort of emotional pain associated with depression. “When I don’t feel so strong, they say to me, ‘she cries all the time, she is a little softy’.” Lynn described what would happen to her if her struggles were revealed:

When people are depressed, people think they are of no use to the community. They just ignore them; I have seen it. I see where they don’t take the person seriously. They say, “Awe, you can get over it” or something. It is not that easy. I want to get over it, but it is hard.

Nneka also said that she did her best to keep her depression quiet. She tried to cover it up, but, she said, her depression manifested itself in destructive ways:

When I get really depressed there is a lot of maladaptive behaviour: the drinking
and the partying, the smoking, the this and that. Dating to forget, the shopping, because if you are not really allowed to externalize what you are feeling internally it comes out in other ways. I think I do this because of the stigma.

The participants suspected that other people in their community were also depressed but kept it quiet due to the stigma. Diane said that when she looked around and evaluated the state of her community, she concluded that many members of her community were stifling their depression. She wondered whether the violence in her home country is due to the silencing of depression:

We don’t hear Jamaicans are going to psychiatrists in droves. But you do hear about that crime wave that is growing and growing, and it is a response to what the community tells you. You are told you are not allowed to shut down, you are not allowed to be depressed. So you lash out and beat everybody that comes in your way, and then you breathe, and then you get up and go again.

Geraldine also suggested that other problems surfaced in her community because of the stigma associated with depression:

There is no outlet to express our feelings; instead we, Black people, start drinking and partying or smoking weed or having sex. . . . There are a lot of issues that we put out in weird ways because there is no other way to vent it or get closure or figure out what is really going on.

Participants recognized that members of their community masked their depression by engaging in unhealthy acts. They, too, reported participating in unhealthy behaviour to keep their own feelings hidden.

In the next section, I discuss how the phenomenon of silencing affected the interactions between participants and mental health professionals they went to for help.
**Mental Health Professionals**

This category contains the participants’ feelings about mental health professionals. They commonly reported that the professionals were ignorant of their reality as Black women and did not value their concerns. Nneka stated that when she reached out for help from the mental health community she was misunderstood:

Every counsellor I have gone to has been a white woman, and they have their own cultural baggage that they bring with them; they can’t leave it at the door. And they come with what they know and they are very attentive and listening, but in terms of voicing back sometimes it feels disjointed and culturally irrelevant.

According to the participants, their therapists did not address the issues that were prominent in their realities. Issues of racism and/or sexism that contributed to their depression were not topics for discussion with the mental health professionals they encountered. Two subcategories emerged here: *Don’t understand my challenges*” and “*Not valuing my experience.*”

![Figure 12. Subcategories under Mental Health Professionals.](image)

**“Don't understand my challenges”**

This subcategory pertains to the participants’ experiences with mental health practitioners who were uninformed about the reality of a Black woman living in a Western society and how
that might contribute to her mental distress. Geraldine expressed her worry that practitioners
would not understand her issues and concerns. She shared her fears around seeking professional help:

When you walk in the door and you see it is a white man that is the worst thing ever you could see, because you know in your mind he symbolizes all the issues you are facing in society. And so now I am going to tell the white man how I am feeling about him.

Yvonne described feeling silenced by the difficulty she had finding an appropriate therapist who understood her reality. She believed that the mental health community in general did not understand the oppression she dealt with on a daily basis. Yvonne found having to expose herself to an individual who resembled the oppressor created anxiety:

The challenge I face is so unique and confined, and I think that is why it is so hard to talk about it and deal with it and even treat it when I have problems. How do I talk about it, the problem, with one who is structurally, politically in competition with me, as a white liberal woman? How do you explain that in the counselling situation when you are sitting across from a woman who is exactly what you just described? Very complex.

This was a hurdle for many of the participants. Their perception of mental health professionals was that they are uninformed about the women’s experiences, which caused participants to maintain their silence and not seek help.

Sandra, however, who did seek mental health support, described her sessions as a workshop for her therapist. She reported that some mainstream therapists are not familiar with the Black female experience in Canada:
I have seen counsellors and therapists—I have been through all sorts of terrible things in life and I always felt that the person didn’t really understand or did not know how to focus on the fact that I am [a] Black [woman] living in Canada and the issues related to that. So I felt that during the time I was getting help I had to educate at the same time.

Like Sandra, Diane felt annoyed by the work she had to do to help her therapist understand what she was going through. She just accepted that her therapist did not have the skills to address issues regarding her race:

My psychiatrist doesn’t get it. I accept that because she is white, she can’t. She doesn’t know. She doesn’t understand the Black part of it. She doesn’t acknowledge the Black part of my challenges.

Participants described Western therapists as unable to address difficult issues such as racism and how it contributed to their feelings of depression. This belief about therapists prevented some participants from seeking help. Others just accepted their therapists’ inability to understand them and kept issues of oppression to themselves. As a result, they were not fully present in their sessions. In the next section, I discuss the subcategory about not having one’s experience valued.

“Not valuing my experiences”

This subcategory describes the participants being silenced by mental health practitioners. Participants revealed that they believed that some mental health practitioners did not value their concerns. They reported that issues such as racism were never discussed in the therapy session. According to Sandra, topics surrounding racism were not considered issues in her therapy sessions. “My therapist never brought up issues of racism and how it was affecting me.”
Participants reported that parts of them were silenced in the therapy sessions because they were not given the space to explore how they truly felt about some crucial issues.

Participants’ detailed incidents in which therapists did not take their emotional pain seriously. Naomi said that even when she initially sought help from her health care provider, she was not taken seriously. She shared the response she received from her family physician when she reached out for help:

I asked him, “How do I relax?” And he said, “Naomi, go and jump in Lake Ontario, because I have patients who come in here that have been through a quarter of what you went through and you are standing up and they are falling apart.” Well, a few months after that I ended up in the psychiatric hospital.

Althea also said that when she tried to reach out for help, her concerns were dismissed. She got the courage to speak openly about her pain and ask for support, but was silenced by the responses she received from health care providers:

When I started doing therapy one time I went to [a mental health centre] because I thought of a gay space. Because you are always looking for the perfect space to explore your issues, my issue was depression. But the therapist was totally inappropriate. I shouldn’t have had a therapist that was a white man, but OK, I thought, a therapist is a therapist. So I went to talk to him and this is what he said to me for verbatim: “The reason why you were sexually abused is because you are good looking.” He did not want to deal with my emotions, he kind of pushed it aside, and he insulted me.

Because of such experiences, participants were left to suffer alone.

Even when a therapist did deal appropriately with the participant’s emotions, issues specific to Black women still went unaddressed. Rita reported that she found a therapist who
would deal with her emotions, but he was unable to deal with issues of racism and sexism. She provided an example of her attempts to introduce the topic of racism and sexism into her therapeutic sessions:

I mentioned a particular incident that may have not happened if I had been a white man. And you know what? It may have been true or it may not have been true, but I needed someone to take that seriously and think about it with me, and that didn’t happen. He said to me, “No, that can’t be true,” and I left and I was like, “Oh shit, why did I do that!” I needed to process that with someone who understood. He was not able to do that with me.

Participants reported that when they mentioned their experiences of oppression, the therapist did not take up the issue and consider how it contributed to their depression. Participants learned very quickly that issues of racism were not open for discussion. The women began to censor themselves. They stopped bringing up any concerns around the oppression they experienced. According to the participants, this type of silencing contributed to their emotional pain. They were not given the opportunity to explore all parts of themselves and therefore silenced deep-rooted sadness that no one wanted to deal with.

In the next section, I explore the subtheme Experiencing Depression. Under this theme I grouped the participants’ disclosures about being fully submerged in their depression.

**Experiencing Depression**

This subtheme exposes what occurred when the participants were in the depths of their depression. They described being isolated and having thoughts of suicide. Participants became overwhelmed by feelings of sadness. Many factors contributed to their feelings, their pain was silenced, and there was no place to turn but inward. The participants’ existence became
increasing difficult, so much so that some thought about ending their lives to stop the pain of depression. Two categories emerged in the participants’ experience of depression: *Going into Solitude* and *Suicidal Ideation* (see Figure 13).

**Figure 13. Categories under Experiencing Depression.**

*Going into Solitude*

This category addresses the isolation of depression. For instance, Cher said, “I just want to be alone.” She said that the pain of depression was so great that she did not want anyone near her. For all of the participants, depression was experienced in isolation.

All of the participants claimed that they isolated themselves when they were depressed. For example, Althea described depression as a feeling that estranged her from everyone. It drew her inward where she experienced being alone with her emotions:

I feel like I don't want to see anyone, I don't care about how I look, or shower or eat. I don't care for food, I don't care for anything. It is almost like a rest. My body is actually detaching from something.

Diane also described feeling detached from others and herself. She wanted to escape the pain:

I remember feeling very clearly I wanted to float. I wanted to escape my skin and just float. It was this overwhelming sense of wanting to float by going inside and shutting myself off from the world.
Participants went into solitude. They reported that this state drew them into the deepest parts of their soul. This became a private and sacred place where they allowed themselves to begin to feel their emotions, especially their pain. Janet claimed that her pain was so deep that she could feel the despair and suffering of her ancestors:

I would just sit in my house all day. Not just a loneliness; sort of like, like a real sadness comes over me and it gets into all these layers, all the layers of my ancestors’ struggles and pain. I get paralyzed by the feeling. I can't move; I just sit on my bed for 45 minutes.

Other participants also reported feeling the pain of their ancestors. Geraldine said, “My pain is bigger than me, my pain is all the struggles and suffering of my ancestors always fighting.” Althea also felt the pain of her ancestors, which raised many questions for her. “There are all these questions, like who am I? What am I feeling? Questions about everything.” During this time of solitude participants searched for the answers.

Solitude became a time to confront their sadness on their own, to feel the pain they were harbouring. Nneka said that her time of solitude was when she could explore her feelings and thoughts:

I would just want to sit at home . . . just sitting in the dark not saying a word. It became therapeutic; I would feel the pain. I would think of all sorts of things.

Participants not only felt their emotions in their time of solitude; they also engaged in conversations with what they considered to be a higher spiritual entity.

According to Lorraine, this is when she had intimate conversations with God and expressed her deeply sad feelings. She asked God for the meaning of her suffering: “So why am
I, Lord, feeling such pain? Why do I cry?” Lorraine poured out her heart to her God in her time of solitude. She was so depressed that she demanded answers for her pain.

The participants’ emotions were so painful that some admitted to contemplating suicide. In the next section, I discuss participants’ thoughts around suicide.

**Suicidal Ideation**

This category deals with participants’ feelings about ending their lives. Suicide was seen as an attempt to take control of their lives. According to the participants who had had this experience, their depression reached a point where they thought there was no reason to live. Participants said that thoughts of suicide were comforting, an option they could choose if they had to. Participants also said that it gave them some power over the debilitating effects of depression, and was seen as a way of removing themselves from their suffering. They did not fear suicide; in fact, they saw it as a practical way to take control of their depression.

Geraldine said that the idea of suicide is constantly present for her: “Suicide is never far from my thoughts—it is always there in the background.” During the participants’ time of solitude they all realized that to continue to hide their emotional pain was detrimental to their well-being. It was too painful to continue to hide behind a façade of strength. Yvonne remarked that she could understand the reasoning behind someone taking her own life:

I can see how people can commit suicide because it is the next inevitable step if you are immobilized and you are feeling depressed and you feel there is no way out logically.

Suicide came to be seen as a practical option for many of the participants; it was a way of regaining the control that they had lost to depression.
Diane reported that knowing other people who had committed suicide made it seem like a valid option. She felt that it was up to her to control her destiny, to decide whether to live or to die. For instance, Diane described admiring a colleague for having had the “strength” to end her life: “I thought, ‘How brave. How beautiful; that is what I will do.’” She felt no fear at the prospect of taking this step.

Participants stated that the charade of pretending to be strong was coming to an end. They no longer could continue to suffer in silence. Naomi reported that she began to put things in order to prepare for her suicide. She called the Children’s Aid Society to take care of her children after she was gone:

I had it all planned. I knew Children's Aid took care of children, so I told them, “I want you to take care of my children because I am not well enough to take care of them the way that I should.”

Participants felt that they had finally discovered how to take control of their depression when they decided that it was up to them to decide whether to end their lives or to continue living. Some of the participants suggested that they saw suicide as a sign of self-control. Rita said that she felt herself beginning to take control of her life when she discovered suicide as an option. She believed that suicide was a way of taking action in response to her deep-seated feelings of anger and depression:

I did a lot of stuff to hide it [the depression] and that made me feel really upset, like really angry, and the only thing I thought of was, the only thing I could say is that I really did not feel uncomfortable with the idea of dying and the idea of killing myself. That was the only thing out of all the symptoms of depression that I think I felt comfortable with. I am not ashamed of that. Anything else—the crying, the wanting to be alone, all those things—I felt embarrassed about; killing
Rita openly welcomed the idea of suicide. She felt empowered by the realization that she could take her life if she wanted:

I feel suicide is the most respectable and brave thing to do. I would not tell my friends or my family or anyone about it. . . . I am very open to the idea of doing it at some point because I feel like, why do I have to struggle with this? It is not good on other people seeing you like this; it is not good on yourself, and there really isn’t a point when you get that low. . . . And I also felt at that time that, yes, it would be a selfish thing to do because people would be upset, but people would probably recognize at the end that it was something that had to happen, so I am OK with it.

Diane’s depression became so overwhelming that she attempted to end her life:

I attempted suicide twice, but I was not successful. I just felt I could never explain what was wrong, and it felt like if I was not here then that would be better for everyone. I am depressed and I have nothing to be depressed about. Clearly there is something wrong with me. So I attempted to end my life.

Depression became so overwhelming that suicide seemed like the only option. The idea that suicide was a form of control over one’s life and offered a sense of empowerment was shared by Diane:

I attempted to commit suicide, but I was not successful. But it is always in the back of my head. Right now I am choosing to live.

Participants expressed the importance of attempting to bring control back into their lives. They believed depression had taken it away. Suicide became an option that offered participants some control.
Summary

It was difficult for the participants to put into words what depression was like for them. They described it as something that took over their bodies, spirits, and minds, paralyzing them to the point where they no longer recognized themselves. Their self-esteem was so low that they felt unfeminine or like failures because they did not possess the attributes of the Strong Black Woman. This also contributed further to their feelings of depression. The participants also stated that conflicts they experienced in their families caused their depressed feelings. Many felt that their depression could be attributed to their own mothers’ lack of nurturing when they were children. They did not feel loved and lived with deep sadness throughout their childhoods and into adulthood. They also described the trauma of the loss of their immediate family through divorce as extremely emotionally draining, leaving them feeling alone and isolated.

Participants also discussed the struggles of being a Black female in Western society and how the discrimination and oppression they faced as a result left them with feelings of worthlessness. Many described feeling ashamed of their feelings and said that they did not want anyone to know that they were “emotionally weak.” Their mothers, friends, and community did not tolerate any discussion of depression. Participants felt that they had no one to talk to and that depression caused them to become estranged from their friends and family. Some reached out to the mental health system for support but found that they were not understood and their experiences were not validated. This contributed to their feelings of isolation. Depression itself compounded their sense of isolation and led them to retreat into solitude. They described wanting to be alone and spoke of not caring anymore. Thoughts of suicide became prevalent.

Some participants viewed suicide as a feasible option available to them if they chose. The women revealed that knowing they had power over their lives by having the ability to choose
whether or not to die allowed them to contemplate what it meant to continue living. This was the participants’ turning point to coping. In the next section, I discuss actions participants took to start the journey to well-being.

**Turning Point**

![Diagram of Turning Point]

**Figure 14. Subthemes under Turning Point.**

The notion of a turning point emerged from participants’ descriptions of their darkest times of isolation, that is, the point at which they were faced with the choice of continuing to live or ending their lives. This was the moment at which they reached a turning point. Participants’ responses revealed that they touched a turning point when they experienced a moment of awareness that led to a significant change in their thinking as well as in their way of handling their depression. Although participants faced numerous challenges that contributed to their depression, they also went through turning points that encouraged them to adopt alternative ways of looking at their lives. Participants began to see their world differently and became more optimistic about their future. The change in their ways of thinking and ways of dealing with issues helped enhance their coping capabilities and motivated them to continue their efforts to deal with their depression. Three subthemes emerged under Turning Point: *Becoming Aware: “I*
Becoming Aware: “I Have to Change”

Many of the participants described a turning point in their lives that occurred when they were depressed and isolated from others. At that moment they “took a look inside” themselves and saw their inner strengths. For example, Cher said that when she was depressed she wanted to be completely alone. During her time of isolation, away from all the demands and expectations she felt were placed on her, she began to feel free. Cher suddenly began to feel hopeful. She identified this as a “turning point” that helped her regain her strength and start thinking more positively. As a result, her perspective began to change:

When I am alone, away from all the demands, I don’t feel so overwhelmed and I begin to look at things in a clearer picture. It kind of brings me out of my state of depression and I begin to see the bright light. I now can put together and prioritize things, I can accomplish things now.

Like Cher, Nalya realized that things in her life needed to change. She could no longer continue to ignore her depression because it was beginning to affect her physical well-being. Nalya explained that because her physical health was compromised, her approach to dealing with her issues changed. She felt motivated to address the issues affecting her mental well-being. Some participants shared that when they realized the negative effect of denying their feelings and the consequent depression, they experienced a moment of awareness that led to the rediscovery of their power to make positive changes in their lives. This was their turning point. For instance, Asha was having difficulties with the Ministry of Immigration: they would not accept that the child she brought with her when she immigrated to Canada was her biological daughter, which
prevented them from settling in Canada, which, in turn, affected her mental well-being. Consequently, she became depressed. A moment of consciousness led her to decide to get control back into her life:

So looking back, I say, OK, you were in a very dangerous and risky position at that time. I realized I have to snap out of this; something is wrong with me because that is not who I am. Then I slowly came out from that dark place and coming back to life and I began talking again to the immigration and they sent me to do a DNA [test] for me and my daughter.

Asha discovered the strength to regain the person she knew herself to be when she experienced the moment of realization that she referred to as a turning point. Similarly, Naomi shared that when she realized that she had an innate ability to listen to others and help them feel better, it proved a turning point for her: she decided to do something about her emotional well-being:

I would always listen to my classmates. They would usually come to me and tell me about their problems. And then I realized that I had problems too. . . . I realized how important listening was; that is when I decided to look for someone professional to talk to.

Cher, Nalya, Asha, Naomi, and many of the other participants described turning points in their lives, times when they discovered new energy to do something about their situation. They discovered the inner strength to start the process of making a change in order to cope with their depression and ultimately have a more fulfilling life.

In the next section, I discuss the subtheme of the responsibilities of a mother.
The Responsibility of Being a Mother

This subtheme pertains to the role that being a mother played in the lives of some of the participants. Many claimed that they could not continue being depressed because they had children. For instance, Lynn shared that her role as a mother pulled her out of the depths of depression:

There are certainly days that I would love to be able to curl up in bed for a lot longer, but I think of my children. If I didn’t have something that was pushing me a little bit, like my children, maybe I would be there a lot longer, which I don’t need to be, and I wouldn't force myself to snap out of it. My children force me to snap out of it.

Participants believed that their children needed them to be strong, and this eventually boosted their resilience, allowing them to deal with their challenges.

This subtheme pertains to participants finding a turning point in their love for their children, which allowed them to face and begin to deal with their depression. Many participants indicated that their having children encouraged them to be strong, which eventually led them to coping with their challenges. Lynn stated, “I see my daughter suffering with depression too, and I have to be careful because I know she is watching me and I need to be strong for her.” Leslie said that the love for her daughter was instrumental in leading to a turning point. She discovered that the only way she could protect her daughter was to take care of her own mental well-being. This was a dramatic change in her perspective:

I realized that to show my love for my daughter I had to take care of myself. I am not helping her, nor am I helping myself, if I continue being depressed.
Many other participants also said that they took care of their mental health and faced their depression for the sake of their children. Sandra said that when she was going through her divorce she needed to put things in place for her sons, but that it was most important that she reach out for support for herself in order to take care of her sons during an emotionally very difficult time:

I knew I was going to leave my husband, so I told the social workers and the teachers and everything that we are going to be separating and things have not been good at home. I wanted them [her sons] to have support, so I put that in place. But I also realized that I would need support, so I put my name on the list for therapy.

Many participants reported that they became strong for the sake of their children. They felt that it was their responsibility as mothers to be able to take care of their children's mental well-being by addressing their own mental health issues. They felt that their children needed them to be emotionally strong and they wanted their children to be happy and well taken care of. As a result, they gathered the strength to face their depression. Participants said that they knew it was crucial for them to address their mental health because they had seen their mothers suffer and were beginning to see their own children struggle as well. In the next section, I discuss the finding that the realization of the possibility of the transgenerational transmission of depression served as a turning point for all of the participants.

“I Don't Want To Be Like My Mother”

Many of the participants considered the realization that they did not want to reproduce their mother’s lives as a turning point. Participants’ awareness of their own depression and their ability to see their mothers’ emotional pain gave them the courage to break the cycle. They
wanted to end the legacy of depression in their families. Participants said that observing their mothers suffering with depression was a turning point for them because they came to the realization that they needed to change to prevent depression from trickling down to the next generation. Lorraine explained that the dynamics of her relationship with her son became frighteningly familiar to her; they were beginning to resemble the relationship she had with her mother, a relationship that had contributed to her depression. Lorraine shared her thoughts:

"You [referring to her mother] still have some really fucked-up innate ways of relating to me or treating me and consequently I take those fucked-up ways and I treat my son the same fucked-up way, you know what I mean. And every so often he [her son] calls me Grandma. He calls me Grandma to let me know I am acting just like her towards him, and it grounds me back to earth and then I have to rethink the whole thing."

This became a turning point for Lorraine. She reported that after a few of these encounters with her son she gained a deeper understanding of what was happening between them. She did not want to continue to have this kind of interaction and discovered she had the power to change it by learning new ways of interacting with her son: “I now think about things before I react to my son. I stop and say, ‘OK, what is he saying? What is really going on here?’”

Like Lorraine, Janet was motivated to change her perspective because of her fear of becoming depressed like her mother:

"I am afraid I am going to end up like my mom, who is unhappy. So I have to change things—not only for me but for her. It is hard: she is my single mom and I have gotten all my learning from her . . . but it needs to be done."
Participants were motivated to change their families’ destinies by changing their perspectives and addressing their mental well-being. Like Janet, Nalya was concerned about depression being passed down from one generation to the next in her family. Nalya had no children at the time of the interview, but she believed that she needed to make some changes to protect her future children and grandchildren from depression:

I feel that depression has followed me; it is like characteristics that are passed down from my parents and their parents’ parents because they have been subjected to certain things and they have not dealt with it in the right way because they did not have the resources, and therefore have passed it on to me, and it may be unconsciously. It doesn’t mean they are doing it on purpose; you want your kids to turn out the best they can, but if you don’t know how to deal with things, then how are you going to teach your kids to deal with things? So I have to deal with things so it doesn’t happen to my kids and their kids.

Like Nalya, Diane felt that she needed to become a role model by dealing with her depression and learning to deal with issues in a healthy way for her children. Diane wanted to take care of her emotional well-being so that her daughters would not head down the same path of depression that she and her mother had travelled.

My mother was depressed, I suffer from depression, and now it is up to me to change this course. It is up to me to be their [her children’s] role model and be happy so they will be happy.

Participants believed that healing themselves would prevent their offspring from suffering as they had. Yvonne stated:

The intergenerational stuff is just utterly important and we got to address it. And it’s got to start with every one of us putting our foot down and saying we are no
longer going to hurt. We are going to start admitting to the pain and dealing with it so the next generation doesn't need to deal with it.

The participants believed it was up to them to take care of their own mental well-being and that of future generations. They did not want the cycle of depression to continue.

Through participants' commitment to change their perspective they discovered the strength of their ancestors. They spoke about having a “resilience gene” that they inherited from their ancestors—by way of their mothers—which they drew upon. Nalya declared that discovering the strength of her ancestors was also a turning point for her:

I discovered I am very strong. I find that comes from something deep-rooted within me. Some people don’t always recognize it, but when I did, it is such a power, it is an amazing power and it has really helped me.

The participants did not see their turning points as isolated phenomena; the turning point transcended the generations.

**Summary**

The research did not begin with a question about the process of moving from a place of depression to coping. Yet, throughout the interviews participants shared the critical moments in which they identified that they no longer wanted to be in a place of depression and began a process of coping. The concept of “turning point” captures these moments described by participants in the interviews. These places of awareness were grouped in the following three subthemes: *Becoming Aware: “I Have to Change”*; *The Responsibility of Being a Mother*; and *“I Don't Want to Be Like My Mother.”*
These three subthemes describe the catalysts for the participants’ beginning to cope; the next section reveals how they did.

**Coping**

The key theme *Coping* pertains to the participants’ various ways of navigating depression. All the participants explained that in the midst of their depression they used various strategies to help them cope. They suggested that the personal strategies they implemented in their lives, together with the external support they received, proved crucial to their being able to move towards a place of well-being. Yet no single coping strategy outweighed the others; in fact, all the strategies together had a collective effect on the participants’ mental well-being. Under this theme four subthemes emerged: *Gaining Personal Strength; Confronting Oppression; Talking Without Fear: Speaking the Truth; and Reaching Out for Support.*

![Figure 15. Subthemes under Coping.](image)

**Gaining Personal Strength**

The subtheme *Gaining Personal Strength* refers to participants’ implementation of various strategies to build their psychological well-being. Participants revealed that when they paid attention to their physical, spiritual, and cognitive needs they began to build inner strength.
They found various ways to communicate their feelings and to attend to their physical, spiritual, and mental selves. Some participants reported that listening to music, expressing their feelings on paper, and finding other ways to take care of themselves physically, spiritually, and mentally helped rebuild their inner strength. From this three categories emerged: Finding the Right Song: Picking Up My Spirit; Expressing Feelings Through Words; and Self-Care (see Figure 16). These three categories contain the strategies that the participants used to regain their personal strength.

**Figure 16. Categories under Gaining Personal Strength.**

**Finding the Right Song: Picking Up My Spirit**

Some participants used rhythm, singing, and listening to music as a coping strategy. They revealed that music helped trigger emotions that were locked inside them and needed to be expressed.

Rita said that listening to music touched her deep inside her heart and triggered feelings that helped her move out of depression:

Just listening to music has been a really big thing for me, having music that I can associate particular memories with. Where I can remember when things were different or I remember when I felt really good—that is really helpful.
Nalya reported that she would get “lost in the music.” Nalya also used music to trigger emotions that she felt she needed to get out. It became a vital coping tool.

If I can find the right song, that can help me to relate to my pain. It can help me because I feel that there are times when I feel like I want to cry but the tears are not coming. I put on a piece of music and it will bring the tears out of me and I would feel better.

Music brought to the surface pleasant and unpleasant emotions that participants felt they needed to befriend. According to them, music touched emotions that were locked away, and listening to music became, for them, a healing practice.

Like Nalya, Kim used music as a tool to help her cope. She used music to recognize, approach, and accept various emotions. This became very important during periods of depression. Kim used making music as a coping ritual that was performed during her private times. She did not have a formal structure for her musical expression. Instead, she allowed the energy of the music to express itself through her in any form:

I like to stay up at night and sing. I would be singing in front of the mirror. Sing and dance. It would help me stop thinking about whatever was bothering me and I would get lost in a song.

Engaging in music through singing also allowed participants to feel their pain and to escape it when it became overwhelming. Participants often said that they would get lost in listening to music and in expressing themselves in song.

Some participants claimed that religious music, in particular, proved helpful. For instance, Lisa stated that she found this genre of music empowering:
Listening to some sort of praise music that really helps me get up and start coping a little bit better. . . . The language the music is speaking and the type of instruments that [are] being played helps me when I am feeling low . . . certain arrangements have a certain way of picking up my spirit . . . certain songs that are reflective . . . that really speaks to the fact that this time will not last . . . things are temporary.

Rita, Nalya, Kim, Lisa, and others claimed that they felt better after they found the right song.

Participants used music to help them express emotions, trigger pleasant memories, escape from pain, and feel empowered. Music and singing also took them on a journey to reclaim their voice in their private space. Feeling their emotions through music was very powerful, but expressing their thoughts was another critical component of coping. In the next section, I discuss how participants used writing as a coping tool.

Expressing Feelings Through Words: “A Cerebral Journey of Self-Love”

This category pertains to the participants’ use of the technique of writing down their feelings to help them cope. They reported that writing was instrumental to their ability to express their thoughts about issues they were struggling with; they wrote about their personal journey of self-empowerment and the strained relationships they had with their mothers. Naomi said: “I began to write. I wrote down everything I was feeling.” Participants used their journals to formulate their thoughts and feelings about the challenges they faced. They used the act of writing to explore their mental well-being. For Lorraine, writing became a tool she used to discover who she was. Lorraine shared her journal and described how she went about expressing herself with pen and paper:

This book is a reflection of my spiritual evolution from struggling and suffering.
To help me discover who I am and what I want to become. It shares with you my joys and my love, my hopes and my shame, whether it is the joy of knowing the heights of one’s own heart desire where I express my love and happiness.

Like Lorraine, Janet used writing as a tool to explore her thoughts. This was her way of discovering what she needed in her life:

I have this notebook that I started . . . “cerebral journey of self-love.” . . . I’ve always been a person that thinks a lot. I think to the point of freaking myself out. I think it through . . . and so a lot of it has to do about getting it down on paper and seeing visually my life’s map . . . it is really an exercise for my brain.

Participants reported that it was helpful to write down their feelings. It helped them understand their emotions and it eased the pain of depression. For Nneka, writing was an important part of building her ability to cope:

I mainly write when I get to a bottom and I will just sit and just write . . . writing my feelings down . . . writing for me is therapeutic . . . I find it helps me get in touch with myself better . . . I can sit down and have a conversation with myself when I write. I can talk to my inner voice and just have a conversation.

Lorraine, Janet, and Nneka said that writing helped them get in touch with their inner selves and build their self-esteem. They also mentioned that expressing their feelings on paper was instrumental to their processing their feelings about their mothers.

One of the things many of the participants mentioned was that they wrote about their mothers’ abandonment of them and the estranged relationships they had with them. Lorraine said that she wrote because of her need to understand why her mother had left her. Her journal was a place for her to write down her thoughts:
In the Time of the Sunrise [the name of her journal] came about at a time when my mother and I were at war with each other and I needed peace within my soul. So I expressed my feelings into words . . . I asked why did she leave me? . . . Why do I hurt?

Nalya also said she wrote in her journal to answer the many questions she needed to process about her mother’s anger. She said that through writing she began to realize that her mother’s anger was really about her mother’s sadness. Through her writing about her mother’s pain, Nalya began to be empathic towards her mother and was able to see another side of her, which helped Nalya understand and forgive:

I wrote about my mother’s sadness. . . . I wrote about the times I would hear her cry at night to herself. . . . I began to feel for her when I wrote about those times. . . . I think she felt she had no one to talk to and you should not feel that you can’t go to someone and talk. . . . Writing made me take a step back because there were ways she dealt with me . . . when I was younger. I could not understand it. I didn’t understand why and what was the need for such things. But now, as I get older and as I write, I begin to understand her . . . there was so much that she was going through at that time that it must have been overwhelming.

Participants said that putting their feelings into words was a valuable coping strategy for them. Janet found it so helpful that she wanted to share it with her mother in order that she, too, would have a way of coping:

It really helps. I am going to write a notebook for my mom, right. So on each page I do, like, different things. Like I will start . . . with my own affirmations . . . and I want her to identify areas in her life where she sees stress and to map out her life and the instances she feels has put her on a path voluntarily and not voluntarily and what that has meant. Like the things she wants to forgive herself and these are all things I am doing right.
Expressing their feelings on paper was a therapeutic exercise for the participants, and they wanted their mothers to benefit from it as well. For many, writing became a practice that fostered their healing. Throughout the interviews, participants discussed a number of practices they used to help them cope. In the next section, I discuss various self-care strategies.

**Self-Care: Attending to the Body, Spirit, and Mind**

Participants engaged in various acts of self-care to build up their inner strength. They did this on an ongoing basis as a form of coping and a way to prevent future episodes of depression. Participants monitored how their bodies responded to various stimuli, nurtured their spirits, and monitored their thought processes to help prevent them from falling into a state of depression. Participants’ self-care included caring for each part of themselves. No one part was more important than the others, but all aspects needed attention.

The phrase “attending to the body, spirit, and mind” captures the acts of personal self-care that participants engaged in to prevent a new episode of depression. Many used exercise as a form of “antidepressant.” For instance, Geraldine believed exercise and eating well kept depression at bay:

I make sure I work out because that helps me with my energy and my endorphins. And I make sure I eat healthily because I know when I eat junk food that, especially sugar, that just totally throws me off. So I do a lot of things proactively to make sure I am healthy and therefore translate into being happier.

Some of the participants described their belief that there was a connection between food and emotional well-being. Like Geraldine, Althea became aware of the different reactions she had to
different foods and began to stay away from certain ones. This helped her gain some control over her mental well-being:

I need to be aware of everything from eating, like I drink coffee, right, and I know at certain times of the day if I feel low, is that depression or I am tired or the effects of caffeine or whatever. You know, just being more aware of what affects me. . . . So I limit my coffee intake; I try to exercise more; I try to eat well because that affects me.

Ann also believed that taking care of her physical health was an important part of her coping and self-care. She explained that after her divorce she joined a Brazilian martial arts class to help her cope. She used it as a form of exercise, and it subsequently helped her manage her depression:

I take capoeira classes. Gets my endorphins up and helps me cope. My divorce was difficult, but capoeira class got my body moving and helped me feel better about myself.

Engaging in activities that improved the participants’ physical well-being also improved their ability to cope with their emotions. Care of their bodies was seen as a preventative for depression. This coping strategy was implemented on a regular basis. Being physically well helped the participants manage their depression and prepared them for healing.

The participants were also concerned about their spiritual well-being. For Lorraine, the spiritual constituted a crucial element in her coping process. Her attitude that she would get through whatever she was going through came from her spiritual belief. Lorraine began to view her depression as almost a spiritual experience that she had to go through in order to find peace and happiness. She believed that her depression provided her with spiritual wisdom:

Each episode of depression are lessons I am supposed to learn and insight I need
to learn in this life to help my spirit move to the next level of consciousness to the next lifetime. Each episode teaches me something else about myself, and learning to cope has made me stronger.

As in the case of Lorraine, Althea’s spiritual perspective on her depression helped her cope by providing her with a reason why she suffered with depression. Althea embraced her depression because it offered important information for her on her spiritual path in life:

Depression sets in to tell me that I am not being on the right path at a certain time when I need to be. And the depression is stopping me to slow me down to think about things more carefully. So, you know, there are those aspects of it that I think need to be looked at spiritually, by speaking to the spirit.

Having a spiritual explanation for depression helped participants cope.

Participants stated that their mental well-being also formed part of becoming emotionally healthy. According to the participants, it was crucial for them to engage in acts that helped control their negative thoughts, which at times created havoc in their minds and led them into a state of depression. Geraldine spoke about engaging in activities that provided her with positive mental stimulation. She did things that calmed her mind and helped her control her unwanted thoughts:

I am very proactive in terms of what I do in how I think and what I do in terms of staying present. I try not to let my mind wander because that can get me in trouble.

Reading was a mindful activity that participants used to keep their minds from wandering into negative thoughts. For instance, Lynn stated that reading was important to help people “get out of their heads.” It was a way for her to escape the negative thoughts that circled in her mind.
I find it hard to not think about myself. But by reading I am going into someone else’s thoughts frame, you know, reading why did they do this and why do they come to this conclusion. I like mysteries because it has to work my brain wondering who did it or things like that . . . reading I find I get involved in the scheme of it and try to, you know, oh, I wonder who did this? Who killed the person? . . . Something to get my brain active.

Like Lynn, Lisa found reading to be a therapeutic escape that became an important part of her self-care. By reading she was able to let go of negative thoughts:

What always helps me to cope is after some time, after a little while I really take an inner look. I really look at myself; I try to find things I could read. For me, I always know that things will make me feel better. Even though I may feel bad and I may want to stay there for a little bit, I know certain things will trigger an emotion within me so I go to those things, like some sort of self-help books and magazines. I don’t even want to quote the name of this magazine, but if I buy this magazine, it just helps to uplift me, you know. It is a Black women’s magazine. Black women’s magazines inspire me that I can read and I can say, OK, all right, I need to just dust myself off.

Reading various kinds of literature helped participants change their perspectives and get out of their heads. Lorraine felt that

I am too self-absorbed, you know, because I think when I get depressed, I kind of recoil back into myself. And I don’t think that is a really safe place to be wrapped up into your mind and into your self . . . so I find reading helps me to escape and get outside of myself.

Almost all the participants reported that their self-care included caring for their bodies, finding a spiritual explanation for their depression, and nurturing their minds by gaining a positive perspective. All three categories were instrumental in uplifting their psyches. As a result,
they became motivated to deal with the challenges in their lives. In the next section, I discuss how participants coped with the oppression in their lives.

**Confronting Oppression**

This subtheme relates to how important it was for participants to know their history, so that they could cope with the various oppressions they faced in Canadian society. According to the participants, knowing their history helped them find the resilience they felt they had inherited from their ancestors. Participants explained that knowledge of their ancestors’ survival of slavery built their trust in themselves, making them confident that they would be able to cope with the everyday oppression they faced in society today. Hence two categories emerged: *Knowing My History*; Amazing Power of The Ancestors (see Figure 17).

<table>
<thead>
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<th>Confronting Oppression</th>
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<tbody>
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<td>Knowing My History: Building Resilience</td>
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**Figure 17. Categories under Confronting Oppression.**

**Knowing My History: Building Resilience**

This category explicates the ways in which participants were able to cope with oppression. They stressed that having knowledge of their ancestors, of where they came from and how they struggled to survive, helped them build their own internal resilience. For instance, Geraldine associated the resilience her ancestors showed by dealing with their challenges with her personal inherent strength. It provided her with a platform from which to be proud of her
ethnicity, cultural heritage, and traditional roots. She felt that it was part of her nature, due to her lineage, to be strong.

Well, just from knowing my history as a Jamaican, like the Arawak Indians and the Maroons and the people from the Gold Coast or Ghana who were warriors, or the Ashantis that were brought over to Jamaica and who uproared all the time . . . I have that Jamaican culture, just being very, you know, ambitious.

Many other participants expressed similar views. They said that knowing their history and what their people had gone through encouraged them and gave them the strength to deal with oppression and depression. For example, Nalya said that knowing her history played a critical role in developing the coping skills she needed to address her challenges:

I love to know things about my past because as Black people we cannot walk to any kind of museum and see our past and see our culture. We can’t even really look up our family name because it is not ours. So I like to do as much reading to know how we struggled and survived. It encourages me to be strong and move forward.

For Nalya, learning about her history was a source both of nourishment and of healing from her depression. Like Nalya and many other participants, Lisa spoke openly about the struggles her ancestors went through and said that this provided her with proof that she came from a long line of strong people. Her way of coping was to focus on their strength to help build her own inner strength.

Surviving through the centuries whether you are born Canadian or an immigrant or your parents, parents were from the islands or from Africa, we just have resilience. So it is like focusing on the positive.
Those participants who knew their history were thankful for the struggles their ancestors had gone through and believed that they inherited their resilience to help them cope with the oppressions they faced today.

Amazing Power of the Ancestors

This category emerged as the basis of an important strategy that participants used to cope with their depression. Many participants explained that they gained self-confidence and empowered themselves by tapping into the energies of their ancestors. They felt that there was something innate that they could use to help themselves and their community. Geraldine said that when she tapped into that part of herself she was able to feel better and to give to her community:

I am a warrior because I am always fighting and I always believe in a greater goal in that something will come from this experience. I will see something that I can help others and that is sort of how I carry my life. Because right now I am working with at-risk youth; the after-school program, right, so I feel like I am giving back and I am using my experience to help them because I see myself in them. Their parents are not home, they are neglected, they are acting out, the same kinds of issues are developing with them. So in those little ways, that is how I curb my depression . . . at least I am helping others to have more choices.

Many of the participants spoke about being strong because of their ancestors. This contributed positively to their coping capabilities. Yvonne said that she leaned on her inner strength, which she believed came from her ancestors, to deal with the oppression she faced. She was forced to be strong not only for herself but also for her son. It was crucial for her to be able to cope for the sake of the next generation:
I guess the resiliency came out of me, too, because you draw upon your well of whatever you have when facing racism and I had to dig real deep right . . . that I had to dig even deeper for my son, because we really did not know what was going on with him. . . . So I think it is both being a Black woman having a certain way of seeing; we are the ones that get things done.

Like Yvonne, Nalya said she found her strength when she went inwards, and that it was crucial to her coping:

We are very strong, I find. And I find that comes from something deep-rooted within us. Some people don’t always recognize it, but when we do, it is such a power. Like it is an amazing power and it can really help you just looking at our mothers. And certain things I didn’t know about my mother when I was younger and I know about her now and it amazes me how she was able to take care of us while she was going through certain things.

Participants talked about adopting their mothers’ strength as their own internal strength. The strength they discovered helped them find the courage to speak about their depression and to stop silencing their feelings. In the next section, I discuss talking without fear.

**Talking Without Fear: Speaking the Truth**

This subtheme refers to the participants’ speaking the truth about their feelings and removing the stigma from depression. From their turning points onwards they became aware and began to acknowledge and accept the various emotions they were feeling. This meant that they stopped denying their feelings and began speaking the truth about how they were feeling inside. To do this they had to confront the stigma of depression and begin to address their challenges.

This subtheme pertains to participants’ acknowledging and honouring all their emotions as a form of coping. They suffered with depression; they silenced their emotional pain for years;
and they experienced the physical, emotional, and spiritual repercussions. Participants could no longer deny their feelings if they wanted to move forward and begin the process of healing. Due to the participants’ past experiences of depression, they came to the realization that they needed to accept and speak the truth of depression in their lives. For example, Nneka explained:

I realized it is OK to talk about it [depression] and it is OK to be depressed, and even just taking away that barrier of kind of shame associated with depression kind of makes it easier to where I can actually feel my emotions and I feel entitled to my emotions and it is OK to feel like this and it is OK to go through my ups and downs and my moods and what have you. I mean, what is in the confines of societal boundaries, like don’t start yelling at people or what not, the way I feel is the way I feel and it is OK.

Like Nneka, Nalya felt that in order for her to cope, she had to accept that she is a person who struggles with depression and be all right with it. This acceptance helped her heal:

I am more real with myself and I am not really looking to hide that from people because, at the end of the day we are not perfect, and I don’t think anyone should look for this perfect status of themselves. I think I should just try to continue trying to improve myself. And being real with myself is going to let me remember and never forget that inside needs improvement.

By acknowledging her depression Nalya began to accept herself. Yvonne, too, said that she became aware of her limits and did not apologize for her feelings anymore. Yvonne found that creating boundaries with people made for an important coping mechanism:

What was crucial for me was learning to set boundaries, learning to say no. Learning to know when you have reached your point of no return so you can sit back . . . that is how I deal with it.
According to many of the participants, being honest with themselves and with others by speaking the truth about their depression was an important coping strategy. They no longer ignored their feelings but instead validated their emotions of sadness and despair. For instance, Rose stated: “I am not Superwoman and I am no longer striving to be that.” Participants felt a sense of relief when they stopped trying to portray themselves as other than they were. All their emotions became acceptable ones that were honoured and respected. Nalya said she began to discover the good in the process of not denying her emotions and allowing them expression through her tears:

I believe in crying, like I really do. I don’t think it should be looked at as if you are soft or whatever. And that is another thing in the Black community, too; people are always concentrating on your strength for the outside. It is always something about, you know, she always cries all the time, she is a little softy whatever, and it has nothing to do with that you need to get that out, man, like you need to get it out.

Like Nalya, Nneka expressed how important it was for her to speak the truth about her feelings as a way of coping, and she encouraged all Black women to do the same:

Black women need to say, I am going through a depressive state right now, it is OK. I am fine, but I am just a bit depressed right now, and I need to talk to someone about it, and it is OK.

Participants believed that no longer silencing their feelings was an important step. Speaking the truth about their emotions was an integral part of changing their perspective and finding the help and support they needed. In the next section, I discuss how reaching out for support helped the participants cope.
**Reaching Out for Support**

This subtheme pertains to an important coping strategy described by the participants. They were not used to asking for help or even admitting they needed help. Once participants had the courage to speak the truth that they struggled with depression, they were ready to reach out and accept help. Four categories of sources of support were identified: *Faith and Spirituality; Having Intimate Friends: My Support System; Family: Unconditional Support; Finding the Right Psychotherapist; and Building a Connection with Mother* (see Figure 18).

![Figure 18. Categories under Reaching Out for Support.](image)

**Faith and Spirituality**

Faith was described as one of the main support mechanisms for coping with depression. Participants reported that their strong faith led to a deeper connection with their God, which strengthened them mentally and emotionally. Althea explained that when she reached out to her faith and began to perform spiritual rituals, her relationship with a higher power provided her with the much-needed emotional strength she was looking for:

I wake up in the morning and I do my citations and speak to my ancestors and I feel like I am walking in the world with my ancestors on my back and looking over my shoulders and I feel like I have support and every day is a new day . . . when I start my day with my ancestors.
Like Althea, Lisa said that her strong spiritual beliefs sustained her emotionally when she was experiencing depression. She cited a passage from the Bible that she frequently relied on when she needed extra emotional support:

In Psalm 23 it says . . . Even though I walk in the valley of the shadow of death, I will fear no evil, and the Lord said that we are walking through the valley of the shadow of death and on that interpretation it is a matter that we are going to go through things. We are not staying there . . . the word of God helps me to get through things.

As Lisa explained, her strong belief in the words of God, a higher spiritual power, helped her know that her depression would pass and that she would soon feel empowered. Many other participants described how their strong devotion and faith helped them develop a close connection with God and a better understanding of life, which assisted them in facing any of life’s challenges. Lorraine explained that reaching out to God for support helped her on her journey to healing:

I talk about my spirit; that is what brings me back to a state of not being depressed. . . . My faith in my higher entity, my God, my spiritual advisor . . . guides me to where I need to be.

Many others described their faith as an important support system for them. Yvonne said:

I am not the most religious person, but the church has given me a lot of support. And I see how they have been helpful in supporting many of us through trying times.

In the next section, I discuss how participants used talking to close friends as another crucial coping strategy.
Having Intimate Friends: My Support System

Having good friends was described as one of the main support mechanisms that helped participants resist and cope with depression. They said that their strong connections with other women who were mentally and emotionally like them strengthened their ability to cope. For example, Diane described friendship as a crucial element in coping with her depression:

If I didn’t have friends here or somewhere else that I can be in touch with, there is no way I can make it through this depression. And there is no way that I can keep my head above the water and not fly. If I didn’t have my friends, it would be just a downward spiral straight into depression.

Participants reached out to other women. Their friendships with other women were an important element of their coping. They sought out women with whom they knew they could share their feelings without being judged. Althea said that her friendships became an important part of her life:

My support system, my friends . . . being able to talk about how I am feeling and being able to express myself about any situation that comes up helps me because, and being open to their feedback, because they would say, “Well, I think you are just thinking too much about that” or “No, that is not who you are. Why are you taking that on?” Right, and so that is really helpful.

Participants stated that they relied on their friendships for support and comfort. Like Althea, Sandra claimed that her friends were able to lift her up a bit through the dark periods of depression.

My friend Mary . . . I don’t know how I would have survived without her . . . she was just a rock. I was able to call her at any time and I could cry. . . . She had been there with me through that whole thing when I lost my job, she was there.
When I had to go to Human Rights . . . she was there. When I couldn’t speak at Human Rights, she spoke for me. I mean, I feel so utterly blessed to have her in my life.

Participants expressed their closeness with their friends by referring to them as sisters. Diane said that she felt very close to a particular friend to whom she believed she could disclose anything, and who had her best interests at heart:

Well, I have a friend in New York, and I talk to her maybe twice a day. . . . Sometimes it is just important that someone hears me or, for her, because she is not in my position, she is not affected emotionally the way I am both by whatever situation it is, my supervisor, my ex-husband, all of these various things. She can see it in a different way. And saying, don’t get stuck in that, she can say, “yes, I know that happened, but you don’t have to run on to the worst possible thing that could happen,” especially in dealing with my husband. . . . I find she is wonderful for saying, “stop,” right, “just don’t do that to yourself.” So I find that helpful and it feels like a sisterhood with her.

Participants said that the act of reaching out to other women was instrumental to their coping.

Rose also said that support from other women was vital to her healing. She found like-minded women she felt safe enough to share her feelings with and spoke freely about her concerns with them:

I talk about it with friends who are in the same position as I am in terms of feeling depressed. I can talk to them and they understand things, that is, and share not just talk about it, which is good too, but to come up with some kind of solution.

Like Rose, Althea said that it was important to be able to talk to other women with whom she felt safe enough to share her struggles:
I kind of have intimate relationships with most of my friends in terms of talking and creating dialogue about how we are feeling and what we are going through. So we talk openly about depression and, you know, if someone needs to take medication or whatever, we talk openly about it, as opposed to how most of us grew up, where it was we could not talk about it, there is no space for that. And I think that is the best way.

Diane said that her bond with other women was critical to her well-being. She alleged that the support she received from her friends protected her from depression:

I find that my friends are like signposts . . . like speed bumps. They slow the process of depression, and just slowing that helps you to, oh look, I can grab onto this thing. If you are doing that mad slide down, that spiral you are going down so fast with your eyes closed that you cannot possibly help yourself get out, but I find my friends act as a speed bump, you know, talking to my friends slows down the process.

Friends became the participants' safe haven: they provided a space in which participants felt heard and supported. According to the participants, their friends were their lifeline. They were present during the bad times and helped participants process their feelings. Participants maintained that what they had with their friends provided them with substance and meaning in their lives. It fostered the coping skills they needed to move from depression to healing. Another kind of support for the participants came in the form of family members, who I turn to in the next section.
**Family: Unconditional Support**

Participants also spoke about the support they received from family members as an important coping tool. Asha said that if it had not been for her family members stepping in and helping her through her darkest days, she did not know what she would have done.

In 5 months, the only survival at that time was my family, especially my sisters, who became my aid. . . . That is my younger sister . . . she was calling every day, and I was not speaking to her because I didn’t have the energy and the will to have conversations on the phone. She decided to come and to stay with me and to cook and to talk to me and ask me that we can go for walks sometimes at night time, you know, what we went through and she understands. So she stayed with me. That was the major help that I got to get through.

Like Asha, Cher said that her family played an important role in her coping. For Cher, her mother was the person she could rely on and who provided her with unconditional support:

My mother was always a great listener. Great supporter for me, good at encouraging me and pushing me . . . telling me; “you go for what is good for you.” I think that really works for me.

Family was important to the participants. They spoke about how being close to their family members helped them cope. Sandra said that when she was feeling depressed, she tried to reach out for support from her family: “What helps me is time off from work to visit my family. That always seems to help me.” Participants reached out to their families for support, and some also reached out to the mental health community.
Finding the Right Psychotherapist

Participants found that making a connection with the right mental health professional helped them get through their various challenges. Nalya elaborated by saying she found it extremely helpful to be finally heard:

I have in the past spoken with a counsellor in regards to certain things I did not like in my life. It was helpful. I mean, she [therapist] was just there to listen and an impartial ear.

Nalya’s therapist was there to listen to her, not to judge her. This was an important coping strategy for participants who felt comfortable enough to reach out to the mental health profession. It was useful if they received comfort and found that their feelings were accepted without judgment. Participants needed a space where they felt understood and where they could express their feelings free from judgment. Sharon searched for a while to find a safe space. She finally found it:

There was one therapist that I saw after my separation, and she said to me... as I was pouring out my heart and everything, she looked over, and she had a bouquet of flowers over there, and she got up as I was just kind of talking and she got a scissors and she cut off a little flower and she handed it to me. And I looked at it and I said, “What is this for?” as I was bawling. She said, “You are going through mourning right now. You are mourning the loss of a dream, you are mourning the loss of your husband and everything you ever wanted.” And I get emotional just thinking about it. She acknowledged my sadness and that meant more to me than anything else, and I feel like in that moment I did more growing emotionally than I had with all the other years of counselling.

Althea also found a therapist she felt she was able to work well with. This therapist accepted Althea for who she was:
Eventually I have seen a therapist that I had in the U.S. She was really good. . . . She listened to me, and she had some spiritual practices as well, and that was great for me.

Participants revealed that they worked well with therapists who had the courage to witness and acknowledge their emotional pain. For the participants, it was extremely therapeutic to be heard. Therapy became a place where the participants could vent and express all their thoughts and feelings. Diane said that it was reassuring for her to have a safe space to voice her feelings. Just knowing that there was a place to go when things became overwhelming was critical to her coping:

I had the wonderful benefit of professional help. And now one of the things I do is I have a psychiatrist who I see about once a month, sometimes not so frequently, but even when I am not feeling depressed I am aware that my life right now is very stressful and I am not sure if it is kind of like having a tally man, if I think to myself, well, I have a shrink. If things get bad I can always go. Having that regular check-in I found to be wonderfully helpful. . . . So I keep my shrink on retainer.

For Diane it was beneficial just knowing that her therapist was there if she needed someone to listen. Participants claimed that they stopped silencing their emotions and began to speak their truths. They found therapists they felt comfortable with and were able to remove the façade of being emotionally strong. Many said that the most crucial element to the therapeutic process was their being heard. Participants felt that when they had a therapist who was brave enough to support them and to listen to them without judging or stereotyping them, this would eventually help them heal.
Building a Connection with Mother

This category refers to participants’ attempts to build a healthy relationship with their mothers in order to help them cope with their depression. Participants said that they found peace when they were able to improve their relationships with their mothers. For Althea, building a healthier relationship with her mother meant creating boundaries. Althea said that she informed her mother that her actions and behaviour affected her emotionally and that she would like her to stop doing the things that had a negative effect on her:

I just stand my ground and I say, you know what you are doing is making me feel this way, and I don’t want to feel this way. And I tell her [mother], you know, when we go through this thing, I just get depressed. I can’t get out of bed for 3 days. I just tell her how her behaviour affects me and how I internalize it. I say the whole thing and then it helps me because I get it out.

According to Althea, articulating to her mother how she felt helped them build a healthier relationship.

Because of their own experience with depression, participants said that they began to understand their mothers’ behaviour better. Participants came to understand that their mothers had learned to silence their own hurt. Lorraine said: “When I first met her, I said, oh, my Bitch, Bitch. But then over the years I realized that she was that way because of how she was brought up.” The concept of being emotionally strong in connection with their mothers had historical implications for some of the participants. This requirement to be strong at all costs was passed down from one generation to the next.

Participants tried to find ways in which they and their mothers could heal together from the depression that was afflicting them both. Janet stated that she needed her mother to heal from
depression in order for her to be fully healed herself. She spoke about needing to form a better relationship with her in order to cope. It was as if healing her mother’s wounds formed part of her own healing: “I want her to heal, but also in her healing, I am also healing. . . . hopefully, I heal, she heals.”

Participants felt that as they improved their coping strategies they were beginning to understand what their mothers were going through. They were able to connect with their mothers with understanding and compassion. Nalya explained that she could relate to her mother better after her own experience with depression. Now she believes that they have a healthier relationship:

Now we are better. I can go and I can say what I want now that I am older, nothing disrespectful, but I can speak my mind and let her know that sometimes she went overboard.

Some of the participants explained that they were now able to communicate with their mothers. They could verbalize their boundaries and create their own values to engage in a dialogue of compassion. Participants said that this also helped them form healthier relationships with their own children.

Coming to understand their mothers’ experience of depression helped participants forgive their mothers for the pain they felt growing up. Throughout the interviews the participants emphasized that intergenerational healing was the cornerstone of their own healing. Their relationships with their mothers were important to their healing. Healing with their mothers also meant preventing the transmission of depression to the next generation.
**Summary**

Participants shared the many ways in which they managed their depression. They described gaining personal strength by taking care of themselves: music helped with expressing their emotions, writing in their journals assisted them to articulate how they were feeling, and they took care of their bodies, spirits, and minds. They were aware of the oppression they faced as Black women in Canada. They believed that educating themselves about the history of their people and getting in touch with their ancestors was a way to help them build their resilience.

Participants also dealt with the stigma of depression and began to be honest with themselves and others. They were able to find support in their faith and spirituality, in their friends, family, and by seeing a psychotherapist. Participants' understanding that their depression came and went throughout their lives and that they needed general coping strategies in good times and bad helped them keep healthy in between episodes of depression and manage their depression when another episode of it began.
Chapter Six
Discussion

This chapter explores the main themes discussed in the results chapter: *Depression*, *Turning Point*, and *Coping*. Each of these themes is discussed in relation to the key points raised by the results. Previously published literature has been cited throughout this discussion chapter to develop the arguments and debates around the main themes. Finally, I explore the development of a theory of healing.

**Depression**

Depression for Black Canadian women is a very complex process, however, it mainly rests on individuals’ perception that they do not meet the expectations of Black womanhood. This is a race-gendered experience in which participants’ believed that Black womanhood is being a Strong Black Woman.

The data from this study corroborated the literature that suggests that the image of the mythical Strong Black Woman plays a significant role in Black Canadian women's experience of depression (Beaudoef-Lafontant, 2005, 2007, 2008; Edge & Rogers, 2005; Schreiber et al., 2000). For instance, Beaudoef-Lafontant (2005, 2007, 2008) argued that the image of the Strong Black Woman is a central social factor contributing to the emotional and psychological problems of Black women. As Ali et al. (2010) found in their study, Caribbean women living in Toronto, Canada, receive high praise for trying to “have it all” by raising a family and simultaneously pursuing a career. Being able to manage “it all” is characteristic of the Strong Black Woman. In the present study it appeared that this expectation that one be a Strong Black Woman was extremely present in the lives of the participants and affected their sense of self.
Participants’ low self-perception was based on their inability to meet the requirements of the myth, and this ultimately resulted in depression.

Another noteworthy finding from the data is that all 20 participants stated that the multiple oppressions of racism, sexism, and classism caused their depression. This is an interesting finding in contrast to Beagan et al.’s (2012) finding that racism is not linked to depression among African Canadian women. Part of the reason for their finding may have been participants’ taboo around talking about depression and hence not correlating their experiences of racism to feelings of depression. The current study may have been able to identify the connection because the study participants had already faced the stigma of depression by volunteering to be a part of a study that asked them to self-identify as an individual struggling with depression. Another reason could be that this study not only looked at the oppression caused by racism but at racism, sexism and classism as interlocking systems of oppression that the participants identified the reason for their symptoms of depression. This is supported by a number of studies that have found that the social context of women's lives is a primary reason for their depression (Brown et al., 2011; Edge, 2013; Etowa, Wiens, Bernard, & Clow, 2007; Kinyanda et al., 2011; Smith-McKeever et al., 2012). For example, Dawn Edge (2013) argued that the intersectional oppressed identities of Black British women put them at higher risk for prenatal depression. She said that:

Whilst biological models exist, it is generally agreed that the major risks for the onset of prenatal depression are predominantly psycho-social factors such as the material and social deprivation to which Black and minority women are disproportionately exposed. (p. 40)

The internal and external oppressions affecting Black Canadian women serve as powerful reinforcements of the status quo and limits them in their abilities to realize their true selves.
Participants in the current study clearly felt that their depression was connected to their living with the intersection of multiple oppressions as well as their subjective perception of Black womanhood.

The results of the present study also suggest that depression for Black Canadian women is linked to family conflict; this finding resembles those reported by Dennis, Basanez, and Farahmand (2010) based on their investigation of college students. They found a “strong correlation between intergenerational conflict and increased depression” (p. 126). Some of the participants in the current study claimed that not having their mothers present in their lives when they were young was a root cause of their depression. They described their mothers as angry, violent, and sometimes physically absent.

Black Canadian women look to their mothers for guidance and support, as this is the basis of female identity (Townsend, 2008). According to Miller and Parker (2009); “Black mothers play a vital role in teaching their daughters what it means to be Black and female” (p. 207). The mother-daughter relationship becomes complex and intense when it is navigated in the midst of a hostile environment of intersecting oppressions. This means that the education of a girl into Black womanhood includes equipping her with skills essential for navigating a society that devalues their very existence. Collins (2000) maintained that teaching daughters to resist racist oppression is a key maternal task.

The socialization of Black daughters by their mothers has been called “armouring” (Edmondson, Bell, & Nkomo, 1998). Black Canadian daughters are armoured based on their mothers’ view that in order to survive the multiple oppressions in Canadian society, one must become a Strong Black Woman. Hence, Black mothers raise their daughters to survive in an environment plagued with violence, neglect, and anger. Turnage’s (2004) research reminds us
that Black mothers want to protect their daughters from experiencing the same trauma they experienced by assisting their daughters to develop an armour of emotional strength. The process of socialization is vital: Black mothers are given the difficult task of preparing their daughters to fight against racism and sexism at the same time as they struggle with their own set of oppressions. As a result some Black mothers may become depleted as they struggle on two fronts: for themselves, and for their daughters. This became quite apparent in the interactions between participants in the current study and their mothers the participants described. The women reported feeling alienated by their mothers’ demonstrations of Strong Black Womanhood.

The parent-child bond has long been given significance in the psychology literature (Ainsworth, 1960; Bowlby, 1973; Brenning, Soenens, Braet, & Bosmans, 2012; Karen, 1994; Townsend, 2008). For example, Townsend (2008) stated that “the mother-daughter relationship is purported to be critical for the healthy self-esteem and psycho-social development of girls” (p. 431). Hendrika Freud (2011) concurred that the emotional development of girls is subject to the quality of their relationship with their mothers. She theorized that the connection between mother and daughter is a “symbiotic illusion” (p. 3). As Black Canadian women see themselves through their mothers’ eyes, the value they place on themselves is determined by both their mothers' sense of self and by how the mothers see their daughters. Hendrika Freud (2011) pointed out that what occurs between mothers and daughters is the reflection of each in the other:

Mother and daughter keep mirroring themselves in each other, as in the fairy tale of Snow White: Mirror, Mirror on the wall, who is the loveliest of them all? Involuntarily... a daughter remains inside her mother's range of influence and will continue to be a part of her mother, body and soul. Instead of her own desires, she must fulfill her mother's wishes. (p. 3)
In Black Canadian mother-daughter relationships, “mirror, mirror on the wall” leads to the question: “Who is the strongest of them all?”

Collins (2000, as cited in Miller & Parker, 2009, p. 210) explained that human ties, including mother-daughter relationships, can be freeing and empowering as well as simultaneously confining and oppressive. The same spaces where mothers function as beacons of support and strength can also be sites of oppression that keep daughters silenced. Hendrika Freud (2011) also described the mother-daughter relationship as complex: “For the woman, the inner bond with the mother can be a source both of strength and of frustration” (p. 3). The relationships Black Canadian daughters share with their mothers can turn into love-hate relationships. On one hand, daughters admire their mothers’ emotional strength; on the other hand, the “emotional strength” portrayed by mothers becomes a barrier to intimacy. As a result, daughters begin to yearn to be close to their mothers. This yearning by the child for the mother’s attention is what Klein (1959, as cited in Karen, 1994, pp. 43–44) theorized the phenomenon of the love-hate relationship between infants and their mothers, which she explained as the root of children’s depression. She referred to it as the “depressive position.”

This depressive position, which according to Klein (1935, as cited in Karen, 1994, pp. 43–44) can begin in early infancy and be activated later, especially during times of loss. For some people it forms a prominent part of their adult psychology. Infants come to know that the wonderfully good mother and the terrifying mother are, in fact, the same person. Mourning the loss of the perfect object now recognized as imperfect and, above all, separate, can prove a difficult task for the child (Klein, 1959, as cited in Rusbrider, 2012, p. 145).

In the current study, many of the participants reported that they felt their mothers were emotionally unavailable to them and mourned not being close to them. On the one hand, the
mother is the image of love, on the other; she is the object of hate. This relationship is further complicated for Black mothers and daughters by the pervasive intersecting racism, sexism, and classism in Western society.

Participants in the present study and in Bamacca-Colbert, Umana-Taylor, and Gayles’s (2012) research reported difficult relationships with their mothers. Many identified their mothers as the cause of their depression. Bamacca-Colbert et al. (2012) discovered a link between adolescents’ depressive symptoms and mother-daughter conflicts. “Not only did frequency of mother-daughter conflict predict depressive symptoms but the emotional support adolescents perceived from their mothers does as well” (p. 417). The present study confirms these findings.

The research findings also revealed that depression is silenced because of the stigma surrounding the condition. The stigma of depression was said to come from the participants themselves, from their mothers, and from the community. Participants in the current study spoke about how they were at first unaware that they suffered from depression and then later deliberately ignored their symptoms. They were also silenced by their own mothers’ silence on the subject of depression, and being told “to stop being sad.” This is reaffirmed by Woods-Giscombé (2010), who said that Black women “feel obligated to manifest strength and suppress their emotions” (p. 672). Depression is seen as a disgrace by some Black Canadian women. Participants described fearing that their depression meant disgracing not only themselves but also their families and ancestors. Miller and Parker (2009) stated “the legacies of slavery continue to have adverse effects on Black communities” (p. 209). This is particularly the case in the racist ideology that suggests Black women do not suffer from depression. Participants in the present study felt obligated to continue the fight against oppression by being Strong Black Women, much as their mothers and ancestors had done before them. The pain of disappointment at being
depressed was deep-rooted, because it made them feel that they were not doing their part in fighting oppression. Participants became overwhelmed by their sense of obligation to be emotionally strong and hence felt inadequate when they became depressed. They described feeling like an outcast from themselves, their families, and their communities.

To understand the participants’ reactions towards their own depression, one must be conscious that depression is seen in Canadian Black communities as a threat not only to the individual's well-being but also to the well-being of the family and the community. The cultural message that Black women should not be depressed is also illustrated in Schrieber et al.’s (2000) study of Black Caribbean Canadian women. The participants in that study also articulated the need to move quickly away from depression—or run the risk of exile.

According to Beagan et al. (2012), Black Canadian women believe they need to be strong all the time. There is no room for emotional weakness or illness; they are the pillars of their race, families, and communities. Hence, being depressed is shameful in the context of Black womanhood and, hence, in the Black community.

The data showed that the experience of depression forced participants to go into solitude. During this time participants reported having suicidal ideations. This mirrors Borum’s (2012) research in which participants expressed the view that depression for them was “so unpleasant that they would rather die than to feel hopeless and lonely” (p. 321). The humiliation of seeing oneself as depressed can bring thoughts of suicide for Black Canadian women. Participants in the present research described feeling so ashamed of their emotions that they wanted to hide from the public eye. This phenomenon echoes the findings of Schreiber et al.’s (2000) study, which revealed that depression is thought of as a private experience in which Black Caribbean
Canadian female participants took the precaution of isolating themselves in order to hide their pain from others.

Suicidal ideation occurred when participants in the current study isolated themselves from their community. Yet, the option of suicide was viewed as a source of control and power over their emotions. Even in the depths of the contemplation of suicide, the desire to be a Strong Black Woman remained present for the study participants. However, this moment of deep contemplation became a turning point at which the participants decided to not end their lives but instead to live.

**Turning Point**

A turning point that moved participants from a place of such deep depression that they were having suicidal thoughts to a place of coping occurred when participants became conscious of how their experience of depression affected others. Participants described an incident that triggered awareness, which brought on a time of reflection and led to a change in behaviour. The turning point was felt in the body, mind, and spirit. At one moment, participants paused, contemplated their lives, and took action.

Becoming conscious of the connection between emotions, thoughts, and behaviours can be described as a turning point. Usually something triggered a shift in awareness. With the new perspective, which arrived quite suddenly, their perspective on the world changed, and from that time onwards, nothing looked the same. It is what is commonly known as the “Aha” moment. Schreiber (1996) refers to this as “cluing in” (p. 484). For example, in the current study, Lorraine, one of the participants, explained that her turning point occurred when her son referred to her as “grandma” in the middle of one of their arguments. Lorraine said that she felt shivers
throughout her body; she stopped talking and became conscious that history was repeating itself. At that moment Lorraine became aware that she was treating her son the same way her mother had treated her: “It grounded me and I was able to think of an alternative approach to deal with the situation.” Lorraine's new perspective triggered a change in her behaviour towards her son. When an individual's awareness is shifted, he or she begins to see the world differently and takes action.

The data showed that the responsibility of being a mother was an important aspect of coming to a turning point. When Black Canadian women experience a moment of consciousness that leads to change, it includes their family members. Gilchrist and Camara (2012) also discovered a vital connection between the turning point and depression’s effect on family members in their research on Ghanaian and African American mothers: “Whatever you are going to do, you cannot do it without considering that baby” (p. 92). The responsibility of being a mother helps Black Canadian women come to a new awareness because of the Afrocentric notion that everything is connected (Borum, 2012). Black women do not see themselves as mere autonomous individuals, as indicated in Armour, Bradshaw, and Rosenborough’s (2009) study of African American people recovering from mental illness. Their participants did not view themselves as separate from their families. This concept of the family held true in the present study as well: Black Canadian women keep family, specifically their children, at the centre of their consciousness.

Another finding from the data was “I do not want to be like my mother;” this also motivated change for participants in the study. The fear of duplicating the negative behaviours they observed in their mothers and then the realization that they were inadvertently repeating these behaviours with their children brought on a shift in their way of seeing and doing things.
Many of the participants in the current study believed that their mothers were depressed. They came to this conclusion when they recognized that they were exhibiting patterns of behaviour that they had observed in the mothers. At this moment of awareness participants began to see that depression not only affected them but also the most vulnerable family members, their children. Saavedra-Rodriguez and Feig’s (2013) research supports the findings of this study that chronic stress can be transmitted across multiple generations. Similarly, Boyd, Diamond, and Ten Have (2011) found maternal depression has been associated with child maladjustment. They argue that “the severity of maternal depressive symptoms can lead to more current stressors and or parenting difficulties, thereby impacting the offspring’s internalizing and externalizing behaviour problem” (Boyd et al., 2011, pp. 603–604). Black Canadian women who are able to detach themselves in order to witness the interactions they have with their children can become conscious of parental behaviours that caused them pain in their own childhood. This will alert them to the extent to which their mothers' depression has “spread” to them, and as well as to how their depression can trickle down to their children.

Awareness triggers change, marking a pivotal point in Black Canadian women's emotional well-being. Katz, Hammen, and Brennan (2013) found a direct link between the depressive symptoms of youth and their mothers’ depression:

Indirect effect of maternal depression on youth depressive symptoms via mother–child relationship discord and youth romantic relationship quality provides further evidence for the negative psychosocial and psychopathological outcomes of children of depressed mothers and the intergenerational transmission of relational difficulties. (p. 86)

Canadian Black women are motivated to break the vicious cycle of depression being passed down from one generation to the next.
Black Canadian women's consciousness can promote self-empowerment, allowing them to take action and break the legacy of depression. The participants in this study demonstrated this intention by vowing not to repeat their mothers’ behaviour of silencing her children’s’ emotions. They were ready to change by acknowledging that they experienced depression through their bodies, spirits, and minds. This new consciousness can stop history from repeating itself. The turning point for Black Canadian women in this study came with the realization that it was up to them to address depression by acknowledging the hurt. Depression does not have to be passed down to the next generation; coping with depression is vital not only for Black Canadian women but also for their children.

Coping and Resilience

Black Canadian women cope with depression with numerous problem-focused and emotional-focused coping strategies (Lazarus & Folkman, 1987). There are several theories related to coping and resilience that are influenced by an Afrocentric worldview (Beagan et al., 2012; Borum, 2012; Greer, 2011; Sisley, Hutton, Goodbody, & Brown, 2011; Utsey, Bolden, Lanier, et al., 2007). Doornboos, Zandee, and DeGroot (2012) found that Black women manage reoccurring episodes of depression by actively fighting against the depression that threatens their everyday life. The data from the present study revealed a number of coping techniques, such as self-care, knowing one’s history, building on ancestral connections, and seeking support from friends. Similarly, Scottolon and Stoppard's (1999) research on Canadian women identified that they were proactive in addressing depression before it reoccurred.

In the current study, participants wanted their multiple coping techniques to serve not only them but also their mothers’ healing and their children’s protection. This was significant as coping was shaped by how it affected both those afflicted and others around them. This may be
explained by the participants’ ancestry: in that communal heritage, possibly embedded into their consciousness, what affects one affects the others. The contextual basis for Black Canadian women’s coping style is an Afrocentric worldview that is based on the harmony of mind, body, and spirit, alongside ancestral knowledge and communal survival. Hence Black Canadian women's coping is not just about the self but is placed in the context of family and community. Utsey, Bolden, Lanier, et al. (2007) have pointed out that coping for individuals of African descent is a communal act that is seen as helping every one.

Being informed about the history of their ancestors, and the latter’s survival of multiple oppressions, proved empowering for the participants in the present research. According to Some (1999), knowing their history is important for people of African descent: “In indigenous cultures, this is crucial to life, because to forget the way life used to be lived is to become endangered” (p. 124). Participants in the current study said that they found strength in the history of their ancestors. Similar findings occurred in Borum’s (2012) research, which discovered “the belief that one's ability to know thyself in the context of history, culture, heritage, community and struggles provides protection for African American women against suicide, depression and other mental health concerns” (p. 323). In this and other studies (for example, Borum, 2012; Schreiber et al., 2000) knowing the history of one’s people was found to contribute to the ability to cope. It was therapeutic for the participants in the current study to inform themselves about their history.

Spirituality was another form of coping used by the Black Canadian women in the study. A shift in perspective occurred when participants in the study saw their experience of depression as a spiritual one. This “celestial passage” was also articulated in Sisley et al.’s (2011) research in which they found that Black women's experience of depression was spoken of as a spiritual journey. Likewise in the current study, participants reported that depression has spiritual
significance. Depression drew them into solitude. In these private moments they were often able to hear the wisdom of their ancestors, which reassured them that they were not alone. They believed that this journey of depression was travelled before by their mothers and ancestors, therefore, they no longer felt so alone. Depression thus became a spiritual teacher, and coping the tool to assist in the understanding and acceptance of the various aspects of themselves. The notion that one can learn from depression was also reported in a Canadian study conducted by O’Mahoney, Donnelly, Bouchal, and Este (2013) with immigrant women who had postpartum depression. Their participants, “experiencing many negative emotions . . . found that a new sense of agency was created and they had more meaning and purpose in their life after struggling with PPD (postpartum depression)” (O’Mahoney et al., 2013, pp. 309–310). Recovering from depression can give meaning to life.

Getting close to the various emotions associated with depression, Black Canadian women come to understand why they are depressed and how the affliction can be used as a tool to assist them in their lives. This form of spirituality provided meaning for their suffering. Beagan et al. (2012) explained that spirituality for Black Canadian women offers personal meaning making that “restores confidence, self-esteem and sense of self-worth” (p. 117). As participants in the current study reported, their depression informed them if they were in the right place in their lives at that moment or if a change needed to occur. In Sisley et al. (2011), the participants reacted likewise: “Emotional struggles were framed as personal journeys or battles” (p. 397). Coping with depression can be a spiritual experience.

It is important to note that Black Canadian women’s connection to the ancestors is also spoken of in spiritual terms. Ancestors are regarded as one of the closest links individuals have to the spirit world (Waldron, 2012). Beagan et al. (2012) stated that, “the sense of spiritual
community that Black women described was not limited to those who were still living. Some had a clear understanding that ancestors provided spiritual support” (p. 114). Participants in the present research also described a belief that their ancestors are spirit helpers assisting them through this life. Participants believed that the spirits of their ancestors were with them, encouraging them through their various challenges.

Western scholarship describes the notion that one’s ancestors influence one’s well-being as epigenetic (Heim & Binder, 2012). This is the view that individuals inherit the effects the environment had on their ancestors; theorizing that the lives of ones’ parents and grandparents can directly manifest in an individual’s well-being today. African traditions have been aware of such ancestral influence for centuries (Mbiti, 1970). For instance, the ancestral spirits are of fundamental significance for the South African Zulu people. They acknowledge that: “Although the ancestors are regarded as having gone to abide in the earth, they continue to have a relationship with those still living” (Lawson, 1984, pp. 24–25). As with the Zulu people, this is also the lived reality of the participants in this study. Participants referred several times to the history of their people and how it contributed to their depression, but also to their coping strategies. Ancestral awareness occupies an important place in many Black peoples' lives, and this knowledge is essential to understanding Black Canadian women's experience of depression and coping.

Interestingly, both in the current study and in Schreiber et al.’s (2000) research, participants struggled with depression, yet they also claimed to be “inherently resilient.” Their resilience was said to come from their ancestors, and allowed them to manage their depression. This is a common phenomenon in many other studies of people of African descent (see Edge & Rogers, 2005; Schreiber et al., 2000). For Black Canadian women, the history of their people
surviving the transatlantic slave trade attests to the notion of “the survival of the fittest.” One of the study participants, Nalya, declared, “I am resilient because of my ancestors’ strength that has been passed down from generations to generations.” The notion of culturally inherited resilience provides Black Canadian women with some solace during the depths of depression. They find strength and courage in knowing they come from a lineage of strong and courageous people.

Black Canadian women are able to cope when they create their own definition of a strong Black woman with support of their ancestral knowledge. Thomas et al. (2011) reported that their African American female participants claimed to possess an inner strength that they had inherited from their ancestors, a strength they believed is found particularly in women with African roots.

Glass (2012), however, reported that women of African descent who outwardly pride themselves on their ability to manage it all have a tendency express their distress openly and seek support:

An interesting factor emerged in exploring the benefits of a resilient self and how this self-perception might at times interfere with the ability to express vulnerability and to seek and accept support from others. (p. 102)

Black women manage to face oppression by portraying the image of the Strong Black Woman (Edge & Rogers., 2005; Schreiber et al., 2000; Thomas et al., 2011), yet at the same time they suffer emotionally because they are hiding behind the mask of strength (Beauboeuf-Lafontant, 2005, 2007, 2008; Edge, 2013; Woods-Giscombé, 2010). This indicates that the effects of the image of the Strong Black Woman in Black Canadian women's lives are complex. In the words of Woods-Giscombé (2010), the myth aids with the “preservation of self and family and
community, but at the same time it is a liability which contributes to relationship strain, stress-related health behaviours and stress embodiment” (p. 680).

Schreiber et al. (2000) found that Black women first questioned the old definition of the Strong Black Woman and then developed new approaches by changing their behaviours in order to find healing. This required taking the risk of challenging the common notion of Black female strength. Black Canadian women who deconstruct the image of the Strong Black Woman begin to speak their truth, challenging the concept of what it means to be a Black woman and constructing their own definitions of strength. Thomas et al.’s (2011) study of young African American women found that in order to discover their own ontological selves and happiness, they challenged the common perception of what it means to be “strong.”

Addressing the stigma of depression is also a way of coping. Participants confronted the stigma by connecting with close friends and family members with whom they could openly talk about their depression. Schreiber (2000) stated that we must recognize “that social stigma may prevent a woman from talking directly about her pain of depression” (p. 41). Therefore, it is extremely powerful when Black Canadian women can find a support network that allows them to express their depression openly. Engaging in an open, safe dialogue about mental health challenges can be a significant first step in the healing process.

However, one interesting point is that only one participant in the this study candidly that she used antidepressants as a form of coping. This was also the case in Scottolon and Stoppard's (1999) research, which found that Canadian women living in rural New Brunswick discovered that they were able to manage their depression without the assistance of antidepressants. This may have been the finding in the current study because the participants were self-diagnosed as
having depression, rather than having received the diagnosis from a mental health professional, so for many of them medication for coping would not have been an option.

Another coping mechanism that arose from the research was the implication of mothers in participants’ healing. Many spoke about healing that included building a connection with their mothers. By having compassion for and an understanding of their mothers’ plight, Black Canadian women are able to form a connection with their mothers that enables them to heal their own pain. Hendrika Freud (2011) advised that daughters must break free from their mothers’ gazes to create their own sense of self yet rely on their mothers as well: “A girl needs to be able to shape her own identity but, at the same time, continues to need her mother throughout her life as model and counsellor” (p. 3). Black Canadian mothers’ roles in their daughters’ lives is significant as they are the cornerstones of the younger generation’s emotional well-being. As Turnage (2004) stated, a mother’s acceptance allows the Black daughter to accept herself and provides a platform for the daughter to expand her definition of herself. Supportive relationships with their mothers equip Black daughters with the skills needed to develop positive images of themselves as Black women. As Miller & Parker (2009) suggest mothers become the “refuelling stations” (Turnage, 2004, p. 160) that allow daughters to continue to develop their own sense of self.

**A Model of Healing for Black Canadian Women**

The healing model for Black Canadian women uses the theoretical framework of the interconnectedness of healing from depression of Black Canadian women and its complex layers. Isolating the themes of the Strong Black Woman, mother-daughter relationships, and transgenerational trauma/resilience transmission around the circular relationship between depression and coping illustrates the complex influences all these themes have in the lives of
Black women dealing with depression. Recognizing that the road to healing involves understanding these three themes, as well as the concepts of community engagement and self-definition, allows Black Canadian women to move from depression to a place of healing (see Figure 19).

**Figure 19. Healing Model for Black Canadian women.**

The model illustrates that the image of the Strong Black Woman is prominent in Black Canadian women's schema of self. This mythical icon is implanted in Black females' consciousness at a very early age as they witness their mothers and grandmothers striving to live
up to its standards. Black women deal with oppression by portraying the image of the Strong Black Woman, but at the same time they suffer emotionally from hiding behind that mask of strength. This indicates that the image of the Strong Black Woman has a multifaceted effect in Black Canadian women's lives. The healing paradigm reveals that Black Canadian women do not necessarily need to take on the characteristics traditionally associated with this historical icon such as suppressing emotions and neglecting oneself to be considered a Strong Black Woman. By redefining the Strong Black Woman role and making it one’s own, one begins to construct an ontological sense of “strength.” Developing an alternative understanding of “strength,” Black Canadian women are able to move to a place of healing. Strength redefined includes the courage to fight against the stereotype of the Strong Black Woman and begin to attend to one’s feelings and care for one’s body, spirit, and mind.

The second theme the diagram depicts is the mother-daughter relationship. Black mothers are responsible for preparing their daughters for Black womanhood which includes preparing them to face multiple and intersecting oppressions such as racism and sexism in a society that attempts to exclude them. This is why mothers instil in their daughters that they need to be Strong Black Women. Black Canadian mothers thus pass down messages of self-reliance, stoicism, and selflessness to their daughters—with all the good and bad effects that come with them. The task for Black daughters is to meet their mothers' expectations by becoming self-reliant, stoic, and selfless, an image the mothers themselves represent. This influences Black Canadian women's perception of their world and their ways of being. This can also result in a fragile relationship between Black mothers and Black daughters. As Black mothers, who are surrounded by multiple forms of discrimination in their own lives and their own emotional needs are unmet, will sometimes neglect the emotional needs of their daughters, leaving the latter
yearning for their mothers' attention. Black Canadian women's process of moving from depression to coping includes dealing with the relationship they have with their mothers and finding a way to form a relationship with themselves outside of their mothers’ gaze. When Black Canadian women are able to develop their own autonomous selves alongside of their relationships with their mothers they are able to begin healing from depression.

The third theme is transgenerational trauma/resilience transmission. Black Canadian women do not experience depression and coping in isolation. Black Canadian women's depression does not only include their own personal pain but mirrors the difficulties of their mothers, the anxiety of the anticipated struggles of their children, and the sorrow for the persecution endured by their ancestors. Hence, healing is rooted in Black Canadian women's compassion for their mothers' pain, the well-being of their offspring, and the inherited resilience of their ancestors. When Black Canadian women model healthy coping traits this can be passed on to the next generation and it can also be taken up by the past generation as a new way of approaching challenges. Black Canadian women thus have the power to change the course of their families' histories. The journey from depression to healing comes full circle for Black Canadian women when it includes the acknowledgment of and interaction with close kin present and past.

Community engagement also plays a critical role in Black Canadian women's healing. Community is a central component of Black women's mental well-being. Black Canadian women understand themselves in relationship to members of their community. The support and engagement Black Canadian women have within their community helps to restore their health and create an environment of healing.
For Black Canadian women, an individual’s well-being is often rooted in the group’s experience of healing. Underlying such a sentiment is the notion that whatever happens to the individual also happens to the whole; likewise, what happens to the whole also happens to the individual. When healing takes place in the community it touches the individual in a profound way.

Healing is a collective process that includes family, friends, community, and institutional systems in addressing the determinants of health such as, but not limited to, race, gender, and socioeconomics. Addressing racism, sexism, and classism in the society not only contributes to the restoration and balance of a community, it also restores the health of the individual. The connection between the whole and the individual leads us to the fourth point of the healing model, self-definition healing.

Black women have a distinctive definition of self. The self for Black Canadian women is situated in the group, so self-definition is understood in relation to the community. This does not suggest that Black Canadian women must succumb to the expectations of the community but rather that they accept themselves as individuals who are part of a community. They have a vital role to play in being themselves in the context of relations with others. Therefore Black Canadian women's experience of depression and coping allows for the discovery of personal, authentic inner strength within the context of a community. When Black Canadian women begin to challenge the expectations placed on them and become their true selves within their community, they begin to move to a place of healing.

Black Canadian women's self-definition draws on their sense of knowing themselves as individuals in the context of their relationship to their mothers, their children, and their ancestors. Hence the process of self-definition occurs both within and outside the boundaries of the
community. Black Canadian women cannot heal in isolation. Healing occurs both in the self and with the family and community.

Black Canadian women understand that their healing is not theirs alone but requires the inherited resilience from their mothers and ancestors. This recognition gives Black Canadian women a deep awareness of the healing process. When Black Canadian women heal themselves, they are also healing their mothers' pain, protecting their children, and giving respect to their ancestors' plight. As such, their healing has transformative power; it can change the course of their family’s and community’s histories. Eventually, thus, “I am, because we are,” and “we are, because I am” becomes possible.
Chapter Seven
Conclusion

This research is critical for understanding Black Canadian women who struggle with depression and their journeys from depression to coping and healing. By adopting a constructivist grounded theory approach and an intersectionality framework the study offered participates an opportunity to have their experience of living with depression witnessed and documented. Twenty Black women shared their personal accounts of depression at the intersection of race, gender, and socioeconomic status. This research differed from many previous studies of depression; rather than looking at the condition from within the mainstream frame of reference for depression, it explored the women’s experiences in an organic manner, identifying the unique challenges of being a Black Canadian woman in multicultural Toronto dealing with depression and coping experiences. In this way, this research endeavour affirms that Black Canadian women have a unique experience of depression. Furthermore, this study highlighted that depression and healing for Black Canadian women not only involves the individual but also transcends onto their ancestors, immediate family, and future generations.

The findings of the study are extremely relevant for mental health practitioners that work with Black Canadian women and for researchers in the area of depression and multicultural counselling. As the analysis of the data and the discussion of the results conveys, the three emergent core themes, the mythical image of the Strong Black Woman, mother-daughter relationships, and transgenerational trauma and resilience transmission, are the foundation for a theory of healing that incorporates community engagement and a self-definition of healing that incorporates an in-depth understanding of a healing-from-depression schema for Black Canadian women.
I now discuss the implications, strengths, and limitations of the study, and make some suggestions for future research.

**Implications for Mental Health Practitioners**

It has been estimated that 776,500 Canadian men and 1,329,381 Canadian women have been diagnosed by a health professional as having a mood disorder such as depression (Statistics Canada, 2013b). In a country with a diverse population, Black Canadians represent the third largest minority group in Canada (Statistics Canada, 2013a). Studies have shown a link between social factors such as race, gender, and low socioeconomic status and depression. Mental health professionals are likely to encounter Black Canadian women in their practice. The findings of this study can create awareness in the field of mental health that Black Canadian women have particular needs when struggling with depression. Interventions employed must meet these specific needs. The model of healing developed in this research addresses the health and mental health needs of Black women clients.

Drawing on the DSM-IV definition of depression and the view of depression in Black women found in the psychological literature (Beauboeuf-Lafontant, 2005, 2007; Jones & Shorter-Gooden, 2003; West et al., 2010), I have suggested that depression manifests in a specific way in Black Canadian women. Research on Black women's depression has extended the meaning of depression by including Black women's narratives of how it manifests itself physically, spiritually, and emotionally in their lives. Hence, familiarity with Black Canadian women's narratives of depression can help practitioners to identify the pathology and design an appropriate intervention. As revealed in the results chapter, several participants did not use the term *depression* in their descriptions of their distress; instead, they used somatic and spiritual descriptions of what was occurring in them. This is critical when mental health practitioners are
probing and listening for symptomatology. The disorder can be missed if mental health practitioners are not aware of the cultural interpretations of the experience of depression. It is important for therapists to be aware of how their clients communicate their mental health challenges to make a proper assessment.

The results of the current study indicate that participants were initially unaware of their depression. Yet when they understood that they were experiencing depression, they went through a stage of trying to understand how their depression worked. Participants said that they came to understand the chronic nature of their depression and sought ways not to be rid of it but to slow down the process when the next wave of depression occurred. Mental health practitioners can encourage practical preventative approaches to assist clients to gain control over their mental health. This can include healthy eating, daily physical activity to build endorphins in the body, and spiritual and/or religious practices.

Practitioners can also educate clients about the chronic nature of depression and provide them with resources, help them build on their social supports, and identify ways to develop a social network. Building community can be used as to combat depression among Black Canadian women. Mental health practitioners can help to create support groups that specifically meet the needs of Black Canadian women. Gathering like-minded individuals who are willing to speak openly about their depression and the ways they cope can help break the isolation and allow Black Canadian women to become authentic in their process of self-love; this is extremely therapeutic and can help prevent an episode of depression.

Another form of building authentic community is brainstorming with clients to identify individuals who have been supportive. Utilizing clients’ resources such identifying caring family
members, ancestors, friends, community, and spiritual leaders can help clients cope with their depressive episodes.

The healing-from-depression schema for Black Canadian women provides an important way of conceptualizing Black Canadian women's experience of depression and coping. Black Canadian women face the particular challenge of being Black and female in Canada. The model recognizes that it is important for therapists to consider Black Canadian women's multiple and intersecting identities, identities that have been historically oppressed in Canadian society and which thus contribute to the women’s unique hardships. In addition, therapists need to consider the range of adversities the women confront, such as racism, sexism, and classism. It is critical when working with Black Canadian women to have an understanding of their history of oppression; this was found in the study to be a critical factor in how the participants constructed their knowledge of themselves and the world around them. The traumas of racism, sexism, and classism have captured their consciousness as a people. To ignore intersecting oppressions in Black Canadian women's lives is to ignore the reality of the Black Canadian female client. This has serious implications, as ignorance of the clients' ancestral history effectively silences the client.

It is also helpful for Black Canadian women to know their history. This helps them to be proud of who they are as women of African descent, that is descendants of a culture and heritage that has been in existence since long before the transatlantic slave trade. Encouraging women to learn more and practice the their indigenous heritage can help build pride and authentic self-love. For Black Canadian women to know their true self they need to go back to the source, to connect with their rich African culture, to learn to accept who they are as they are. Moving away from
our indigenous sense of being can trigger depression, hence getting close to their African culture creates healing.

The model of healing identifies the mythical icon of the Strong Black Woman as playing a significant role Black Canadian women’s lives. Practitioners need to address how this image may be influential in their clients’ core beliefs. Characteristics commonly associated with this icon are suppressing emotions and sacrificing oneself for others needs may be playing out in the therapeutic process. For instance, the Black female client may be accommodating the therapist’s needs over her own by concealing painful information in the belief that she must not overburden the therapist. As well, practitioners must mindful that they do not reproduce the stereotype of the Strong Black Woman by focusing solely on the client’s resilience and not allowing space for the woman to express her feelings of shame, loss, and sadness.

Practitioners need to understand that emotional strength for Black Canadian women can be simultaneously hurtful and helpful. Therefore they must proceed with caution in deconstructing the image of the Strong Black Woman because it has provided protection from intersecting oppressions for generations. Clients may resist questioning the role of this historical icon. Before exploring this area, the therapeutic alliance should, therefore, be well established. Black Canadian female clients need to feel safe enough to unmask and expose their vulnerability in front of the mental health professional. Once the therapeutic alliance has been well established, clinicians can assess what it means for the client to be a Strong Black Woman and explore alternative ways for her to define herself.

While we need to acknowledge the individual client, the healing model requires that mental health practitioners are aware that Black Canadian women present in a relational context referring to others in their exploration of psychological well-being. This was a significant finding
of the study. For instance, the mother-daughter relationship constitutes an area of fruitful inquiry. Exploring the relationship the clients have with their mothers may provide the necessary understanding of how they have come to know themselves.

Healing the relationship Black Canadian women have with their mothers might become important in the therapy. Even if clients cannot have a joint session with their mothers, discussion around their relationship with their mothers can still prove beneficial. A therapeutic intervention that may be helpful is the Gestalt exercise of the empty chair, which offers clients an opportunity to speak with their mothers and explore their feelings. This may bring closure as some clients gain an understanding of and compassion for their mother's position while also understanding and having compassion for their own emotional pain.

Another key finding was the transgenerational trauma/resilience process which participants in the present research found had affected their mental health. Working with ancestors in a therapeutic setting can be very helpful for Black Canadian women. Therapists can make room for clients to speak about their beloved dead relatives and about how they provided love and comfort. Creating rituals for honouring ancestors can also prove therapeutic to Black Canadian women.

The healing-from-depression schema reminds clinicians that Black Canadian women's healing is community based. Black Canadian female clients are motivated to change when they can see that it will not only benefit them but also their families and communities. Therapists can encourage clients to address their needs by framing this as an unselfish act that transcends their individual lives and affects their loved ones and their community.
Last and most important, healing occurs not only in the therapist’s office but in concert with other professionals. Taking a holistic approach to treating depression is consistent with how Black Canadian women experience depression. Working with other professionals to build a team of care can be beneficial to clients. For instance working in unison with registered dieticians to help establish a healthy diet and food security, with spiritual and religious leaders to provide meaning to their experiences, sociologists to identify the cultural interpretation clients’ symptoms of depression, social workers to provide crisis intervention and mobilize support, and nurses to assist in the management of care that involves monitoring and active follow-up. Hence, healing of depression is not done in isolation; it takes a community of professionals to heal Black Canadian women’s depression.

Strengths

Incorporating a constructivist grounded theory methodology and intersectionality theory created a comprehensive exploration of Black Canadian women’s coping with depression. The constructivist grounded theory methodology supported a participatory form of knowledge construction based on participants' narratives of their lived experiences. Furthermore, an intersectionality approach to understanding Black Canadian women's mental health allowed for a full, in-depth understanding of the subjective experiences of what it means to be Black, female, of a particular socioeconomic status and depressed. The use of these methodologies uncovered a paradigm shift in the area of depression and healing research: that the experience of depression and coping is influenced by an individual's multiple intersecting identities.

This study broadens our understanding of depression and coping by recognizing the unique experiences of Black Canadian women struggling with depression at the intersection of multiple identities. By applying the approach of intersectionality, the study provided an
opportunity for Black Canadian women's wisdom to be acknowledged and included in the academic scholarship on depression.

The literature on Black Canadian women's depression usually focuses on a single dimension of their identity: blackness, or femaleness or socioeconomic status. On the contrary, this study reveals that by acknowledging the full range of Black Canadian women's intersecting identities, depression shows to manifests itself in a particular way in Black Canadian women's lives. Moreover, having identified the specific factors that make Black Canadian women’s experiences unique, this study has uncovered the facilitators of healing specific to them.

The current study provides a paradigm shift in the psychological thinking about healing. Healing does not occur in isolation. This study broadens the multiple aspects of healing by highlighting that the contexts of self-healing and community healing are intertwined. This research adds to the scholarship that Black Canadian women understand healing as moving beyond the individual. When Black Canadian women heal the self, they heal their community, and when the community heals, Black Canadian women heal. This notion allows for innovative psychotherapeutic interventions to assist Black Canadian female clients in their healing journey.

Limitations

The study had a few limitations that must be taken into account. First, the study selected Black women who self-diagnosed with depression. The range of depression and/or stress among the participants may have been wide and/or discontinuous. The study participants may have varied in the degree and intensity of their depressive symptoms. Consequently, the selection criteria used limited the precision with which depression was defined in the study. In addition,
participants relied on memory and reflected from their current standpoint, which may have influenced their perceptions of their depression and their healing.

Second, the study participants were women who were interested in discussing depression, which may have resulted in a biased sample. Furthermore, researcher subjectivity also limits the generalizability of the findings. The use of a constructivist grounded theory approach involves interpretation from the researcher’s starting point of Black women’s healing.

Third, it was beyond the scope of this study to further investigate the personal relationships between mothers and daughters, so only the participants’ perspectives on their relationships with their mothers were available. Participants’ diagnoses of their mothers’ depression were subjective, and mothers’ own perspectives on their mental well-being were not included. Because participants did not have the qualifications or training to formally diagnose their mothers with a mental health illness, their conclusions about their mothers’ mental health were based on speculation. Given that the participants identified their mothers as playing a significant role in their experience of depression, their turning point, and their coping, it would be fruitful to investigate their mothers’ accounts of depression and coping in future research.

Fourth, while intersectionality theory takes into consideration the whole individual with all her multiple identities, this study restricted itself to race, gender, and socioeconomic status. A more in-depth, inclusive analysis is warranted, that is, one that also takes into consideration identities such as sexual orientation, religion/spirituality, age, and (dis)ability.

**Future Research**

The present study develops a healing-from-depression model for Black Canadian women within an understanding of Black Canadian women’s intersectional identities. Although the
model provides a preliminary understanding of how Black Canadian women heal from depression and the kinds of coping strategies they use, these processes need to be more fully explored. Such an exploration could include and investigation into contextual factors such as the mother-daughter relationship and intersecting oppressions passed down through the generations that may affect the healing process. Future research could focus on increasing our knowledge of parent-child dynamics and on how intersections of oppression have played a role in each of the involved persons’ lives.

In light of the profound effect transgenerational trauma/resilience transmission has on individuals’ well-being, future research could examine the relationship between grandparent, parent, and child. A replication of the current findings using other forms of data collection and analysis (e.g., both qualitative and quantitative measures) across different populations, such as Black Canadian men and their fathers, would be beneficial. It is important to consider the role of mothers more closely as well as in the journey of depression to coping, as well as the role of fathers in women’s mental well-being. Given that Black men are an under-researched population, although they are negatively overrepresented in the media and in the criminal justice system, it is critical for research on and with Black men to look at all aspects of their lived experiences.

The present study required participants to self-diagnose with depression. Future research could look at individuals who have been clinically diagnosed by a health care professional to see if their experiences of depression and coping are consistent with the findings of the current study with respect to mythical icon of the Strong Black Woman, the mother-daughter relationship and transgenerational trauma/resilience transmission as well as the conclusion that self-definition and community engagement are healing agents for Black Canadian women.
References


Appendix A
Interview Questions

Below is a sample of the question I will be asking in the interview. These questions will only be used when participants require clarification. I will not be necessarily following this script. The interview is designed to be semi-structured so it can go wherever the conversation takes us, and the comfort in discussing their experiences.

Semi-structured Interview Questions:

Interviewer: I am interviewing Black women living in Toronto and exploring their ideas about depression and resilience. During the following questions I will ask you about your experience of depression and how you cope. The interview will be divided into three themes: depression, coping and how the mental health field could assist Black women through the healing process. Do you have any questions? Is it okay if we begin?

Section One: Depression

1. What do you feel happens when one gets depressed?

   Probing questions:
   
   What are your thoughts regarding depression?

   How do you define depression?

   How do you think it occurs?

2. What do you feel led to your psychological distress and why were you depressed?

   Probing questions:

   Why do you feel you got depressed at this time in your life?

   What was happening for you to believe that you were depressed?

3. What is your experience of depression?

   Probing questions: When do you get depressed?

   What gets you depressed?
What are the causes of your depression?

4. How has your psychological distress informed you about yourself?

Probing questions:
- What do you know now about yourself since you have experienced depression?

5. How does your social location such as gender, race class, ability and sexuality and nationality contribute to your depression and your coping?

Section Two: Coping

1. What do you do to cope?

Probing questions: What actions do you take?
- How do you cope with life, work and family?

2. What do you do when you are faced with challenges in your life?

Probing questions: Do you rely on family members or friends?
- Do you rely on religious beliefs or your culture?

3. What do you think helps you feel positive towards life?

Probing questions: Is there something that you believe that helps you feel good about life?

Section Three: The Mental Health Field

1. How can the field of mental health help Black women, who are struggling with depression, feel a sense of wellbeing?

Probing question: What would you tell a counselor to do when working with Black women who are suffering from depression.

2. Is there anything you would like to add to this discussion?

Thank you for your time.
Appendix B
Recruitment Poster

Black Women & Depression

Are you a Black woman interested in talking about your experience of depression in your life?

Would you like to participate in a University of Toronto doctoral study on Black women’s depression?

Participation involves a one time interview.

Criteria:
Black woman between the ages 18-65
Self diagnosis as having depression or has experienced depression in the past.

Contact:
Deone Curling Ed.D., candidate
Phone: 416-317-8573
Email: dcurling@oise.utoronto.ca

All information will remain confidential
Appendix C
Letter of Intention

As part of my doctoral thesis in Counselling Psychology at the Ontario Institute for Studies in Education of the University of Toronto I am conducting a study to understand the interconnection of the characteristics of depression and resilience among Black Canadian women living in Toronto. I would like to develop a theory that will be added to the research on Black Canadian women's psychology so that professionals in the field of mental health can work in a more culturally sensitive way with Black Canadian women.

I plan to speak with twenty Black Canadian women who are currently residing in Toronto and who believe they have depression or have experienced depression in their lives. Through semi-structured interviews the research hopes to gather information on how Black women think about their experience with depression and their resilience. The interview will last about two hours (15 minutes preparing for the interview, 90 minutes for in the interview and 15 minutes for you to ask questions about the process you have just been through). The interview will be conducted by me at the Ontario Institute for Studies in Education of the University of Toronto, or at a mutually convenient time and place to be decided by both of us.

Your personal details and information will be kept confidential with complete anonymity. Your name and all other personal details which may identify you (even remotely identify you) will not be used either in discussions and seminars, or in any written form the research may take. The data collected in the course of this research may be used for publication in journals or books, and/or for public presentations, but your identity (as mentioned earlier) will absolutely not be revealed. The data will be retained for a period of seven years by myself and will be kept in a secure location; it will be accessible only to me, my supervisor Dr. Roy Moodley and thesis committee members: Dr. Njoki Nathani Wango and Dr. Charmaine Williams. The tape recordings will be erased within a month of the transcripts being done.

It is hoped that you will feel engaged in a confidential discussion around your mental well being and the opportunity to explore areas of coping. However, it is important to be aware that there is potential of emotional risk involved in your participation in this research. Discussions exploring issues around depression may be distressing for some participants. If this occurs the interview can be stopped or slowed down at your discretion to support you through this process. I will also be available to speak to you during and after the interview and will provide a resource list of distress centres, therapists and/or social service agencies for added support. It is also important to be aware that your participation in this research is completely voluntary, and you may refuse to participate or withdraw from the study at any time without negative consequences. You are also free to answer some questions and not others.

If you would like a copy of the results of this research when it is available, I would be very happy to offer it to you. If so, please fill in your name and mailing or email address on the next sheet. You can contact me at 416-317-8573 or email me at dcurling@oise.utoronto.ca you can also contact my supervisor Dr. Roy Moodley at 416-978-0721. As well if you have any questions regarding your rights as a participant you can contact the Ethic Review Office at ethicsreview@utoronto.ca or 416-946-3273.

Thank you for your consideration in this project,

Deone Curling
Doctoral candidate
Counselling Psychology
Appendix D

Letter to Potential Participants

Dear Potential Participant,

Re: Research project: Black Canadian Women's Resilience in the Midst of Depression.

Hello, my name is Deone Curling and I am a doctoral candidate in the Department of Adult Education and Counselling Psychology at the Ontario Institute for Studies in Education of the University of Toronto (OISE/UT). As part of my doctoral thesis I am conducting a study to understand the relationship between the characteristics of depression and resilience among Black Canadian women living in Toronto. I would like to develop theory that will be added to the research on Black Canadian women's psychology and then produce some ideas and theories to counsellors so that they can work in a more culturally sensitive way with Black Canadian women.

If you are a Black women living in Toronto who have self diagnosis as experiencing depression presently or in the past, between the ages of 18 and 65 and would like to share your experiences with depression, and your thoughts on resilience to create a culturally appropriate counselling model to assist counsellors in helping Black women cope with depression please contact me at 416-317-8573 or email me at dcurling@oise.utoronto.ca. I would be happy to arrange a suitable time and space for us to meet to discuss the research, and answer any questions you may have.

If you are interested in being interviewed as part of the study your personal details and information will be kept confidential with complete anonymity.

Your thoughts and ideas will be insurmountable to the enrichment of the field of Black Canadian women's mental health practices and I look forward to hearing from you.

Sincerely,

Deone Curling

Doctoral candidate in counseling psychology
Appendix E
Consent Form

Consent Form
Research Study
Black Canadian Women’s Resilience in the Midst of Depression

1. Please read this form very carefully.
2. If there is anything you do not understand about the information sheet or you wish to ask any questions please speak to the researcher.
3. Please check that all the information on the form is correct. If it is and you understand the explanation then sign the form below.

YES I have been given written explanation of the study by the researcher, including full details of any potential psychological risks, my rights (patients, human rights, and cultural rights) and what is to be done to me. I have been given the opportunity to ask questions.

YES I have had enough time to think about the study, talk to my therapist/counselor, and/or relatives and friends about it (if I wish) and to decide without pressure if I want to take part.

YES I understand the decision is up to me and that I can change my mind at anytime, and withdraw from the study.

YES I understand that I am free to answer some questions and not others.

YES I have been assured that all information collected in the study, will be held in confidence and if presented (in a conference, journal, and clinical meetings) my personal details will be removed.

YES I agree that the researcher may withdraw me from the study should I experience any “psychological distress” in the study.

YES, I read the attached consent letter and I agree to participate in this study.

YES a copy of the consent form has been given to me.

Signed..............................................................

Date.................................................................
## Appendix F

### Demographics of Participants

<table>
<thead>
<tr>
<th>Participants Pseudonym name</th>
<th>Origin of nationality</th>
<th>Length of time in Canada (At the time of the interview)</th>
<th>Socioeconomic status</th>
<th>Age range (At the time of the interview)</th>
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<tbody>
<tr>
<td>Njeri</td>
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<td>lower socioeconomic status</td>
<td>20-25</td>
</tr>
<tr>
<td>Diane</td>
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<td>lower socioeconomic class</td>
<td>30-35</td>
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<td>Althea</td>
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<td>middle socioeconomic status</td>
<td>45-50</td>
</tr>
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<td>40-45</td>
</tr>
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<td>Geraldine</td>
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<td>30-35</td>
</tr>
<tr>
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<td>30-35</td>
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<tr>
<td>Cher</td>
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<td>40-45</td>
</tr>
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<td>Canadian</td>
<td>born in Canada</td>
<td>lower socioeconomic status</td>
<td>30-35</td>
</tr>
<tr>
<td>Participants Pseudonym name</td>
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<td>Length of time in Canada (At the time of the interview)</td>
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</tr>
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<td>40-45</td>
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<td>60-65</td>
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<tr>
<td>Sharon</td>
<td>British</td>
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<td>lower socioeconomic status</td>
<td>40-45</td>
</tr>
</tbody>
</table>
Appendix G
Resource List

Resource List

Women's Health in Women's Hands Community Health Centre (WHIWH - CHC):
WHIWH - CHC is a team of health professionals who work from an inclusive, feminist, anti-oppressive framework. They specialize in working with immigrant and/or refugee women, women with disabilities, young women and older women. Within these groups they prioritize women from the Caribbean, African, Latin American and South Asia. They provide confidential counseling, support, information, advocacy and appropriate referral. 
Contact information (416) 593-7655

Substance Abuse Program for African Canadian and Caribbean Youth (SAPACCY)
SAPACCY provides services to African Canadian and Caribbean Youth and their families. They help youth and their families make positive choices about substance use and mental health issues. Their priority population is Black youth ages 13-24. Contact information is 416-535-8501 ext. 6767

Across Boundaries
Across Boundaries (AB) is an ethno-racial community mental health centre that provides a range of supports and services to people of colour including immigrants and refugees who are experiencing mental health problems. The centre provides a holistic approach to dealing with mental health problems recognizing the interdependence of the spiritual, emotional, mental physical, social, cultural, linguistic, economic and broader environmental aspects of health that affect the well being of people of colour. Contact information is (416) 787-3007

Toronto Rape Crisis/ Multicultural Women Against Violence (TRCC/MWAR)
TRCC/MWAR is a grassroots, women-run collective working towards a violence-free world by providing anti-oppressive, feminist peer support to survivors of sexual violence through support, education and activism. TRCC/MWAR operates on principles of mutual respect and anti-oppression. They believe survivors of sexual violence are experts in their own healing. Together they work toward creating a thriving community, empowering survivors of all races, classes, ages, gender identities, sexual orientations, abilities and spiritualities. Contact information (416) 597-1171
Sherbourne Health Centre Community Health Centre:
Urban primary health care centre serving diverse communities of southeast Toronto. It offers counseling, support, outreach, health promotion and educational programs contact 416-324-4180

Sistering
Support homeless, under-housed and low income women in the Toronto community. It offers information/ referral, advocacy, social/recreation programs, transportation and practical help. Contact 416-588-3939

Barbra Schlifer Clinic
Provide counselling, legal, interpretation, information and referral for women who are survivors of violence.
Contact 416-323-9149