"How Do You Run Away from Racism?": A Critical Race Analysis of Accessing Mental Health Counselling in St John's, NL

by

© Kamira (Camila) Fujiwara

A thesis submitted to

The School of Graduate Studies

in partial fulfilment of the requirements for the degree of

Master of Social Work

School of Social Work

Memorial University of Newfoundland and Labrador

July 25, 2023

St. John's Newfoundland and Labrador

ABSTRACT

This critical ethnographic study utilizes concepts from critical race theory to explore the experiences of racialized people when navigating mental health services, specifically mental health counselling. This research has three objectives:

1. To better understand how racialized people navigate the mental health system when they access (or try to access) mental health counselling in Newfoundland and Labrador.
2. To explore how racism impacts racialized people's need to access mental health counselling as well as experiences of accessing such supports.
3. To critically challenge social work and other professional knowledge about institutional racism in mental health services.

Nine racialized individuals completed in-depth interviews that explored their experiences of seeking and/or accessing mental health counselling in St John's, NL. The findings reflect the complexities of the lives of the participants while examining the permanence of racism within our mental health institutions. Participants shared experiences of racism through all stages of access and service, as well as reported racism as a reason for seeking services. These stories offer critical challenges for social work and other professionals within mental health services to understand and address systemic institutional racism in mental health services.

ACKNOWLEDMENTS

I am grateful to the research participants, who took time from their busy lives to share their stories. Thank you for your strength and courage in sharing some of your vulnerable stories. I have thought about you throughout this whole process, and I hope that I have honored your realities and insights. I have learned the most from your knowledge and lived experiences.

Thank you to Dr. Sobia Shaikh, who was not only my thesis supervisor, but my mentor, neighbour, and biggest cheerleader. Throughout this process I have struggled with imposter syndrome. I am the first in my family to complete graduate school, and I would not have done this thesis if I had not met Dr. Shaikh who saw that I was capable even when I doubted myself. Not only was she supportive, but she was also incredibly patient and empowered me in ways that I did not realize until the near completion of this thesis. This experience has challenged me in ways that have opened my mind and deepened my critical thinking skills. In this way, this experience has been life changing. Sobia, thank you for all your support and in believing in me.

I want to thank my husband, Gerald Singh who supported me through this process emotionally and intellectually. I could not have done this without the unconditional support and love from my partner. Gerald comforted and reassured me during the most difficult times of this process. He is the most patient, kind, and loving partner I could ask for. Gerald, thank you for being my rock!

Thank you to my sister, Sofia Fujiwara-Widell, who as I write this is in her final week of her first pregnancy, and she still managed to have the energy to reach out and provide her support. The completion of this thesis coincides nicely with the introduction of her first baby, and I can’t wait to meet my nephew, Kaito!

A big thank you to my academic circle of support including Siham Elkassem, Dr. Janes and the external readers, Drs. de Jong and Adjei for their time and thoughtful comments. It takes a community to complete such an endeavour, and I am extremely grateful to have met and learned from you. Finally, special thanks to all the wonder staff at the Writing Centre, School of Social Work, and the School of Graduate Studies (especially Andrew Kim!).

TABLE OF CONTENTS

CHAPTER ONE: INTRODUCTION

Institutional racism presents itself in the lives of racialized people when seeking and navigating mental health counselling services. From the perspective of racialized people, this research offers an explicit investigation of how institutional racism presented itself in all stages of access to mental health counselling. This topic was born through a culmination of personal and professional experiences. It came from a desire to explore past experiences that left me frustrated, confused and at times burnt out in the helping profession. While at times healing, the research has further deepened and challenged my way of thinking when it comes to my role as a racialized social worker working in the field of mental health. This project reflects my political stance with the use of critical race theory concepts as a reflection of how I experience and navigate the world and seek to dismantle hidden structures of systemic oppression.

In this chapter, I describe my research journey and how my personal narratives have shaped this thesis. I offer rationale as to why this research is needed through the exploration of my lived experiences with race and racism, and reflections on place, time, and language. I end this chapter with a summary of the research purpose and an outline of this thesis.

Territorial Acknowledgment

I respectfully acknowledge that this research was conducted on the island of Ktaqmkuk (colonially known as “Newfoundland”), which is the unceded territory of the Beothuk and Mi’kmaq peoples. I also acknowledge that Labrador is the traditional and ancestral homelands of the Innu of Nitassinan, the Inuit of Nunatsiavut and the Inuit of NunatuKavut.

I am grateful for my time as a guest on this traditional territory, and this thesis is a love letter to my time there. Through times of joy and struggles, community members, friends, neighbours, and colleagues provided me with the strength to pursue this research.

I had the honour of writing and finishing this thesis on the unceded territories of the Lkwungen (Lekwungen) peoples, known today as the Esquimalt and Songhees nations. I am grateful to the Coast Salish peoples for the beautiful land that I now call home.

This acknowledgment is important as I reflect on how colonization impacts my learning journey as a graduate student and social worker. Social work and the helping profession cannot move forward unless we recognize how our professions have harmed and continue to harm Indigenous communities. Social work was and continues to be complicit in the cultural genocide of the Indigenous peoples of Canada. As Cindy Blackstock (2017) reminds us, "there are more First Nations children in child welfare care today than at the height of residential schools by a factor of three" (p. 74). For other mental health professions such as psychology and psychiatry we cannot ignore how these fields utilized scientific racism to justify the subjugation of Indigenous, black, and racialized peoples (Fernando, 2014; Williams et al., 2022a).

Blackstock (2017) writes, "if reconciliation means not having to say sorry twice, Canada is failing" (p. 72). As a society, we continue to harm Indigenous communities. As a field, we continue to privilege Eurocentric ways of thinking and being, anything that deviates from this is Othered. We are simply not doing enough. We need to acknowledge how racism is permanently embedded in our professions. This is a narrative that will continue to emerge in this thesis.

Recognizing the permanence of racism does not mean defeat. Instead, it becomes a continuous battle that needs flexibility, creativity, and adaptability. I begin this journey with you, armed with even more questions than before, with some reflections from critical race theorist Derrick Bell (1992):

> […] it is not a matter of choosing between the pragmatic recognition that racism is permanent no matter what we do, or an idealism based on the long-health dream of

> attaining a society free of racism. Rather, it is a question of *both, and. Both* the recognition of the futility of action – where action is more civil rights strategies destined to fail – *and* the unalterable convictions that something must be done, that action must be taken (Bell, 1992, p. 199).

Reflections on Race and Racism in my Personal Narrative

I am aware and honoured that my research interests and values have been informed by my lived experiences, both in my personal and professional spheres. From a young age, I became deeply aware of how the world racialized me, and how fluid this experience could be.

I was born in Japan, where having one non-Japanese parent made me a *hafu*. This was my first introduction to *Otherness*, where I felt at times, like an outsider even within my family. Then moving to Canada at the age of fourteen, I went from being *Japanese Argentinean* to simply *Asian*. My appearance imposed this new label and facilitated many uncomfortable interactions in the form of guessing games.

Are you sure you're not Hawaiian? I knew you were some kind of Asian! My boyfriend thought you were First Nations.

As a young, racialized woman I frequently felt watched, and objectified; my actions and presentation were being dissected only to confirm prescribed racial biases. Female bodies are seen as objects, targets of control. Knowing what I was racially would help others decide how to exotify and dominate me. This was my first introduction to *intersectionality.*

My cousin was married to a Japanese woman. Are you sure you're Japanese? You're big for one. I know three words in Japanese, sayonara, konichiwa, and utsukushii!

I arrived in St. John's, Newfoundland and Labrador in the summer of 2019, nine months before the COVID-19 pandemic restrictions took effect. Moving to St John's, NL, felt like a

shock to the system. Compared to Vancouver, the city of St John's was much smaller and has a smaller presence of racialized people. I became curious as to what the experiences might be for other racialized people in the city.

This research topic was shaped by my lived experience as a racialized social worker living in St John's, NL. Having lived in Newfoundland and Labrador for three years, I immersed myself in the realities of living there as a racialized person. I interacted with many systems as a resident of St. John's, NL. I worked in a non-profit community organization and briefly at a post-secondary institution, rubbing shoulders with many service providers in the province. This *immersion* helped shape my research questions.

When I began the Master of Social Work (MSW) program at Memorial University of Newfoundland and Labrador (MUNL), I went into the program with the goal and assumption that mental health professionals simply required stronger anti-racism training. This assumption was formed during my formative time working in the settlement sector. As a case worker, I became frustrated at the medical system as I saw how newcomer families that I worked with were being pushed from specialist to specialist without any real acknowledgment of the impacts of trauma and racism. During this time, I also noticed great gaps and barriers in services, including a lack of access to first-language interpretation and mental health counselling. During my years working with various racialized communities (including migrants, international students, Indigenous youth, immigrant and refugee families, and racialized women), I heard service providers say that working with this population was not worth their time, that they should be "grateful" to be here, and that they needed fewer services. When I applied for the MSW program, I believed that the solution was to provide training and more culturally safe services. I believed that the issue was around access. Surely that would solve *the problem.*

Throughout my research journey (and with the help of my thesis supervisor, Dr. Shaikh), my understanding of mental health access for racialized people has become critical and complex. There is no denying that service barriers exist for racialized people, but such focus only goes skin-deep. As I started to dig deeper and scratch beneath the surface, I was confronted with uncomfortable tensions. I was faced with realizations that racism is embedded in our institutions, and our mental health practices and services are rooted in racist ideologies. What did this mean for someone who works and continues to work in mental health? Some of these tensions are explored and addressed in this thesis, while others I am still pondering.

Reflections on Time and Place

In this section, I explore how my personal experiences of living in St John's, Newfoundland and Labrador during the global COVID-19 pandemic impacted my understanding and perspectives on the research topic. Research completed in Newfoundland and Labrador about racialized communities largely frames this population as "newcomers", and therefore, topics around settlement, retention, and labour market need dominate this area (Fang et al., 2019; Li & Grineva, 2016; Li & Que, 2016; Mullings et al., 2020). Paralleling this trend, Newfoundland and Labrador's cultural psyche perpetuates the trope that anyone without familial ties to the province is a *come from away,* or CFA for short (Shaikh & Selby, 2023). This, in combination with the province having the lowest rate of immigration among the Canadian provinces (Statistics Canada, 2020), perpetuates the rhetoric where anyone racialized as *non-white* and *non-local* is marked as a perpetual foreigner (Wu, 2002).

Castagno (2012) writes that immersion is a key component of critical ethnography. As a new resident of St John's, NL, I was exposed to a new reality of being racialized that was enmeshed with being a permanent outsider. At times I felt like I lived in a bubble, with most of

my friend group being racialized, creating community as outsiders. Some of the most illuminating experiences I had were in taxi cabs. Taxi drivers would often ask if I was a student and would comment on my English, saying they often could not understand the accents of other racialized customers. They would tell me they felt the government was prioritizing newcomers and ignoring the needs of the locals, and the rising concern of homelessness and addiction that coincides with the bust of a "boom and bust" economy. There was one cab driver that asked me where I was from, and parked at the front of my house showed me his Mandarin lesson audiobook and told me how to say "beautiful woman" in Mandarin. While these were relatively harmless experiences, this gave me an understanding of what strangers saw me as.

I conducted this research during a time of reckoning in North America. I began my research during the COVID-19 global pandemic, which saw border states closed and saw many migrants being displaced (Hamilton et al., 2022). With the global pandemic, many countries (including Canada) saw a rise in violent anti-Asian hate crimes (Zhao et al., 2022) and anti-Black racism in China (Adebayo, 2022; Ouassini, 2022) and beyond. The murder of George Floyd in 2020 sparked outrage internationally and renewed support for the Black Lives Matter movement (Ray, 2022). In Canada, the nation was forced to face the horrors of colonization and cultural genocide with the "discovery" of more than 2000 unmarked graves (Thorne & Moss, 2022). Yet, despite all these painful events, critical race theory (see Chapter Two) continues to be under attack in North America (Ray, 2022). The COVID-19 pandemic has overwhelmed and transformed the healthcare (including mental health) system in Canada (Bonardi et al., 2022; Hawke et al., 2021; Moynihan et al., 2021; Moroz et al., 2020; Yu et al., 2022). Specific to Newfoundland and Labrador, the province has been impacted by the October 2021 healthcare cyber-attacks (Strong et al., 2022), and a dire shortage of medical professionals (Quinn, 2022;

Quinn, 2023a; Quinn, 2023b). This socio-political context shaped my research in both conscious and unconscious ways.

During the COVID-19 pandemic, I experienced forms of vicarious trauma as I witnessed violent hate crimes on the news towards people that looked like me, and others who did not. While I did not experience anything explicit, I felt anxious to leave the house. I remember reaching out to some of my other Asian friends, and we did not know how to console each other. I recall being uncomfortable and hyper vigilant at the grocery store, feeling that people were staring at me and not wanting to stand too close. I felt terrified of sneezing for fear that would cause someone to act aggressively. Was this paranoia? I will never know but fearing for my safety felt real in those moments, especially when you are the only "Asian" at the grocery store.

When the borders closed, and international students were stranded in the province I heard a director of a non-profit that served people with precarious economic resources say, "if they [international students] don't have the money, then don't come." I was deeply insulted by this comment but could not articulate in that moment why I felt so much anger in my body. Throughout the writing of my thesis, this memory that I thought I had buried has resurfaced. I have been provided with language as to why such comments are dangerous.

I saw Newfoundland and Labrador as a unique place to explore the process of racialization, and how this impacts people's experiences of accessing mental health counselling. A literature review by Hannson et al. (2012) found that research on mental health prevalence in racialized communities were mostly based on three urban cities in Canada, Vancouver, Montreal, and Toronto. The research on the experience of racialized people in Newfoundland and Labrador when accessing mental health or health care systems was limited (Hunt, 2020; Mullings & Gien, 2013; Reitmanova & Gustafson, 2007, 2009a, 2009b).

Mainstream discourse depicts Newfoundland and Labrador as a friendly and welcoming place (Newfoundland and Labrador Tourism, n.d.; Robinson, 2010). However, Shaikh and Selby (2023) problematized how a "polite dismissal" of the existence of racism in the province denies opportunities to have actual conversations about racism and Islamophobia. At times, the question became, "does racism exist in NL?" (CBC radio, 2018 as cited in Shaikh & Selby, 2023). A common attitude they experienced from locals was that racism only existed due to a lack of exposure to racialized people.

This thesis is also informed by my personal experiences in anti-racism work and activism in the province. During my time in St John's, NL, the news reported explicit examples of racism in the province (Roberts, 2022; Salters, 2021; Beaudoin, 2022). However, these incidents were depicted as one-off events (or 'bad apples') that ignored larger systemic forces that keep racism permanent in our lives (Hantke, 2022). Hantke writes, "The 'bad apples' narrative ignores the broader context of historically established systemic racism" (p. 179). Therefore, a denial that racism exists (or is due to a few "bad apples" individuals) creates the perception that when racist incidents do occur, they are one-off events, unrelated or unlinked to larger systemic oppression. Despite the polite dismissal and fringe narratives, anti-racism work is needed and exists in the province. There are community reports (Shaikh & Selby, 2019), autoethnographic research (Shaikh & Selby, 2023), government-led anti-racism committees (Government of Newfoundland and Labrador, 2022), and anti-racist grass-roots movements (Anti-Racism Coalition of Newfoundland and Labrador, n.d.; Black Lives Matter NL, n.d.; Migrants Students United Newfoundland and Labrador, n.d.), which clearly indicates that anti-racism work is alive and needed.

Reflections on Language

This section explains the purposeful use of the word *racialization* for this thesis. In anti-racism work, language is fluid and contextual. I argue that racialization highlights an active stance of something being imposed onto our bodies rather than a reflection of our (falsely presumed) static identities. In other words, the term acknowledges that the shared experiences among the research participants of this thesis are the experiences of living in a racist society rather than their racialized bodies being essentialized markers. I then recognize the origins and explore the limitations of the term People of Colour (POC) and Black, Indigenous, and People of Colour (BIPOC).

My use and selection of the word *racialized* has been an intentional one. Racialization can be defined as "a process whereby racial meaning is constructed to create categories attributed to particular groups and is reinforced through social processes that result in system-wide racial inequalities" (Este et al., 2018, p. 4). Rather than problematic ideas about race, the word racialized is also conceptually linked to racism. "Racialization becomes racism when it involves the hierarchical and social consequential valuation of racial groups" (Clair & Denis, 2015 as cited in Este et al., 2018, p. 4). This definition acknowledges how race is a social construction rather than a biological marker.

The word racialized indicates something is being done unto us, whereas other terms (such as visible minority or BIPOC) are static markers of identity, which runs the risk of essentializing our identities (Daniel, 2020). Daniel (2020) writes, "What BIPOC does not do is capture that verb, that something is happening to us… the process of being racialized. That is the issue. BIPOC is passive. It's missing the piece that articulates a process of racialization" (para. 11). The fluidity of racialization lends itself to be applicable to other complexities in the lives of

racialized individuals. Racialization has shifted to include identities beyond "race" to include other markers such as culture, religion, and even social practices (Fernando, 2017). For example, Fernando (2017, 2018) writes on the racialization of schizophrenia, where disproportionate numbers of Black patients are being diagnosed (see Chapter Four).

While the terms visible minority and non-white are terms that are still in circulation in some legislations, I believe that these terms centre whiteness as the norm. Such terms create a binary of white vs. non-white, or visible vs. invisible, which implicitly creates the notion that white is neutral and not a race (Meraji & Demby, 2020; Ontario Human Rights Commission, 2005). Frankenberg (1988) reminds us that being white is also a racial identity, and how it is "crucial to look at the 'racialness' of white experience" (p. 1). Therefore, whiteness is not neutral or void of racialization.

The use of acronyms Black, Indigenous, and People of Colour (BIPOC), and People of Colour (POC) are still commonly used in anti-racist circles today, and I still use them on occasion (see Appendix A). However, as I embarked on my research journey, I noticed movement and dialogue on the use of these terms in activist circles. Below, I explored the nuances to both sides of the debate. The origins and intention behind these acronyms are explored. Their limitations are explored and addressed by incorporating CRT concepts.

People of Colour's (POC) origins has activist roots. In a video recording of Lloretta Ross, she explains that the term "women of colour" was created as a response to a call for solidarity in the fight against the erasure of the experiences of racialized women (Western States Centre, 2011). Ross explained:

> They didn't see it [Women of Color] as a biological designation. […] It is a solidarity definition. A commitment to work in collaboration with other oppressed women of color

> who have been minoritized. […] It is a term that has a lot of power. (Western States Centre, 2011, 1:24)

Perhaps in a response to criticisms that this acronym flattens the multiplicity of different realities Ross elaborates:

> I think it's a setback when we disintegrate as people of color around primitive ethnic claiming. Yes, we are Asian American, Native American, but the point is, when you choose to work with other people who are minoritized by oppression, you've lifted yourself out of that basic identity into another political being and another political space. (Western States Centre, 2011, 2:13)

Therefore, such labels are important to build community and solidarity, and politicizes our experiences of racism. Despite this, POC has been critiqued for homogenizing different lived realities and not addressing hierarchies within communities of colour (e.g., anti-Blackness within other racialized communities). This led to the development and use of BIPOC (Daniel 2020; Garcia, 2020). The term can be traced to a 2013 tweet indicating that this acronym is more recent in its development (Garcia, 2020). Born through social media, BIPOC also has activist beginnings. The additions of letters for Black and Indigenous were added to acknowledge the distinct history and impact that slavery and genocidal colonization have had on these communities (Daniel, 2020; Garcia, 2020). A variation of BIPOC that has also emerged is IBPOC which aims to decolonize the acronym by putting First Peoples at the front (Twahirwa, 2021).

While the term BIPOC was offered as an attempt to acknowledge that Black and Indigenous communities are impacted by systemic racism and colonization in different ways, it has also been criticized for lumping distinct realities together (Daniel, 2020). Some activists

caution against lumping different histories of racism into one acronym and argue that the term ignores that hierarchies exist within and across communities of colour (Meraji & Demby, 2020). After the assassination of George Floyd in 2020, Black activists and scholars have critiqued the acronym BIPOC stating that anti-Black racism is de-centred and provides an excuse for people who are uncomfortable using the word "Black" to use a neutral term instead (Meraji & Demby, 2020). Similarly, the racism experienced by Indigenous peoples is not grounded in the same history or process, but rather they have unique realities as keepers of the land (Gebhard et al., 2022). The critique on the homogenization of experiences through the term BIPOC and POC will be addressed in this thesis with the use of critical race theory tenets, specifically the concept of differential racialization (see Chapter Two). When appropriate, I will be specific in naming the experience (e.g., anti-black racism, anti-migrant racism).

Despite these criticisms, the terms BIPOC and POC continue to be used. Community organizers (who are often considered to be the creator of such labels) claim that such language helps build solidarity among and across different communities (Meraji & Demby, 2020). Without this unifying identity, it is argued that community activism can face fragmentation (Meraji & Demby, 2020).

In this thesis, I use the word racialized which allows the explicit recognition that participants in this study are unified through their experiences of racism, rather than their racial identities. However, it is important to note that some experiences are unique to specific groups and should not be assumed as encompassing all racialized communities. Therefore, this thesis aims to include language and concepts (such as differential racialization) that acknowledges the specific experiences of some racialized communities (e.g., anti-Black racism, anti-Asian racism), while also recognizing that the underlying factor is the insidiousness of racism.

Important Definitions

Below are some definitions for important terminologies that are used in this thesis.

Anti-Racism:

Anti-racism is an action-oriented perspective that explicitly names and seeks to unmask and dismantle racism (Este et al., 2018). See definition of *Race*, *Racism* and *Racialization* below for more context.

Race:

Race is not a biological category but rather a social construct that has deep implications on people's lives (Este et al., 2018).

Racism:

Jones (1972) defines racism as: "result[ing] from the transformation of race prejudice and/or ethnocentrism through the exercise of power against a racial group defined as inferior, by individuals and institutions with the intentional or unintentional support of the entire culture" (p. 117). This definition acknowledges that there are many levels to racism that are interdependent, specifically individual, systemic, and cultural racism (Bowser, 2017; Jones, 1972; Este et al., 2018). Individual racism (sometimes referred to as everyday racism) is the most recognized form of racism that involves the belief in the superiority of one's racial group (Este et al., 2018). Systemic or Institutional racism refers to "laws, rules, and norms woven into the social system that result in an unequal distribution of economic, political, and social resources" (Este et al., 2018, p. 6). Lastly, cultural racism is considered the "blueprint and architecture for the organization of institutional racism," and permeates societal values (Bowser, 2017, p. 581).

Migrant:

This thesis borrows from the International Organization for Migrant's definition for migrant. Their website states that the term migrant is:

> An umbrella term, not defined under international law, reflecting the common lay understanding of a person who moves away from his or her place of usual residence, whether within a country or across an international border, temporarily or permanently, and for a variety of reasons. The term includes a number of well-defined legal categories of people, such as migrant workers; persons whose particular types of movements are legally defined, such as smuggled migrants; as well as those whose status or means of movement are not specifically defined under international law, such as international students. (International Organization for Migrants, 2023, para. 1).

Racialization:

Racialization is "a process whereby racial meaning is constructed to create categories attributed to particular groups and is reinforced through social processes that result in system-wide racial inequalities" (Este et al., 2018, p. 4)

Whiteness:

Frankenberg (1998) describes three dimensions of whiteness:

> "First, whiteness is a location of structural advantage, of race privilege. Second, it is a 'standpoint' a place from which white people look at ourselves, at others, and at society. Third, 'whiteness' refers to a set of cultural practices that are usually unmarked and unnamed" (Frankenberg, 1998, p. 1).

White supremacy:

> White supremacy can be defined as, "a racist ideology that is based upon the belief that white people are superior in many ways to people of other races, and that therefore, white people should be dominant over other races" (Saad, 2023, p. 38).

Research Purpose

The main purpose of this research is to explore the relationship between institutional forms of racism in mental health services and racialized people's experiences of navigating mental health services, specifically mental health counselling. The research question for this project is "what are the experiences of racialized individuals living in St John's, Newfoundland and Labrador when they access (or try to access) mental health counselling?"

This critical ethnographic research has three objectives:

1. To better understand how racialized people navigate the mental health system when they access (or try to access) mental health counselling in Newfoundland and Labrador.
2. To explore how racism impacts racialized people's need to access mental health counselling as well as experiences of accessing such supports.
3. To critically challenge social work and other professional knowledge about institutional racism in mental health services.

Outline of the Thesis

This thesis is organized into seven chapters. Chapter One introduced the reader to my research journey and contextualizes my reasons (both personal and professional) for engaging in this research. I provided reflections on my personal narrative (in relation to race and racism), to geography and context of this research, and reasons for intentional use of the word racialized.

Chapter Two introduces the reader to critical race theory (CRT), which is the conceptual framework of the thesis. This chapter explores CRT, including its historical context, and a description of its central tenets. The purpose of this chapter is to highlight which CRT concepts were utilized throughout this research.

Chapter Three introduces the reader to my methodological framework, which is Critical Ethnography. This chapter articulates why this framework is appropriate for this research topic, and how it aligns with the conceptual framework of this thesis. A detailed description of research method will be provided as well as some reflection on ethical considerations and study limitations.

Chapter Four is a literature review that is organized into three parts: racism and mental health, racial disparities, and barriers in accessing mental health services, and racism in counselling settings. The intention of this chapter is to examine and problematize relevant literature while providing additional context to the conceptual framework of my thesis.

Chapter Five presents the findings from the interview data that pertain to questions about reasons for seeking mental health services and the experience of accessing said services. Presented in a more descriptive manner, a discussion that critiques the findings are provided at the end of each section.

Chapter Six provides three key findings that emerged throughout the data analysis, through a second-step analysis process that utilized CRT concepts. This chapter interweaves the findings and analysis together. The themes presented in this chapter are Experiences of Racism, Whiteness in Mental Health Services, and Intersectional Identities and Essentialism.

Finally, Chapter Seven provides the readers with three main reflections that emerged through the process of completing my thesis. These reflections materialized through various

stages of the research but were particularly salient through the process of writing, data analysis and through hearing the stories of the research participants.

CHAPTER TWO: CONCEPTUAL FRAMEWORK

In this chapter, I introduce the conceptual framework of this thesis project which consists of six central tenets of critical race theory (CRT). An explanation of what CRT is, as well as its historical context, will be provided. A detailed description and reflection of the tenets will provide context on how these tenets will provide nuance to and enrich my research focus. Finally, CRT concepts are utilized as an example on how to explore dominant narratives about Newfoundland and Labrador.

What is Critical Race Theory (CRT)

Critical race theory (CRT) has been described in various ways including as a movement (Delgado & Stefancic, 2017), as a framework for theorizing space (Cabrera, 2018), as an interdisciplinary activist project (Mullings, 2022) and as an umbrella term for other critical anti-racist theories (Badwall, 2022). Most crucially, CRT's inception is rooted in an activist and action-oriented framework. In other words, "critical race theory from its inception was not intended to be a theoretical framework, but rather a theorizing counterspace for scholars of color to challenge and transform racial oppression" (Cabrera, 2018, p. 209). The multiplicity of these descriptions reflects how CRT has transformed across time and has rich and varied critical epistemological and ontological orientations.

This thesis borrows from Solorzano's definition of critical race theory as "a framework or set of basic perspectives, methods, and pedagogy that seeks to identify, analyze, and transform those structural and cultural aspects of society that maintain the subordination and marginalization of people of color" (Solorzano, 1997 p. 6). At its core, the framework examines the connection between power, race, and racism and seeks to dismantle and transform these power dynamics (Delgado & Stefancic, 2017).

Historical Context

CRT is often included as part of a spectrum of anti-racist critical theories that include frameworks such as anti-colonial, postcolonial, and whiteness studies (Badwall, 2022). However, other authors such as Mullings (2022), argue that CRT offers distinctive features and history that make it unique from other critical theories. CRT as a movement originated in the 1970s in the United States within a community of critical legal scholars and activists (Delgado & Stefancic, 2017). CRT as a movement was a response to the obstruction and hindering of advances that were made during the U.S. civil rights era of the 1960s (Delgado & Stefancic, 2017). Therefore, it is important to note that CRT emerged during an era where Black Americans were fighting for equity and justice. Additionally, CRT is heavily informed by prominent Black scholars (such as Derek Bell, William Edward Burghardt Du Bois) that wrote specifically about the oppression of Black communities and of the Black experience in the United States.

Mullings (2022) cautions against the whitening of CRT, where CRT elements and teachings are repackaged by white-presenting social work scholars. Mullings claims that this contributes to the erasure of Black scholarship as well as the dilution and de-centering of race. While CRT has now been applied to many different sites ranging from education (Hiraldo, 2010; Ladson-Bills & Tate, 1995; Ledesma & Calderon, 2015), to social work (Campbell, 2014; Kolivoski et al., 2014; Razack & Jeffery, 2002), to healthcare (Adebayo et al., 2022; Ford & Airhihenbuwa, 2010), it is necessary to acknowledge that the framework of CRT is rooted in histories of combatting anti-black racism and other interlocking systems of oppression by Black people, primarily in the United States.

First Tenet: Racism is Endemic (Permanence of Racism) and Whiteness

In this section, I explore a central tenet of CRT, that racism is endemic and permanent, and explore how concepts from critical whiteness studies mirror this tenet. CRT's central tenet is the acknowledgment that racism is endemic and deeply embedded in our society and institutions, rendering it *intentionally* unmarked (Delgado & Stefancic, 2017). Abrams and Moio (2009) explain, "because racism is ordinary and embedded, its structural functions and effects are often invisible, particularly to people holding racial privilege" (p. 251). This stance on racism is influenced by Bell's (1998) writings on the permanence of racism, where Bell writes that activists need to treat racism not as something to overcome but as a permanent oppressive force to battle with. Bell writes,

> […] we can only *de*legitimate it if we can accurately pinpoint it. And racism lies at the centre, not the periphery; in the permanent, not in the fleeting; in the real lives of black and white people, not in the sentimental caverns of the mind. (Bell, 1992, p. 198)

Therefore, while racism as permanent is a central tenet of CRT, it also reminds us that anti-racism work must be a continuous process.

Cabrera (2018) argues that, while this and other tenets explain the *nature* of racism, it is not a racial theory. Cabrera claims that CRT tenets function as epistemological and ontological premises, but that these tenets lack an overarching racial theory that explains and describes how contemporary racism operates. To address this void, this thesis borrows from Bowser's (2017) critical review of the theoretical development of the concept of racism that emerged from activist movements in the 1960s. Using Jones' (1972) three levels of racism which include cultural-historic racism, institutional racism, and individual racism, Bowser (2017) writes that the original theory of racism was meant to see three levels of racism linked into a single theory.

However, these three levels have been compartmentalized and tackled as three distinct forms of racism. Bowser uses the imagery of a stool to explain that all three levels of racism are like the three legs of a stool needed for it to *stand*. The imagery of the stool allows us to conceptualize racism beyond the interpersonal, as embedded, and endemic in our institutions and cultures, and instead offers a more integrated theory of racism that acknowledges all three levels of racism as one. Using an example, Bowser demonstrates how addressing only one level of racism proves to be an insufficient anti-racist strategy. He explains that only one level of racism (institutional racism) was addressed in the 1970s. While many institutional changes to "eradicate " overt institutional racism were implemented, racial disparities were still evident in the outcomes (e.g., red lining, educational inequity, etc.). Bowser critiques that cultural racism remained uninterrogated. The author calls for a more advanced theory of racism that integrates all levels and calls for a strategic and multi-leveled approach to anti-racist research. Cultural racism, then is akin to the tenet idea of racism being permanent, normal, and endemic.

To further complicate the first tenet, I will borrow concepts from critical whiteness studies, specifically the concepts of whiteness and white supremacy. Critical whiteness studies is considered an offspring of critical race theory (King & Eidse, 2022). Similarly, Gebhard et al. (2022) interprets whiteness, racism, and colonialism as "interlocking systems that inform each other and are not necessarily distinctive" (p. 6). At the most basic level, whiteness is about unearned power and privileges given to those with white skin, with the understanding that not all white people gain the same benefits (Yee & Dumbrill, 2022). However, whiteness as a social identity and racial marker that is positioned as superior is just one element of whiteness (Gebhard et al., 2022; Frankenberg, 1998). Frankenberg (1998) describes three layers to whiteness:

> First, whiteness is a location of structural advantage, of race privilege. Second, it is a "standpoint" a place from which white people look at ourselves, at others, and at society. Third, "whiteness" refers to a set of cultural practices that are usually unmarked and unnamed. (p. 1)

The three levels of whiteness share some similarities to Jones' three levels of racism. Whiteness as a standpoint reflects similarities to Eurocentrism, which can be defined as "the world seen, described and mapped from European perspective and interests" (Matias, 2022, p. 340). Whiteness as a set of cultural practices is akin to racism as an unmarked force. For example, Delgado & Stefancic (2017) write, "the first feature [of racism], ordinariness, means that racism is difficult to address or cure because it is not acknowledged" (p. 8). Therefore, whiteness and racism are both described as existing insidiously in our lives without being acknowledged.

Being white is more than a racial identity and needs to be explored under the context of white supremacy (Frankenberg, 1998; Saad, 2023). White supremacy can be defined as, "a racist ideology that is based upon the belief that white people are superior in many ways to people of other races, and that therefore, white people should be dominant over other races" (Saad, 2023, p. 38). While white supremacy is depicted in the media as a fringe extremist attitude, such racial hierarchy is upheld by everyday systems and institutions (Saad, 2023).

In summary, critical whiteness studies see whiteness beyond being a racial marker or a "white" person. These concepts will be utilized in Chapters Five and Six, particularly in the discussion about representation among service providers. Whiteness and white supremacy are therefore cultural, rather than biological constructs. The inclusion of whiteness as a worldview and culture mirrors the first tenet. Racism as permanent is explored throughout the thesis, as an overarching theme.

Second Tenet: Race as a Social Construct

The second tenet of CRT recognizes that race is a social construction, meaning that racial categories are socially constructed and dictated by society, therefore lacking any real biological basis. These categories are "invented, manipulated, or retire[d] when convenient" (Delgado & Stefancic, 2017, p. 8). This is not to deny that different phenotypes or observable physical attributes exist, but rather, the meaning and importance that is prescribed to them are socially constructed and have real consequences in our lives (Abrams & Moio, 2013; Delgado & Stefancic, 2017; Giwa & Bagg, 2022). This tenet is utilized throughout my research, particularly in the conceptualization of racialization.

This tenet borrows heavily from W. E. B. Du Bois (1868-1963) and his writings, in which he described race as a social construct created by society (through hierarchies of power) that is imposed onto Black people. Chang (2002) explores how Du Bois' (2007) writings were from an era that was challenging a form of racism rooted in biological determinism and scientific racism. Scientific racism is a form of racism that "attributed intellectual, cultural, and moral capacities on the basis of biological race" (Chang, 2002, p. 87). Scientific racism provided justification for the subjugation and oppression of Black and other racialized groups (Chang, 2002). Therefore, Chang cautions that Du Bois' writings on race were in response to an era where scholars were advocating for the humanity of racialized people, whereas contemporary racism today justifies and excuses racial disparities as a natural consequence of free markets and faulty ideas about meritocracy. This critique reflects how contemporary discourses on racism have shifted. Scientific racism is still present but less at the forefront in medical discourses. As a result, Chang argues that our understanding of race as a social construction needs to move

beyond an analysis of subjugation to one that reflects how individuals and institutions work in unison to create and maintain racial disparities.

Third Tenet: Interest Convergence

The third tenet is called interest convergence, or sometimes material determinism. An example of how this tenet is conceptualized in this thesis is provided in the last section of this chapter. Interest convergence sees systemic racism as a tool to maintain the status quo, where there is little incentive from those in power to eradicate it. This tenet is linked to the permanence of racism because anti-racist initiatives will only progress if those in power have a vested interest. This concept was coined by one of the influential figures of CRT, Derrick Bell. In his original article, "Brown v. Board of Education and the Interest-Convergence Dilemma," Bell (1980) explained, "the interest of blacks in achieving racial equality will be accommodated only when it converges with the interest of whites" (p. 523). Bell (1980) critiqued that the desegregation of schools in the United States happened during a time when the interests of the Black community was converging with the self-interest of the White elites.

Bell's (1980) critical analysis of the desegregation of schools in the United States saw that this did not create educational equity for the Black community, but rather led to differences in the quality of education, and uneven distribution of resources that was facilitated by white families fleeing certain school districts (also known as *white flight*). Racial justice is not just about accessing spaces or being included. Instead, Bell (1980) called for action on creating equitable educational access for Black communities as well as the creation of model Black schools.

Giwa and Bagg (2022) provide a contemporary example of interest convergence by highlighting Canadian immigration policies. Racist immigration policies were overlooked in the

19th-century when labour needs would be fulfilled by exploiting cheap labour (such as the Chinese railway workers). At the same time, these workers were presented with hazardous work conditions, persecuted, and blocked from creating a sense of permanence in Canada (Canadian Broadcasting Corporation, n.d.; The Canadian Encyclopedia, n.d.). Giwa and Bagg write, "The presence of Chinese men was permitted purely to allow White business owners to profit" (p.272). Therefore, these migrants were only allowed to come to Canada to exploit their labour.

While the Immigration Act of 1967 prohibited discrimination based on race or religion, it introduced a new point system that created a hierarchy of immigrants, creating some immigrants as being more *desirable* than others based on access to education and financial resources (Giwa & Bagg, 2022). Therefore, the interest convergence is that racialized migrants could now immigrate to Canada in theory, but only if they serve the interest of the Canadian government. As Giwa and Bagg reminds us, "[…] Black and racialized groups only make gains in society if those gains also benefit the white dominant group" (p. 272). This hierarchy allows Canada to police and regulate who can enter the country as an official migrant.

Fourth Tenet: Differential Racialization

In this section, I explore the tenet of differential racialization with anti-Black and anti-Asian racism as examples of this concept. This tenet is utilized to dispute the flattening of all racialized realities (see Chapter One). Differential racialization sees the process of racialization as an intentional one. Marginalized groups are racialized differently across time by the oppressors to meet historic, economic, or cultural needs of those in power (Abrams & Moio, 2013; Delgado & Stefancic, 2017). Delgado and Stefancic (2017) write, "The differential racialization thesis [...] maintains that each disfavoured group in this country has been racialized in its own individual way and according to the needs of the majority group at particular times in

its history" (p. 79). The tenet of interest convergence also aligns with this tenet as the racialization process is rooted in the self-interest of the oppressors.

Ample examples of differential racialization can be tracked throughout North American history. Delgado and Stefancic (2017) provided the example of Muslims going from *exotic* to *dangerous* post-9/11. Similarly, Japanese agricultural workers were brought to the US for economic reasons, but when World War II broke out, people of Japanese ancestry were seen as security threats and sent to internment camps (Delgado & Stefancic, 2017). These groups were racialized differently at different points in time to meet the social and economic needs of the oppressors (Delgado & Stefancic, 2017).

Differential racialization allows us to explore how social practices and processes such as policing are also racialized. Maynard (2017) writes how policing, and crime are not "race-neutral" concepts. Reflected in the national discourse, the link between Blackness and crime provides justification for the over-surveillance of Black bodies leading to disproportionate arrests (Maynard, 2017). The racialization of Blackness as dangerous serves the oppressors to control the movement of Black bodies through tools such as carding, racial profiling, and ultimately, police brutality (Maynard, 2017). Therefore, police brutality and over-surveillance of Black bodies is something that cannot be applied to all racialized bodies. Anti-Black racism is, therefore, a form of differential racialization.

An element of differential racialization is the temporal nature, of how the racialization process can change over time. Maynard (2017) explains:

> Despite the end of slavery as a legal form of controlling Black movement and curtailing Black freedom, the enduring association of Blackness with danger and criminality was further consolidated, and new forms of policing Black people's lives emerged. Under

> slavery, the policing of everyday Black lives was the standard. […] Emancipation required new, or at least modified, expressions of racial logic […]. (p. 13)

Therefore, anti-Black racism is distinctive in that its genesis stems from the history of enslavement. Without formalized slavery, a new insidious form of slavery emerges through the criminal justice system (Maynard, 2017). Anti-Black racism facilitates a distinct form of racialization that is unique, where Blackness becomes synonymous with dangerous, therefore rationalizing police brutality and the demonization of Blackness.

Anti-Asian racism is another example of how differential racialization changes across time and context. COVID-19 has impacted communities from (or those who are presumed to have ties to) East Asia in ways that have reinforced the racist narrative of East Asians as perpetual foreigners not to be trusted (Li & Nicholson, 2021; Wu, 2002; Zhao et al., 2022). Specifically, COVID-19 has exasperated Sinophobia where anyone that appears "Chinese" is targeted (Gao, 2021).

While being Asian Canadian encompasses a wide range of cultures and experiences, two common narratives imposed on these communities have been the model minority myth and the yellow peril narrative (Li & Nicholson, 2021). These two narratives are temporally interchanged when suitable (Li & Nicholson, 2021; Liu, 2023). The model minority myth is a form of "camouflaged Orientalism" and helps to pit racialized communities against each other by suggesting that other racialized groups are *not* ideal and contributing citizens (Li & Nicholson, 2021). This myth upholds anti-Black racism by establishing racial hierarchies (Liu, 2023). Additionally, this myth operates to silence Asian communities by disregarding and delegitimizing any community struggles (Liu, 2023; Oluo, 2019).

The model minority myth is quick to disappear when it no longer serves the oppressors and is replaced by another narrative. The yellow peril narrative has a long history of seeing Asian migrants are diseased, dishonest, and untrustworthy (Leung, 2008; Li & Nicholson, 2021, Zhao et al., 2022). Leung (2008) writes, "historically, Chinese communities were referred often as the 'Yellow Peril,' comparing the presence of Chinese people to that of the plague. Chinese settlements and expansions were regarded with the same hysteria as an infectious disease spreading across Canada" (p. 137). The discourse of yellow peril sustains anti-Asian racism by controlling the inclusion of Asian communities by perpetuating ideas of "otherness" and "foreignness" (Zhao et al., 2022).

During a time of crisis, such as the COVID-19 pandemic, racialized communities are used as a scapegoat, resulting in an increase in violence towards these communities (Leung, 2008; Li & Nicholson, 2021; Mohanachandran, 2017). However, the COVID-19 pandemic has contributed to the intensification of anti-Black racism in China, highlighting that this phenomenon (of scapegoating) is not exclusive to North America or Europe (Adebayo, 2022; Ouassini, 2022). Adding complexity to the issue, Sinophobia is further fueled by the global tensions between China and Western nations (Zhao et al., 2022).

In these two examples, differential racialization has a convergent effect in making Black and Asian people fear for their safety by constructing their bodies as targets of violence. Police brutality and anti-Asian hate crimes are happening at a particular point in time and in ways that benefit the politically powerful. Any Black resistance (including the Black Lives Matter movement) is quelled with the rhetoric that Black communities are dangerous and therefore delegitimates their anger at anti-Blackness and racial injustice. Anti-Black racism then legitimizes police brutality, where Black bodies become a target of violence and over-

surveillance to erase Black resistance. Parallelly, Anti-Asian racism perpetuates otherness and foreignness in Asian communities. These communities were marked as diseased, dangerous, and untrustworthy, and became the face of a faceless virus that resulted in a global pandemic. Anti-Asian racism and the narrative of *yellow peril* serve to find a scapegoat for the pandemic and legitimized any violence directed at these communities.

Fifth Tenet: Voices of Colour and Counter-storytelling

Critical race theory sees counter-storytelling as a tool that de-centres dominant narratives, by centring voices that were intentionally silenced and suppressed (Delgado & Stefancic, 2017). This tenet is a central part of my thesis, as it prioritizes and centres the lived experiences of racialized people. This process has also been alluded to by critical scholars as the "centering in the margins" (Ford & Airhihenbuwa, 2010; hooks, 1989). The invisibility of racism, particularly from those holding racial privilege, highlights the need to centre racialized voices to uncover these systems of oppression (Delgado & Stefancic, 2017). Counter-storytelling is therefore seen as a response to dominant narratives that mirror existing power relations (Abrams & Moio, 2013). Experiential knowledge gained through lived experience is seen as valuable knowledge (Kolivoski et al., 2014). This politicizes the lived realities and narratives of racialized people.

Mullings (2022) makes the distinction between feminist counter-narratives and the CRT concept of counter-storytelling. She argues that the co-opting and whitening of CRT has led to concepts of CRT being repackaged and used to centre white feminist discourse. This whitening of CRT tenets has led to the intentional erasure of anti-Black racism. Mullings uses the example of the May 2020 murder of George Floyd that re-ignited a global reaction to calls for action against anti-black racism (known as the Black Lives Matter movement). Mullings points out that

despite the original intention of the movement being to centre anti-Black racism, the narrative quickly morphed into a general message of racism. Mullings (2022) writes, “this is an important distinction as the change in language signaled a shift in focus from Black lives, death and pain and instead pivoted to address racism in a diluted and palatable manner” (p. 287). This example highlights how counter-storytelling can be co-opted and diluted when the original goal is to disrupt and interrogate the insidiousness of racism. This example furthermore highlights the importance of differential racialization (see fourth tenet), in that not all racialized realties are the same.

Sixth Tenet: Intersectionality and Anti-Essentialism

In this section I explore the origins of intersectionality within CRT, the anti-essentialist stance, and some limitations to the approach within CRT. In considering the complexities of the racialization process, intersectionality provides a critical and nuanced approach to this thesis. While *intersectionality* is one of CRT’s core tenets, it can be considered an independent framework. Murphy et al. (2009) sees intersectionality as both a methodology and a tool for social change. Similarly, Collins & Bilge (2020) state that intersectionality represents a synergy between critical inquiry and critical praxis. According to the authors:

> Intersectionality investigates how intersecting power relations influence social relations across diverse societies as well as individual experiences in everyday life. As an analytic tool, intersectionality views categories of race, class, sexuality, nation, ability, ethnicity, and age – among others – as interrelated and mutually shaping one another. Intersectionality is a way of understanding and explaining complexity in the world, the people, and in human experiences. (Collins & Bilge, 2020, p. 2)

The term *intersectionality* was coined by CRT scholar Kimberlé Crenshaw (1989). However, the foundations of intersectionality emerged before the CRT movement (Collins & Bilge, 2020; Murphy et al., 2009). Murphy et al. (2009) writes that "the roots of intersectional thinking can be traced back to the writings of late nineteenth- and early twentieth-century African American scholars and intellectuals" (p.17). Therefore, while intersectionality is a pillar within CRT, it is not exclusive to this conceptual framework.

There is disagreement among scholars about the origins of the concept of intersectionality. While Murphy et al. (2009) suggest that the foundations of intersectionality are rooted in Black feminist epistemological thinking, Collins & Bilge (2020) argue that the foundations of intersectionality are rooted in the collective experiences of many intersecting racialized identities. Collins & Bilge (2020) reflect:

> Given the historical discrimination against women of African descent, it is tempting to grant African American women ownership over the seeming discovery of the then unnamed intersectionality. However, in the US, African American women were part of heterogeneous alliances with Chicanas and Latinas, Indigenous women, and Asian American women. (p. 80)

Despite these two different historical interpretations, intersectionality remains a critical framework.

Critics have claimed that intersectionality runs the risk of essentializing identities (Collins & Bilge, 2020). Essentialism is defined as "unchanged, fixed or 'essential' identities that they [people] carry around with them from one situation to the next" (Collins & Bilge, 2020, p. 178). Using an anti-essentialist stance, Collins & Bilge (2020) reconceptualize identity as *subjectivities* that fluctuate depending on context and power relations.

> Rather than a fixed essence that a person carries from one situation to the next, individual identities are now seen as differentially performed from one social context to the next. And those social contexts are shaped by intersecting power relations. (Collins & Bilge, 2020, p. 167)

Therefore, when intersectionality also takes an anti-essentialist stance, it rejects the idea that our social identities are static, categorical, and quantifiable.

McCall (2005) introduced three approaches to intersectionality: intracategorical, intercategorical and anticategorical. While intercategorical approaches utilize fixed categories, anticategorical approach deconstructs and problematizes the use of social identities as static (McCall, 2005; Mehrotra, 2010). An intracategorical approach to intersectionality is rooted in Black feminist epistemologies and highlights the "unique standpoint" of racialized participants (McCall, 2005; Merhotra, 2010, p. 243).

Rooted in Black feminist epistemologies, Crenshaw (1989) took an intracategorical approach to intersectionality, where the focus was on marginalized experiences at "neglected points of intersection" (McCall, 2005, p. 1174). For example, Crenshaw (1989) writes:

> The paradigm of sex discrimination tends to be based on the experiences of white women; the model of race discrimination tends to be based on the experiences of the most privileged Blacks. Notions of what constitutes race and sex discrimination are, as a result, narrowly tailored to embrace only a small set of circumstances, none of which include discrimination against Black women. (p. 151)

Crenshaw highlights the importance of recognizing power differentials within groups. Failing to do so privileges and prioritizes the perspectives that are the least marginalized.

The use of intersectionality in CRT has been met with some critiques. In considering the complexities of the racialization process, intersectionality must adopt a nuanced and critical approach that balances the realities that exist simultaneously. For example, Mehrotra (2010) claims that scholarly literature on intersectionality from North America has heavily focused on race, class, and gender, but needs to expand to include other identities and oppression such as migration and colonization. Intersectionality has also been critiqued as a tool wrongly used to dilute racism and derail anti-racism work (Mullings, 2022). Mullings (2022) writes, "we must work to reject the idea that intersectionality is simply the notice that all forms of discrimination are universal or equal" (p. 288). This sentiment is also echoed when Razack and Jeffery (2002) explain, "when issues of race are introduced, the need to mention other forms of oppression becomes immediately apparent. These reactions deny the saliency of race and limits ways in which such discussions can be included [...]" (p. 261). Therefore, intersectionality should highlight race and racism without downplaying, or impossibly comparing racism to other forms of systemic oppression (Razack, & Jeffery, 2002).

Challenging Dominant Narratives about Newfoundland and Labrador (Ktaqmkuk) using CRT

This section will demonstrate how CRT tenets can add, complicate, and nuance my research. Specifically, I explore the erasure of Indigenous presence as intentional, and using interest convergence, I problematize the province's reputation for white friendliness and of welcoming migrants. Through this analysis, we see how CRT is useful in examining dominant narratives about who belongs in Newfoundland and Labrador.

The cultural narrative that Indigeneity does not exist on the island of Ktaqmkuk feeds into the dominant narrative that the province is a predominantly white space, further perpetuating

whiteness (Manning, 2017). At first glance, Newfoundland and Labrador has a reputation for being a predominantly white province.[1] A report by Statistics Canada (2017) states, "Despite an increase in all the diversity indicators by 2036, Newfoundland and Labrador would remain the least diversified Canadian province from an ethnocultural standpoint" (Statistics Canada, 2017, p. 53). However, Manning (2017) writes that the erasure of Indigenous presence in the province is intentionally facilitated by how colonization shapes cultural memory that selectively bury the story of settler colonialism. Newfoundland's (Ktaqmkuk) cultural identity is rooted in the province seeing itself as being historically exploited by the British Empire and then by the Canadian government. The existence of Indigenous people does not fit this narrative and are falsely depicted as either extinct or assimilated (Manning, 2017). This false narrative depicts the province as a predominantly white, giving power to white settlers as the only ones who truly belong to the province, and who are entitled to govern this land. Ironically, this governing includes who is allowed to immigrate to the province.

Despite racist notions of who is entitled to reside in Newfoundland and Labrador, immigration as a solution to address the economic and demographic needs of the province is an example of interest convergence. Immigration is being welcomed because it aligns with the self-interest of white settlers. In Newfoundland and Labrador, the push for immigration is framed as an economic incentive (Roberts, 2021). Data from Statistics Canada (2020) show that Newfoundland and Labrador's death rate is higher than the birth rate. The provincial Government of Newfoundland and Labrador have made a clear stance to push for more immigration to the province (Government of Newfoundland and Labrador, n.d.). Despite efforts

[1] While not the focus of this analysis, it is important to acknowledge the erasure of other migrant communities in Newfoundland and Labrador, specifically the Lebanese, Chinese, and Jewish communities. For more information see Newfoundland and Labrador Heritage (2008).

being made, Newfoundland continues to have the lowest immigration rate across the Canadian provinces (Statistics Canada, 2020).

The cultural narrative of Newfoundland and Labrador as a welcoming place for migrants is further magnified by its reputation for friendliness (Newfoundland and Labrador Tourism, n.d.). This is highlighted by how Maclean's magazine ranked Newfoundland and Labrador as third on the "Top Ten Friendly People" list (Robinson, 2010). The article states:

> What makes people who live on a rock so friendly? Could be their Celtic heritage, their self-reliance or their remoteness from stressful big cities. Whatever the cause, their spirit is irresistible. If you survive being 'screeched-in' and kissing the cod, you are ready for anything. (Robinson, 2010, para. 4)

The romanticized narrative that the province is friendly and tolerant of new people is also guided by popular culture sensations such as the 2017 Broadway musical, *Come from Away.* This set the stage for the province being seen as an exciting destination full of "simple, largely unskilled labours and fisherpeople who are exceptionally friendly" (Shaikh & Selby, 2023, p. 216), a narrative that also is blatantly classist.

The cultural narrative of friendliness and need of immigrants minimizes and dismisses any evidence of racism in the province. Shaikh & Selby (2023) write on their experiences of "polite dismissal" from community partners, the public, the media, and government around the topic of anti-racism work and in this case in particular, their work around Islamophobia and anti-Muslim racism (p. 211). Shaikh & Selby witnessed this polite disengagement as a tool to question and deny the existence of racism, while framing the solution as a need for more diversity and exposure.

The solution to "solve" racism through an increase of migration, coincidentally aligns with the self-interest of the province. Newfoundland and Labrador is in desperate need of more workers and struggles with population decline. Migrants are being welcomed only to fulfil their economic duties. The depiction of the province being friendly and welcoming, makes conversations about racism difficult. Newfoundland and Labrador as a predominantly white province is a narrative that is complicit in the erasure of the Indigenous peoples of these lands. This story portrays Newfoundland and Labrador as a white province, in need of immigration and void of Indigeneity. This provides power to settler colonialism as white settlers are depicted as the rightful heirs to the land, who can dictate who is allowed to enter.

Summary

This section summarized six CRT tenets that guide the conceptual framework of this thesis. These tenets were the pillars of my research and informed all aspects including the literature review, research methods and findings. I provide an example of how CRT tenets can be utilized to inform research conducted in Newfoundland and Labrador. While CRT came from the experiences of Black resistance during the civil rights era of the United States, CRT's political stance centres the permanence of racism, which can adequately tackle a dominant narrative about Newfoundland and Labrador and its lack of diversity and lack of Indigeneity. In sum, to avoid flattening realities, differential racialization and intersectionality will be employed throughout this thesis.

CHAPTER THREE: METHODOLOGICAL FRAMEWORK

This chapter introduces my methodological framework, critical ethnography. I explain why critical ethnography aligns with my conceptual framework, critical race theory (CRT). I then describe my research methods, including participant eligibility criteria, recruitment and sampling strategies, data collection, and analysis. Finally, I will end this chapter with a discussion of some of the ethical considerations of my research.

Methodological Framework: Critical Ethnography

Ethnography has its historical roots in anthropology and can be defined as "the systematic study of a particular cultural group or phenomenon" (Riemer, 2012, p. 163). Ethnography aims to create rich and descriptive accounts of social phenomena at a particular site by describing patterns and inferring meaning from the perspective of participants in a systematic manner (Castagno, 2012). A key element of ethnography is the immersion of the researcher in the culture or location that is being explored (Castagno, 2012; LeFrançois, 2013), which for this research is mental health services in St. John's, Newfoundland and Labrador.

Critical ethnography was a scholarly response to the colonial history of traditional ethnography being used as a tool by colonizing powers to dehumanize the Other (LeFrançois, 2013). Unlike traditional ethnography, critical ethnography rejects the notion that the researcher is objective, and that research is value-neutral (Castagno, 2012; Madison, 2005). Critical ethnography acknowledges and recognizes the colonial past that ethnographic research has played. Madison (2005) explains:

> What many early researchers, particularly during the colonial and modern period, did not recognize was that their stalwart 'objectivity' was already subjective in the value-laden

> classification, meaning, and worldviews they employed and superimposed upon people who were different from them. (p. 8)

To the critical ethnographer, representations of cultures are never neutral and instead are shaped by the competing interests of all parties involved (Castagno, 2012). Moreover, critical ethnography holds that objectivity is in principle impossible, and formalized institutions committed to objectivity carry an implicit political bias. Critical ethnography therefore sees all research as political and biased; a critical ethnographer's research agenda is explicitly aimed at highlighting inequities and advocating for equitable alternatives (Castagno, 2012).

Critical ethnography seeks to acknowledge and address the power dynamics that are left ignored in traditional ethnographic research. Critical ethnographers seek to "resist domestication" which is described as a form of "benign ignorance" that removes a sense of social responsibility from social justice issues (Thomas, 1993, p. 8). Resisting domestication is described as rejecting surface-level appearances and taken-for-granted assumptions (Madison, 2005). Jamal (2005) writes that critical ethnography is "concerned with unmasking dominant, social structures and the vested interests they represent, with a goal of transforming society and freeing individuals from the sources of domination and repression" (p. 235). Therefore, the critical ethnographer moves to disrupt the status quo by elevating often ignored marginalized voices and stories (Madison, 2005).

Critical Ethnography and Critical Race Theory

Both CRT and critical ethnography come out of critical theoretical traditions (Castagno, 2012). In fact, Madison (2006) describes critical ethnography as "critical theory in action" (p. 16). Critical theory exists within the tensions of positivist and post-positivist thinking. Drawing from Guba and Lincoln's (1994) categorization of four different paradigms of research, Morris

(2006) lays out the differences between critical theory, positivist, and post-positivist researchers. She writes:

> The critical theory researcher agrees with positivism that there is an objective reality, agrees with post-positivism that values mediate a researcher's understanding of that reality, but disagrees with both paradigms and their focus on the researcher as someone standing outside of the research experience doing research *to* people rather than doing research *with* people. (Morris, 2006, p. 131)

Therefore, the critical researcher is intertwined with the research experience.

Critical theory begins with a critical epistemological and ontological stance that recognizes that oppression (such as racism) exists and seeks to understand how oppression shapes how one understands the world. Using critical race theory, the central oppressive force explored is racism. Castagno (2012) provides an illuminating explanation of how critical ethnography and critical race theory can complement each other:

> [...] if I approach my research from a critical race theory perspective, I already assume that racism exists and that race matters in everyday experiences. What I do not know, however, is what racism will look like at a particular site or how racism will have an impact on certain people and experiences. (p. 379)

Therefore, the intention of this project was not to determine whether racism exists but rather *how* it exists. This thesis project did not seek to quantify or measure racism, but rather, to explore how racism presents itself in each context (such as mental health systems), and to provide a rich description (such as ethnographic methods) of how racism impacts the lives of racialized individuals.

Finally, both critical ethnography and critical race theory have a political and emancipatory agenda (Jamal, 2005; Delgado & Stefanic, 2017). Both critical race theory and critical ethnography seek to unmask systems of domination and interrogate the assumption that these interlocking systems remain unmarked. Critical race theory has its origins in activist roots (Delgado & Stefancic, 2017). Similarly, critical ethnography claims an ethical obligation toward social justice and equity (Madison, 2005; Thomas, 1993).

Methods

Methodology refers to a form of inquiry or a way of thinking about the research design, whereas research methods refer to the tools or way of doing the research (Lapan et al., 2012). In this section, I explain the steps taken to implement my research, beginning with the participant eligibility for this study, how they were recruited, and how the data was collected and analyzed.

Eligibility Criteria of Participants

Participation was open to anyone who: self-identified as racialized, was over the age of 18, living (or has lived) in Newfoundland and Labrador, and has accessed (or tried to access) mental health counselling after the year 2020. Minors were not included because the process of providing consent would involve additional logistics of parental consent. Participants were invited to speak about their experiences of accessing mental health counselling.[2]

Participant Recruitment

For recruitment, I utilized my networks as a racialized individual living in St John's, NL. During the three years I lived there, I became well-connected to many racialized and migrant communities and networks. I sent a recruitment poster (Appendix A), and a recruitment document (Appendix B) to various agencies and groups located in the city; I asked them to

[2] Post-positivist and positivist researchers call this form of eligibility criteria convenience or purposeful sampling (Reid et al., 2017).

promote the research project in a non-targeted manner. Some agencies agreed to include the poster in their electronic newsletters and/or mailing lists, and others offered to put up physical posters in their offices or community spaces. I also displayed physical copies of the recruitment poster in community spaces such as local libraries, coffee shops, medical clinics, and around post-secondary campuses. As indicated in the recruitment material, interested participants could reach out to me via email or phone. Once individuals made contact, they were provided a lay summary (Appendix E) and a copy of the consent form (Appendix F) for review. An opportunity to ask any questions or provide concerns was also given. Once participants agreed to partake as an interviewee, an appointment for an interview was scheduled.

Participant Demographics

In the consent forms that were provided to the research participants (Appendix F), anonymity refers to the omission of a participant's identifying characteristics. Because St. John's is a small city, anonymity can sometimes be difficult to achieve. To try and maintain as much anonymity for the research participants of this study, demographics are reported in a group manner in this chapter.

In total, sixteen people reached out expressing interest in participating in the research study, with a total of nine participants being interviewed. The other participants did not follow-up after I sent them more information about the research (see Appendix B and E). Of the nine participants, three identified as male, five as female, and one as non-binary. For racial identity, three participants self-identified as Black, two as Asian, two as South Asian or Brown, and one as mixed-race.

One participant declined the fill out the optional demographical survey (see Appendix D). Languages spoken other than English included Urdu, Punjabi, Hindi, Tagalog, Hiligaynon,

Arabic, Malay, and Hausa. At the time of the interviews, time spent in Newfoundland and Labrador reported ranged from 8 months to 9 years, with a group average of approximately 4 years. The average age (from those who answered the survey) of the research participants was 29 years old.

Seven out of the nine participants came to Newfoundland and Labrador to study at a post-secondary institution. One participant came to Newfoundland and Labrador for employment reasons, and another came to escape a situation of intimate partner violence. All participants (who answered the survey) were born outside of Canada. While this was not intentional, two processes could have facilitated this trend. The first is that although there are racialized communities in Newfoundland and Labrador that have existed for multiple generations,[3] most racialized communities (excluding Indigenous ones) are also migrant communities. The second is that the promotion of the research through avenues such as non-profit organizations, activist groups, and post-secondary universities, may have targeted migrant communities.

Data Collection and Analysis

This study used qualitative data in the form of in-depth interviews, and reflexive journaling. The use of qualitative data allowed for a richness of data (or denser descriptions) that cannot be achieved with quantitative data and allowed for the bi-directional relationship between theory and research to emerge (Jamal, 2005; Reid et al., 2017).

a. Semi-structured interviews

Reid et al. (2017) defines semi-structured interviews as "one-on-one interaction in which the interviewer asked a set of questions but allows for some variation in the order and format of questions. […] probes are used to deepen or expand participants' responses" (pp. 149-150). This

[3] For more information on these communities see Newfoundland and Labrador Heritage (2008).

form of data collection is appropriate for critical ethnography as it prioritizes data that can provide insider knowledge on a topic (Castagno, 2012; Madison, 2005). Critical ethnographers see research participants as subjects with agency; meaning is co-constructed between the interviewer and interviewee (Madison, 2005). While validity is still an important part of the research process, it is balanced with the understanding that interviews provide "a window to individual subjectivity and collective belonging" (Madison, 2005, p. 28).

Due to pandemic restrictions, in-depth interviews were conducted via WebEx® (an online video conferencing platform), and video recorded for the purposes of audio transcription. The interviews took between 60 to 90 minutes and was semi-structured with the use of open-ended questioning (see Appendix C). The interviews took place virtually through my home office. The office had privacy measures in place (e.g., closed door, noise cancelling features such as white noise machine outside the office, etc.). Prior to the beginning of the interview, participants were asked to complete the consent form (Appendix F) and were also invited to fill out an optional brief demographic survey (Appendix D).

Video recordings were transcribed using a software called Trint, and all identifying information was removed and replaced with pseudonyms during the transcription phase. These transcriptions were sent to participants for review and approval to proceed. A 30-minute follow-up interview was offered where participants were able to review the audio transcriptions, provide clarification, and address any questions or concerns. The intention of the follow-up interview was to provide opportunities to address potential concerns around anonymity and confidentiality, as well as provide opportunities for ongoing consent from research participants. No participant requested a follow-up interview.

The in-depth interviews were audio-transcribed and then hand-coded by identifying emergent patterns within and across all interviews. Coding is the process of assigning a word or label that summarizes a section of qualitative data, also known as data bits (Reid et al., 2017). Data bits are portions of data that can "make sense" even when separated from the rest of the data (Reid et al., 2017, p. 244). Data was coded both deductively and inductively. Inductive coding is emergent, meaning that codes emerge from the data, whereas deductive coding is often "researcher-defined" (Reid et al., 2017).

Taking a critical ethnographic approach places importance on *non-literal* meanings in language (Branford, 2006; Carspecken, 1996; Castagno, 2012). Bransford (2006) writes:

> When interviewing participants, it is important to look for anomalies - contradictory answers, defying observed reality, cover-ups, or gaps - in the data elicited […] By getting below the surface, the researcher may be able to identify areas of resistance and agency. (p. 182)

For this reason, Carspecken (1996) differentiates between low-level and high-level codes. Low-level codes are codes that require little abstraction (such as in-vivo codes), and high-level codes involve a great amount of abstraction and are usually coded alongside low-level codes in what is known as "horizon analysis" (p.110). Using this approach for my data analysis, over time each theme developed a group of high-level codes or sub-themes.

After the transcripts were polished[4] and approved by the participants, I familiarized myself with these documents. The initial coding stage involved reading each transcript and highlighting data bits that stood out, such as topics that re-occurred or surprised me. I then coded line by line. I created a Word document for each interview and tracked different codes (with their

[4] I cleaned up or corrected the transcripts because the audio transcription was often not transcribed properly.

data bits), organized them by interview question, but allowed for codes that were unattached to any interview question or probe. I then proceeded to code across interviews and took note of similar themes that emerged.

To provide a more systematic approach, I then used Microsoft Excel to organize these codes and data bits across all interviews. Over time, I started to group code labels together into general trends. As groups and trends emerged, these were labeled with a general theme that reflected all the codes. During this process, codes were also reorganized so that they aligned thematically.

At this stage, I met regularly with my thesis supervisor for feedback and guidance on my coding, data analysis, and exploration of emergent themes. Richardson (2004) reminds us that writing is part of inquiry. She writes, "Writing is also a way of 'knowing' – a method of discovery and analysis. By writing in different ways, we discover new aspects of our topic and our relationship to it" (p. 473). Therefore, the process of writing Chapter Five and Six produced further inquiry and analysis into the data, as well as new emergent themes. An example of this is in Chapter Six, where two sub-themes were originally coded as one.[5] However, through my writing the analysis deepened, and the sub-themes emerged as a two-part narrative and were later separated for further analysis and for readability.

b. Reflexive Journaling

Reid et al. (2017), writes that "critical researchers are active participants in the research process" (p. 51). Critical ethnography rejects the idea of an objective and neutral researcher but rather is an active participant in the co-construction of meaning (Madison, 2005). Reflexive journaling is a recognized approach within critical ethnography. For example, Carspecken

[5] The two sub-themes were: Working with Whiteness and Deconstructing Tokenism and Whiteness

(1996) writes "discovering your own biases is a process that continues throughout a research project by using such methods as keeping a subjective journal during fieldwork - a special notebook in which you daily write down feelings experienced" (p. 41). For this thesis, the process of reflexive journaling was guided by Madison's (2005) reflections on positionality (p.7), Kirby and McKenna's (1989) ideas of the conceptual baggage (p. 32), and Pillow's (2003) reflections on a reflexivity of discomfort (p. 192).

Critical ethnography is considered a form of ethnography with a political purpose (Thomas, 1993; Madison, 2005). However, the methodology has also been criticized for historically focusing on politics at the expense of inadequately interrogating positionality (Madison, 2005). Madison (2005) writes, "politics is incomplete without self-reflection. Critical ethnography must further its goals from simply politics to the politics of positionality" (p. 7). The author cautions that positionality is not to be confused with subjectivity. She writes,

> Subjectivity is certainly within the domain of positionality, but positionality requires that we direct our attention beyond our individual or subjective selves. Instead, we attend to how our subjectivity in relation to others informs and is informed by our engagement and representation of others. We are not simply subjects, but we are subjects in dialogue with others. (Madison, 2005, p. 10)

Our subjectivities cannot be framed as facts, but rather need to be acknowledged as being shaped by our social location. During the research process, our own positionality needs to be explicitly stated, critically examined, and be available for interrogation. For examples of my personal narrative, please see Chapter One.

Kirby and McKenna's (1989) conceptual baggage is the process of making your thoughts and assumptions about the research topic and process explicit, and therefore reveals another layer

of data that is often present but, in the shadows (p. 32). There is an element of vulnerability that presents itself in the process of interrogating one's assumptions and might bring forth difficult and uncomfortable realizations. The authors recommend recording your reactions to the research process in a systematic manner, and methodically re-visit the data in a process called "layering," where old ideas and records are revisited and re-reflected to provide further insight (p. 52). For example, my research began during the COVID-19 global pandemic and ended after the World Health Organization declared it no longer a global emergency (World Health Organization, 2023). Revisiting journal records in the process of layering allowed me to further reflect during the data analysis phase on how the socio-political context impacted the lives of the research participants, my own life, and the research process.

Further nuancing this process is Pillow (2003), who writes on the role of reflexivity as a methodological tool that needs to be approached with caution. Making one's positionality transparent or visible does not automatically make it unproblematic. The author critiques the dangerous assumption that reflexivity allows the researcher to transcend their own subjectivity and biases. Reflexive practice is then considered a form of confession or absolution that is linked to the Enlightenment era's ideals of truth. Reflexivity is also cited as a form of validating the research, getting closer to validity, and therefore *the Truth*. Modernist thinking is still influencing reflexivity as a methodological tool in the way that modernist subjects are seen as singular, fixed, and separate from others. Instead, the author is pushing for a "reflexivity of discomfort," which renders our understanding of ourselves and others as "uncomfortable and uncontainable" (Pillow, 2003, p. 188). Reflexivity of discomfort reconciles with the limitations of being able to understand ourselves and others. It is a form of reflexivity that the author describes as "that seeks to know while at the same time situates this knowing as tenuous" (p.188). This practice was most

salient during my discussion with my thesis supervisor, particularly during the stages of writing my data analysis and findings (Chapter Five and Six).

For this study, I detailed impressions, thoughts, emotions, and reactions throughout the research process using a confidential journal. I would journal after completing each interview, as well as during the coding process. I was also asked to journal by my thesis supervisor while I was trying to define what my research would be about, which helped identify the conceptual and methodological frameworks for this thesis. During the literature review, I also took notes on my impressions and reactions. These journal entries were later revisited and reflected upon in the process that Kirby and McKenna (1989) refer to as layering (p. 52).

During my data analysis, my reflexive journaling allowed me to identify narratives that were particularly salient to me, potentially overlooked, or where I might hold insider knowledge. Marking my conceptual baggage permitted me to explore areas of discomfort and resistance when analyzing the data and consider my ethical limitations. For example, the process of reflexive journalling facilitated recognition that my racialized identity is not a universal experience or marker. For example, while I am an immigrant, I often "pass" for a Canadian as I have been living here for most of my life, and do not have an accent that is usually racialized. While I am not a white researcher, I risk Othering other racialized experiences by being in a position of authority and through the many intersections of my privileged identities.

Ethical Considerations and Limitations

In this section, I explore some ethical considerations and limitations. My first consideration is around navigating anonymity and confidentiality for members of racialized communities in St John's, NL. I then explore some ethical tensions between the role of a practicing social worker

and that of a graduate student researcher. Finally, potential barriers presented during the recruitment process and other research limitations are acknowledged.

In St John's, NL, the racialized community can seem small compared to other major cities in Canada, and anonymity may be difficult to achieve in very particular cases. As a practicing social worker, I did not interview anyone who ever had or currently has a therapeutic or professional relationship with me. My thesis supervisor, Dr. Sobia Shaikh, is very active and visible in racialized and activist communities of St John's, NL. All transcripts were anonymized during the transcription period, where all identifying information was removed and replaced with pseudonyms, and my thesis supervisor only had access to parts of the transcripts after they had been anonymized. I was the only person fully aware of who participated in this research project.

The Tri-Council Policy Statement (TCPS2) writes that the ethical duty of confidentiality must at times be balanced with other duties, such as legal and professional obligations. I had to balance my ethical obligations as a registered social worker with that of a graduate student researcher. If a participant disclosed that they were in imminent harm, as a practicing social worker, I had the duty to report that information to the proper authorities. My ability to protect the participants' data would only be limited if was brought up in these two circumstances: 1) any information of threat of violence to others, particularly to vulnerable populations including children under the age of 16, 2) any information indicating the imminent threat of harm to themselves (the participant). These limitations were clearly indicated in the consent forms, and fortunately, no information was disclosed by any of the research participants to trigger a duty to report.

During the interviews, many interviewees expressed feelings of deep isolation and lack of social supports. As a social worker, I often connect individuals to resources and follow up with

them. However, the role of the researcher conflicted with my personal narrative of a social worker and counsellor, leading to some internal conflict. The interviews were not meant to be counselling sessions, so I was not able to help people process their experiences or emotions. However, as per my university ethics application, all I did was provide all participants with a list of free community mental health resources at the end of the interview, and I clearly indicated that they were under no obligation to pursue any of them (see Appendix G). I did not follow up on whether these resources were explored. At times, the resources on this list provided were not new to the participants, and hence nothing helpful was provided with the list. Lastly, the list of resources provided mostly one-session only, time-limited counseling or crisis lines, and therefore the potential support that was provided was temporary and short-term.

The recruitment process for participation presented some obstacles in the form of potential language, technological and/or financial barriers. Due to a lack of research funding, I was not able to compensate participants for their time, creating a possible financial barrier. All interviews were done virtually, implying a need for technology as well as a secure and private space to participate virtually. While no one who was interested in participating in this study disclosed such barriers, it is important to consider this for future studies.

There were some potential language barriers to this study. I was not able to provide translated documents into other languages or provide interpretation for the interview. This limitation potentially excludes a significant population of racialized community members. Another limitation was that the transcription software I used, made more errors with interviewees that had accents. This resulted, at times, in incoherent transcripts, which were difficult to comprehend.

The experiences of colonization and the deleterious effects it has had on Indigenous communities cannot be applied to all racialized communities evenly. While Indigenous people may experience intersectional racism and colonialism, I did not explicitly reach out to Indigenous communities or use the word "Indigenous" in our recruitment material. Therefore, while Indigenous participants who identified as racialized would not have been turned away, I did not actively recruit Indigenous participants or connect with Indigenous-serving organizations.

Critical ethnographers recommend using peer debriefing to allow for a continuous reflection of possible conflicting interpretations of the data (Carspecken, 1996; Reid et al., 2017). Due to time and other limited resources, other than the follow-up interview, I was not able to engage in this process. Instead, my thesis supervisor provided guidance and feedback on my data analysis.

Lastly, this is a small-scale project, within the parameters of a master's thesis, and more data would strengthen this study. However, a small-scale study also allowed me to explore the narratives and experiences of the participants in more depth, in ways that I might not have been able to if I had done a larger-scale study. This study takes an ethnographic approach, and therefore takes a snapshot of experiences in a specific moment of time and in localized sites. As a research project that utilizes a small sample size, there is the potential assumption that single narratives will be used as a tool to flatten collective experiences. Rather, my research intention is to highlight racism and the unique standpoint of racialized people. My hope is that this thesis leads to more studies and in-depth analysis.

Summary

This chapter described how critical ethnography compliments the conceptual framework of this thesis. Both critical ethnography and CRT hold the political stance that oppression exists.

By starting with this position, I could explore how (rather than why or if) racism exists in the mental health sector of St. John's, NL. I was able to refocus on questions that detailed the experiences of participants and interpret their experiences through a lens that is consistent with a world that systemically racialize people. The use of reflective journalling allowed me to process and reflect on how my personal narratives influenced, strengthened, and impacted my data analysis, and highlighted potential oversights. Through my recruitment strategies and demographic trends of the province, the migrant experience became salient. While unplanned, it created further depth and complexities into the racialization process.

CHAPTER FOUR: LITERATURE REVIEW

The main purpose of this chapter is to critically review relevant literature on racism and mental health counselling. The chapter also serves to further contextualize the conceptual framework of this thesis. In Part I, I explore the literature on the deleterious effects of racism on mental health, with particular attention to how dominant mental health discourses pathologize responses to racism. In Part II, I offer a synopsis of, and critically assess, the literature which identifies that racial disparities and barriers to accessing mental health services are experienced by racialized people. Finally, Part III summarizes the literature about racism in counselling settings. I demonstrate how this research has focused on supporting the learning journey of service providers and lacks the centring of racialized voices.

Part I: Racism and Mental Health

This section challenges the literature that links experiences of racism with poorer mental health outcomes. While the trend is heavily documented, critical scholars problematize this trend by linking it to interlocking systems of oppression (Fernando, 2012; Joseph, 2017; Mills, 2014; Moodley & Osazuwa, 2021). They critique that the legacy of racism in dominant mental health discourses dangerously runs the risk of internalizing responses of racism as a biological deficiency.

The impact of racism on individuals has been heavily researched and has documented deleterious effects on racialized people's health, generally, and more specifically, their mental health (Berry et al., 2021; Comas-Diaz et al., 2019; Hook et al., 2016; Javed et al., 2022; Jones & Neblett, 2019; Lee et al., 2018; Markin & Coleman, 2021; Nadal et al., 2014a; Okazaki, 2009; Owens et al., 2014; Paradies et al., 2015; Waldron, 2010; Williams et al., 2018; Yeo & Torres-Harding, 2021; Yusuf et al., 2021). Experiences of racism have been linked to many adverse

effects including depression, anxiety, and suicidality (Diaz et al., 2001; Hwang & Goto, 2008; Kogan et al., 2022), stress responses (Matheson et al., 2021; Pascoe & Richman, 2009), physical health (Paradies et al., 2015), lower self-esteem (Nadal et al., 2014b) and even an increase in "risk-taking" behaviours (Jamieson et al., 2012).

The impacts of racism on mental health have been explored through multiple frameworks and perspectives. For example, using the framework of social determinants of health,[6] Berry et al. (2021) linked racism to adverse impacts on child development and health, particularly the socioemotional well-being of children. Similarly, a study by Salami et al. (2021) explored the perspectives of African immigrant parents on what factors influenced their children's mental health. Racism was identified as a factor, particularly in areas of education and employment. Utilizing a different framework, Williams et al. (2018; 2022b) described the mental health impacts of racism as a form of "racial trauma" where racism leads to trauma-like symptoms akin to post-traumatic stress disorder (PTSD). Utilizing the framework of racial microaggressions, Nadal et al. (2014a) demonstrated that more experiences of racism were associated with poorer mental health outcomes, specifically depressive symptoms and negative emotions (such as sadness, anxiety, and anger).[7] Some macro-level analysis of racism on mental health is also provided by Williams and Mohammed (2013), who demonstrated how institutional and cultural racism have adverse effects on the mental health of racialized people. For example, their review

[6] The World Health Organization (WHO) defines social determinants of health as "the circumstances in which people are born, grow up, live, work and age, and the systems put in place to deal with illness. These circumstances are in turn shaped by a wider set of forces: economic, social policies, and politics." For more information see: https://www.who.int/news-room/questions-and-answers/item/social-determinants-of-health-key-concepts

[7] A definition for racial microaggression is provided in Part III.

found that institutional processes such as mass incarcerations, forced removals and relocations, police brutality, and witnessing community violence led to poorer mental health outcomes.

While it is crucial to comprehend and document the profound impact of racism on racialized communities, is it imperative that racism not be reduced to an individual pathology (see Fernando, 2012; Joseph, 2017; Moodley & Osazuwa, 2021). Critical scholars caution how the biomedical model continues to have a strong influence on dominant mental health discourses and emphasizes biological deficiency as a root cause of mental illness (Fernando, 2012; Joseph, 2017; Mills, 2014). Such narratives risk framing the problem of racism as an internal issue rather than linking people's responses to a systemic form of oppression (Fernando, 2012; Joseph, 2017; Mills, 2014).

Historically, mental illnesses have been used to depict the racialized individuals as inferior. In the 19th century, Darwinism and the theory of degeneration led to the development of the biomedical psychiatric model in Western psychology (Fernando, 2014). The influence of social Darwinism and eugenics within Western psychology was used to rationalize racial superiority through phenotypic differences and to justify the "strengthening of the human gene pool through genocidal actions" (Moodley & Osazuwa, 2021, p. 10). Race was seen as a genetic marker for being "psychically underdeveloped," less intelligent, and genetically inferior (Fernando, 2014, p. 23). Prominent scholars argued that racialized people were "not psychologically sophisticated, that they represented their illness in physical and somatic ways, and that they found it difficult to express themselves verbally in a way that was consistent with the psychotherapeutic model" (Moodley, 2018, p. 82). The legacy of racism within the foundations of mental health services continue to portray the racialized person as deficient (Moodley, 2018).

The culmination of embedded racist ideologies in mental health systems, and the pathologizing of social suffering is highlighted in the historical analysis of psychosis and anti-black racism (Fernando, 2017, 2018; Joseph, 2017; Metzl, 2010). Fernando (2018) and Metzl (2010) offer an illustration of how Black men are differentially racialized (see Chapter Two for definition). Anti-black racism facilitates a differential form of racialization where Blackness becomes synonymous with dangerous, therefore justifying the control of black lives (Maynard, 2017). Fernando (2018) and Metzl (2010) documented the historical trend of how schizophrenia's public perception changed over time. With the civil rights era, and the removal of dementia praecox (a disorder that was associated with crime and violence) from the Diagnostic and Statistical Manual of Disorders (DSM), schizophrenia has been disproportionately diagnosed onto Black bodies (Fernando, 2018). Metzl (2010) argues that the depiction of schizophrenia as a violent disorder was imposed onto Black men as a form of social control during a time of racial reckoning. He points to cultural references that show that the Black community uses schizophrenia as a metaphor for Black rage. Therefore, schizophrenia and anti-Black racism converge by pathologizing responses to racism. Anger and rage towards injustice are pathologized as dangerous and internalized as a disorder to be controlled by the medical community (Metzl, 2010).

This section of my literature review highlighted the strong connections between mental health and racism. Critical scholars of mental health encouraged us to deepen our understanding of the connections between racism and mental health (Fernando, 2017, 2018; Joseph, 2017; Metzl, 2010, Moodley, 2018). These scholars argued that, in addition to understanding that racism causes mental health and distress, the impact of racism on racialized individuals needs to be understood and acknowledged as a response to the oppression, not as an internalized problem.

This thesis draws from these scholars and endeavours to conceptualize mental health diagnoses and disorders as linked to interlocking systems of oppression.

Part II: Beyond Access

In this section, I review research that demonstrates racial disparities in accessing mental health services. Research identifying access barriers for racialized people is also explored. While there is acknowledgement that racism is a service barrier, my review found a common trend of skill-based competency frameworks as a solution proposed by institutions to address this service barrier (Bhui et al., 2007; Hernandez et al., 2009; Rice & Harris, 2021). Critical race scholars have critiqued skill-based competency education as a solution which inadequately addresses systemic and institutional racism within mental health systems (Fernando, 2018; Joseph, 2017, Moodley et al., 2018).

Despite evidence that racism impacts mental health (Berry et al., 2021; Okazaki, 2009; Paradies et al., 2015), research in Canada demonstrates that white respondents are more likely to report having accessed and utilized mental health services compared to other racialized groups (Chiu et al., 2018; Durbin et al., 2014; Saunders et al., 2018; Tiwari & Wang, 2008). For example, a study by Chiu et al. (2018) showed that mental health service use was generally lower among racialized groups (in this case, South Asian, Chinese, and Black respondents) compared to white respondents. Another study by Saunders et al. (2018) found that immigrant youth were more likely than non-immigrant youth to present to emergency services with a first mental health crisis, suggesting barriers to accessing outpatient mental health care. However, a review by Hannson et al. (2012) critiqued the literature for inconsistent categorization of groups and a saturation of research being completed predominantly from three urban cities (Montreal,

Toronto, and Vancouver) in Canada. Their review found that racialized groups were categorized differently across the literature and demonstrated variability among and within such groupings when it came to reports of mental health prevalence.

Reasons for these disparities in racialized people's access to Canada mental health services have been linked to service barriers that range from cultural stigma, cultural differences in self-reporting trends, language barriers, system navigation difficulties, use of informal supports (such as family or faith-based), racism, and referral biases by healthcare professionals (Feng et al., 2023; Reitmanova & Gustafson, 2007, 2009a, 2009b; Salam et al., 2022; Salami et al., 2019; Thomson et al., 2015; Tulli et al., 2020). For example, a qualitative study by Tulli et al. (2020) looked at the perspectives of immigrant mothers accessing mental health services for their children and identified the following barriers: financial strain, lack of information, feeling unheard during service intake and assessment, racism and discrimination, language barriers, stigma, and feelings of isolation. Participants reported that racism instilled a fear of accessing services and a sense of competition for services among racialized groups. Similarly, a scoping review by Thomson et al. (2015) suggested that racism impacted trust in services for their research participants. They wrote, "Experiences of discrimination at the individual and societal level may lead to low levels of trust in societal institutions, including mental health services" (Thomson et al., 2015, p. 1898). Therefore, racism has been identified in some studies as a barrier to accessing mental health supports.

Interestingly, racism was primarily identified as a barrier through the lens of the migrant experience in some studies (Reitmanova & Gustafson, 2007; Thomson et al., 2015; Tulli et al., 2020). For example, in a qualitative study that explored the perspectives of immigrant Muslim women when it came to maternity health in St. John's, NL, racism was identified as negatively

impacting “resettlement” (Reitmanova & Gustafson, 2007). The povertization of the migrant experience in Canada (which I argue are also tied to racism), such as difficulties finding employment, low income, experiences of discrimination, and social isolation, was also cited as a systemic issue that impedes the settlement experience but was not directly linked to systemic racism (Reitmanova & Gustafson, 2007; Thomson et al., 2015).

The focus on barriers to accessing mental health has been critiqued by Joseph (2017) as limiting our ability to interrogate embedded racism within mental health systems. He warns:

> The solution to the problem of access becomes focused on who needs or seeks services (as a matter to be addressed with education or outreach), rather than critiquing the system, even where there are “good intentions” to direct racialized immigrants to mental health care. (Joseph, 2017, p. 237)

The need to “critique the system” is evident when interrogating the Eurocentric foundations and whiteness of mental health systems (Fernando, 2014; Joseph, 2017; Lazaridou & Fernando, 2022; Moodley et al., 2018).

Rather than interrogating the inherent systemic racism in mental health systems, the solution presented in the literature to access barriers has been to implement specialized services and training through cultural competency frameworks (Bhui et al., 2007; Hernandez et al., 2009; Rice & Harris, 2021). Rice and Harris (2021) define cultural competency as “a set of interpersonal skills that allow health professionals to understand and appreciate individuals of different backgrounds and provide culturally appropriate services to diverse populations” (p. 65). However, Joseph (2017) critiques, “cultural competence approaches tend to focus too much on individual attitudes and less on systemic racism and institutionally embedded racist structures”

(p. 240). Cultural competency misses the mark, as it does not address the legacy of racism within mental health systems and the shadows that remain.

Cultural competency is critiqued for its focus on a skill-based format where clinicians are tested on their mastery of identifying a set of beliefs, attitudes, and behaviours that have been used to describe specific cultural groups (Abrams & Moio, 2009; Metzl, 2010). Metzl (2010) warns that cultural competency frameworks risk "reinforcing the very hierarchies it attempts to work against" (p. 200). He elaborates:

> [...] cultural competency interactions oversimplify the complex ways in which people negotiate difference, a process that is based on the intersubjective responses of two participants rather than the diagnostic observation of just one. […] cultural competency's unidirectional flow reinforces racialized power grids while leaving the culture of the doctor free from diagnostic scrutiny. (Metzl, 2010, p. 201)

Metzl (2010) is speaking of two things: that cultural competency models risk essentializing and flattening culture and that it leaves racism unmarked. Western psychology and psychiatry emerged from Western ways of thinking linked to the European post-Enlightenment Era (Fernando, 2014). Fernando (2014) argues that what arose was a worldview that privileged and valued positivism, causality, objectivism, and rationality. For example, this is reflected in the embracing of the Cartesian division, also known as mind-body dualism, within mental health frameworks, (Fernando, 2014).

Using postcolonial theory, Martinez et al., (2013) problematizes the dichotomy presented in cross-cultural frameworks. They see this dichotomy as essentializing cultures while being upheld by Eurocentric structures that see Western cultures as the "gold standard" (p. 3). They argue that Western culture becomes normalized and centralized while anything else is deviant

(Martinez et al., 2013). Western culture then becomes the measuring stick of all other cultures, thereby reinforcing global power dynamics (Martinez et al., 2013).

In summary, the literature I reviewed demonstrated that there are racial disparities in mental health access and documented both individual and systemic barriers to access. However, critics provide an important analysis that the focus on access by itself does not adequately interrogate the unmarked racism within mental health systems. Culturally competent, skill-based solutions risk both minimizing the existence of racism and leaving racism uninterrogated. Together, this literature suggests that it is imperative to find anti-racist solutions which address the permanence and insidiousness of racism in mental health systems.

Part III: Racism in Counselling Settings

The large volume of resources available about racism in counselling settings points to the existence and prevalence of racism in counselling (Archer, 2021; Bartoli et al., 2015; Chang et al., 2020; Fernando, 2004; Laszloff & Hardy, 2000; Moodley & Khina 2015; Ridley, 2005). Throughout the literature, racial microaggressions were a common framework used to recognize the presence of racism in counselling settings (Hook et al., 2016; Lee et al., 2018; Owens et al., 2014; Yeo & Torres-Harding, 2021). However, while the literature acknowledged that racism remains an issue in the counselling room, I discovered that very little attention was focused on the racialized people who accessed these counselling services. In-depth narratives on the experiences of racialized people were difficult to find. On this basis, I argue that the literature about racism in counselling disproportionately focused on the learning needs of (often white) service providers, rather than highlighting and understanding the complex realities of navigating mental health systems for racialized people.

This literature is relevant because racism matters in counselling. For example, Yeo & Torres (2021) found that 75% of their participants reported that race and culture were relevant topics for them to bring into counselling. Additionally, their participants reported being aware of when counsellors were uncomfortable talking about culture and race, which impacted their trust in the counselling experience. This suggests that talking about race and racism in counselling settings is uncomfortable for some practitioners.

Racial microaggressions[8] in therapeutic spaces were a common analytic framework in this section of the review (Hook et al., 2016; Lee et al., 2018; Owens et al., 2014; Yeo & Torres-Harding, 2021). Sue (2010) define racial microaggressions as "brief, everyday exchanges that send denigrating messages to certain individuals because of their group membership" (p. 24). Racial microaggressions was common in counselling settings and negatively impacted the client-therapist relationship (Hook et al., 2016; Owen et al., 2014; Yeo & Torres, 2021). Hook et al. (2016) found that 81% of participants reported racial microaggressions in counselling. Similarly, Owen et al. (2014) found that 53% of their participants reported experiencing a racial microaggression in counselling and that only 24% of those participants reported having this microaggression discussed afterwards. Yeo & Torres (2021) highlighted the damaging effects that racial microaggression had on the therapeutic alliance and document the importance of addressing this rupture. The literature on racial microaggressions therefore confirms the existence of racism and its deleterious effects on the client-counsellor relationship.

[8] Racial microaggressions lack a macro-level analysis (Lui et al., 2020), and therefore do not align with this research's conceptual framework. Furthermore, while counselling is an interpersonal experience, this thesis conceptualizes counselling services as part of the larger mental health system. While understanding racial microaggressions can help service providers to be mindful of how they might be subtly racist, I argue that it ignores the cumulative harm that mental health systems cause from an institutional and cultural standpoint (Sue, 2010).

When exploring racism in counselling spaces, the experiences and reflective processes of both white and racialized service providers are adequately documented (Ahsan, 2020; Kistan, 2004; McDowell, 2004; Miu & Moore, 2020; Smith et al., 2021; Spalding et al., 2018). For example, Ahsan (2020) explored how white female psychologists understood their whiteness and how it operated in therapy. Miu & Moore (2020) reflected their personal experiences of racism as an Asian American psychiatrist and Black psychiatrist during the COVID-19 pandemic. Spalding et al. (2018) and Kistan (2004) reported on the experiences of racialized counsellors when working with white clients. Literature also exists by white and racialized therapists on how to tackle clients' racist views in counselling (Bartoli & Pyati, 2009; MacLeod, 2013; Drustrup, 2021).

This review found that research that centres the experiences of racialized people in counselling was particularly focused on cross-racial therapeutic relationships when white therapists worked with racialized clients (Chang & Berk, 2009; Chang & Yoon, 2011; Pope-Davis et al., 2002; Rogers-Sirin et al., 2015). In part, this literature may be a response to the research on the "racial matching" of clients and therapists, although not all studies explicitly stated this.

Although the literature about racial matching was inconsistent about the efficacy of the approach (and the results were variable among different racialized group), the general trend suggests that racialized clients prefer to be matched with a therapist of similar racial background (Cabral & Smith, 2011; Ertl et al., 2019; Flaskerud & Liu, 1991; Gamst et al., 2001; Jacobs et al., 2022; Kim & Kang, 2018; Karlsson, 2005; Maramba & Hall, 2002). For example, a study by Kim and Kang (2018) found that racial matching increases the number of counselling sessions.

The authors suggest a stronger therapeutic alliance when working with someone of similar racial background as it provides more "trust" in the counsellor (Kim & Kang, 2018, p. 108).

However, as I suggested earlier, the literature was inconsistent, mostly due to the lack of clarity on key conceptualizations among the studies, including the conflation of race, ethnicity, and culture; overgeneralization of racialized groupings; and methodological differences (Ertl et al., 2019; Karlsson, 2005). The conflation of race and culture makes this literature difficult to summarize succinctly, but it shows that this problem is being identified within other research frameworks. Taking an intersectional approach,[9] Ertl et al. (2019) problematize the use of racial matching as minimizing the multifaceted-ness of our social identities. The authors suggest "multicultural competence" as the solution to the challenges of client-therapist matching (Ertl et al., 2019, p. 316). For example, a study by Owen et al. (2011) found that a mental health professional's multicultural orientation improved the therapeutic relationship. The authors describe multicultural orientation as "a way of being" and "a way of doing," where counsellors implement their cultural awareness, values, and knowledge (Owen et al., 2011, p. 274). Another study by Owen et al. (2016) similarly found that the counsellor with more cultural humility were more successful with racialized clients.[10] These frameworks tackle the issue of racism in counselling differently; as a skill that needs to be harnessed by (white) counsellors. However, racism in counselling gets conflated with culture, and becomes further diluted when the focus is on skill development.

One of CRT's tenets is to prioritize and highlight voices of colour (see Chapter Two). I found that in-depth descriptions and reflections on the experiences of racism in counselling

[9] See Chapter Two for more on the concept of intersectionality.
[10] Owen et al. (2016) defines cultural humility as "an other-oriented stance, which is marked by openness, curiosity, lack of arrogance, and genuine desire to understand clients' cultural identities" (p. 31).

settings for racialized people were difficult to find. This sentiment is echoed by Chang and Beck (2009) who recognized the dearth of research that examines the experiences of racialized people in counselling settings. They write:

> […] few studies have examined how clients' attitudes, perceptions, and experiences relate to [the] therapy process and outcome in actual multicultural counselling relationships. The result is a knowledge base that is somewhat constrained by investigators' understanding of the factors that may affect minorities' experiences of therapy. (Chang & Beck, 2009, p. 4)

Chang and Beck (2009) confirm the knowledge gap on literature that highlights the perspectives of racialized people as "clients."

I found two articles which explored the experiences of racism in counselling settings from the perspective of racialized "clients". One study by Gerrard (1991) looked at the experiences of racism and sexism within counselling settings with racialized women in Canada. Most of her research participants indicated that they would want the issue of race and the whiteness of the counsellor to be explicitly named in counselling. Gerrard recognised the intersectionality of racism and sexism in many of the research participants' narratives, and that these forces sought to "render them powerless" (Gerrard, 1991, p. 564). She concluded that a major limitation was her white identity and advocated for more research conducted by racialized women. Gerrard acknowledged her positionality as a white researcher by writing:

> A white woman examining racism from the perspective of women of colour raises political, ethical, and moral concerns. This is so because of the power differentials that exists between white and people of colour in a racist society such as ours, the way in which the researched have traditionally been objectified by the researcher, and the

> possible exploitation of women of colour in using their stories to benefit others, including myself. (Gerrard, 1991, p. 556)

The lack of experience of racism by the researcher was acknowledged as a limitation. While providing no solution, Gerrard tries to mitigate the impacts of the white gaze on her research participants by leveling researcher-participant power imbalances as much as possible.

A second study by Whitley et al. (2006) explored the stories of immigrants who were reluctant to use mental health services in Canada. Racism was not identified as a factor, which the authors recognized might be due to the reluctance of raising such an issue to white interviewers. They wrote:

> Finally, participants hardly mentioned racism, a theme prominent in the British literature, as a barrier to health care. It is unlikely that this reflects a real belief among participants that racism is absent from the Canadian health care system; it may simply indicate a reluctance to raise the issue with white interviewers. (Whitley et al., 2006, p. 206)

Whitley et al. further argued, alongside Gerrard (1991), that racialized researchers would offer more safety to racialized participants in talking about racism. Lack of racialized voices on experiences of racism seemingly overlaps with the lack of racialized researchers exploring this topic. This thesis presents an opportunity to do both.

While there is some research that looks at the intersections of mental health counselling and racism, the perspectives that centre the racialized client are de-emphasized. The scholarly literature focuses on the needs of those in power–the service provider, who is usually assumed to be white. When the voices of racialized peoples are included, the focus is on the therapist and their learning journey. While this seems pragmatic, as most readers are assumed to be mental health professionals, it risks taking away the nuances and complexities of the lived realities of

racialized peoples. Lastly, the need for research done by racialized researchers was identified (Gerrard, 1991; Whitley et al., 2006).

Summary

My literature review served to further build on and nuanced my conceptual framework in a bi-directional manner. I demonstrated the complexities of linking racism with poorer mental health outcomes, and the dangers of conceptualizing responses to racism as internalized problems. I explored the literature around barriers to accessing mental health services and critiqued a commonly proposed solution of skill-based approaches. Finally, I demonstrated that the narratives present in the literature on racism in counselling settings prioritize the learning needs of counsellors, which minimizes the richness of stories available from the perspective of racialized people.

CHAPTER FIVE: EMPIRICAL FINDINGS AND DISCUSSION – REASONS, ACCESS, AND BARRIERS

Chapters Five and Six report on the findings and subsequent analysis of the interview data. In lieu of separating the findings and discussion chapters, I have opted to integrate findings and discussion in Chapter Five and Chapter Six. Chapter Five constitutes both the findings that emerged from participants' empirical responses to the interview questions, and a discussion of each finding. In Chapter Six I report and discuss findings that emerged from a second-step analysis using CRT concepts.

This chapter describes themes that emerged from the nine participants' direct responses to interview questions about their lived experiences of seeking and accessing mental health services (see Chapter Three and Appendix C). This chapter provides a descriptive account of two main themes: *participant reasons for seeking counselling*, and *access and barriers*. The theme of participant reasons for seeking counselling complicates and contextualizes the lived realities of the research participants by exploring why they sought out mental health counselling. The theme of access and barriers provides further information about the participants experiences of seeking or accessing mental health counselling services in St John's, NL.

As I discussed in Chapter Three, the findings in Chapters Five and Six are presented in an aggregate form primarily to ensure the anonymity of the participants. Additionally, unless necessary for analysis of the narrative, the gender inclusive pronouns of they/them will be used to increase participant anonymity. While each interview was analyzed individually, the purpose of the research was to understand the overall themes presented collectively by all the research participants. To ensure anonymity, any quotes elaborating on these themes do so without providing specific details about the participant unless it is salient or necessary to elaborate on a particular aspect of the narrative.

Participant Reasons for Seeking Counselling

This theme describes why the nine research participants sought mental health counselling. Most participants reported multiple and complex reasons for pursuing mental health counselling. The data analysis produced four different sub-themes categorized as the following: *support for a mental health disorder or diagnosis*, *racism*, *interlocking systemic oppression*, and *therapy as coerced*. A discussion is provided at the end of this section that problematizes how dominant mental health discourses individualize suffering rather than recognize the systems of oppression that are at play and impacting people's lives.

Support for a Mental Health Disorder or Diagnosis

Five participants self-identified as having a mental health diagnosis, and they sought support around this. These participants self-identified with the following mental health disorders: attention deficit hyperactivity disorder (ADHD), post-partum depression, post-traumatic stress disorder (PTSD), eating disorders, depression, and anxiety.

For some, their diagnosis provided a straightforward reason for obtaining counselling services. For example, participant 2 who was diagnosed with ADHD sought services because they needed a prescription refill and felt that their diagnosis was impacting their ability to maintain relationships. However, other participants identified their mental health diagnoses as being connected and interlinked with narratives of trauma and oppression.

Another participant shared having diagnoses of ADHD, PTSD, and an eating disorder. Their reasons for accessing counselling went beyond their mental health diagnoses.[11] Throughout the interview, this participant disclosed experiences of trauma, childhood abuse, transphobia, and racism. They recounted, "As a kid, I was constantly abused. I dealt a lot with abuse as a kid. […]

[11] To protect their anonymity, this participant's number ID will not be included.

So that trauma sort of they came they rose up to the surface as well when I was in Canada." Not only was this excerpt troubling, but this participant also shared that their parents wanted to inflict harm on them based on their gender identity. While the participant sought mental health services due to their mental health diagnoses, they also explained that their diagnoses were linked to their experiences of childhood trauma and transphobia. Therefore, a mental health disorder had varied meanings for different participants. For some, it was a way to address or explain personal problems (such as maintaining relationships); for others, it was a response to experiences of violence and interlocking systemic oppression.[12]

Racism

This section explores experiences of racism as a reason for accessing mental health counselling. Most participants (seven out of nine) explicitly discussed their experiences of racism in a variety of settings including within mental health systems, court (legal) systems, public settings (such as on the street), virtual platforms, non-profit agencies, and post-secondary institutions. This supports the literature in Chapter Four, that indicates that racism has been linked to poorer mental health outcomes (Berry et al., 2021; Comas-Diaz et al., 2019; Hook et al., 2016; Javed et al., 2022; Jones & Neblett, 2019; Lee et al., 2018). These experiences were reported as having impacted overall well-being, but only three participants directly stated that racism was a reason for seeking mental health counselling. This finding does not mean that racism did not impact the lives of other racialized individuals; rather, they did not explicitly identify this as a reason. While racism might not be the only factor, it can present itself insidiously through various avenues such as social isolation, rejection, and marginalization.

[12] The latter is further explored in the sub-theme Interlocking Systemic Oppression

An example of an explicit statement of racism as a reason for mental health counselling is demonstrated in the excerpt below. Participant 8 expressed:

> Racism is the reason why I went for, one of the reasons why I went for counseling. Because I've never been that down or that depressed in my entire life. Like I never really faced, I never faced racism before. I didn't know what it felt like.

Participant 8 shared that they had never experienced racism until coming to Newfoundland and Labrador. They explained further:

> You know, back in [country of origin] we are all Black people, even if you are light skinned, you're Black. They didn't, you know, trying to objectify me or have like a fetish for me or, you know, say insulting words to me or call me this or call me that. Even if they do, I can say back to them because we are all the same. Right?

The participant shared that their racialized identity shifted; what it means to be a Black person, in a Black body, had different meanings in their country of origin and in Canada. As indicated in my conceptual framework (see Chapter Two), this shift demonstrates that race is a social construct, relies on time and place, and that racialization is a process where difference is constructed and strengthened through social structures and systems (Este et al., 2018).

Participant 1 relayed that they sought counselling because they felt lonely and was mistreated based on their race. They reflected: "I think loneliness was a really big one. Um, and how like I'm mistreated based on my looks and color and you know, they just like make assumptions based on my background." The participant further reflected on how their experience of isolation and the pandemic lockdowns in NL were distinct. They shared that their sense of loneliness was not exacerbated by the lockdown restrictions, as it was for others. They reflected:

> And loneliness was especially hard because like and it's not because of COVID. I think what triggered me was like, you know, everyone was like screaming, Oh, I have cabin fever, you know? But by 2020, I lived there for five years... And like, I had cabin fever for like fucking five years, you know.

When individuals are actively and continuously marginalized in society, social isolation and exclusion exacerbate the harms of racism and other forms of oppression. The undertones of resentment in this participant's story were fueled by the lack of societal recognition that racialized people, particularly people with histories of migration, are often socially isolated.

Clearly, social isolation creates serious consequences for the well-being of people who are racialized. A study by Best et al. (2021) demonstrated that pandemic quarantine measures were correlated with elevated negative emotions and distress. A protective factor identified by their research was social cohesion and connectedness. Best et al. (2021) claim, "Individuals embedded in socially cohesive neighborhoods experienced less depression, worry, emotional distress and panic" (p. 150). However, in the case above, social isolation was complicated by interpersonal and systemic racism. The participant stated that they did not feel lonely or isolated due to pandemic restrictions, but rather, this loneliness stemmed from discrimination and social exclusion based on racism.

Interlocking Systemic Oppression

In addition to racism, five participants identified or alluded to other forms of structural oppression as a reason for seeking mental health support. They disclosed that they sought counselling due to systemic forces such as homophobia, transphobia, ableism, gender-based violence (such as sexual assault), family violence rooted in heterosexism, grief, and family separation due to migration (diaspora).

For example, participant 7 disclosed that the primary reason she sought mental health counselling was that the trauma of sexual assaults had impacted her daily living and ability to complete school. She recounted:

> I just wanted to kind of work through the trauma that I've been through because I just had a series of sexual assaults happen so close to each other. And it's been really hard trying to work my way back from that. […] I feel like I could definitely do a lot better academically if I was in sound place, if I just was able to work through everything and just, you know […] Just because I don't want to fail out I guess, I worried about that a lot.

While the participant is clear on the impacts of trauma on their well-being, this trauma is based on the systemic issue of gender and gender-based violence. Tseri (2018) cautions that trauma therapy can individualize issues of gender-based violence by "reduc[ing] social justice issues into psychological symptoms" (p. 251). Individualizing trauma ignores the power relations of gender, as well as other dynamics such as the precarious status this student holds. When the participant said, "I don't want to fail out […] I worried about that a lot," it is important to note that this student is an international student, and failing would mean having serious implications for their status in Canada (Government of Canada, 2023c).

Participant 3, who was a permanent resident, shared the trauma of being separated from their family. This participant sought bereavement counselling due to the grief they experienced from the loss of their mother. At the same time, their grief and pain were further complicated by being part of a diaspora. A sense of disconnection from home, distance due to geography, and inability to travel due to time or money are inextricably linked with their experiences of grief. They shared, "It was when my mother passed away and wasn't able to go back to the [country of origin]. […] I think because not being able to... be there for my mom was kind of traumatic for

me too." This participant also shared many stressors for them as a new immigrant in St John's, NL. They reflected:

> Yeah, but it seems like a lot of the stressors have been sort of moving here and, you know, having an adjustment in your lifestyle, your income, like your job, like not being able to work your, the profession that you have been working for so long. A lot of like, yeah, a lot of stressors that I think are kind of environmental it sounds like, and systemic.

This participant shared that the stressors of being an immigrant were systemic and compounded their grief. Their grief then becomes racialized, as it is tied to being part of a diaspora, being geographically separated from family.

In summary, this section highlighted how one of the main reasons for seeking mental health counseling can be externalized. Structural forms of oppression, and its impact on the individual, created reasons for seeking mental health support. The problems might be presented as internal reasons such as grief or depression, but such expressions are responses to external factors represented in systemic oppression.

Therapy as Coerced

The theme of therapy as coerced emerged from the narratives of two participants who were mandated to complete mental health counselling by their post-secondary institution, or risk expulsion. Two participants reported struggling with suicide. [13] Both students were international students, meaning that their status in Canada was intrinsically tied to being enrolled in a post-secondary institution. Their post-secondary institution ordered that they attend mental health counselling provided by the university, or else risk expulsion. Both participants shared that it was not a choice for them. The first participant shared:

[13] These participants will not be numbered to further protect their anonymity.

> I had to do therapy or else I would not be taken back to [the post-secondary institution]. Yeah. So that was part of the reason why I went for therapy. […] They said if I'd have to go for therapy, then the therapist will give me a letter saying I'm good to go. […] Like I just had to do it because I didn't want to get kicked out […].

The second participant shared concerns that the confidentiality of these counselling sessions was being compromised. They recounted:

> So, they made me sign a contract saying that anything I say to a therapist will be disclosed to [another department]. Yeah. It was very concerning. […] And then I figured out that [another department] was going to [student clinic] to ask about whether I should be allowed to live [on-campus].

Such an experience left this participant to mistrust university support services and felt that the counselling experience was "unhealthy." They disclosed:

> I couldn't see a therapist at [student clinic] for a long time after that. […] It was basically unhealthy therapy. And like, it's just hard to open up right when you, basically, you know it's going to be used against you.

Similarly, the first participant felt that they did not benefit from the experience. They reported:

> She was just there, you know, I would talk, then she would say something and then at some point, you know, she was just suggesting, I just do this do that do that. And these are things that I've tried before. It doesn't, it just wasn't for me. And then I just said, well, thank you. Then when it was over, I was glad I didn't have to go back there again.

Because of this, both participants felt they could not share openly during their counselling experience, and lost trust in the counselling services available to them as students.

During the interviews, both participants revealed that they had struggled with family violence, childhood abuse, racism, homophobia, and transphobia. For example, one participant shared:

> One of the reasons I tried to die by suicide was the fact that I felt very invalidated in my gender identity. And I did not feel like there was any way for me to be accepted for my gender identity.

This participant disclosed repeated experiences of transphobia on campus, such as misgendering, use of their dead-name, and sexual harassment. For example, the participant disclosed that the student clinic still insisted on using their dead name. They said:

> [Student clinic] has denied to get my name changed for any other services so they still have my dead name on file even for internal use like even for e-mails or for conversations […] I mean, it's not the first time that has happened [services using dead name] to me that happened to me in [Health Authority] as well, when I was in there in the hospital at the E.R.

Rather than the institution addressing these stressors, the students were held accountable for what happened to them and mandated to attend counselling services. Despite the institution's obligation to prioritize the well-being of the student and the wider community, the student's mental health became subject to criminalization through the process of liability and expulsion. Expulsion in this case is a form of punishment that has exacerbated consequences for international students. As the students discussed in their interviews, being expelled would mean a loss of status in Canada, and for these students, being sent back to a violent home life. Additionally, for international students in general, there is an added financial toll and precarity in their status in remaining in Canada.

Discussion

In this section, we explored the multi-faceted reasons for why the research participants sought out mental health counselling in St John's, NL. For a small minority, the reason was quite singular and particular, but for most, the reasons were complex and interconnected. While mental health diagnosis was a salient reason for some, for most participants this diagnosis was clearly linked to other narratives in their lives. Despite this analysis, the biomedical model still holds a strong influence on contemporary dominant mental health discourses by putting emphasis on biological deficiency as a root cause of mental illness (Fernando, 2014; Joseph, 2017; Mills, 2014). These discourses internalize and individualize the problem, while simultaneously pathologizing social issues (Fernando, 2014; Joseph, 2017; Mills, 2014).

Mills (2014) explores how suicide is portrayed as an individual or biological deficit rather than a response to suffering from inequality and oppression. For the two participants that were coerced into attending mental health counselling, not only were their experiences negative and harmful but they were also treated as risks and liabilities to themselves and to the larger university community. Not only is this a "pathologizing of social problems as mental illness" (Joseph, 2017), but it is also a criminalization (through the process of liability) and marginalization of students who are already vulnerable as temporary status holders.

When problematizing the link between mental health and social oppression, the mad studies[14] concept of healthification[15] proves useful. *Healthification* is defined as, "the conversion

[14] Mad studies is an umbrella term for a movement that is critical of the mental health system and is informed by the perspectives of psychiatric survivors and mad-identified researchers and academics (LeFrançois et al., 2013). Mad studies see the pathologizing of social suffering as a form of social control and argue that psychiatry, historically, was and still is used as a form of social control (LeFrançois et al., 2013).

[15] Mills (2014), a mad studies scholar, provides a harrowing example of healthification through a case study of the mass farmer suicides in Vidarbha, India. These farmers' suicides are seen by the government as an individual deficit, despite the evidence that the suicides were political responses to global power imbalances and socio-

of social problems into health problems. As with the medicalization of human distress at the level of the individual, healthification functions to divert attention from the systemic and hegemonic conditions that undermine human well-being" (LeFrançois et al., 2013, p. 336). Therefore, responses to experiences of racism, and other forms of violence need to be conceptualized and explored as responses to systemic manifestations of oppression. The theme of coercion towards an individual requiring counselling or clinical intervention, effectively putting the onus of responsibility on the person facing harm, was explored. As the institution followed a healthification approach, it was able to exert its authority towards ostensibly caring for the students. However, this approach offloaded responsibility for the students' well-being on the students themselves, which ultimately protects the interests of the institution.

While only three participants explicitly reported racism as a reason for seeking mental health services, most reported experiencing racism in their lives. The next section provides narratives of how racism presented itself through access and experiences of mental health counselling and services.

Access and Barriers

The theme of Access and Barriers aligns with the research question: what are the experiences of racialized individuals living in St John's, Newfoundland, and Labrador when they access (or try to access) mental health counselling? The question has two parts to it: how are participants accessing services and what happens when they do?

---

economic suffering. Intervention strategies are focused on preventing suicides, citing genetic deficiencies, and pre-existing mental illnesses of farmers, rather than exploring the core issue of poverty due to globalization. Mills (2014) calls this the "psychiatrization of economic suffering," (p. 41) seeing the government response as a tool to mute social suffering.

In this section, we explore the following sub-themes: *access pathways of research participants*, *service barriers identified by research participants*, and *anti-migrant racism in emergency services*.

Access Pathways of Research Participants

This section maps out each research participant's pathway to accessing (or trying to access) mental health counselling services. By providing an overview of how participants entered mental health systems, it provides context to the "culture" of mental health services as racialized and migrant participants experienced it. Access patterns are identified, laying the groundwork for the subsequent sub-themes.

Each pathway is documented in Table 1. The first column lists the initial referral, which details who referred the participant to services. The referral pathways included self-referrals or referrals made by an organization or institution (e.g., a university). Being self-referred indicates that the individual sought out services without being prompted or coerced to do so. The second column maps out the entry point, which is the first service that the participant accessed. Entry-point services ranged from outpatient programs, emergency services, private counselling, and student health clinics. The last column provides details as to whether the entry point service (column 2) referred the participant to any additional referrals or services.

Table 1
Access Pathways of Research Participants, St John's, NL

Initial Referral	Entry Point	Additional Referrals
University staff	University Counselling Interns	N/A
Self-referred	Student Health Clinic	Student Clinic Group (insomnia)
Self-referred	Outpatient Community-based program	N/A
Self-referred	Outpatient bereavement program	N/A
Emergency	Emergency Services	No Access
University mandated	Student Health Clinic	N/A
Employer	Employee Assistance Program	N/A
Self-referred	Community-based youth counselling	N/A
Self-referred	Student Health Clinic	Outpatient Group Program (eating disorder)
Self-referred	Student Health Clinic	Outpatient Group Program (trauma)
University mandated	Student Health Clinic	N/A
Self-referred	Private counselling	N/A

Note: Online counselling or e-therapy was not included; some participants had multiple access pathways

Table 1 allows us to explore what services were accessed by the research participants. A few commonalities and patterns were identified. During the time of the interviews, six participants were international students, as demonstrated by the concentration of services being

accessed on campus. The implications of this are further explored in the discussion portion of this section. While most referral pathways were self-referral or voluntarily referred, two participants were coerced into accessing mental health counselling. These narratives were explored under the therapy as coerced. Both students were international students, where threats of expulsion due to poor mental health had serious implications for both. Their mental health became criminalized through the lens of liability.

Finally, all the services listed in the last column (additional referrals) were group-based mental health programs. These group-based programs addressed a specific topic or mental health concern which were: insomnia, eating disorders, and trauma. This pattern suggests that group-based therapy required additional steps to be able to access these services.

While varied, participants' narratives of how they first tried to access mental health counselling in St. John's, NL, showed that there was a large concentration of university-funded or sponsored services. This is not surprising since all participants in the study had recently migrated to the city for school or work. Furthermore, as I elaborate in the subthemes below, international students had unique experiences and barriers.

Service Barriers Identified by Research Participants

This sub-theme explores service barriers that were identified by the research participants of this study. Consistent with the literature review, racialized participants reported various service barriers to accessing mental health services (Chiu et al., 2018; Durbin et al., 2014; Saunders et al., 2018). The barriers reported by participants were further categorized into six different types which included: *no access*, *format*, *financial barriers*, *time*, *disrupted care*, and *precarious care* (see Table 2). This section reports and describes all the service barriers identified, but particular focus and analysis will be taken on the last two barrier types.

Table 2
Barriers Identified by Research Participants

Barrier type	Code Labels
A: No access	High turnover (no follow-up), no answer, conflict of interest, voicemail only
B: Format	Single-session approaches, group therapy
C: Financial barriers	Private therapy, e-therapy
D: Time	Wait times, time-limited based on status, wait lists, limited sessions
E: Disrupted care	Disrupted care, disrupted access
F: Precarious care	Precarious care based on immigration/citizenship status (international students and asylum seekers)

$N = 9$

a. No Access

The barrier of no access refers to when participants were not able to access services due to issues such as high staff turnover or not receiving a follow-up response. During the time of the interviews, there was one participant who was not able to access any counselling services in the city of St John's, Newfoundland, and Labrador.[16] While the participant did try to access e-therapy and private counselling, she experienced financial barriers to these forms of support. Because she was not an international student, she was not able to access university-funded mental health services. As a result, the only mental health services she was able to access were emergency services (paramedics), which did not include mental health counselling. The outcome of the interaction resulted in a list of resources that were provided to her by the paramedics, none of which resulted in any access to additional mental health services. She disclosed:

[16] This participant's narrative is further explored in Chapter Six under the theme of Intersectional Identities and Essentialism and will therefore not be numbered to further protect her anonymity.

> And they gave me a bunch of numbers that I could call. I gave it a try once. I got a lot of recordings. Couldn't get through to an actual person. Gave up pretty quickly just because I was so busy and, you know, overwhelmed with so many other things.

b. Format

Format refers to how the delivery method of services (such as group therapy or single session approaches) were a barrier. For example, one participant disclosed that single-session approaches felt inadequate in addressing their complex realities. Participant 4 shared:

> I did have one session with one person one time, and that was it. She made a point that I knew and it was clear to me that this was the arrangement [single session], which is what deterred me from, you know, reaching out again.

While single session approaches can provide low-barrier access, they are in some ways *also* a barrier. Having to re-tell one's trauma narrative and re-establishing trust with a new person can prove challenging. Single-session approaches are widely used in mental health community services, and therefore such responses need to be considered (Hymmen et al., 2013).

c. Financial Barriers

Financial barriers refer to how services such as private therapy are not accessible due to cost. Participant 8 simply stated, "I don't think I can afford it." This is consistent with literature that cites financial pressures among international students and immigrants (Khawaja & Stallman, 2011; Salam et al., 2022).

d. Time

Time refers to time-bound constraints such as limited counselling sessions and wait times. The interview participants who were students unanimously spoke about wait times to access services at their university student clinic. Participant 5 shared:

> The fact that your therapy [student clinic] is very precarious with these as well, like for, I believe, six sessions over the entire year […] And they also are very strict on the kind of support they can give you. And there is very little help available at the [student clinic].

e. Disrupted Care

Disrupted access refers to disruptions in access to services. For example, two participants experienced disruptions to their psychiatric medications at the university clinic. Participant 7 shared:

> I actually first got an anti-depressants last year with the first therapist. And then when it was time for me to see the doctor and see if I was going well or if they needed to change, I wasn't able to get an appointment, so I just, like, stopped it abruptly like that.

This abrupt stop in their medication had a significant impact on their mental health. They reported:

> In the beginning my mood was definitely terrible. There was just dealing with suicidal ideations and things like that. And when I got off it got worse. And I actually put in a request for a therapist with the [student clinic] but I wasn't able to get connected with someone for the fall semester.

Participant 5 shared a similar example. They recounted:

> I don't have ADHD medications because the [student-run clinic] that did my diagnosis no longer exists. And also they did not officially send my diagnosis over to [student clinic] or anywhere else. They were supposed to give me a copy as well, which did not happen. So I couldn't get any medications for like ADHD.

This participant also disclosed that the health authority had lost their referral from the student clinic, possibly due to the healthcare cyberattacks that happened in late October 2021 (Strong et al., 2022). They said:

> But when I call them back apparently the file doesn't exist anymore, so I'm not sure what happened. […] I'm guessing something went wrong with the whole hack thing [cyberattacks of 2021] that happened. But either way, there's no way for me to go back into the wait list unless I want to wait for, like, eight months without the urgent referral. […]

While wait times are common frustrations in mental health access across Canada (Moroz et al., 2020), COVID-19 pandemic has further exasperated the capacity of these services (Moynihan et al., 2021; Moroz et al., 2020). These examples of disrupted access might be linked to the COVID-19 global pandemic, the October 2021 healthcare cyber-attacks (Strong et al., 2022), as well as the shortage of medical professionals in Newfoundland and Labrador (Quinn, 2023a).

f. Precarious Care

Precarious immigration status was a significant service barrier that emerged from the intersections of mental health access and one's immigration status in Canada. As summarized in Table 2, precarious immigration status care was an emergent service barrier identified by those with temporary status in Canada. Six out of the nine research participants were international students, meaning their status and ability to stay in Canada were tied to their active enrolment with a post-secondary institution (Government of Canada, 2023b). Precarity of their immigration status impacted their ability to access services. Unique stressors for international students included barriers to services due to having temporary student status, and lack of support for asylum seekers.

Participants shared having to give up a lot to move to Canada as an international student, such as leaving home and what is familiar to them. Participant 1 shared:

> Like, this is all I worked for. Like, you know, like I left my family life, my friends, everything that was familiar to me, all the food, all the sports, politics, I left everything and like cut everything off. […] like your visa status is basically linked to your degree. It's like if you drop out of school, you're kind of like kicked out of the country, basically.

Academic pressures are magnified when one's ability to stay in Canada depends on one's academic performance. The pressure of this was shared by several students, which negatively added to their mental health. For example, participant 7 shared their hope that accessing support would allow them to focus on their studies. They explained:

> I feel like I could definitely do a lot better academically if I was in sound place, if I just was able to work through everything and just, you know […] Just because I don't want to fail out I guess, I worried about that a lot.

However, access to some on-campus resources was limited to students actively enrolled in classes. This participant also shared, "I'm not able to go [to the student clinic] because I'm not enrolled for the summer." This is a concern as international students might need to work during their scheduled breaks, (Government of Canda, 2023a) but then will not have access to on-campus counselling services during this time. Additionally, students expressed concerns that the number of counselling sessions was limited per semester, and sometimes difficult to book due to long wait times or unavailability. This exacerbated the academic pressures that students feel.

Finally, a lack of support for those seeking asylum in Canada was identified by one participant.[17] To their knowledge, there are no formalized supports for refugee claimants in St.

[17] To protect their anonymity, this participant's number ID will not be included.

John's, NL. This participant shared that even a provincial immigration official suggested to them to "go back into the closet," meaning to hide their gender and sexual orientation identity. They shared what was suggested to them: "Like the amount of advice I've gotten is honestly limited to - go back into the closet, try the provincial immigration office and try out the [university department]. None of the three can help. […]" This student emphasizes that the lack of access to services magnified their vulnerability. They further explained:

> A little concerning also, because that sort of thing really pushes on the temporariness of students and exploits students. […] I think equity is a massive concern, and I feel like with me also being migrated, it sort of exacerbates it in terms of like the precarity with your status.

In summary, these narratives highlight structural and programmatic barriers to service access. Participants' stories showed that there were some unique barriers that arose in response to socio-historical events as well as the participant's status in Canada. Reports of limited support, time constraints, and long-wait times may have been exacerbated by the COVID-19 pandemic and other socio-political stressors. A lack of stable and continuous care was also linked to the experiences of international students and new residents.

Anti-Migrant Racism in Emergency Services

In this section, I explore one participant's experiences of accessing emergency mental health services. [18] While emergency services are not technically a counselling service, I argue that it is an access point for mental health services and future counselling. While three participants disclosed experiencing anti-migrant racism within emergency services, one narrative is highlighted as it offers a complex exploration of how emergency services are a dangerous

[18] To protect their anonymity, this participant's number ID will not be included.

space for those with precarious status. Throughout this participant's narrative, two discourses about migrants emerged: one of migrants as competition for resources, and another of migrants being a burden on the healthcare system.

While this participant was in the Emergency Room (ER) at a local hospital, they shared that a training nurse asked other staff if they should be attending Canadian citizens before those with temporary status. They shared:

> The training nurses actually walked in and asked the other nurses in the front if they're required to take citizens before me.

This story offers insight into one discourse of anti-migrant racism, namely, that migrants are less important (or perhaps deserving) than citizens, and not a priority for care. The potential harm is intensified when service providers are gatekeepers of services. In emergency rooms, where triaging and wait times are dangerously long, migrants are seen as taking up resources that should be reserved for citizens. This discourse has serious impacts on all aspects of healthcare, including mental health.

When migrants are seen as inconvenient or sources of competition for limited services, their presence is then monitored. Migrants are marked by the length of validity of their medical insurance card. The participant reflected:

> […] I guess you could figure out someone's temporary status through the term MCP as well, because it's only valid for a very short period of time.

When temporary residents or migrants are marked on their healthcare cards, and they are also racialized, it amplifies them as a target of anti-migrant racism in emergency services. This is echoed in how the participant shared they feel unsafe accessing emergency services as someone with precarious status. The participant revealed:

> I cannot have [my medical records] disclosed on Eastern Health Records because immigration subpoenas […] the rules they have on excessive demand on health and social services. […] a student in P.E.I. who was detained by CBSA after, like, accessing mental health support.

The participant referred to the Immigrant and Refugee Protection Act (IRRA) which cites inadmissibility to Canada under health grounds. The Division 4, subsection 38(1) of the IRPA states:

> A foreign national is inadmissible on health grounds if their health condition (a) is likely to be a danger to public health; (b) is likely to be a danger to public safety; (c) might reasonably be expected to cause excessive demand on health or social services. (Minister of Justice, 2023)

When speaking about the fear of being deemed an "excessive demand" on healthcare, this participant referenced a case of an international student in Prince Edward Island who was detained after accessing mental health services (MacKay, 2021). Especially for those who are asylum seekers, with temporary status or are undocumented, emergency services then become a place of surveillance and control where those with precarious status are unsafe to seek services.

Emergency services upholds migrant tensions through two systems: one sees migrants as competition for medical services, and the other depicts migrants as undeserving of being in Canada if they are a "burden" on the healthcare system. Migrants are only welcomed through an interest convergence that fulfills the economic interests of Canada (Giwa & Bagg, 2022). Behind the rhetoric of bringing more migrants into Newfoundland is the underlying dichotomy of the deserving versus undeserving migrant. Villegas & Blower (2019) define deservingness as "the value imbued onto individuals, depending on their social location(s), and how actors use that

value to rationalize whether someone is accepted into a community" (p. 71). If migrants are not able to perform this duty, they are deemed inconvenient and a drain on resources, and therefore a burden. Emergency services become a place for surveillance and monitoring while dangerously intersecting with the immigration system in perilous ways.

Discussion

One major narrative that emerged from the analysis of the theme of Access and Barriers was linked to the precarious status of international students, and how this impacted their ability to access services. At the time of the interviews, six of the nine research participants identified as international students. As a result, there was a concentration of access pathways to services on campus. While this might seem logical, a narrative of precarious and disrupted access to services on campus is cause for concern.

A study by Banerjee et al. (2022) found that racialized students in Canadian universities self-rated poorer health outcomes compared to white university students. This discrepancy is supported by research that demonstrates that international students face status-specific stressors such as financial pressures and discrimination (Khawaja & Stallman, 2011). However, several excerpts throughout this chapter showed how academic pressure and the precarity of their status were highly intertwined for international students. Therefore, an important stressor to consider is the precariousness of an international student's status.

Stein and de Andreotti (2016) problematize the discourses and systems that support international student recruitment as the same ones that facilitate racism. Western knowledge and education are constructed as epistemologically and ontologically superior and universal. Three racialized tropes are created through this dominant global imagery: international students as

cash, competition, and/or charity (Stein & de Andreotti, 2016, p. 226). In the over-arching theme of Access and Barriers, all three racialized tropes were present.

The trope of international students as cash sees Western education as a desirable product for purchase, and an opportunity for social mobility. Students are seen as valuable assets to the Canadian economy. Access to on-campus mental health services then becomes conditional if they can pay their tuition. International students as competition see students as "threatening outsiders who might either return home and enable their home country to compete better economically with the West, or who might overstay their conditional welcome and threaten the entitlements of national citizens" (Stein & de Andreotti, 2016, p. 233). This narrative is salient in Anti-Migrant Racism in Emergency Services. Finally, international students as charity see "the West's Others" as "objects of benevolence" in need of "catching up" (Stein & de Andreotti, 2016, p. 234). This trope is explored in this section through the grateful immigrant rhetoric.

Stein & de Andreotti's (2016) trope of the international student as cash is reflected in how student reported that their ability to access on-campus services was pending active registration in classes. This implies that students are only deserving of on-campus services if they are paying tuition. Some students did mention the option for an app-based counselling service open to international students, but none spoke highly of this service.

The narrative of international students as competition was echoed in how many students reported limited and time-bound on-campus services. Competition for resources on-campus risks creating a tense environment. While this theme in relation to on-campus services was not reflected or fully explored in the interviews, the theme of anti-migrant racism was visibly present in stories about accessing emergency services (such as the ER and with paramedics).

Similarly, international students as charity are reflected in the following excerpt. One participant reflected:

> And then I think the thing is, as immigrants, even if they are disempowered, even in the face of racism, they won't complain because their belief is they are thankful that they in are Canada. You know, people would say things like, you should be grateful right here. Like because they believe that where the country you are coming from, was not good for you, that's why you had to run away and come here.

This student shared that migrants are internalizing that they need to be "grateful" for being in Canada. This "grateful immigrant" rhetoric speaks to the international student as a charity, in that students are imagined as coming from backward, violent, or oppressive nations.

Conclusion

The themes of participant reasons for seeking counselling, and access and barriers offer a snapshot of racialized and migrant people's experiences of accessing mental health services in St John's, NL. The first theme contextualized the lives of the research participants by providing complexity to their reasons for seeking support. Access and barriers provided an overview of where people went for mental health counselling, and what barriers they experienced. Through the identification of access patterns, a particular focus was taken on status-specific experiences. The case example found in anti-migrant racism in emergency services amalgamates all points of tension between access and status. The permanence of racism is demonstrated through explicit hierarchy of worthiness. The permanence of racism in mental health services is further explored in the next chapter.

CHAPTER SIX: FINDINGS AND DISCUSSION THROUGH CRT

Chapter Six presents three emergent themes that were brought forth using CRT as the conceptual framework throughout the data analysis (see Chapters Two and Three). This chapter provides an overview of findings from a second-step data analysis, where codes were further analyzed and categorized thematically to align with CRT concepts and terminology. The three major themes presented in this chapter are: *experiences of racism, whiteness in mental health services, and intersectional identities and essentialism.*

Experiences of Racism

The exploration of racism is central to this research project. One of the three research objectives were to explore how racism impacts racialized people's need to access mental health counselling as well as experiences of accessing such supports. One of the interview questions (see Appendix C) explicitly asked, how do you think race or racism did (or did not) impact your experience? This question was clearly asked but not always answered explicitly. Some initially hesitated in naming their experience of racism, but later revealed its presence in their lives (see racism as unmarked). Some were quicker to respond, and others denied ever experiencing racism (see coping and/or denial). The data analysis provided three sub-themes: *racism as permanent, racism as unmarked, and denial and/or coping.*

Racism as Permanent

CRT conceptualizes racism as invisible to those that hold racial privilege (Abrams & Moio, 2013; Delgado & Stefancic, 2017). Counter-storytelling is a tool within CRT to challenge and de-centre dominant narratives that are upheld by those with racial privilege (Abrams & Moio, 2013; Delgado & Stefancic, 2017). Thus, counter-storytelling elevates and centres voices of

colour that are calculatedly and intentionally silenced and suppressed. These counter-narratives challenge dominant narratives and therefore, the status quo.

Influenced by the writings of Derrick Bell (1992), one of CRT's central tenets is that racism is normal, insidious, and permanent in our societies. This section presents narratives that focus on counter-narratives of the existence and permanence of racism within mental health institutions. While it might not be visible to those that hold racial privilege, my interviews revealed that it was very visible to the research participants. I highlighted these narratives to counter the dominant narrative that racism is no longer present or has been eradicated in our institutions. This counter-narrative makes visible that because racism is so heavily enmeshed in our institutional foundations, it is hard to pull apart.

Participant 8 externalized racism by describing the harrowing image of trying to run away from the inescapable. The participant had experienced family violence and was able to escape such trauma, but not being able to "run away" from racism was a jarring reality. They shared:

> And then when I faced racism here, it just made me kind of like, wonder, I know, I know, I before I moved here, I had, like, a lot of problems, but that was different because this was something that, how to do it, family related. I could run away from it, but how do you run away from racism?

This participant poignantly pointed to the pervasiveness and ever-present nature of racism in their experience of living in St. John's that moved beyond the personal and interpersonal. The participant's feeling that they could escape family-related problems, but not racism, underlined the permanence and insidiousness of racism.

Participant 4 shared how the existence of racism in mental health services not only discouraged them from accessing services but worsened their situation. They shared:

> So, once I started to realize that racism *does* very much exist in this area, it really discouraged me from reaching out to anyone else. Mental health support included. Because that's not helping me. It's just adding to my problem.

Because of racism embedded in mental health services, the harm they experienced not only discouraged them to seek out services but also harmed them, by "adding to [their] problem." This experience suggests that systemic racism in mental health services makes it unsafe to even try to access services. This narrative contradicts literature that suggests that racialized people are reluctant to access mental health services due to stigma or cultural differences (Feng et al, 2023; Reitmova & Gustfason, 2007, 2009a, 2009b; Salami et al., 2019; Salam et al., 2022; Thomson et al., 2015; Tulli et al., 2020). Significantly, participant narratives showed that they experienced a lack of safety due to embedded systemic and institutional racism in services.

In conclusion, counter-storytelling as a tool within CRT aims to disrupt dominant narratives that maintain the status quo. In this section, we demonstrated that racialized participants gave testimony to the existence of racism within our mental health institutions. Presenting these counter-narratives refocuses on the harm caused by racism as a reason for differences in accessing mental health services by racialized people.

Racism as Unmarked

CRT views racism as intentionally unmarked, and unacknowledged (Delgado & Stefancic, 2017). Five participants shared examples and experiences of racism that felt subtle or intentionally unmarked. In these cases, racism presented itself as a feeling or energy in the environment where one has seemingly unexplainable feelings of rejection, dismissal, or of feeling unsafe. Bowser's (2017) conceptualization of the three levels of racism as a singular

racial theory is helpful to explore how racism is an unmarked force, akin to the conceptualization of cultural racism, was present in participants' stories.

Participant 4 shared an unexplained feeling of rejection over the phone with a service provider (intake nurse at the health authority). Racism here is described as having a subtle presence. The participant said:

> I want to say yes [that racism was a factor]. It's hard to actually give you a concrete, you know, tangible reason why. *I* know why. I know, like, when I speak to someone over the phone, I'm able to feel certain ... It could be a very subtle rejection. But it's still a rejection.

Racism as perceived by racialized groups, therefore, is not always overtly visible or identifiable, making it challenging to articulate.

When it came to group counselling settings, two participants shared similar experiences of discomfort (both with the local health authority). While nothing explicitly or overtly racist was articulated, there was an unmarked tension for both. For example, participant 6 shared their need to self-censor themself when it comes to experiences of racism and being racialized. They shared:

> I would be nervous to share this with people who I'm ... I don't really know what their values are, or their beliefs are. And so, I wouldn't want to offend them, even if they're not a minority, because they, you know, sometimes people can take it personally.

The participant censored themselves because they were the only racialized person in the room and did not feel comfortable voicing experiences of racism. I asked the participant if by "taking it personally" they meant that they were worried that other group participants would be offended and think they were calling them [other participants] racist, to which they replied, "Exactly."

This narrative demonstrates how in a culture that silently upholds a racial hierarchy, the responsibility falls on the racialized person to accommodate and not distress the dominant group. The racialized person is accountable for self-monitoring their language and presence.

Similarly, participant 7 shared her reluctance to disclose experiences related to her racialized identity in a group therapy setting, specifically, about her struggles to find suitable hair care for, as she called it, “Afro hair” in the city. She shared:

> I feel like there's some, some things that I'm not comfortable sharing just because I'm not sure they understand. Or why I'm making such a big deal out of it. Right. I feel like there some things that I'm not able to share. Because maybe it wouldn't make sense to them, I guess.

The participant felt the need to minimize her struggles and was reluctant to share an important part of her identity. As Oluo (2019) writes, white supremacy has ridiculed and shamed Black hair, which is reinforced through a Eurocentric standard of white beauty and respectability. The participant’s reluctance highlighted the Eurocentrism of the therapy group, where an access to adequate hair care is unspeakable, and thus, racialized.

Racism as an unmarked force, therefore, represents an environment where unmarked power differentials are felt but not seen. Power imbalances exist but remain invisible as they are insidiously hidden. Bowser (2017) writes that despite overtly institutional practices being eliminated, cultural racism persists and is evident in societal outcomes such as educational inequity. Therefore, establishing equitable policies and procedures only addresses institutional racism. Cultural racism can include unspoken norms, rules, and hierarchies that result in an unexplained tension for racialized people navigating mental health systems. This tension is

experienced through feelings of being unsafe, or as an invisible barrier that cannot be overcome. Since these forces are unmarked, they are harder to articulate or gather evidence for.

Denial and/or Coping

Since racism is normalized, it is not always visible and apparent, even to racialized people who experience it (Delgado & Stefancic, 2017). CRT conceptualizes racism as strategically unmarked, leading to the possibility of the oppressed being blind to their own marginalization (Cabrera, 2018). While most of the research participants discussed how racism impacted their daily lives, two participants spoke of never experiencing racism in Newfoundland and Labrador.

Participant 9 said they could not remember any experiences with racism but felt that such experiences were not something they would be impacted by. They explained:

> I don't really pay attention to people who have nothing to do with me, so I'm not affected. […] You know, death by a thousand cuts. Some people have thicker skin than others. […] I'm a resilient person, and people can't bug me for stupid things like sexism and racism. I'm an [professional in a male-dominated field]. I've had more experiences in sexism than I have racism.

Much of the participant's explanation of why they had not experienced or felt racism, is that they have "thicker skin" and personal beliefs that the opinions of others are not important. The participant's use of the metaphor of "thick skin" and "a thousand cuts" is often used by critical race theorists to describe microaggressions, used to signify the accumulation of many interpersonal experiences (Nadal et al., 2011; Sue, 2021; Young et al., 2020). They also stated that they are a "resilient person" and "not affected." While the attitude of being *immune* to racism can be a coping strategy, it risks being a slippery slope toward victim blaming. This

dangerous narrative implies that those who cannot ignore or endure the impacts of racism as weak and inferior. Such frameworks risk individualizing the experiences of racism and focusing on individual experiences of racism (usually associated with explicit racial abuse by individuals) rather than systems and structures promoting racism.

Similarly, participant 2, who was not fond of the terms race and racism, expressed that they did not perceive any personal encounters with racism in Newfoundland and Labrador. They shared:

> I don't think race is a problem at all. I think more than race, it is a sense of cultural awareness that is sometimes missing, particularly in terms of how Western cultures are more individualistic and Eastern cultures are more collectivist. […] I don't see discrimination. I have never experienced a single racist incident since I've come [to] Newfoundland, even though this is one of those provinces which has a relatively low minority demographic.

This participant felt that the issue was not about racism but about cultural differences.

While suggesting culturally specialized services, or increasing cultural competency, as a solution to missing "cultural awareness," many practitioners and scholars caution against this approach. The critique is that these approaches frequently focus on individual attitudes and cultural differences, rather than interrogate the embedded racist structures in our services (Joseph, 2017; Martinez et al. 2013). Using postcolonial theory, Martinez et al. (2013) critically examines the binary frameworks commonly used in cross-cultural frameworks, particularly the dichotomy of collectivist versus individualistic cultures. They argue that this dichotomy oversimplifies and essentializes cultures, perpetuated through Eurocentrism, that upholds Western cultures as the ultimate standard. These constructed binaries of West versus East, and

North versus South reproduce postcolonial narratives where cultural differences are explained through the centring of Whiteness and Western culture. Such definitions were established by European imperialists and Orientalism scholars as highlighted by Edward Said (1978).

The experiences of these two research participants provided insight as to how racism is normalized and sometimes denied. Critical race theorists have interrogated how some racialized people might agree with racist ideologies or disagree with anti-racism work. When racism is intentionally left unmarked and normalized those that are oppressed by racism might not be able to or willing to see this reality.

Whiteness in Mental Health Services

White supremacy and the permanence of racism are interconnected concepts (see Chapter Two). Borrowing from Frankenberg's (1998) framework on whiteness, I explore how whiteness as a culture is embedded in mental health services. The two sub-themes that emerged inductively throughout the interviews are: *working with whiteness and deconstructing tokenism using critical whiteness studies.*

Working with Whiteness

This subtheme explored research participants' reflections on working with white counsellors. Five participants highlighted how working with counsellors that have not experienced racism or of being racialized was difficult. For several participants, a lack of shared lived experience of being racialized and of experiencing racism served as a therapeutic barrier.

Participant 1 shared his experiences about mental health counselling, and some limitations they experienced. They said:

> You can never explain racism to a white person, basically, unless you've experienced it. Look, there is, there are some experiences that no matter how hard you try to like to help one understand they just won't unless they go through it, you know.

When the participant said, “no matter how hard you try” and “unless they go through it,” they shared that racism can only be fully understood if one has lived experienced in a racialized body. They are implying that experiences of racism are difficult to articulate and understand cognitively. For this participant, racism is a visceral experience that cannot be explained fully through words.

Another participant shared similar sentiments where he experienced a complete disconnect with his counsellor who was neither racialized nor gay.[19] He explained:

> But the thing is, the person I did therapy, which was a white lady, so there's no way she can relate to me like that. And she was straight too, basically like how did that even connect? And I will talk about my problem then she would just be like, “things will get fine”, and like, no offense, but that's not what I'm looking to hear. But if it was a Black man, I would tell you at least there is one part he could understand because he knows how being Black and what we went through. There's no way I can tell her because she never faced racism before. She never faced homophobia before. She was never violated or never insulted, you know things like that.

This participant shared that his disconnection with this counsellor was intensified by the absence of shared experiences with both racism and homophobia. He shared that if the therapist was Black then at least there would be one thing he could feel understood by. Not only did he find this counselling experience unhelpful (as indicated when he says, “That’s not what I’m looking

[19] This participant will not be numbered to further protect his anonymity.

for"), the potential harm caused in this experience is most likely exacerbated by the fact that he was coerced into this counselling experience.[20] Similar to the first excerpt, when the participant says, "there's no way she can relate to me," he is sharing that experiences of racism cannot be shared without having experienced it firsthand. When he said, "she was never violated or never insulted," he is alluding to how racialized and queer bodies are targets of violence due to systemic oppression. Therefore, racism is experiential and can only be felt directly.

Participant 6 shared her unique experiences within the intersections of sexism, anti-Asian racism, and racial fetishization and the impact these forces had on her sense of self. These oppressive forces impacted her body image in ways that she could not articulate to her white counsellors. She shared:

> But at the end of the day, I felt like there were things that I just could not really talk about because they're white. […] I feel like after I moved here from [Country of Origin] part of how, part of why my ED [eating disorder] kind of ramped up I feel was because of the stereotype that, you know, Asian women are supposed to be tiny or like expected to be small and skinny […]. So I felt like I couldn't really talk about how my race and ethnicity intersected with my eating disorder.

In this narrative, she racializes her eating disorder experience. When the participant said, "After I moved here," this suggests that the intersections of sexism, racism, and racial fetishization emerged through her experience of migrating to Canada. For this participant, even being in a program that specifically supports those with eating disorders, her experiences of being racialized as an Asian woman in Canada cannot be articulated to the predominantly white staff.

[20] See sub-theme of therapy as coerced in Chapter Five.

Even for someone who reported that racism was not an issue for them,[21] having a white therapist took additional effort for them. Participant 9 did not express feelings of being misunderstood but rather felt the need to teach the counsellor what it meant to be racialized. They shared:

> None of my therapists have been racialized. […]. It would have helped if that person could, had a similar background as me in terms of, I think like understanding or feeling understood or feeling heard. But I just took the time to explain the things that I wanted to explain so that person would have the understanding that I wanted them to have. But of course, you know, if it's it was someone else who had a similar background, we wouldn't have had to spend that time.

Having someone from a similar background would have allowed them to feel "understood" or "heard," but without these options, they consciously make the effort to explain their experiences.

In conclusion, despite a wide range of experiences (positive and negative) in mental health counselling, experiences of racism were difficult to articulate to white counsellors. Racism becomes difficult to understand if one does not experience the racialization process. This provides unique insight into the "racial matching" phenomena in counselling. The literature review chapter (Chapter Four) of this thesis found that there is a general pattern that racialized clients prefer being matched with a therapist of a similar racial background (Cabral & Smith, 2011; Flaskerud & Liu, 1991; Gamst et al., 2001; Jacobs et al., 2022; Kim & Kang, 2018; Maramba & Hall, 2002). However, these narratives suggest that the concern is not about the desire of having a counsellor from the "same" cultural or racial background. Instead, the

[21] See first narrative under sub-theme of denial and/or coping.

disconnect stemmed from white therapists not having lived experiences of being racialized and experiencing racism.

Deconstructing Tokenism and Whiteness

In the section above, I explored how racialized participants struggled to connect with predominantly white counsellors who have never experienced racism. Experiencing racism was described by participants as an embodied experience that could not be verbally or cognitively shared. Using critical whiteness studies, this section explores how the potential solution of bringing in more racialized counsellors could possibly miss the mark. Using concepts of whiteness and white supremacy, I examine how whiteness needs to be explored beyond a racial identity and needs to include whiteness as a standpoint and culture (Frankenberg, 1998).

When it came to mental health systems, participant 6 shared that racism will always be an issue because they are racialized, and most service providers are white. They shared:

> I feel like being a racialized person... it's just always… it's like... I feel like the issue is just always going to be there any way when you go to places that are, where mostly white people work and you're trying to get services from them. Like it's, it's always going to be a problem.

The participant shares that accessing services with mostly white staff is “a problem” for racialized people. Whiteness does include unearned power given to those racialized as white, but critical whiteness studies goes beyond this interpretation. Whiteness includes worldviews and cultures that are embedded in our systems (Gebhard et al., 2022; Frankenberg, 1998).

Some participants explored the meaning and potential limitations of bringing in more racialized staff as a solution to the problem of a “mostly white” profession. While this question was not explicitly asked, a few participants shared their experiences and potential concerns about

such inclusion. One participant shared a cautionary tale about tokenism. Tokenism is defined as "the practice of making only a perfunctory or symbolic effort to do a particular thing, especially by recruiting a small number of people from underrepresented groups" (Saad, 2023, p. 226). Participant 5 asked a board member of a non-profit organization why there were no racialized staff members. They shared the response:

> There's no BIPOC representation. They said we have queer people instead and we also have [an Indigenous staff] […] told me that BIPOC folks usually don't need as much support as white people have needed and the kind of services they provide.

The use of the word "instead" implies that one marginalized group is enough representation. One marginalized group (racialized identities) is replaced with another (queer identities), where marginalization becomes a numbers game or simply, a box to check. Having one staff member from a marginalized identity being "enough" representation is concerning, as it clearly tokenizes the one Indigenous (and other queer) staff. The assumption becomes that this staff member will represent entire communities. This flattens and essentializes identities and experiences, and most notably dismisses the mental health needs of "BIPOC folks." This coupled with the narrative that racialized folks "don't need as much support" is disturbing as it completely ignores the idea that racialized people might feel unsafe accessing their services.

Tokenism then becomes a slippery slope where Indigenous and/or racialized service providers risk becoming the voice of entire communities, some of which are not their own. This is reflected in the following excerpt, where participant 1 shared their concerns about the inclusion of racialized counsellors in ways that could be tokenistic.

> You know, and again, even like people say, like, oh, you know, having more people of color diversity. Oh, that's kind of doable. But again, even if they still did grow up here,

> they still don't know the struggles of being kind of like an immigrant or a temporary immigrant, you know?

This participant's insight touches upon the importance of taking an intersectional and anti-essentialist approach to representation. One racialized counsellor could not possibly represent an entire spectrum of experiences when other factors such as migrant status create nuances within such realities. The participant is implying the importance of differential racialization,[22] and that citizenship privilege among racialized people needs to be considered as a marker of marginalization. As well, the participants' perspective is consistent with Mehrotra's (2010) claims that scholarly literature on CRT's tenet of intersectionality from North America has heavily focused on race, class, and gender, but needs to expand to include other identities and oppression such as migration and colonization. This limitation is further explored in the next theme.

Finally, participant 6 interrogated the idea that inclusion and representation does not address whiteness in services. They shared:

> I feel like there's this whole idea of, like, inclusion being the best thing that can happen. But sometimes, it's like, I wish people would think maybe they don't want to be included in your little circle. Maybe it's more so about like taking a step back and just kind of de-centering yourself.

The participant reflected that inclusion of racialized staff is something that is imposed onto racialized people without acknowledgment of who gets to decide when and how it happens.

Finally, racialized staff can still perform whiteness. As Yee & Dumbrill (2022) writes, "a major barrier to challenging whiteness is that both white people and people of colour continue to

[22] See Chapter Two for a definition and explanation.

stay trapped in performing whiteness, without changing any of the structures and systems" (p. 297). Whiteness as a worldview and an unmarked culture present in mental health services cannot be dismantled by simply hiring more racialized staff. Simply replacing white therapists with racialized therapists will not interrogate systems that uphold racial hierarchy.

In conclusion, interrogating what racialized representation could look like within a predominantly white workforce needs to explore how whiteness is more than just "being white." Therefore, mental health services need to look beyond inclusion strategies and diversity hires. Rather, services need to explore how racism continues to exist within its policies, practices, and organizational culture.

Intersectional Identities and Essentialism

As I describe in the conceptual framework (Chapter Two), intersectionality allows us to understand our social identities as fluid and fluctuating depending on context and power relations (Collins & Bilge, 2020). These realities are mediated by power relations that are sometimes challenging to pull apart. In this section, I explore two narratives to illustrate the richness of taking an intersectional approach to understanding the experiences of racialized and migrant people.[23] While these narratives are not directly related to experiences of accessing mental health services, they are connected to the individual's sense of well-being and therefore aim to contextualize the experiences and lives of racialized people.

I unpack participants' stories through two different approaches to intersectionality: intracategorical and anticategorical (McCall, 2005; Mehrotra, 2010; Murphy et al., 2009). Through the narrative of a participant who identifies as a Black gay man, I explore the subtheme of *complexities of belonging* through an intracategorical approach. Similarly, through the

[23] In order to protect their anonymity, these participants' number ID will not be included.

subtheme of *policed for authenticity* I explore one woman's narrative through the intersections of Muslimness and foreignness which ultimately led to multiple rejections and a lack of formalized and social supports.

Complexities of Belonging

In this section, I elaborate on the experiences of one participant who faced a lack of safety in his racialized communities due to his sexuality, and the dehumanization of his racial identity within the 2SLGBTQ+ communities. He relayed how being a Black gay man meant being racialized and sexualized in ways that were dehumanizing and aberrant. This participant shared their narrative of experiencing social isolation, unsafety, and double rejection from his communities. This had implications for the participant's overall mental well-being, and barriers to accessing informal and formal mental health supports.

The participant spoke about the homophobia he felt in his racialized community in St John's, Newfoundland. He disclosed:

> I try to avoid [people from West African country] because most of them are homophobic and I have to either hide who I am to be with people that don't like me for who I am or I stay by myself.

At the same time, this participant also experienced anti-Black racism and racial fetishization from the 2SLGBTQ+ community. He explained:

> Well, the queer community here, it's a lot of pain, a lot of, I would say, racism, because in respect to, you know, finding someone that just wanted to be friends with a black person, a white person is, for instance, trying to befriend a black person, it's really hard because, for over a year and I've tried, I would say everyone just tried to sexualize me. That's what they see me for. They don't want to be friends.

When the participant said, “they don’t want to be friends” it indicates a desire for connection and community. However, these experiences resulted in racism in the form of exoticization as erotism.

The participant shared that this experience of rejection from both the West African and queer communities felt like a “double dose.” He shared:

> Because even if you're queer, there's nothing that, there are people that don't even like you. Imagine being black. People don’t like you, and you’re queer, again. It's like double dose of the problem that imagine you meet someone that is racist and homophobic. Where you, they hate you for your color. They hate you for being who you are.

The description of a “double dose” closely parallels Crenshaw’s (1989) now-famous and often-cited analogy of a traffic intersection to illustrate the concept of intersectionality. She writes:

> Discrimination, like traffic through an intersection, may flow in one direction, and it may flow in another. If an accident happens in an intersection, it can be caused by cars traveling from any number of directions and, sometimes, from all of them. Similarly, if a Black woman is harmed because she is in the intersection, her injury could result from sex discrimination or race discrimination [...] I am suggesting that Black women can experience discrimination in ways that are similar to and different from those experienced by white women and Black men (Crenshaw, 1989, p. 149).

The traffic analogy metaphor demonstrates how intersectionality is more than the sum of our multiple identities, but rather the creation of unique and complex experiences. Our identities cannot be quantified, measured, or compared in a systematic manner. Therefore, intersectionality understands that the collision of our multiple identities creates experiences and realities that are too fluid to quantify (Crenshaw, 1989; Murphy et al., 2009).

For this participant, being Black and queer created an experience of double rejection (the double dose), and at the same time, a distinctive experience of racial fetishization, and a form of intragroup unsafety due to homophobia. At the same time, being Black and gay were never static identities, and the meaning behind such identities fluctuated depending on presenting power relation (Collins & Bilge, 2020). The participant was racialized in a way that was dehumanizing, and his queerness was sexualized as deviant and aberrant. As a result, he experienced intragroup homophobia and of sexualized racism.

Policed for Authenticity

One participant was racialized as not being Muslim and foreign *enough.* Specifically, her racial identity was scrutinized through a lens of a perceived lack of vulnerability, authenticity, and deservingness by mental health service providers and her racialized community. The participant identified as Arab Muslim. However, being mixed-race, the participant did not fit a prescribed mold of what an Arab Muslim woman might *stereotypically* look like through the white gaze. This resulted in a feeling of "Constant scrutiny. Constantly, you know, discrediting my story."

When sharing her experiences of trying to access mental health services, she disclosed she was not able to access any in the city of St John's, NL.[24] Her entry point to services was through emergency services paramedics. She felt that the paramedics questioned her racialized identity, her authenticity, and her deservingness of receiving support. She said:

> And I don't think they [paramedics] believed me for a second. I think they just thought I was totally insane. Yeah, I'm sure they didn't believe I was from the Middle East or that any of that had happened to me just because maybe the way I look or the way I sound or

[24] While the participant did say she tried to access e-therapy, this proved to be too much of a financial burden.

> whatever. I definitely felt totally dismissed. […] I constantly face this like, they read my name, they're expecting a certain person to appear before them, and then when I'm there, it's like… Right?

Her experiences with the emergency services paramedics were negative and impactful. She disclosed that the paramedics spoke to her in a manner that, "I wouldn't talk to a dog that way". While her name is racialized (a marker of Otherness), this suggested that paramedics walked into this situation assuming they were going to meet a certain presentation of *Muslimness* and were skeptical when this image was not fulfilled. This participant felt that she did not fit the stereotype of what people see as an Arab Muslim woman and that her identity was being determined as inauthentic, fake, and therefore not worthy of services. The participant shared that she felt that her appearance impacted the service provider's willingness to support her. She shared:

> Like I can't help but feel like if I had an accent, if I look different, if this, if that, if I covered [wear a hijab] even, I would probably get more help, because I fit a certain box. Maybe. Something tells me, maybe I would.

Being an Arab Muslim woman without a hijab and without an accent was seen as a lack of vulnerability and foreignness. This vulnerability was a marker of deserving support and kindness. The paramedics would not believe her Muslimness, because she did not fit the stereotypical image of what Arab Muslim women should look like. In Newfoundland and Labrador, anyone Muslim is most likely assumed to be a perpetual foreigner (Shaikh & Selby, 2023). This stereotype, that all Muslim women should be vulnerable and foreign, while problematic, became an indicator of helplessness and a criterion for accessing services through

the lens of whiteness. The service providers perceived that she lacked vulnerability and therefore was not deserving of their support.

Not only was her authenticity questioned within mental health services, but the participant also shared experiencing rejection by the Muslim community in St. John's, Newfoundland. She shared:

> So I grew up Muslim and there is a Muslim community here in St John's, but, I tried to approach some of the members, but because I don't cover, I think a lot of the time I'm just, I feel like they don't believe me for one. Like, you're not a Muslim, you're not Arab. And I know maybe I don't look it, sound it, but, I am like, that's who I identify as I grew up Muslim, Arab. Um, so I, so, yeah, I don't, I don't feel accepted by that community. […] I tried multiple times and it was always the same thing. I'd get these, looks, like, you're an imposter, you're just trying to, you're just a spy, right?

A lack of an accent and hijab became an indicator of inauthenticity. She was policed for authenticity by both her religious community and emergency services. Specifically, she was deemed as not foreign enough and therefore not Muslim enough.

The impact of these experiences left her feeling rejected and created a deep sense of social isolation. The participant shared her worries about not having any social support. She shared:

> […] It's very discouraging, I feel like, If I were to find myself in that same situation of desperation where I needed to talk to someone right there and then, I really have nowhere to turn. I have no one to count on, I have no one to talk to. And it's, I try not to dwell on that, and I hope I don't find myself in that place, but it's very likely because I simply haven't dealt with everything that I've been through, so it's there, I'm just ignoring it.

This narrative shows how our identities are socially dictated and performed. This participant's Muslimness was not her own. It was policed and scrutinized by both service providers and the Muslim community. An "authentic" Muslim was determined by dominant discourses (brought forth by those in power) and these narratives were absorbed and internalized within her community. This intersectionality of Muslimness, and foreignness produced a unique experience of double rejection, which further fueled a deep sense of social isolation for the participant.

Anticategorical approaches to intersectionality take an anti-essentialist stance toward social identities by challenging the conceptualization of social identities as static (Mehrotra, 2010). The concept of intersectionality proves useful in this narrative because it demonstrates how our social identities are not static, but in fact constantly in flux, and influenced by the perceptions of others. Mehrotra (2010) critiques that intersectionality needs to better explore and include experiences and identities of migration, religion, and nationhood. As mentioned in the conceptual framework (Chapter 2), CRT is rooted in North American Black Feminist epistemologies and explores power relations through a domestic and North American-centric lens. However, experiences of migration and settlerhood further complicate the reimagining of identities. This demonstrates the importance of taking an intersectional approach when conceptualizing the concept of racialization.

While postcolonial or anticolonial theories are not part of this thesis's conceptual framework, it is possible that this narrative demonstrates some limitations to CRT, as it pushes the boundaries of identity by refocusing on the power established by the legacies of imperialism and colonialism. Orientalism sees Western supremacy as a form of cultural domination where the West positions itself as superior and constructs the East, (which includes the Middle East) as inferior, vulnerable, and primitive (Said, 1978). This participant's appearance was policed for

authenticity based on dominant discourses of what Muslimness should look like. These discourses are shaped by a long colonial history of Western supremacy. Within these dominant narratives, Muslimness is synonymous with foreignness, and Muslim women are marked as vulnerable. These narratives were also internalized by the Muslim community, leading to double rejection for this participant.

Conclusion

A CRT lens allowed me to interpret my findings consistent with an anti-racism stance. Alternatively, if I had taken the responses of participants for granted, I could have tried to parse whether and to what degree racism was experienced in Newfoundland. However, through a CRT framing, I was able to explore the layers of racism as they presented themselves and were experienced by different participants. In acknowledging that whiteness is not biological and racism not individual, the responses of participants showcased the permanence and depth of racism as a mechanism that maintains the self-interest of those in power.

CHAPTER SEVEN: CONCLUSION

This thesis explored how institutional racism presented itself through the experiences of racialized people seeking mental health counselling. The use of critical race theory (CRT) concepts illustrated how racism exists rather than *if* or *why* it exists. Critical ethnography deepened the exploration of location and context – mental health services in St. John's, NL. Finally, my literature review served to deepen my conceptual framework (in a bi-directional manner), and further influenced my data analysis. The findings reflected the complexities the participants' lives in relation to the permanence of racism within our mental health institutions. Participants shared experiences of racism through all stages of access and service, as well as reported racism as a reason for seeking services.

In this final chapter, I explore four main learnings and reflections that emerged throughout my thesis, and possible related antiracist strategies. These emerged through various stages of my research but were particularly salient through three avenues. One was through the application of CRT concepts throughout this thesis, particularly through the data analysis and literature review. The second was through the incredible and courageous insight provided by the research participants. Finally, through the process of writing and re-writing of this thesis, new realizations emerged.

CRT: Where it Can Take Us, Where it Might Not

This thesis utilized CRT concepts to guide its conceptualization of the topic, the data analysis, and interpretation of findings. CRT allowed this research to step away from questions about whether racism exists, and instead explore how it exists and continues to evolve. Further, consistent with a CRT political stance, the thesis highlighted racialized voices. In this section, I

explore some of the strengths and limitations of CRT that were identified throughout the research process.

Utilizing CRT benefitted my thesis in various ways. First, CRT's political stance explores racism as a given; questions on whether racism exist are considered futile (Bell, 1992; Delgado & Stefancic, 2017). CRT concepts allowed for the link between racism and mental health to be problematized further as an experience linked to systemic factors. The person experiencing racism and struggling with their mental health is not the issue to be fixed, but rather, systemic racism is the problem.

In this thesis, CRT amplified racialized voices as a political stance. The inclusion of marginalized voices has been echoed by Kolivoski et al. (2014) who linked racial disparities in accessing mental health services due to the lack of consultation of racialized voices. Additionally, mental health interventions centre whiteness as the norm by being predominantly designed at universities for and by upper to middle class white populations (Kolivoski et al., 2014). This suggests that racialized voices are not included in discourses that pertain to them. Similarly, the literature review showed that racialized voices were prioritized when it benefitted the learning needs of mental health professionals, in ways that did not challenge the system.

The application of CRT concepts was not without its limitations. These limitations were noticed during the data analysis and writing of my findings, demonstrating how writing is also a form of inquiry (Richardson, 2004). During my data analysis, I experienced some difficulties utilizing CRT concepts when exploring the effects of global migration and the construction of the dichotomy of East versus West.

The introduction of migration and precarious status in Canada was an added dimension to the racialization process in this thesis. Most research participants identified as international

students and/or recent migrants to the province. This may have been due to demographics in Newfoundland and Labrador: while racialized people from multiple generations do exist, most racialized people (excluding Indigenous communities) are migrants or have migrated from other Canadian provinces (Newfoundland and Labrador Heritage, 2008; Statistics Canada 2017, 2020). As well, as I suggested in my research design (Chapter Three), this may have been an artefact of my recruitment process. An exploration of xenophobia, migration and diaspora were not originally included in the imagining of the research objectives and questions. Therefore, before interviewing the research participants, the research focus and interview questions highlighted areas of racism and racialization but did not prompt for more exploration on topics of migration and diaspora. For example, the limitations of CRT in relation to migration and diaspora were most salient during the data analysis of one participant's narrative who's Muslimness was judged as not being authentically foreign enough by both the dominant and Muslim communities. While the depiction of Muslimness as foreign (or exotic) and vulnerable is also racism (specifically anti-Muslim racism) it is also rooted in imperialism and colonialism. Orientalism (postcolonial theory) critiques how such narratives are constructed through Western domination (Said, 1978).

While CRT concepts have been utilized to explore the topic of migration, detention, and citizenship (Sanchez & Romero, 2010), it has also been critiqued for inadequately explored experiences of migration and colonization (Mehrotra, 2010). This could be due to the origins of CRT, which are rooted in Black epistemologies and experiences set in the Western world, which provides a specific standpoint that could potentially overlook experiences that emerge from the global power dynamics of Western domination. Because of this limitation, other critical theories such as postcolonial theory might provide future guidance.

Racism as a Three-Legged Stool

In this section, I explore how racism presented itself as multi-leveled. The research findings demonstrate how racism was present in all stages of accessing mental health counselling, including participants' reasons for seeking services, their efforts to seek said services, and during the counselling experience. This realization has serious implications for anti-racist movements.

As I explored in Chapter Five, many participants identified racism as a reason for seeking mental health support. Participants reported experiencing racism in many spaces within and outside mental health services. Service barriers identified by participants prevented access and made mental health care precarious, and highlighted how racism exists in the process of accessing services. When experiencing services (in other words, undergoing a "session"), racism presented itself through whiteness, and lack of shared experiences of racism by counsellors and other mental health professionals.

These narratives demonstrated how racism exists at multiple levels through cultural, institutional, and individual racism (Jones, 1972). Using the imagery of a three-legged stool, Bowser (2017) reminds us how all three levels are needed for racism to "stand." Using Cuba as an example, Bowser highlights how cultural racism remained unacknowledged in their anti-racist strategies. Cuba had actively removed many institutional barriers for Afro-Cubans, but due to cultural racism, significant racial disparities continued, and racist ideologies are passed down to future generations.

This recognition of racism as multi-leveled has serious implications for anti-racist initiatives. The literature review demonstrated how mental health research frequently fails to acknowledge the legacies of scientific racism and Eurocentrism in its services. Such cultural

racism persists today and is left uninterrogated. While such acknowledgment and recognition are important, that is only the first step. In the next section, I further explore and critique other anti-racist initiatives. I explore how hiring strategies for more representation are insufficient anti-racist strategies.

Representation Matters - Sort Of

The second reflections from this thesis draws heavily from the insights and reflections of the research participants, particularly from narratives that reflected on representation and tokenism. Participant stories problematized the literature on racial matching of client-counsellor relationships. They also complicated anti-racist initiatives that aim to increase representation and visibility of racialized staff in the mental health sector.

The literature review highlighted how client-counsellor racial and cultural matching leads to better counselling outcomes (Cabral & Smith, 2011; Ertl et al., 2019; Kim & Kang, 2018; Karlsson, 2005). However, participant narratives demonstrated that the need for representation of mental health counsellors went beyond identity. Rather, participants share that they preferred to have a counsellor who would have the shared experience of being racialized and of experiencing racism firsthand. Participants shared how racism is something that is difficult to express, and better understood if experienced personally. This finding challenges the racial matching phenomena beyond a matching of identities where being racialized is seen as a marker. Instead, the matching of shared experiences illustrates the racialization process as a marker of lived realities that are often Othered. This reframing moves away from the essentialization of identities as static, to one that sees identities to be based on experiences or fluctuating subjectivities (Collins & Bilge, 2020). As Stuart Hall (2017) explained:

> Identity is not a set of fixed attributes, the unchanging essence of the inner self, but a constantly shifting process of *positioning.* In fact, identity is always a never-completed process of becoming - a process of shifting *identifications*, rather than a singular, complete, finished state of being. (Hall, 2017, p. 16, as cited in Collins & Bilge, 2020).

Collin and Bilge (2020) drew from Hall's work to capture how our identities rely on context rather than our inner essence. Thus, being racialized is more than a marker of difference, but also a process of undergoing othering and marginalization. Participants were looking for counsellors who had the shared experience of being racialized and had experienced racism.

While the findings of this thesis highlighted the importance of having mental health professionals with lived experiences of racism, participants also cautioned against tokenism. Anti-racism initiatives must be careful not to think that the solution to addressing racism in mental health services is to employ more racialized staff. While this is important, representation risks being relegated to a quota of bodies which need to be recruited for hiring. This is highlighted in how the findings found that marginalized identities are seen as interchangeable in the workforce; racialized staff were not needed if other marginalized identities (in this case 2SLGBTQ+) were represented.

Finally, the research showed the need for staff representation to take an intersectional approach. Findings showed that being racialized contained a multiplicity of experiences that included migration and precarity of status. Not all racialized professionals can identify with these experiences. Strategies to potentially "diversify" the workforce needs to consider diversity within diversity of the racialized experience. Having a few racialized staff in a tokenistic manner will not and cannot adequately represent the spectrum of racialized experiences.

As I suggested above, hiring more racialized staff might not always advance anti-racist strategies. CRT sees racism as endemic and embedded in our systems and institutions (Delgado & Stefancic, 2017). Therefore, strategies to improve representation in the workforce needs to acknowledge how this will be done under a system that continues to be racist. Racialized mental health professionals need support in such systems in ways that acknowledge how they are also navigating racism. Such supports to racialized counsellors (and mental health professionals in general) may be in the form of clear policies and practices to ensure, for example, that interpersonal and institutional racism is addressed as it occurs. Highlighting racialized voices, another strategy may include reviews of services and practices led by racialized counsellors and service users, which consider explicitly the everyday effects of institutional racism on services. Given that counselling is done within a larger mental health system, local and site-specific reviews cannot occur without simultaneously advocating for anti-racist evaluation and changes throughout the mental health system. These potential strategies must take a multi-levelled and on-going approach, in ways that recognize the multi-layered and permanent nature of racism.

At the same time, CRT depicts racism as unmarked in a racist world, and thus we cannot always rely on racialized people, service users or counsellors, to always be aware of, and explicitly articulate or name their own marginalization. It is quite possible for hypothetically new racialized hires to espouse racist ideologies and be complicit in racism, Eurocentrism and systems of whiteness. The concept of whiteness not only includes a racial marker, but also sees whiteness as a standpoint and as a set of unmarked cultural practices that are deemed the norm (Frankenberg, 1993). Therefore, racialized staff can also perform whiteness (Yee & Dumbrill, 2022). Racialized staff still risk othering the people they serve, even if they share the same

racialized identity. As such, hiring more racialized staff might not, by itself, advance anti-racism change.

Anti-racism strategies need to look beyond diversification of mental health professionals and the workforce. While representation matters, it must take a nuanced and critical approach. Representation needs to be explored beyond narrow understandings of essentialized identities to strategies that explore identity as fluid subjectivities rooted in context and experiences. Racism is embedded throughout our mental health systems, and hiring practices cannot substitute for anti-racist change. A multi-levelled approach that is on-going and flexible needs to be considered. What is meant by flexibility is considered the following and final section.

Conclusion: Unpacking the Uncomfortable Truth on the Permanence of Racism

In this concluding section, I unpack the implications of the permanence of racism within mental health services and counselling. This conclusion emerged early in the conceptualization of my thesis, particularly through the writing and application of CRT concepts. It became a central theme in this thesis, in understanding how anti-racism in mental health counselling might be best framed. An exploration on one of my findings will highlight how the uncomfortable truth about racism came to be.

Perhaps the most poignant narratives were participant experiences of anti-migrant sentiments in emergency services. These narratives not only show how racism is permanent but also how the permanence presents itself through a hierarchy of deservingness. Anti-migrant racism portrayed non-citizen patients as a burden on resources and less deserving of services. Emergency services overlapped with the immigration system in dangerous ways that confirm that racism monitors the presence of migrant bodies. This surveillance and triaging of services are upheld by immigration policies, dominant narratives about migrants, and xenophobia.

Anti-racism strategies will fail if they do not recognize the existence and permanence of racism. Discourse and dialogue on whether racism exists deviates energy and the attention away from effective strategies (Shaikh & Selby, 2023). All three levels of racism—cultural-historic racism, institutional racism, and individual racism- need to be addressed (Bowser, 2017; Jones, 1972). As such, all strategies to address racism in mental health services need to be flexible, adaptable, and constantly aware of the insidiousness of racism. Bell (1992) wrote, "it is a question of *both, and. Both* the recognition of the futility of action […] - *and* the unalterable convictions that something must be done, that action must be taken" (p. 199), this has deep implications for anti-racism work. Effective anti-racist strategies need to remain forever vigilant and evolving. Such initiatives will also stall if the assumption is that racism can be fully eradicated.

In closing, I end this journey with you the way I started, with some reflections by critical race theorist Derrick Bell (1992). He wrote:

> Armed with this knowledge, and with the enlightened, humility-based commitment that it engenders, we can accept the dilemmas of committed confrontations with evils we cannot end. We can go forth to serve, knowing that our failure to act will not change conditions and may very well worsen them. We can listen carefully to those who have been most subordinated. In listening, we must not do them the injustice of failing to recognize that somehow they survived as complete, defiant, though horribly scarred beings. We must learn from their example, learn from those whom we would teach. (Bell, 1992, p. 198)

While this excerpt reflects the difficult truth about racism, it also lights my hope. In my research, disturbing narratives emerged on the intersections of mental health and racism at all points of entry. However, Bell reminds me of the importance of listening to the voices of the research

participants. While many of the experiences disclosed were horrifying, they survived. Their survival is an act of resistance. Their existence is a political act. Their endurance is anti-racist.

To the participants of this study: in the end, this thesis was to honour you and your stories, thank you.

REFERENCES

Abrams, L. S., & Moio, J. A. (2009). Critical race theory and the cultural competence dilemma in social work education. *Journal of Social Work Education, 45*(2), 245-261. https://doi.org/10.5175/JSWE.2009.200700109

Adebayo, C. T., Parcell, E. S., Mkandawire-Valhmu, L., & Olukotun, O. (2022). African American women's maternal healthcare experiences: A critical race theory perspective. *Health Communication*, *37*(9), 1135-1146. https://doi.org/10.1080/10410236.2021.1888453

Adebayo, K. O. (2023). Adebayo, Pandemics and management of "dangerous communities": Ebola, COVID-19, and Africans in China. *The Professional Geographer*, *75*(1), 164-174. https://doi.org/10.1080/00330124.2022.2048867

Ahsan, S. (2020). Holding up the mirror: Deconstructing whiteness in clinical psychology. *Journal of Critical Psychology, Counselling and Psychotherapy*, *20*(3), 45-55.

Anti-Racism Coalition Newfoundland and Labrador. (n.d.). *About ARC-NL.* https://arcnl.ca/about

Archer, D. (2021). *Anti-Racist psychotherapy: Confronting systemic racism and healing racial trauma.* Each One Teach One Publications.

Badwall, H. (2022). Critical race theory for social work. In S. S. Shaikh, B. A. LeFrançois & T. Macias (Eds.), *Critical social work praxis* (pp. 254-261)*,* Fernwood Publishing.

Banerjee, A. T., Lau, A., & Bender, J. L. (2022). Poor health disparities among racialized students in a Canadian university. *Journal of American College Health*, 1-5. https://doi.org/10.1080/07448481.2022.2047702

Bartoli, E., & Pyati, A. (2009). Addressing clients' racism and racial prejudice in individual psychotherapy: Therapeutic considerations. *Psychotherapy: Theory, Research, Practice, Training*, *46*(2), 145-157. https://doi.org/10.1037/a0016023

Bartoli, E., Bentley-Edwards, K. L., García, A. M., Michael, A., & Ervin, A. (2015). What do white counselors and psychotherapists need to know about race? White racial socialization in counseling and psychotherapy training programs. *Women and Therapy*, *38*(3–4), 246–262. https://doi.org/10.1080/02703149.2015.1059206

Beaudoin, L. (2022, June 21). *Coming face-to-face with racism: How hate-provoked graffiti brought these two racialized Newfoundlanders and Labradorians to tears – and why "doing better" is urgent.* The Independent. Retrieved July 21, 2023, from https://theindependent.ca/news/coming-face-to-face-with-racism/

Bell, D. (1992). *Faces at the bottom of the well: The permanence of racism*. Basic Books.

Berry, O. O., Londoño Tobón, A., & Njoroge, W. F. (2021). Social determinants of health: the impact of racism on early childhood mental health. *Current psychiatry reports*, *23*(5), 1-10. https://doi.org/10.1007/s11920-021-01240-0

Best, L. A., Law, M. A., Roach, S., & Wilbiks, J. M. P. (2021). The psychological impact of COVID-19 in Canada: Effects of social isolation during the initial response. *Canadian Psychology / Psychologie canadienne, 62*(1), 143–154. https://doi.org/10.1037/cap0000254

Bhui, K., Warfa, N., Edonya, P., McKenzie, K., & Bhugra, D. (2007). Cultural competence in mental health care: a review of model evaluations. *BMC health services research*, *7*(1), 1-10. https://doi.org/10.1186/1472-6963-7-15

Black Lives Matter NL [@black_lives_matternl]. (n.d.). *Posts* [Instagram profile]. Instagram. Retrieved September 9, 2011, from https://www.instagram.com/black_lives_matternl/?hl=en

Blackstock, C. (2007). Residential Schools: Did They Really Close or Just Morph Into Child Welfare? In *Indigenous Law Journal,* 6 (1), 71-78.

Bonardi, O., Wang, Y., Li, K., Jiang, X., Krishnan, A., He, C., Sun, Y., Wu, Y., Boruff, J. T., Markham, S., Rice, D. B., Thombs-Vite, I., Tasleem, A., Dal Santo, T., Yao, A., Azar, M., Agic, B., Fahim, C., Martin, M.S., … Thombs, B. D. (2022). Effects of COVID-19 Mental Health Interventions Among Children, Adolescents, and Adults Not Quarantined or Undergoing Treatment Due to COVID-19 Infection: A Systematic Review of Randomised Controlled Trials. *The Canadian Journal of Psychiatry. 67*(5), 336-350. https://doi.org/10.1177/07067437211070648

Bowser, B. P. (2017). Racism: Origin and theory. *Journal of Black Studies*, *48*(6), 572-590. https://doi.org/10.1177/0021934717702135

Bransford, C. L. (2006). The use of critical ethnography in managed mental health care settings. *Journal of Sociology and Social Welfare*, *33*(4), 173-191.

Cabral, R. R., & Smith, T. B. (2011). Racial/ethnic matching of clients and therapists in mental health services: a meta-analytic review of preferences, perceptions, and outcomes. *Journal of counseling psychology*, *58*(4), 537-554. https://doi.org/10.1037/a0025266

Cabrera, N. L. (2018). Where is the racial theory in critical race theory?: A constructive criticism of the crits. *The Review of Higher Education,* 42(1), 209-233. https://doi.org/10.1353/rhe.2018.0038

Campbell, E. (2014). “Using critical race theory to measure “racial competency” among social workers.” *Journal of Sociology*, *2*(2), 73-86. https://doi.org/10.15640/jssw.v2n2a5

Canadian Broadcasting Corporation Learning. (n.d.) *Legacy of Hate: Chinese immigrants encounter prejudice and violence as they settled in Canada.* Retrieved July 21, 2923, from https://www.cbc.ca/history/EPISCONTENTSE1EP11CH3PA3LE.html

Carspecken, P. F. (1996). *Critical ethnography in education research*. Routledge.

Castagno, A. E. (2012). What makes critical ethnography “critical”? In S. D. Lapan, M. T. Quartaroli,, & F. J. Riemer, (Eds.), *Qualitative research: An introduction to methods and designs* (pp. 373- 390). Jossey-Bass/Wiley.

Chang, D. F., & Berk, A. (2009). Making Cross-Racial Therapy Work: A Phenomenological Study of Clients’ Experiences of Cross-Racial Therapy. *Journal of Counseling Psychology*, *56*(4), 521–536. https://doi.org/10.1037/a0016905

Chang, D. F., & Yoon, P. (2011). Ethnic minority clients’ perceptions of the significance of race in cross-racial therapy relationships. *Psychotherapy Research*, *21*(5), 567–582. https://doi.org/10.1080/10503307.2011.592549

Chang, R. S. (2002). Critiquing “race” and its uses: Critical race theory’s uncompleted argument. In F. Valdes, J. M. Culp & A. P. Harris (Eds.), *Crossroads, directions, and a new critical race theor*y (pp. 87-96). Temple University Press.

Chiu, M., Amartey, A., Wang, X., & Kurdyak, P. (2018). Ethnic differences in mental health status and service utilization: A population-based study in Ontario, Canada. *Canadian Journal of Psychiatry*, *63*(7), 481–491. https://doi.org/10.1177/0706743717741061

Collins, P. H., & Bilge, S. (2020). *Intersectionality* (2nd ed.). Polity Press.

Comas-Díaz, L., Hall, G. N., & Neville, H. A. (2019). Racial trauma: Theory, research, and healing: Introduction to the special issue. *American Psychologist*, *74*(1), 1-5. https://doi.org/10.1037/amp0000442

Crenshaw, K. (1989). Demarginalizing the intersection of race and sex: A black feminist critique of antidiscrimination doctrine, feminist theory and antiracist politics. University of Chicago Legal Forum, 8(1), 139-167.

Daniel, K. (2020, November 12). Why BIPOC is an Inadequate Acronym. *Chatelaine*. Retrieved July 21, 2023, from https://www.chatelaine.com/opinion/what-is-bipoc/

Delgado, R. & Stefanic, J. (2017). *Critical race theory: An Introduction* (3 ed.). New York University Press.

Díaz, R. M., Ayala, G., Bein, E., Henne, J., & Marin, B. V. (2001). The impact of homophobia, poverty, and racism on the mental health of gay and bisexual Latino men: Findings from 3 US cities. *American Journal of Public Health, 91*(6), 927–932. https://doi.org/10.2105/AJPH.91.6.927

Du Bois, W. E. B. (2007). *The souls of Black folk.* Oxford University Press.

Durbin, A., Lin, E., Moineddin, R., Steele, L. S., & Glazier, R. H. (2014). Use of mental health care for nonpsychotic conditions by immigrants in different admission classes and by refugees in Ontario, Canada. *Open Medicine*, *8*(4), e136-e146.

Ertl, M. M., Mann-Saumier, M., Martin, R. A., Graves, D. F., & Altarriba, J. (2019). The impossibility of client-therapist "match": Implications and future directions for multicultural competency. *Journal of Mental Health Counseling, 41*(4), 312-326. https://doi.org/10.17744/mehc.41.4.03

Este, D., Sato, C, & Jacob, A. (2018). Introduction: The Colourblind Society. In D. Este, L. Lorenzetti, & C. Sato (Eds.), Racism and Anti-Racism in Canada (pp. 1-34). Fernwood Publishing.

Fang, T., Sapeha, H., & Neil, K. (2018). Integration and retention of refugees in smaller communities. *International Migration*, *56*(6), 83–99. https://doi.org/10.1111/imig.12517

Feng, R.Y., Krygsman, A., Vaillancourt, T., & Vitoroulis, I. (2023). Experiences of racial microaggression among immigrant and Canadian-born young adults: Effects of double stigma on mental health and service use. *International Journal of Social Psychiatry*, *0*(0), 1-13. https://doi.org/10.1177/0020764023117437

Fernando, S. (2004). *Cultural diversity, mental health and psychiatry: The struggle against racism*. Routledge.

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

Fernando, S. (2014). Racism in psychiatry. In R. Moodley & M. Ocampo (Eds), *Critical psychiatry and mental health: Exploring the work of Suman Fernando in clinical practice.* Taylor & Francis Group.

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

Fernando, S. (2018). Racialisation of the schizophrenia diagnosis. In B. M. Z. Cohen (Ed.), *Routledge International Handbook of Critical Mental Health* (pp. 195-201). Routledge.

Flaskerud, J. H., & Liu, P. Y. (1991). Effects of an Asian client-therapist language, ethnicity and gender match on utilization and outcome of therapy. *Community Mental Health Journal*, *27*(1), 31-42. https://doi.org/10.1007/BF00752713

Ford, C. L., & Airhihenbuwa, C. O. (2010). Critical race theory, race equity, and public health: toward antiracism praxis. *American Journal of Public Health*, *100*(S1), S30-S35. https://doi.org/10.2105/AJPH.2009.171058

Frankenberg, R. (1993). *White women, race matters.* Taylor & Francis Group.

Gamst, G., Dana, R. H., Der-Karabetian, A., & Kramer, T. (2001). Asian American mental health clients: Effects of ethnic match and age on global assessment and visitation. *Journal of Mental Health Counseling*. *23*(1), 57-71.

Gao, Z. (2022). Sinophobia during the COVID-19 pandemic: Identity, belonging, and international politics. *Integrative Psychological and Behavioral Science*, *56*(2), 472-490. https://doi.org/10.1007/s12124-021-09659-z

Garcia, S. E. (2020, June 17). *Where Did BIPOC Come From?* The New York Times. Retrieved July 21, 2023, from https://www.nytimes.com/article/what-is-bipoc.html

Gebhard, A., McLean, S., & St. Denis, V. (2022). Introduction. In A. Gebhard, S. McLean, V. St Denis (Eds.), *White benevolence: Racism and colonial violence in the helping profession* (pp. 1-22). Fernwood Publishing.

Gerrard, N. (1991). Racism and sexism, together, in counselling: Three women of colour tell their stories. *Canadian Journal of Counselling and Psychotherapy*, *25*(4), 555-566.

Gien, L., & Mullings, D. V. (2013). Culturally competent (appropriate) health and long-term care services for older immigrants in a small urban center Of Newfoundland. *International Journal of Humanities and Social Science Invention, 2*(9)*,* 81- 89.

Giwa. S. & Bagg L. (2022). Applying critical race theory to understand antecedent risk factors for gang involvement and desistance among young black men. In S. S. Shaikh, B. A. LeFrançois & T. Macias (Eds.), *Critical social work praxis* (pp. 264-279)*,* Fernwood Publishing.

Government of Canada. (2023a, May 18). *Work off campus as an international student.* https://www.canada.ca/en/immigration-refugees-citizenship/services/study-canada/work/work-off-campus.html#who-can

Government of Canada. (2023b, June 15). *Study in Canada as an international student.* https://www.canada.ca/en/immigration-refugees-citizenship/services/study-canada.html

Government of Canada. (2023c, June 16). *Your conditions as a study permit holder in Canada.* https://www.canada.ca/en/immigration-refugees-citizenship/services/study-canada/study-permit/prepare-arrival/study-permit-conditions.html#s01

Government of Newfoundland and Labrador. (2022, April 6). *Ministerial committee on anti-racism continuing to take action* [News Release]. https://www.gov.nl.ca/releases/2022/exec/0406n01/

Government of Newfoundland and Labrador (n.d.). *Office of immigration and multiculturalism*: *Welcome to Newfoundland and Labrador immigration.* Retrieved July 21, 2023, from https://www.gov.nl.ca/immigration/

Guba, E.G., & Lincoln, Y.S. (1994). Competing paradigms in qualitative research. In N.K. Denzin, & Y.S. Lincoln (Eds.), Handbook of Qualitative Research, (pp. 105-117). Sage Publications, Inc.

Hamilton, L. K., Esses, V. M., & Walton-Roberts, M. (2022). Borders, Boundaries, and the Impact of COVID-19 on Immigration to Canada (Editors' Introduction). *Studies in Social Justice*, *16*(1), 1-8. https://doi.org/10.26522/ssj.v16i1.3641

Hantke, S. (2022). Unmasking the Whiteness of Nursing. In A. Gebhard, S. McLean, V. St Denis (Eds.), *White benevolence: Racism and colonial violence in the helping profession* (pp. 177-188). Fernwood Publishing.

Hansson, E. K., Tuck, A., Lurie, S., & McKenzie, K. (2012). Rates of mental illness and suicidality in immigrant, refugee, ethnocultural, and racialized groups in Canada: A review of the literature. *The Canadian Journal of Psychiatry*, *57*(2), 111-121. https://doi.org/10.1177/070674371205700208

Hawke, L.D., Sheikhan, N.Y., MacCon, K., & Henderson, J. (2021). Going virtual: Youth attitudes toward and experiences of virtual mental health and substance use services during the COVID-19 pandemic. *BMC Health Services Research*, *21*(340), 1-10. https://doi.org/10.1186/s12913-021-06321-7

Hernandez, M., Nesman, T., Mowery, D., Acevedo-Polakovich, I. D., & Callejas, L. M. (2009). Cultural competence: A literature review and conceptual model for mental health services. *Psychiatric services*, *60*(8), 1046-1050. https://doi.org/10.1176/ps.2009.60.8.1046

Hiraldo, P. (2010). The role of critical race theory in higher education. *The Vermont Connection*, *31*(1), 53-59.

Hooks, B. (1989). Choosing the margins as space of radical openness. *Framework: The Journal of Cinema and Media*, *36*, 15–23.

Hook, J. N., Farrell, J. E., Davis, D. E., DeBlaere, C., van Tongeren, D. R., & Utsey, S. O. (2016). Cultural humility and racial microaggressions in counseling. *Journal of Counseling Psychology*, *63*(3), 269–277. https://doi.org/10.1037/cou0000114

Hunt, S. L. (2020). *Exploring colonization and mental health from the perspective of a First Nations community in Labrador.* [Master's thesis, Memorial University of Newfoundland]. Memorial University Research Repository. http://research.library.mun.ca/id/eprint/14568

Hwang, W.-C., & Goto, S. (2008). The impact of perceived racial discrimination on the mental health of Asian American and Latino college students. *Cultural Diversity and Ethnic Minority Psychology, 14*(4), 326–335. https://doi.org/10.1037/1099-9809.14.4.326

Hymmen, P., Stalker, C. A., & Cait, C. A. (2013). The case for single-session therapy: Does the empirical evidence support the increased prevalence of this service delivery model?. *Journal of Mental Health*, *22*(1), 60-71. https://doi.org/10.3109/09638237.2012.670880

International Organization for Migrants (2023). *Who is a migrant?* https://www.iom.int/who-migrant-0

Jacob, C. J., Robbins, M., & Turner, C. (2022). A Qualitative Inquiry of Improved Alliance in Hispanic Families Paired with Hispanic Therapists in Functional Family Therapy. *Family Journal*, *30*(4), 499-506. https://doi.org/10.1177/10664807221104111

Jamal, S. (2005). Critical Ethnography an effective way to conduct anti-racist research. In G. J. S. Dei, & G. S. Johal (Eds.), *Critical Issues in Anti-Raicst Research Methodologies* (pp. 225 -239) . Peter Lang Publishing, Inc.

Jamieson, J. P., Koslov, K., Nock, M. K., & Mendes, W. B. (2013). Experiencing discrimination increases risk taking. *Psychological science*, *24*(2), 131–139. https://doi.org/10.1177/0956797612448194

Javed, Z., Haisum Maqsood, M., Yahya, T., Amin, Z., Acquah, I., Valero-Elizondo, J., Adrieni, J., Dubey, P., Jackson, R.K., Daffin, M. A., Cainzos-Achirica, M., Hyder, A. A., & Nasir, K. (2022). Race, racism, and cardiovascular health: Applying a social determinants of health framework to racial/ethnic disparities in cardiovascular disease. *Circulation: Cardiovascular Quality and Outcomes*, *15*(1), e007917. https://doi.org/10.1161/CIRCOUTCOMES.121.007917

Jones, S. C. T., & Neblett, E. W., Jr. (2019). The impact of racism on the mental health of people of color. In M. T. Williams, D. C. Rosen, & J. W. Kanter (Eds.), *Eliminating race-based mental health disparities: Promoting equity and culturally responsive care across settings* (pp. 79–97). Context Press.

Joseph, A. (2017). Pathologizing distress: The colonial master's tools and mental health services for "newcomer/immigrants". In A. J. Joseph (Ed.), *Doing anti-oppressive practice: Social justice social work* (pp. 233-251). Fernwood Publishing.

Karlsson, R. (2005). Ethnic Matching Between Therapist and Patient in Psychotherapy: An Overview of Findings, Together With Methodological and Conceptual Issues. *Cultural Diversity and Ethnic Minority Psychology, 11*(2), 113–129. https://doi.org/10.1037/1099-9809.11.2.113

Khawaja, N. G., & Stallman, H. M. (2011). Understanding the coping strategies of international students: A qualitative approach. *Journal of Psychologists and Counsellors in Schools*, *21*(2), 203-224. https://doi.org/10.1375/ajgc.21.2.203

Kim, E., & Kang, M. (2018). The effects of client–counselor racial matching on therapeutic outcome. *Asia Pacific Education Review*, *19*(1), 103–110. https://doi.org/10.1007/s12564-018-9518-9

King, R., & Eidse, J. (2022). The performativity of whiteness and anti-black racism in an academic supervisory relationship. In S. S. Shaikh, B. A LeFrançois, T. Macias (Eds.)., *Critical social work praxis* (pp. 294-302). Fernwood Publishing.

Kirby, S. & McKenna, K. (1989). *Experience, research, social change: Methods from the margins*. Garamond Press.

Kistan, N. (2004). *How do the perceptions of visible minority counsellors regarding race, impact the counselling relationship with majority (white) clients?* [Master's thesis, University of Victoria]. UVicSpace. http://dspace.library.uvic.ca:8080/handle/1828/506?show=full

Kogan, C. S., Noorishad, P. G., Ndengeyingoma, A., Guerrier, M., & Cénat, J. M. (2022). Prevalence and correlates of anxiety symptoms among Black people in Canada: A significant role for everyday racial discrimination and racial microaggressions. *Journal of Affective Disorders*, *308*, 545-553. https://doi.org/10.1016/j.jad.2022.04.110

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

Ladson-Billings, G., & Tate, W. F. (1995). Toward a critical race theory of education. *Teachers College Record*, *97*(1), 47-68.

Laplan, S. D., Quartaroli, M. T. & Riemer, J. F. (2012). Introduction to Qualitative Research. In S. D. Lapan, M. T. Quartaroli, & F. J. Riemer (Eds.), *Qualitative research: An introduction to methods and designs*. (pp. 3-18). Jossey-Bass/Wiley.

Laszloffy, T.A. & Hardy, K.V. (2000). Uncommon Strategies for a Common Problem: Addressing Racism in Family Therapy. *Family Process,* 39(1), 35-50. https://doi.org/10.1111/j.1545-5300.2000.39106.x

Lazaridou, F., & Fernando, S. (2022). Deconstructing institutional racism and the social construction of whiteness: A strategy for professional competence training in culture and migration mental health. *Transcultural Psychiatry*, *59*(2), 175-187.

Ledesma, M. C., & Calderón, D. (2015). Critical race theory in education: A review of past literature and a look to the future. *Qualitative inquiry*, *21*(3), 206-222. https://doi.org/10.1177/1077800414557825

LeFrançois, B.A. (2013). Ethnography. In T. Teo (Ed.). *Encyclopedia of critical psychology: Springer reference*. Springer-Verlag Berlin Heidelberg. doi:10.1007/SpringerReference_304748

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

Lee, E., Tsang, A. K. T., Bogo, M., Johnstone, M., & Herschman, J. (2018). Enactments of racial microaggression in everyday therapeutic encounters. *Smith College Studies in Social Work*, *88*(3), 211–236. https://doi.org/10.1080/00377317.2018.1476646

Li, Y., & Nicholson, H. L., Jr (2021). When "model minorities" become "yellow peril"-Othering and the racialization of Asian Americans in the COVID-19 pandemic. *Sociology Compass*, *15*(2), e12849. https://doi.org/10.1111/soc4.12849

Li, X., & Grineva, M. (2016). Academic and social adjustment of high school refugee youth in Newfoundland. *TESL Canada Journal*, 34(1), 51-71. http://dx.doi.org/1018806/tesl.v34i1.1253

Li, X., & Que, H. (2016). Integration and career challenges of newcomer youth in Newfoundland in Canada. *FIRE: Forum for International Research in Education*. *2*(3). https://doi.org/10.18275/fire201602031082

Lui, H. (2022). From model minority to yellow peril: The shifting narratives of Asian international students. *Journal of International Students, 13*(1), 79-84. https://doi.org/10.32674/jis.v13i1.4686

Lui, P. P., Berkley, S. R., Pham, S., & Sanders, L. (2020). Is microaggression an oxymoron?: A mixed methods study on attitudes toward racial microaggressions among United States university students. *PLOS ONE*, *15*(12), Article e0243058. https://doi.org/10.1371/journal.pone.0243058

Macdonald, M. (2016, July 8). *Scott Brison wants Atlantic Canada to drop come-from-away label.* CBC News. Retrieved July 21, 2023, from https://www.cbc.ca/news/canada/nova-scotia/scott-brison-cfa-ban-1.3670135

MacKay, C. (2021, August 26). *Former P.E.I. student detained, faces deportation for accessing mental health care.* CBC news. Retrieved July 21, 2023, from https://www.cbc.ca/news/canada/prince-edward-island/pei-detained-immigration-status-1.6150443#:~:text=Mehdi%20Oussama%20Belhadj%20Hassine%20was,help%20for%20his%20mental%20health

Macleod, B. P. (2013). Social justice at the microlevel: Working with clients' prejudices. *Journal of Multicultural Counseling and Development*, *41*(3), 169–184. https://doi.org/10.1002/j.2161-1912.2013.00035.x

Madison, S. D. (2005). *Critical ethnography: Methods, ethics, and performance*. Sage Publications.

Manning, S. M. (2018). Contrasting colonisations: (Re)storying newfoundland/ ktaqmkuk as place. *Settler Colonial Studies*, *8*(3), 314–331. https://doi.org/10.1080/2201473X.2017.1327010

Maramba, G. G., & Nagayama Hall, G. C. (2002). Meta-analyses of ethnic match as a predictor of dropout, utilization, and level of functioning. *Cultural Diversity and Ethnic Minority Psychology*, *8*(3), 290–297. https://doi.org/10.1037/1099-9809.8.3.290

Markin, R. D., & Coleman, M. N. (2023). Intersections of gendered racial trauma and childbirth trauma: Clinical interventions for Black women. *Psychotherapy, 60*(1), 27–38. https://doi.org/10.1037/pst0000403

Martínez Mateo, M., Cabanis, M., Stenmanns, J., & Krach, S. (2013). Essentializing the binary self: individualism and collectivism in cultural neuroscience. *Frontiers in Human Neuroscience*, *7* (289), 1-4. https://doi.org/10.3389/fnhum.2013.00289

Matheson, K., Pierre, A., Foster, M. D., Kent, M., & Anisman, H. (2021). Untangling racism: Stress reactions in response to variations of racism against Black Canadians. *Humanities and Social Sciences Communications, 8*(34), 1-12. https://doi.org/10.1057/s41599-021-00711-2

McCall, L. (2005). The complexity of intersectionality. *Signs, 30*(3), 1771-1800. https://doi.org/10.1086/426800

Mehrotra, G. (2010). Toward a Continuum of Intersectionality Theorizing for Feminist Social Work Scholarship. *Affilia*, *25*(4), 417–430. https://doi.org/10.1177/0886109910384190

Meraji, S. M., & Demby, G. (Hosts). (2020, September 30). *Is it time to say R.I.P. To 'POC'?* [Audio podcast]. NPR Code Switch. https://www.npr.org/2020/09/29/918418825/is-it-time-to-say-r-i-p-to-p-o-c

Metzl, J. M. (2010). *The protest psychosis: How schizophrenia became a black disease*. Beacon Press.

Migrants Students United – Newfoundland and Labrador (MSUINNL) [@msuinnl]. (n.d.) *Posts* [Instagram profile]. Instagram. Retrieved September 9, 2021, from https://www.instagram.com/msuinnl/

Mills, C (2014). *Decolonizing global mental health: The psychiatrization of the majority world.* Routledge.

Minister of Justice. (2023, June 21). *Immigration and Refugee Protection Act* (S.C. 2001, c.27). Retrieved July 21, 2023, from https://laws.justice.gc.ca/PDF/I-2.5.pdf

Miu, A. S., & Moore, J. R. (2021). Behind the masks: Experiences of mental health practitioners of color during the COVID-19 pandemic. *Academic Psychiatry*. *45*(5), 539-544. https://doi.org/10.1007/s40596-021-01427-w

Mohanachandran, M. (2017). The Othering of the Black Community in News Media Reports During the Ebola Epidemic of 2013 to 2016. *NEXUS: The Canadian Student Journal of Anthropology*, *25*, 44-51.

Moodley, R., & Khina, B. (2015). Therapy without borders: Bridging counseling and psychotherapy across cultures. In R. Moodley, M. Lengyell, R. Wu, & U. P. Gielen (Eds.), *International counseling case studies handbook* (pp. 277–291). American Counseling Association. https://doi.org/10.1002/9781119222781.ch35

Moodley, R., Mujtaba, F., & Keiman, S. (2018). Critical race theory and mental health. In B. M. Z. Cohen (Ed.), *Routledge international handbook of critical mental health* (pp. 79-88). Routledge.

Moodley, R. & Osazuwa, S. (2021). Configurations of race and culture in mental health. In R. Moodley & E. Lee (Eds.), *The Routledge international handbook of race, culture and mental health* (pp. 69-80). Routledge.

Moroz, N., Moroz, I., & D'Angelo, M. S. (2020). Mental health services in Canada: barriers and cost-effective solutions to increase access. *Healthcare management forum 33*(6), 282-287. https://doi.org/10.1177/0840470420933911

Moynihan, R., Sanders, S., Michaleff, Z. A., Scott, A. M., Clark, J., To, E. J., Jones, M., Kitchener, E., Fox, M., Johansson, M., Lang, E., Duggan, A., Scott, I., & Albarqouni, L. (2021). Impact of COVID-19 pandemic on utilisation of healthcare services: a systematic review. *BMJ open*, *11*(3), e045343. https://doi.org/10.1136/bmjopen-2020-045343

Mullings, D.V. & Gien, L. (2013). Culturally competent (appropriate) health and long-term care services for older immigrants in small urban center of Newfoundland. *International Journal of Humanities and Social Science Invention, 2*(9), 81-89.

Mullings, D. V., Giwa, S., Karki, K. K., Shaikh, S. S., Gooden, A., Spencer, E. B., & Anderson, W. (2021). The settlement and integration experience of temporary foreign workers living in an isolated area of Newfoundland and Labrador, Canada. *Journal of International Migration and Integration*, *22*(3), 1085–1104. https://doi.org/10.1007/s12134-020-00788-9

Mullings, D. V. (2022) Situation anti-black racism and racism through a critical race theory lens: Commentary on social work theory and practice. In S. S. Shaikh, B. A. LeFrançois & T. Macias (Eds.), *Critical social work praxis* (pp. 264-279), Fernwood Publishing.

Nadal, K. L., Issa, M-A., Leon, J., Meterko, V., Wideman, M., & Wong, Y. (2011). Sexual orientation microaggressions: "Death by a thousand cuts" for lesbian, gay, and bisexual

youth. *Journal of LGBT Youth, 8*(3), 234-259. https://doi.org/10.1080/19361653.2011.584204

Nadal, K. L., Griffin, K. E., Wong, Y., Hamit, S., & Rasmus, M. (2014a). The impact of racial microaggressions on mental health: Counseling implications for clients of color. *Journal of Counseling & Development, 92*(1), 57-66. https://doi.org/10.1002/j.1556-6676.2014.00130.x

Nadal, K.L., Wong, Y., Griffin, K.E., Davidoff, K., & Sriken, J. (2014b). The adverse impact of racial microaggressions on college students' self-esteem. *Journal of College Student Development 55*(5), 461-474. https://doi.org/10.1353/csd.2014.0051

Newfoundland and Labrador Heritage. (2008). *Other Ethnic Groups.* Retrieved July 21, 2023, from https://www.heritage.nf.ca/articles/society/other-ethnic-groups.php

Newfoundland and Labrador Tourism. (n.d.). *Discover our People & Culture.* Retrieved July 21, 2023, from https://www.newfoundlandlabrador.com/about-this-place/people-and-culture

Okazaki, S. (2009). Impact of racism on ethnic minority mental health. *Perspectives on Psychological Science*, *4*(1), 103-107.

Oluo, I. (2019). *So you want to talk about race*. Basic Books.

Ontario Human Rights Commission. (2005). *Policy and guidelines on racism and racial discrimination.* Retrieved from https://www3.ohrc.on.ca/sites/default/files/attachments/Policy_and_guidelines_on_racism_and_racial_discrimination.pdf

Ouassini, A., Amini, M., & Ouassini, N. (2022). # ChinaMustexplain: Global Tweets, COVID-19, and Anti-Black Racism in China. *The Review of Black Political Economy*, *49*(1), 61-76. https://doi.org/10.1177/0034644621992687

Owen, J., Tao, K. W., Drinane, J. M., Hook, J., Davis, D. E., & Kune, N. F. (2016). Client perceptions of therapists' multicultural orientation: Cultural (missed) opportunities and cultural humility. *Professional Psychology: Research and Practice, 47*(1), 30-37. https://doi.org/10.1037/pro0000046

Owen, J., Tao, K. W., Imel, Z. E., Wampold, B. E., & Rodolfa, E. (2014). Addressing racial and ethnic microaggressions in therapy. *Professional Psychology: Research and Practice*, *45*(4), 283–290. https://doi.org/10.1037/a0037420

Owen, J.J., Tao, K., Leech M. M., & Rodolfa, E. (2011). Client's perceptions of their psychotherapists' multicultural orientation. *Psychotherapy 48*(3), 274-282. https://doi.org/10.1037/a0022065

Paradies, Y., Ben, J., Denson, N., Elias, A., Priest, N., Pieterse, A., Gupta, A., Kelaher, M., & Gee, G. (2015). Racism as a determinant of health: a systematic review and meta-analysis. *PloS One*, *10*(9), e0138511. https://doi.org/10.1371/journal.pone.0138511

Pascoe, E. A., & Smart Richman, L. (2009). Perceived discrimination and health: A meta-analytic review. *Psychological Bulletin, 135*(4), 531–554. https://doi.org/10.1037/a0016059

Pillow, W. (2003). Confession, catharsis, or cure? Rethinking the uses of reflexivity as methodological power in qualitative research. *International Journal of Qualitative Studies in Education*, *16*(2), 175-196. https://doi.org/10.1080/0951839032000060635

Pope-Davis, D. B., Toporek, R. L., Ortega-Villalobos, L., Ligiéro, D. P., Brittan-Powell, C. S., Liu, W. M., Bashshur, M. R., Codrington, J. N., & Liang, C. T. H. (2002). Client perspectives of multicultural counseling competence: A qualitative examination. *The Counseling Psychologist*, *30*(3), 355–393. https://doi.org/10.1177/0011000002303001

Quinn, M. (27 April 2022). *St. John's family waiting months for N.L. collaborative clinic after losing family doctor.* CBC News. Retrieved July 21, 2023, from https://www.cbc.ca/news/canada/newfoundland-labrador/collaborative-care-wait-1.6431208

Quinn, M. (22 February 2023a). *Despite recruitment efforts, N.L.'s family doctor shortage is getting worse.* CBC News. Retrieved July 21, 2023, from https://www.cbc.ca/news/canada/newfoundland-labrador/family-doctor-shortage-growing-1.6754849#:~:text=In%202019%2C%20public%20polling%20done,province's%20aging%20physician%20population%20retire

Quinn, M. (10 July 2023b). *Change coming for registered psychiatric nurses who can't work in N.L., says health minister*. CBC News. Retrieved July 21, 2023, from https://www.cbc.ca/news/canada/newfoundland-labrador/registered-psychiatric-nurse-pilot-1.6900249

Ray, V. (2022). *On critical race theory*. Random House LLC.

Razack, N., & Jeffery, D. (2002). Critical race discourse and tenets for social work. *Canadian Social Work Review/Revue canadienne de service social*, *19*(2), 257-271.

Reitmanova, S., & Gustafson, D. L. (2008). "They can't understand it": maternity health and care needs of immigrant Muslim women in St. John's, Newfoundland. *Maternal and child health journal, 12*(1), 101-111. https://doi.org/10.1007/s10995-007-0213-4

Reitmanova, S., & Gustafson, D. L. (2009b). Primary mental health care information and services for St. John's visible minority immigrants: Gaps and opportunities. *Issues in Mental Health Nurs*ing, *30*(10), 615-623. https://doi.org/10.1080/01612840903033733

Reitmanova, S., & Gustafson, D. L. (2009a). Mental health needs of visible minority immigrants in a small urban center: Recommendations for policy makers and service providers. *Journal of Immigrant and Minority Health*, *11*(1), 46-56. https://doi.org/10.1007/s10903-008-9122-x

Reid C., Greaves, L. & Kirby, S. (2017). *Experience, Research, Social Change: Critical methods* (3rd ed.). University of Toronto Press.

Rice, A. N., & Harris, S. C. (2021). Issues of cultural competence in mental health care. *Journal of the American Pharmacists Association*, *61*(1), e65-e68. https://doi.org/10.1016/j.japh.2020.10.015

Richardson, L. (2004). Writing: A method of inquiry. In C. K. Hesse-Biber, & P. Leavy (Eds.), *Approaches to qualitative research: A reader on theory and practice*. (pp. 473- 495). Oxford University Press.

Riemer, F. J. (2012). Ethnographic Research. In S. D. Lapan, M. T. Quartaroli, & F. J. Riemer (Eds.), *Qualitative research: An introduction to methods and designs*. (pp. 3-18). Jossey-Bass/Wiley.

Roberts, D. (2021, June 23). *'Population' crisis can be overturned with plans to recruit newcomers, Furey says.* CBC News. Retrieved July 21, 202, from https://www.cbc.ca/news/canada/newfoundland-labrador/nl-immigration-investments-1.6077138

Roberts, D. (2022, August 22). *Racist incidents happen 'over and over again,' activists say after tirade goes viral: RNC investigating viral video of racist tirade*. CBC News. Retrieved August 22, 2022, from https://www.cbc.ca/news/canada/newfoundland-labrador/hate-incidents-arc-nl-1.6556682

Robinson, C. (2010, May 10). *Top Ten Friendly People: Chris Robinson's Top Ten Favourite Places.* Maclean's. Retrieved July 21, 2023, from https://www.macleans.ca/society/life/top-ten-friendly-people/

Rogers-Sirin, L., Melendez, F., Refano, C., & Zegarra, Y. (2015). Immigrant perceptions of therapists' cultural competence: A qualitative investigation. *Professional Psychology: Research and Practice*, *46*(4), 258-269. https://doi.org/10.1037/pro0000033

Saad, L. (2020). *Me and white supremacy: Combat racism, change the world, and become a good ancestor.* Sourcebooks, Incorporated.

Said, E. W. (1978). *Orientalism*. Pantheon Books.

Salami, B., Salma, J., & Hegadoren, K. (2019). Access and utilization of mental health services for immigrants and refugees: Perspectives of immigrant service providers. *International Journal of Mental Health Nursing*, *28*(1), 152-161. https://doi.org/10.1111/inm.12512

Salami, B., Alaazi, D. A., Ibrahim, S., Yohani, S., Scott, S. D., Vallianatos, H., Urichuk, L., & Islam, B. (2022). African immigrant parents' perspectives on the factors influencing their children's mental health. *Journal of Child and Family Studies, 31*, 142-154. https://doi.org/10.1007/s10826-021-02130-y

Salam, Z., Odenigbo, O., Newbold, B., Wahoush, O., & Schwartz, L. (2022). Systemic and individual factors that shape mental health service usage among visible minority immigrants and refugees in Canada: a scoping review. *Administration and Policy in Mental Health and Mental Health Services Research*, *49*(4), 552-574. https://doi.org/10.1007/s10488-021-01183-x

Salter, D. (2021, October 10). *Consultations continue for minister's anti-racism committee.* NTV. Retrieved July 21, 2023, from http://ntv.ca/consultations-continue-for-ministers-anti-racism-committee/

Sanchez, G., & Romero, M. (2010). Critical race theory in the US sociology of immigration. *Sociology Compass*, *4*(9), 779-788. https://doi.org/10.1111/j.1751-9020.2010.00303.x

Saunders, N. R., Gill, P. J., Holder, L., Vigod, S., Kurdyak, P., Gandhi, S., & Guttmann, A. (2018). Use of the emergency department as a first point of contact for mental health care by immigrant youth in Canada: A population-based study. *CMAJ*, *190*(40), E1183–E1191. https://doi.org/10.1503/cmaj.18027

Shaikh, S. S. & Selby, J. A. (2019). *Addressing Islamophobia in NL: Community Report*. Memorial University. https://www.mun.ca/relstudies/more/AddressingIslamophobia/AI_Report_Recommendations_FINAL.pdf

Shaikh, S. S., & Selby, J. A. (2023). 'Wait, What?! Islamophobia exists in Newfoundland and Labrador?': Theorising polite dismissal of anti-islamophobia public engagement. In L. D'Haenens, & A. Mekki-Berrada (Eds.), *Islamophobia as a form of radicalisation: Perspectives on media, academia and socio-political scapes from Europe and Canada.* (pp. 211-228). Leuven University Press.

Smith, L., Proctor, G., & Akondo, D. (2021). Confronting racism in counselling and therapy training—Three experiences of a seminar on racism and whiteness. *Psychotherapy and Politics International*, *19*(2), 1-11. https://doi.org/10.1002/ppi.1579

Solorzano, D. G. (1997). Images and words that wound: Critical race theory, racial stereotyping, and teacher education. *Teacher Education Quarterly*, *24*(3), 5–19. https://doi.org/10.2307/2347808

Strong, H., Pickles, A., & Hartery, A. (2022). Lessons Learned from a Cyberattack on the Healthcare System of Newfoundland and Labrador: A Radiology Perspective. *Canadian Association of Radiologists Journal*, *73*(3), 601-602. https://doi.org/10.1177/08465371221081549

Spalding, B., Grove, J., & Rolfe, A. (2019). An exploration of Black, Asian and minority ethnic counsellors' experiences of working with White clients. *Counselling and Psychotherapy Research*, *19*(1), 75-82. https://doi.org/10.1002/capr.12194

Statistics Canada. (2017). *Immigration and diversity: Population projections for Canada and its regions, 2011 to 2036* (Catalogue No. 91-551-X). Prepared by J.-M. Morency, É. C. Malenfant, & S. MacIsaac. Retrieved from https://www150.statcan.gc.ca/n1/en/pub/91-551-x/91-551-x2017001-eng.pdf?st=G6BOyP_n

Statistics Canada. (2020). Table 17-10-0008-01 Estimates of the components of demographic growth, annual [Data table]. https://doi.org/10.25318/1710000801-eng

Stein, S., & de Andreotti, V. O. (2016). Cash, competition, or charity: international students and the global imaginary. *Higher Education, 72*(2), 225-239. https://doi.org/10.1007/s10734-015-9949-8

Sue, D. W. (30 March 2021). *Microaggressions: Death by a thousand cuts*. Scientific American. https://www.scientificamerican.com/article/microaggressions-death-by-a-thousand-cuts/

Sue, D. W. (2010). *Microaggressions in everyday life: Race, gender, and sexual orientation.* John Wiley & Sons, Inc.

Tiwari, S. K., & Wang, J. L. (2008). Ethnic differences in mental health service use among White, Chinese, South Asian and South East Asian populations living in Canada. *Social Psychiatry and Psychiatric Epidemiology*, *43*(11), 866–871. https://doi.org/10.1007/s00127-008-0373-6

The Canadian Encyclopedia. (n.d.). *Timeline Asia-Canada.* Retrieved July 21, 2023, from https://www.thecanadianencyclopedia.ca/en/timeline/asia-canada

Thomas, J. (1993). *Doing critical ethnography*. SAGE Publications, Inc.

Thomson, M. S., Chaze, F., George, U., & Guruge, S. (2015). Improving immigrant populations' access to mental health services in Canada: A review of barriers and recommendations. *Journal of Immigrant and Minority Health*, *17*(6), 1895–1905. https://doi.org/10.1007/s10903-015-0175-3

Thorne, N., & Moss, M. (2022). Unmarked Graves: Yet another Legacy of Canada's Residential School System: An Interview with Niki Thorne. *New American Studies Journal: A Forum*, *72*, 1-8. https://doi.org/10.18422/72-24

Tseris, E. (2017). A feminist critique of trauma therapy. In B. M. Z. Cohen (Ed.), *Routledge international handbook of critical mental health* (pp. 251-257). Routledge.

Twahirwa, R. (2021, June 8). *The Bravest Road: Why BIPOC/IBPOC is essential to understanding Caanda's racial history.* Medium. https://medium.com/@rptarticles/the-bravest-road-why-bipoc-ibpoc-is-essential-to-understanding-canadas-racial-history-f0126c6b73e4

Villegas, P. E., & Blower, J. (2019). " Part of being Canadian is having access to healthcare": Framing the boundaries of healthcare deservingness for non-citizens through the interim

federal health benefits program. *Canadian Journal of Communication, 44*(1), 69-88. https://doi.org/10.22230/cjc.2019v44n1a3280

Waldron, I. (2010). The impact of inequality on health in Canada: A multi-dimensional framework. *Diversity in Health and Care*, *7*(4), 261-270.

Western States Center. (2011, February 15). *The Origin of the phrase "Women of Color"* [Video]. YouTube. https://www.youtube.com/watch?v=82vl34mi4Iw

Whitley, R., Kirmayer, L. J., & Groleau, D. (2006). Understanding immigrants' reluctance to use mental health services: a qualitative study from Montreal. *The Canadian Journal of Psychiatry*, *51*(4), 205-209. https://doi.org/10.1177/070674370605100401

Williams, D. R., & Mohammed, S. A. (2013). Racism and health I: Pathways and scientific evidence. *American behavioral scientist, 57*(8), 1152-1173.

Williams, M.T., Metzger, I.W., Leins, C., & DeLapp, C.L. (2018). Assessing Racial Trauma Within a DSM–5 Framework: The UConn Racial/Ethnic Stress & Trauma Survey. *Practice Innovations, 3*, 242–260. http://dx.doi.org/10.1037/pri0000076

Williams, M. T., Faber, S. C., & Duniya, C. (2022a). Being an anti-racist clinician. *The Cognitive Behaviour Therapist*, *15*, e19.

Williams, M. T., Khanna Roy, A., MacIntyre, M. P., & Faber, S. (2022b). The traumatizing impact of racism in Canadians of colour. *Current Trauma Reports*, *8*(2), 17-34.

World Health Organization (2023, May 5). WHO Director-General's opening remarks at the media briefing – 5 May 2023. Retrieved from https://www.who.int/news-room/speeches/item/who-director-general-s-opening-remarks-at-the-media-briefing---5

Wu, F. H. (2002). *Yellow: Race in America beyond black and white*. Basic Books.

Yee, J. Y., & Dumbrill, G. C. (2022). Evolving theory of whiteness: A journey from W.E.B. Du Bois to shame and call-out culture. In S. S. Shaikh, B. A. LeFrançois, T. Macias (Eds.)., *Critical social work praxis* (pp. 294-302). Fernwood Publishing.

Yeo, E., & Torres-Harding, S. R. (2021). Rupture resolution strategies and the impact of rupture on the working alliance after racial microaggressions in therapy. *Psychotherapy*, *58*(4), 460–471. https://doi.org/10.1037/pst0000372

Young, K., Punnett, A., & Suleman, S. (2020). A little hurts a lot: Exploring the impact of microaggressions in pediatric medical education. *Pediatrics*, *146*(1), 1-3. https://doi.org/10.1542/peds.2020-163

Yu E., Xu B, & Sequeira L. (2022). Determinants of e-Mental Health Use During COVID-19: Cross-sectional Canadian Study. *Journal of Medical Internet Research*, *24*(11), 1-15. https://doi.org/10.2196/39662

Yusuf, H. E., Copeland-Linder, N., Young, A. S., Matson, P. A., & Trent, M. (2022). The impact of racism on the health and wellbeing of black indigenous and other youth of color (BIPOC youth). *Child and Adolescent Psychiatric Clinics*, *31*(2), 261-275. https://doi.org/10.1016/j.chc.2021.11.005

Zhao, K., O'Connor, C., Lenz, T., & Fang, L. (2022). Conceptualizing anti-Asian racism in Canada during the COVID-19 pandemic: A call for action to social workers. *Journal of Ethnic & Cultural Diversity in Social Work*, *31*(3-5), 302-312. doi: 10.1080/15313204.2022.2070892

APPENDICES

Appendix A – Recruitment Flyer

Appendix B – Recruitment Letter

Recruitment Letter

Greetings!

I am writing to invite you to participate in a research project entitled, **Experiences of Mental Health Counselling for Racialized People in Newfoundland and Labrador.** The study is being conducted by myself, Camila Fujiwara, graduate student at the School of Social Work, Memorial University of Newfoundland and Labrador. The goal of this study is to better understand the experiences of navigating mental health counselling for racialized people living in Newfoundland and Labrador.

I am looking for people who currently live or have lived in Newfoundland and Labrador. I am looking to explore experiences of accessing (or trying to access) mental health counselling after the year 2020. You must be over the age of 18 and self-identify as racialized.

Your participant would be greatly appreciated and is completely voluntary. This study is not a requirement of any organization, and your decision whether to participate will not be reported. Should you agree to participate, your identity will be anonymized, and all other identifying information will be removed and replaced with pseudonyms on our transcripts and publications.

You will be asked to:

- Participate in a 60-to-90-minute audio-recorded interview via Webex about your experiences of accessing mental health counselling and how that has impacted you. Hand-written notes will also be taken.
- Agree to participate in a 30-minute follow-up interview to clarify the findings of the initial interview and to review your audio transcription.

Please keep in mind that the purpose of this research is not to study individual participants, but rather the organizational processes and identify the overall theme. Our objectives are to better understand how racialized people navigate mental system when they access (or try to access) mental health counselling in Newfoundland and Labrador; to explore how racism impacts racialized people's need to access mental health counselling; and to advance anti-racist knowledge and analysis about racism and mental health services within social work and other professions.

If you are interested or have any questions, please feel free to contact me at cfujiwara@mun.ca or by phone at 709-500-4300. You can also contact my MSW thesis supervisor, Dr. Sobia Shaikh, at sshaikh@mun.ca.

Please note: this research has been reviewed and approved by the Interdisciplinary Committee on Ethics in Human Research, Memorial University's Ethics Review Board and conforms to the standards of the Canadian Tri-Council Research Ethics guidelines. If you have ethical concerns about the research, such as the way you have been treated or your rights as a participant, you may contact the Chairperson of the ICEHR at icehr@mun.ca or by telephone at (709) 864-2861.

Appendix C – Interview Questions

Interview Questions

The interview follows a semi-structured approach in order to provide flexibility during the interview process (Carspecken, 1996).

1. Topic Domain: social supports mapping
   - Started question: **Can you tell me about your social supports in St. John's, NL?**
   - Underlying categories (do not want to explicitly ask): informal supports
   - Follow-up questions: If you've had a difficult day, who do you reach out to? What communities do you feel a part of?

2. Topic Domain: The issue that prompted them to seek out counselling
   - Starting question: **What made you seek out mental health counselling?**
   - Underlying categories: Intention
   - Follow-up questions: What were your goals when you started counselling?

3. Topic Domain: Experiencing counselling
   - Starting question: **What happened when you went there?**
   - Underlying categories: Access
   - Follow up question: Was it what you expected? Were you successful in accessing it? When was this? What date was this? Is there another experience you'd like to share? Can you describe it as though it were a scene from a movie?

4. Topic Domain: Impact of counselling
   - Starting question: **What did you get out of it?**
   - Underlying categories: impact
   - Follow up question: What did you gain? Any difficulties/limits of the experience? How do you feel that experience(s) has affected you now?

5. Topic Domain: The impact - racism
   - Starting question: How do you think race or racism did (or did not) impact your experience?
   - *Underlying categories: experience of systemic racism*
   - Follow up question: Can you elaborate on [one example or perception]? What advice would you give individuals (service users), service providers, policy makers?

6. Topic Domain: Future oriented supports
   - Starting question: What do you want moving forward?
   - Underlying categories: evaluation

- Follow up question: Were your goals and/or needs met? What did they do to support their mental health in other ways?

Appendix D – Brief Demographic Survey

Brief Demographic Survey

As all parts of this interview, this demographic survey is optional to answer.

How old are you?_____

What is your gender identity?_____

What is your racial identity?_____

What are your cultural or ethnic identities?_____

Which languages do you speak?_____

How long have you been in Newfoundland and Labrador? Were you born here?

_____

Where is "home" for you?_____

Appendix E – Lay Summary

Title:	Experiences of Mental Health Counselling for Racialized People in Newfoundland and Labrador
Researcher(s):	Camila (Kamira) Fujiwara, MSW student at the School of Social Work at Memorial University of Newfoundland and Labrador (MUNL), cfujiwara@mun.ca, 709-500-4300
Supervisor(s):	Dr. Sobia Shaikh, Assistant Professor, School of Social Work, Memorial University of Newfoundland, and Labrador (MUNL)

I am a graduate student completing her master's in social work at Memorial University of Newfoundland and Labrador. As a racialized social worker (woman of colour), I provide mental health support to individuals. I also receive counselling for my own mental health. I am interested in hearing the experiences of racialized individuals when they access mental health counselling. I believe this research is important because our experiences are not always centred or validated. If you feel this way, I would love to interview you.

This study will use qualitative data in the form of in-depth interviews, textual data, and personal reflexive journaling. The research question for this project is "what are the experiences of racialized individuals living in St John's, Newfoundland, and Labrador when they access (or try to access) mental health counselling?"

This critical ethnographic research has three objectives:

1. To better understand how racialized people navigate the mental health system when they access (or try to access) mental health counselling in Newfoundland and Labrador (NL).
2. To explore how racism impacts racialized people's need to access mental health counselling.
3. To advance anti-racist knowledge and analysis about racism and mental health services within social work and other professions.

I am hoping to recruit 6 participants for these interviews. To be eligible, you must be over the age of 18, self-identify as being racialized, and be living (or have lived) in Newfoundland and Labrador. We are also looking for participants who have accessed or tried to access mental health counselling after the year 2020.

In-depth interviews will be conducted via WebEx and audio recorded. Hand-written notes will also be taken during the interview. The interview style will be semi-structured and will use open-ended questioning. These interviews will be transcribed (putting your words into written form) using Trint (an audio transcription software) and then hand coded. Interviews will be hand-coded for emergent themes, which are themes that come up within and across all interviews. Brief demographic data will be collected.

If you'd like to participate in an interview, we can first set up a time to meet and chat about the interview process. This provides an opportunity for you to ask questions and see if this is something you'd like to participate in. If you feel that this is something you'd like to do, then we can set up a time for the interview.

Appendix F – Consent Form

Informed Consent Form

Title:	Experiences of Mental Health Counselling for Racialized People in Newfoundland and Labrador
Researcher(s):	Camila (Kamira) Fujiwara, MSW student at the School of Social Work at Memorial University of Newfoundland and Labrador (MUNL), cfujiwara@mun.ca, 709-500-4300
Supervisor(s):	Dr. Sobia Shaikh, Assistant Professor, School of Social Work, Memorial University of Newfoundland, and Labrador (MUNL)

You are invited to take part in a research project entitled *"*Experiences of Mental Health Counselling for Racialized People in Newfoundland and Labrador.*"*

Informed Consent: This form is part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. It also describes your right to withdraw from the study. In order to decide whether you wish to participate in this research study, you should understand enough about its risks and benefits to be able to make an informed decision. This is the informed consent process. Take time to read this carefully and to understand the information given to you. Please contact the researcher, *Camila Fujiwara*, if you have any questions about the study or for more information not included here before you consent. It is entirely up to you to decide whether to take part in this research. If you choose not to take part in this research or if you decide to withdraw from the research once it has started, there will be no negative consequences for you, now or in the future.

Purpose of Study:
As part of my master's thesis, I am conducting research under the supervision of Dr. Sobia Shaikh. By participating, you will be contributing valuable knowledge to assist the researchers in better understanding the lived realities of racialized people in Newfoundland and Labrador. The main purpose of this research is to explore the relationship between institutional forms of racism in mental health services and racialized people's experiences of navigating mental health services, specifically mental health counselling. The research question for this project is "what are the experiences of racialized individuals living in Newfoundland and Labrador when they access (or try to access) mental health counselling?"

This study has three objectives:

1. To better understand how racialized people navigate the mental health system when they access (or try to access) mental health counselling in Newfoundland and Labrador.
2. To explore whether and how racism impacts racialized people's need to access mental health counselling as well as experiences of accessing such supports.
3. To add to social work and other professional knowledge about institutional racism in mental health services.

What you will do in this study:
You will be asked to participate in a 60–90-minute interview session via Webex which will be audio-recorded and then transcribed using a software called Trint. I will also be taking handwritten notes during the interview. The goal of the interview will be to gain insight into the experiences and impact of navigating and accessing mental health counselling in Newfoundland and Labrador. You will be asked questions around your social supports, your reasons for seeking counselling, your experiences of accessing counselling, the impact, and future supports and recommendations. You may skip any questions that you do not wish to answer during the interview, and/or choose to alter or discard any of your responses to the interview questions upon review of your transcript. Following the initial interview, you will be asked to participate in a 30-minute follow-up interview to review your audio transcription. The full transcription of this interview will be provided to only you, for your verification and approval.

Length of time:
For this study you will be asked to:

- Participate in a 60-to-90-minute audio-recorded interview via Webex about your experiences of accessing mental health counselling and how that has impacted you. Hand-written notes will also be taken. You will also be asked to complete a short optional demographic survey.
- Participate in a 30-minute follow-up interview to clarify the findings of the initial interview and to review your audio transcription.

Withdrawal from the study:
As part of the ongoing consent process, you have the right to withdraw at any point in the interview process. This includes before, during and after the interview. Ongoing consent means that you are able to ask questions at any point in the research process and are able to withdraw from the study up to one-month after the 30-minute follow-up interview. Ongoing consent also means that you can refuse to answer any questions asked of you if you feel uncomfortable. One-month after your follow-up interview, the information that you share will begin to be integrated into the study's data analysis, and it may be difficult to take your information out of this analysis. You will have an opportunity to ask questions about the study, and request any changes to the information you shared, during our 30-minute follow up to review the audio transcription.
In the event you withdraw from the study, all associated data collected will be immediately destroyed wherever possible. All electronic data (recordings, transcripts, participant codes, journal

notes, memos, and documents provided during the interview process) associated with your involvement in this study will be deleted, and all hardcopy material will be shredded and disposed of.
Your decision to stop participating, or to refuse to answer certain questions, will not affect your relationship with the researchers, Memorial University, or any other group associated with this project.

Possible benefits:
By participating, you will be contributing valuable knowledge to assist the researchers in better understanding the lived realities of racialized people in Newfoundland and Labrador. The research will offer an opportunity to reflect on your experiences in a way that is validating and where you feel heard. You will also help shed light on the impacts of racism on one's mental health and how racism might impact the experiences of counselling. Lastly, this research will add to social work and other professional knowledge and provide guidance on next steps forward. At community and organizational levels, this proposed research can produce practice, policy and advocacy recommendations for service providers that support service recipients that are racialized. The research will also allow organizations to be more reflexive of how they might better support antiracist organizational change.

Possible risks:
As a practicing social worker, I have extensive experience supporting people through difficult conversations about racism and mental health. I will provide all participants with a list of resources and community referrals, including confidential mental health phone lines.
During the interview, you may experience discomfort as you will be asked to share your experiences of accessing mental health counselling and possible experiences of racism. Please let me know if you are uncomfortable or need additional support during or after the interview. You can stop participating in the interview at any time, for any reason, if you so decide. You may ask me to stop the audio recording at any point in the interview. If you require any additional emotional or counselling supports, I will provide all participants with a list of resources and community referrals that you can avail of on your own accord.

Confidentiality
Confidentiality is ensuring that identities of participants are accessible only to those authorized to have access. Your identity and mental health services you accessed will be confidential and all data will be anonymized. I (Camila Fujiwara) have ownership of the data. I will be the only person collecting the research data as well as be the only person to have full access of this data. My thesis supervisor (Dr. Shaikh) will have access to some transcriptions (as needed) but only after all identifying information have been erased and replaced with pseudonyms.
The interview will be audio–recorded and handwritten notes will also be taken. Because WebEx is a video conferencing platform, if you do not wish to be video-recorded, you will need to turn

off your camera during the interview. If you do not consent to being audio-recorded, I will ask for your consent for me to take just hand-written notes during the interview.

You may ask the interviewer to stop the audio-recording at any time. You may consult the video conferencing platform's (Webex) privacy statement at https://www.cisco.com/c/en_ca/about/legal/privacy-full.html. All handwritten notes will be transcribed into electronic format, and you will be provided with a copy to review. All identifying information will be removed during the time of audio transcription. Research data will be anonymized and then coded (removing direct identifiers from the relevant data and replaced with a code). The code key will be stored in a password-protected folder (only accessible to the PI) and kept separately from the participant interview data.
In some very particular cases, there are limits to confidentiality, and I may have a duty to report this information to the proper authorities. This situation may happen if you disclose information indicating that someone is at imminent risk of being harmed (particularly vulnerable populations such a child under the age of 16), as well as information indicating imminent threat of harm to yourself. In these cases, I will alert you that I will have a duty to report and will try my best to make this process as collaborative as possible.

Anonymity:
Anonymity refers to not disclosing participant's identifying characteristics, such as name or description of physical appearance. There may be limits to participant anonymity, particularly if a research participant chooses to tell someone about their participation with the study. In some provinces, in NL specifically, racialized communities are well-connected and in some cases, anonymity may be difficult to achieve. Therefore, there is the risk that you may be identifiable to some informed readers in the findings due to the relatively small and specific target population of this study, particularly if you agree to the use of direct quotes.
Because Dr. Sobia Shaikh and I are both members of the racialized community in NL, there is a possibility that we know each other in other settings. As a practicing social worker, I will not interview any person who has been or is a current client of hers. Dr. Shaikh is a community leader and public figure. She will not have any direct involvement with participants (e.g., recruitment, interviewing), and will only have access to transcripts after they have been anonymized. However, there are potential limits to anonymity in cases where there is a pre-existing relationship. If you have any concerns, about anonymity or confidentiality, please let me know as soon as you can during, before or after the interview.
During the individual interviews, all research participants will be reminded of the importance of maintaining confidentiality and will be assured that if individuals are named, I will assign pseudonyms at the time of transcription. In addition, I will make all efforts to ensure that individuals will not be identified in final publications and presentations. Your interview and transcript (will be anonymized by removing identifying information and replaced with pseudonyms) and confidential, and you will have the opportunity to ask for changes in your transcript, should you feel that you may be affected adversely in any way. The data analysis will

be presented in aggregate form during research dissemination. Specifically, although each interview will be analyzed individually, the purpose of the research is to understand the overall themes presented within and across all interviews. Any quotes that are used to elaborate on these themes will be used without identifying information.

Recording of Data:

This study will include a 60-to-90-minute audio recorded interview via Webex. The second interview (30-minute follow-up interview) will also be recorded for record-keeping purposes. You may consult the video conferencing platform's (Webex) privacy statement at https://www.cisco.com/c/en_ca/about/legal/privacy-full.html. All audio recordings will be transcribed into electronic format using a transcription software called Trint, and you will be provided with a copy to review.

Storage of Data:

I (Camila Fujiwara) will have ownership of the data. I will be the only person collecting the research data as well as be the only person to have full access of this data. My thesis supervisor (Dr. Shaikh) will have access to some transcriptions (as needed) but only after all identifying information have been erased and replaced with pseudonyms.

Research data will be anonymized and then coded (removing direct identifiers from the relevant data and replaced with a code). The code key will be stored in a password-protected file (only accessible to the PI) and kept separately from the participant interview data. After the study is completed, the code key will be kept for 10 years then destroyed with the rest of the electronic data.

During the study, all hard copy data (such as consent forms, reflexive journal entries) will be digitized immediately. Hard copies of research data will be stored in a locked cabinet. Electronic data will be stored in a password protected folder on a secure and password protected computer used for research purposes by the PI. Furthermore, any hard copy data that includes identifying information (such as signed consent forms) will be stored separately from any participant interview data.

Electronic data will be backed up using a password protected USB stick. This USB stick will be stored in a separate locked cabinet. Once the study is completed, the USB stick will be destroyed. Once the study is complete, all hard-copy data (consent forms, reflexive journal notes, etc.) as well as the USB stick will be destroyed. Electronic data will be stored in a password protected folder on a secure and password protected computer. All data will be stored for a minimum of five years, as required by Memorial University policy on Integrity in Scholarly Research. After ten years, all electronic data will be erased and destroyed, and the hard drive will be reformatted (if still usable, to be reused).

Reporting of Results:

The data collected will be used to produce a thesis and has the possibility of being used for journal articles and conference presentations. The completed thesis will be publicly available on

Memorial University's QE II Library database at http://collections.mun.ca/cdm/search/collection/theses The data analysis will be presented in aggregate form during research dissemination. Specifically, although each interview will be analyzed individually, the purpose of the research is to understand the overall themes presented within and across all interviews. Any quotes that are used to elaborate on these themes will be used without identifying information.

Sharing of Results with Participants:
Participants will be asked to review their transcriptions to ensure that any possibility of identification or breach to anonymity is reduced. Each participant will be sent a thank you email and notified when my final thesis publication is publicly available. As well, any publications that are publicly available through open sources will be accessible on my academia.edu page.

Questions:
You are welcome to ask questions at any time during your participation in this research. If you would like more information about this study, please contact: Camila Fujiwara by email at cfujiwara@mun.ca or by phone at 709-500-4300. You may also contact my thesis supervisor, Dr. Sobia Shaikh at sshaikh@mun.ca or by phone at 709-864-7516
The proposal for this research has been reviewed by the Interdisciplinary Committee on Ethics in Human Research and found to be in compliance with Memorial University's ethics policy. If you have ethical concerns about the research, such as the way you have been treated or your rights as a participant, you may contact the Chairperson of the ICEHR at icehr@mun.ca or by telephone at 709-864-2861.

Consent:
Your signature on this form means that:

- You have read the information about the research.
- You have been able to ask questions about this study.
- You are satisfied with the answers to all your questions.
- You understand what the study is about and what you will be doing.
- You understand that you are free to withdraw from the study without having to give a reason and that doing so will not affect you now or in the future.
- You understand that any data collected from you up to the point of your withdrawal will be destroyed.

If you sign this form, you do not give up your legal rights and do not release the researchers from their professional responsibilities.

Your signature: (*replace italicized text as these are examples*)

I have read what this study is about and understood the risks and benefits. I have had adequate time to think about this and had the opportunity to ask questions and my questions have been answered. ☐

I agree to participate in the research project understanding the risks and contributions of my participation, that my participation is voluntary, and that I may end my participation. ☐

I agree to be audio-recorded during the interview via WebEx ☐ Yes ☐ No

I agree to the use of quotations. ☐ Yes ☐ No

A copy of this Informed Consent Form has been given to me for my records.

I _____*(participant's name),* consent to participate in the "Experiences of Mental Health Counselling for Racialized People in Newfoundland and Labrador" study conducted by Camila Fujiwara. I have understood the nature of this project and wish to participate. I am not waiving any of my legal rights by signing this form. My signature below indicates my consent.

_____ _____

Signature of participant Date

Researcher's Signature:

I have explained this study to the best of my ability. I invited questions and gave answers. I believe that the participant fully understands what is involved in being in the study, any potential risks of the study and that he or she has freely chosen to be in the study.

_____ _____

Signature of Principal Investigator Date

Appendix G – Community Supports

Help Lines:

1. Mental Health Crisis Line, Local: (709) 737-4668, Toll Free: 1-888-737-4668
   The Mental Health Crisis Line is a free, confidential service for individuals, family, and friends. The crisis line is province-wide, 24 hours a day.

2. CHANNAL Warm Line, Local: (709) 753-2560, Toll Free: 1-855-753-2560
   A peer-based non-emergency support line operated by people with lived experiences. Open from 11:00 am – 11:00 pm.

3. Kids Help Phone, Phone: 1-800-668-6868
   Confidential and anonymous, 24/7 phone line offers professional counselling. For ages 5-29.

4. Crisis Text Line, Text "Talk" to 686868
   Connect with a Crisis Responder who is a trained volunteer. Available 24/7

Low-Barrier Counselling Services in St. John's, NL

1. CHANNAL Peer Support Centre, (709) 753-7710, Address: 70 The Boulevard, St. John's.
   Community agency led by people who live with mental illness/mental health issues. CHANNAL offers one on one peer support, group peer support and public education and training. Open Tuesday - Friday from 10:00 am - 4:00 pm.

2. Doorways Walk-in Clinic, (709) 752-4903
   One session at a time" counselling, walk-in service available.

3. St. John's Women's Centre, (709) 753-0220, Address: 170 Cashin Avenue Extension, St. John's.
   Right Here, Right Now Counselling, single session therapy to women and non-binary people. Drop-In available Tuesdays and Wednesdays 12:00 pm – 5:30 pm.

4. Jacob Puddister Foundation, (709) 689-3452, Address: 65 Lemarchant Rd
   Free Counselling for Youth ages 12-35, 10 free sessions of therapy with the same counsellor

Appendix H – Interdisciplinary Committee on Ethics in Human Research (ICEHR)

Approval Letter and Extension

MEMORIAL UNIVERSITY

Interdisciplinary Committee on
Ethics in Human Research (ICEHR)

St. John's, NL Canada A1C 5S7
Tel: 709 864-2561 icehr@mun.ca
www.mun.ca/research/ethics/humans/icehr

ICEHR Number:	**20222831-SW**
Approval Period:	May 10, 2022 – May 31, 2023
Funding Source:	
Responsible Faculty:	Dr. Sobia Shaikh School of Social Work
Title of Project:	*Navigating mental health counselling for racialized people in St John's, NL*

May 10, 2022

Ms. Camila Fujiwara
School of Social Work
Memorial University

Dear Ms. Fujiwara:

Thank you for your correspondence addressing the issues raised by the Interdisciplinary Committee on Ethics in Human Research (ICEHR) for the above-named research project. ICEHR has re-examined the proposal with the clarifications and revisions submitted, and is satisfied that the concerns raised by the Committee have been adequately addressed. In accordance with the *Tri-Council Policy Statement on Ethical Conduct for Research Involving Humans (TCPS2)*, the project has been granted *full ethics clearance* for **one year**. ICEHR approval applies to the ethical acceptability of the research, as per Article 6.3 of the *TCPS2*. Researchers are responsible for adherence to any other relevant University policies and/or funded or non-funded agreements that may be associated with the project. If funding is obtained subsequent to ethics approval, you must submit a Funding and/or Partner Change Request to ICEHR so that this ethics clearance can be linked to your award.

The *TCPS2* **requires** that you **strictly adhere to the protocol and documents as last reviewed** by ICEHR. If you need to make additions and/or modifications, you must submit an Amendment Request with a description of these changes, for the Committee's review of potential ethical concerns, before they may be implemented. Submit a Personnel Change Form to add or remove project team members and/or research staff. Also, to inform ICEHR of any unanticipated occurrences, an Adverse Event Report must be submitted with an indication of how the unexpected event may affect the continuation of the project.

The *TCPS2* **requires** that you submit an Annual Update to ICEHR before **May 31, 2023**. If you plan to continue the project, you need to request renewal of your ethics clearance and include a brief summary on the progress of your research. When the project no longer involves contact with human participants, is completed and/or terminated, you are required to provide an annual update with a brief final summary and your file will be closed. All post-approval ICEHR event forms noted above must be submitted by selecting the ***Applications: Post-Review*** link on your Researcher Portal homepage. We wish you success with your research.

Yours sincerely,

James R. Drover

James Drover, Ph.D.
Vice-Chair, ICEHR

JD/bc

cc: Supervisor – Dr. Sobia Shaikh, School of Social Work

Fujiwara, Kamira <cfujiwara@mun.ca>

ICEHR Clearance # 20222831-SW – EXTENDED

1 message

dgulliver@mun.ca <dgulliver@mun.ca> Tue, May 9, 2023 at 5:56 AM
To: "Fujiwara Camila(Principal Investigator)" <cfujiwara@mun.ca>
Cc: "Shaikh Sobia Shaheen(Supervisor)" <sshaikh@mun.ca>, dgulliver@mun.ca

MEMORIAL UNIVERSITY
Interdisciplinary Committee on
Ethics in Human Research (ICEHR)

ICEHR Approval #:	20222831-SW
Researcher Portal File #:	20222831
Project Title:	*Navigating mental health counselling for racialized people in St John's, NL*
Associated Funding:	Not Funded
Supervisor:	Dr. Sobia Shaheen Shaikh
Clearance expiry date:	**May 31, 2024**

Dear Ms. Camila Fujiwara:

Thank you for your response to our request for an annual update advising that your project will continue without any changes that would affect ethical relations with human participants.

On behalf of the Chair of ICEHR, I wish to advise that the ethics clearance for this project has been extended to **May 31, 2024**. The *Tri-Council Policy Statement on Ethical Conduct for Research Involving Humans* (TCPS2) requires that you submit another annual update to ICEHR on your project prior to this date.

We wish you well with the continuation of your research.

Sincerely,

DEBBY GULLIVER
Interdisciplinary Committee on Ethics in Human Research (ICEHR)
Memorial University of Newfoundland
St. John's, NL | A1C 5S7
Bruneau Centre for Research and Innovation | Room IIC 2010C
T: (709) 864-2561 |
www.mun.ca/research/ethics/humans/icehr | https://rpresources.mun.ca/